

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP  
CLINICIAN WORKGROUP

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WEDNESDAY  
DECEMBER 9, 2015

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Bruce Bagley and Eric Whitacre, Co-Chairs, presiding.

PRESENT:

BRUCE BAGLEY, MD, Co-Chair  
ERIC WHITACRE, MD, FACS, Co-Chair  
TERRY ADIRIM, MD, MPH, FAAP, American Academy of Pediatrics\*  
BETH AVERBECK, MD, Minnesota Community Measurement  
MADY CHALK, PhD, MSW, Treatment Research Institute  
LUTHER T. CLARK, MD, Individual Subject Matter Expert  
STEPHEN FRIEDHOFF, MD, Anthem  
SCOTT FRIEDMAN, MD, American Academy of Ophthalmology  
SCOTT FURNEY, MD, FACP, Carolina's HealthCare System  
LINDA GILLAM, MD, MPH, American College of Cardiology  
STEPHANIE GLIER, MPH, Pacific Business Group on Health  
RACHEL GROB, PhD, Center for Patient Partnerships

KATE KOPLAN, MD, MPH, Kaiser Permanente\*  
ROBERT KRUGHOFF, JD, Consumers' CHECKBOOK  
BARB LANDRETH, RN, MBA, St. Louis Area Business  
Health Coalition  
AMY MOYER, The Alliance  
MARCI NIELSEN, PhD, MPH, Patient-Centered  
Primary Care Collaborative  
JANIS ORLOWSKI, MD, Association of American  
Medical Colleges  
JAMES PACALA, MD, MS, National Center for  
Interprofessional Practice and Education  
  
DIANE PADDEN, PhD, CRNP, FAANP, American  
Association of Nurse Practitioners  
  
CYNTHIA PELLEGRINI, March of Dimes  
  
DAVID J. SEIDENWURM, MD, American College of  
Radiology  
  
WINFRED WU, MD, MPH, Primary Care Information  
Project  
  
GIRMA ALEMU, MD, MPH, Health Resources and  
Services Administration (non-voting)  
  
PETER BRISS, MD, MPH, Centers for Disease  
Control and Prevention (non-voting)  
  
KATE GOODRICH, MD, Centers for Medicare &  
Medicaid Services (non-voting)

NQF STAFF:

CHRISTINE CASSEL, MD, President and CEO  
HELEN BURSTIN, MD, MPH, FACP, Chief Scientific  
Officer  
ANN HAMMERSMITH, JD, General Counsel  
ELISA MUNTHALI, MPH, Vice President, Quality  
Management  
MARCIA WILSON, Senior Vice President, Quality  
Measurement  
POONAM BAL, Project Manager  
SEVERA CHAVEZ, Project Analyst  
ANDREW LYZENGA, Senior Project Manager  
REVA WINKLER, MD, PhD, Senior Director

ALSO PRESENT:

SOPHIA AUTREY, CMS  
DAN BAROCAS, MD, Vanderbilt University\*  
CHRISTOPHER BEADLES, MD, RTI International\*  
  
SEPHEEN BYRON, MHS, NCQA  
  
STEPHANIE CARTER, American Academy of Dermatology  
  
ALYSSA CRAWFORD, Mathematica Policy Research  
  
REBECCA HANCOCK, American Academy of  
Ophthalmology  
  
ALESIA HOVATTER, CMS (Physician Compare)  
  
RABIA KHAN, MPH, CMS (MSSP)\*  
  
MOLLY MACHARRIS, CMS (MIPS)  
  
KORYN RUBIN, American Medical Association

\* present by teleconference

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

2 9:00 a.m.

3 DR. WINKLER: Good morning everyone.

4 To get us started this morning, it's  
5 my pleasure to introduce NQF's President and CEO,  
6 Dr. Chris Cassel.

7 DR. CASSEL: Beautiful, Reva, thank  
8 you.

9 So, I'm going to keep this short and  
10 sweet because I know you have a very busy day  
11 ahead of you.

12 And, I first want to thank Bruce and  
13 Eric for co-chairing this really important  
14 component of MAP and important part, actually, of  
15 American health care.

16 And, to welcome you all to the  
17 National Qualify Forum, particularly those of you  
18 who have not been part of an NQF committee  
19 before. I think, as I look around the room, I  
20 think most of you have.

21 But, I also particularly want to thank  
22 Reva and the just amazing NQF staff who get this

1 task every year. Some people refer to this time  
2 of year as holiday season. Here at NQF, we refer  
3 to it as MAP season.

4 And so, it's a very intense period of  
5 very, very important work and none of it could  
6 happen without the excellent staff that we have.

7 So, I also -- none of it could happen  
8 without you, without the input and careful work  
9 and deliberation of these committees. So, we  
10 really appreciate you taking the time to provide  
11 this valuable input from all the different  
12 stakeholder perspectives.

13 Eric was just commenting about what an  
14 unusual dialogue this is for most of us in health  
15 care who go to meetings of doctors or hospitals  
16 or health plans or consumer groups.

17 And, this is the only place, really,  
18 where all of those perspectives come together  
19 around one table and really commit to the serious  
20 work of consensus building which is not easy, and  
21 yet, vitally, vitally important.

22 Last year, the staff, I want to call

1 out our staff developed a more streamlined and  
2 manageable process for the MAP work that you're  
3 doing. And, we got rave reviews from the  
4 committee for the much better way the materials  
5 were brought together, the background was  
6 presented, et cetera.

7 And, I think you'll find this year  
8 that that has even improved more. So, we really  
9 -- but, we always like health care, like  
10 everything else, we can always improve. So, we  
11 welcome your input and feedback.

12 So, let me just say that something  
13 that you all know which is this is particularly  
14 this year a challenging and important time for  
15 clinician quality measurement. That's perhaps  
16 evidenced by the more than 200 public comments  
17 that we got just on this issue alone, over 550  
18 overall in MAP which is a significant increase  
19 from last year and the year before.

20 So, increasingly, more and more people  
21 are paying attention and offering their input.

22 And, of course, this year, we have a

1 whole new set of really important work in helping  
2 CMS to meet the goals of the MACRA legislation  
3 and, in particular, the Merit-Based Incentive  
4 Payment System, or the MIPS, to consolidate a  
5 line and strengthen the clinician incentive  
6 programs and the measures that are used there.

7 So, you are playing actually a very  
8 important part to help this program meet those  
9 goals.

10 And, with that, I think I'm just going  
11 to stop and let the work begin.

12 Thank you.

13 CO-CHAIR BAGLEY: I think, Ann, you're  
14 next.

15 MS. HAMMERSMITH: Thank you.

16 For those of you who have served on  
17 MAP committees before, what I'm going to say is  
18 familiar to you, but I always like to remind  
19 everyone before you do the oral disclosures.

20 The MAP disclosures are done in two  
21 steps because we have subject matter experts who  
22 sit on the committee and we have organizational



1 members. This group is -- primarily consists of  
2 organizational members.

3 That disclosure is very simple and you  
4 got a form from us that is so short, you may not  
5 remember it.

6 So, we'll start with the  
7 organizational member disclosures, because those  
8 are the simplest. If you're on the phone, I will  
9 call on you.

10 Just to remind you, the only thing  
11 that you need to disclose if you're an  
12 organizational member is if you have an interest  
13 of \$10,000.00 or more that is relevant to the  
14 work of this committee. That's the only  
15 disclosure you have to make.

16 The \$10,000.00 or more is personal to  
17 you, not your spouse, not your children, not your  
18 parents, just you.

19 So, I'll remind you of who the subject  
20 matter experts are. Your Chair, Bruce Bagley,  
21 and your Vice Chair, Eric Whitacre, are both  
22 subject matter experts. And, Luther Clark and

1 Constance Dahlin, or Dahlin, are subject matter  
2 experts.

3 So, with that, I'm just looking around  
4 the table, start with Beth Averbeck. Tell us who  
5 you're with and if you have anything to disclose.

6 MEMBER AVERBECK: Beth Averbeck with  
7 Minnesota Community Measurement, nothing to  
8 disclose.

9 Thank you.

10 MEMBER MOYER: Amy Moyer with The  
11 Alliance and I have nothing to disclose.

12 DR. CLARK: Luther Clark.

13 MS. HAMMERSMITH: You're a subject  
14 matter expert.

15 DR. CLARK: Oh, sorry, okay.

16 MEMBER PADDEN: Good morning. Diane  
17 Padden, American Association of Nurse  
18 Practitioners and I have nothing to disclose.

19 MEMBER GROB: Hi, I'm Rachel Grob with  
20 the Center for Patient Partnerships at the  
21 University of Wisconsin Madison. I have nothing  
22 to disclose.

1                   MEMBER FRIEDMAN: Good morning. Scott  
2                   Friedman, American Academy of Ophthalmology. I  
3                   have nothing to disclose.

4                   MEMBER WU: Winfred Wu from the  
5                   Primary Care Information Project and I have  
6                   nothing to disclose.

7                   MEMBER ORLOWSKI: Good morning. Janis  
8                   Orlowski with the Association of American Medical  
9                   Colleges. I have nothing to disclose.

10                  MEMBER NIELSEN: Marci Nielsen with  
11                  the Patient-Centered Primary Care Collaborative  
12                  and I have nothing to disclose.

13                  MEMBER KRUGHOFF: Robert Krughoff,  
14                  Consumer's CHECKBOOK Center for the Study of  
15                  Services. I have nothing to disclose.

16                  MS. HAMMERSMITH: Peter, we'll have  
17                  you introduce yourself later.

18                  DR. CHALK: I'm Mady Chalk from  
19                  Treatment Research Institute. I'm representing  
20                  the Duals Work Group here as a liaison. Nothing  
21                  to disclose.

22                  MEMBER GILLAM: Linda Gillam

1 representing the American College of Cardiology  
2 and I have nothing to disclose.

3 MEMBER GLIER: Stephanie Glier with  
4 the Pacific Business Group on Health. I have  
5 nothing to disclose.

6 MEMBER FURNEY: Scott Furney with  
7 Carolina's HealthCare System. I have nothing to  
8 disclose.

9 MEMBER SEIDENWURM: David Seidenwurm,  
10 American College of Radiology. I have a  
11 consulting contract with The Alliance for  
12 Radiology Quality that's a conflict, potentially.

13 MEMBER LANDRETH: Barb Landreth with  
14 the St. Louis Area Business Health Coalition. I  
15 have nothing to disclose.

16 MEMBER FRIEDHOFF: Steven Friedhoff  
17 representing Anthem. I have nothing to disclose.

18 MEMBER PACALA: Jim Pacala  
19 representing the National Center for  
20 Interprofessional Education and Collaborative  
21 Practice. I have nothing to disclose.

22 MS. HAMMERSMITH: Okay, thank you.

1 Is Kate Koplan on the phone?

2 MEMBER KOPLAN: Yes, this is Kate  
3 Koplan, actually, and I'm representing Kaiser  
4 Permanente. I'm from the Georgia Region and I  
5 have nothing to disclose.

6 MS. HAMMERSMITH: Thank you.

7 Now, we'll move on to the subject  
8 matter experts who got a much longer form.

9 MEMBER ADIRIM: Wait, wait. This is  
10 Terry Adirim from the American Academy of  
11 Pediatrics.

12 MS. HAMMERSMITH: Oh, okay.

13 MEMBER ADIRIM: Sorry about that. I  
14 have nothing to disclose.

15 MS. HAMMERSMITH: Thanks, Terry.

16 So, we'll go on to the subject matter  
17 experts. The subject matter experts sit as  
18 individuals, unlike those of you who just  
19 disclosed.

20 Many of you said your name and said  
21 I'm here representing such and such organization  
22 which is exactly what you are doing.

1           So, with organizational members, we  
2       expect you to bring a certain point of view to  
3       the table, that's why you're on this committee.

4           Subject matter experts are not  
5       representing their employer, anyone who may have  
6       nominated you, any professional society with  
7       which you're associated. You're sitting as an  
8       expert, as an individual.

9           Because of that, we ask you for a more  
10      detailed disclosure akin to what we do for  
11      standing committees and the CSAC.

12          So, we are looking for you to disclose  
13      anything that you think is relevant to the work  
14      of this committee. Please don't summarize your  
15      resume. We're particularly interested in  
16      consulting, speaking, grants, research that you  
17      may have.

18          So, with that, I'll start with the  
19      Chair and Co-chair.

20          CO-CHAIR BAGLEY: Good morning. I'm  
21      Bruce Bagley and I come with a boatload of biases  
22      but no conflicts. But, let me tell you about a

1 couple of things that I do.

2 I am on the NCQA CPM Committee which  
3 oversees the HEDIS measures, so that certainly is  
4 something you should know about. It's obviously  
5 it's not a paid position.

6 I'm also on the Board of Directors of  
7 HCI3 with oversees both the PROMETHEUS Payment  
8 System and Bridges to Excellence. And, that also  
9 is a volunteer position.

10 In addition to that, I serve as a  
11 Senior Consultant to the AMA, but not anything to  
12 do with their financial, you know, revenue type  
13 things.

14 And, I also work with the American  
15 Association of Physician Leadership which does  
16 not really deal with this type thing.

17 Thank you.

18 CO-CHAIR WHITACRE: My name is Eric  
19 Whitacre. I'm a surgeon in private practice in  
20 Tucson, Arizona. I have no conflicts, but I  
21 should disclose that I am a member both of the  
22 American College of Surgeons as well as the

1 American Society of Breast Surgeons.

2 Have been on a number of committees  
3 and I'm currently on the Coding and Reimbursement  
4 Committee at the American College of Surgeons as  
5 well as the Performance Measures Committee of the  
6 College of Surgeons.

7 I've also been on the Board of the  
8 American Society of Breast Surgeons and represent  
9 that society at the AMA RUC.

10 DR. CLARK: Good morning. I'm Luther  
11 Clark. I'm the Global Director for Scientific,  
12 Medical and Patient Perspective in the Office of  
13 the Chief Medical Officer at Merck  
14 Pharmaceuticals. Other than that, I have no  
15 conflicts.

16 MS. HAMMERSMITH: Thank you.

17 Is Constance Dahlin on the phone?  
18 Constance Dahlin?

19 Okay, and finally, we'll ask our  
20 Federal Representatives to introduce themselves.

21 So, Kate?

22 DR. BRISS: I'm Peter Briss, I'm with



1 the Centers for Disease Control and Prevention  
2 and I have nothing to disclose.

3 DR. GOODRICH: I'm Kate Goodrich with  
4 CMS, nothing to disclose.

5 MS. HAMMERSMITH: I can't see all of  
6 you. Oh, yes.

7 DR. ALEMU: Girma Alemu with HRSA. I  
8 have nothing to disclose.

9 MS. HAMMERSMITH: Okay. Thank you for  
10 making those disclosures.

11 Do you have anything you would like to  
12 discuss with each other or questions for me?

13 Okay. And, just a final reminder, if,  
14 during the meeting, you think you have a  
15 conflict, you think someone else has a conflict,  
16 if you think someone is behaving in a biased  
17 manner, please speak up in real time.

18 We want to know that. We rely on you  
19 to let us know. If you are not comfortable  
20 bringing it up openly in the meeting, please  
21 approach your co-chairs who will work with NQF  
22 staff or you can approach NQF staff and we will

1 deal with it.

2 Thank you.

3 CO-CHAIR BAGLEY: A couple of  
4 housekeeping things at the start of the meeting.

5 I've already noticed microphone  
6 problems and the microphones aren't as much for  
7 us around the table as they are for the people on  
8 the phone. And, all of you have been on a phone  
9 call like this, right? And you know how hard it  
10 is sometimes. So, please get your mouth fairly  
11 close to the microphone, make sure the red light  
12 is going and I think we'll do better.

13 The other thing I want to talk about  
14 is these cards. It helps me if you would kind of  
15 turn them this way so I can see them. And, I  
16 know it's popular in this town to stand up your  
17 card when you want to talk. We're not going to  
18 do that this way because that doesn't work very  
19 well for us.

20 And, if you just catch our eye, we'll  
21 get your name on a list and we'll get you up.  
22 And, if it looks like we don't have your eye, try

1       it again and I'll read off the list of 39 people  
2       that are before you and then you'll know that  
3       you're still on the list.

4               But, I think we can make that work a  
5       little bit better than this business because  
6       people drop them off the table and forget to put  
7       them down and then who knows which one went up  
8       first and all that kind of stuff.

9               So, I think it just works better,  
10       certainly for us.

11               So, with that, I think we probably  
12       should start with the opening.

13               Eric, did you have anything else that  
14       you wanted to say at the outset?

15               CO-CHAIR WHITACRE: Only to add, if  
16       it's okay with everyone, if we can be on a first  
17       name basis, if that works. We've done that  
18       previously and that's no disrespect, it's just a  
19       small group and we're going to roll up our  
20       sleeves and get into it.

21               CO-CHAIR BAGLEY: Okay. Kate, you're  
22       at the top of the agenda here. Help us out.

1 DR. GOODRICH: Okay, thanks.

2 So, I wanted to take a moment to talk  
3 a little bit through a few things including sort  
4 of the process related to how we -- and, I know  
5 on previous calls, you've heard the measures  
6 under consideration process, so I'm just going to  
7 touch on that very briefly.

8 A little bit about from more of a  
9 process standpoint, our approach to MIPS because  
10 that's really the big program we're going to be  
11 mostly focused on for the next two days. We'll  
12 also be talking about the Medicare Shared Savings  
13 Program.

14 And then, what I see as, and what CMS  
15 sees as, the role of the MAP in helping us  
16 develop our policies and selecting measures for  
17 that program.

18 So, a little bit first, this is going  
19 to be a little bit more MIPS focused because I  
20 know that's what we're really -- the program  
21 we're all thinking about for the most part for  
22 the next couple of days.

1                   So, obviously, the MACRA legislation  
2                   passed on I believe it was April 16th of this  
3                   year. Since that time, we've put out a Request  
4                   for Information. Thank you to those of you who  
5                   personally or your organizations responded to us.  
6                   We got a lot of comments on that that have been  
7                   very helpful to us.

8                   We did solicit comments specifically  
9                   on measurement and received quite a bit of input  
10                  on not only so much specific measures but  
11                  measurement policy. So, I think that's been very  
12                  helpful.

13                  We are in the process and have been in  
14                  the process for several months now of designing  
15                  the initial policies and standing up the  
16                  operational tactical approaches to the MIPS  
17                  program.

18                  We anticipate that we'll have a  
19                  proposed regulation. Our goal is to get it by  
20                  the end of March. We hope to do that. We'll see  
21                  how that goes.

22                  And, the reason for that and instead

1 of putting it in the Physician Fee Schedule Rule,  
2 was really to give people more time to comment.  
3 We know there's a great deal of interest  
4 nationally from all stakeholders in this program.

5 And, we felt like with the Physician  
6 Fee Schedule Rule which comes out July 1st and is  
7 finalized in November, that that may not be  
8 enough time. And, quite frankly, it would put a  
9 lot of pressure on us to get the final rule out  
10 in time given that it's going to be a pretty  
11 large rule for a brand new program.

12 We also have to set the parameters for  
13 alternative payment models, eligible alternative  
14 payment models. So, a lot of work's going to go  
15 into it.

16 So, we're hoping to finalize it  
17 sometime in, you know, if we can, September or  
18 October. But, that will give folks, I think,  
19 more time to be able to comment on it.

20 So, just sort of that sort of a time  
21 line that we're looking at now.

22 You know, with the law passing in

1 April, you know, as regards to the measures, it  
2 does say in the legislation that we should use  
3 the measures that are in existing programs, at  
4 least to begin.

5 But, it also requires that CMS develop  
6 a measure development plan or strategy and that  
7 we seek comment on that to inform measure  
8 development that we would actually do ourselves  
9 or measures that we would want to use and that  
10 are most appropriate for the MIPS program and  
11 also for alternative payment models.

12 So, that measure development plan  
13 which many of you, by the way, already have given  
14 us some input on what should be in there, is to  
15 be -- by law, has to be posted for comment by  
16 January 1st and we are on track to do that.

17 It will actually not be in the Federal  
18 Register, it'll be on our website, so we will  
19 send out links to our LISTSERVs including NQF so  
20 that they can also send it to partner  
21 organizations. And, we definitely want your  
22 comment on that.

1                   And, we have to finalize the plan, I  
2 believe it's by May. And we have to do this  
3 every year.

4                   So, you know, MACRA outlines some  
5 parameters for us for the types of measures that  
6 should be in the MIPS program. It's very clear  
7 about the direction of measurement for the MIPS  
8 program.

9                   And, I'll be honest, I think that, you  
10 know, at least at the high level parameters that  
11 are outlined that they got it right.

12                  There's a focus on outcome measures,  
13 focus on patient reported outcome measures,  
14 appropriate use, patient safety, care  
15 coordination which, you know, as you all know  
16 from having sat around this table and in the  
17 world that you work in, is the direction that  
18 we've been wanting to go for transformation of  
19 the health care system anyway.

20                  But, it certainly is helpful to have  
21 that defined in legislation for this program.

22                  So, obviously, our measure development



1 plan is going to be very focused on those areas.

2 But, like with everything else, the  
3 devil's in the details and how that executed.  
4 So, that's where we do think we need very, very  
5 specific input.

6 As we have been talking through the  
7 four categories of MIPS, of quality measurement,  
8 resource use measurement, meaningful use of EHRs  
9 and clinical practice and proven activities,  
10 we've been working on all four of those  
11 categories as well as, of course, scoring  
12 methodology.

13 The law also asks us to engage  
14 stakeholders early and often throughout the  
15 process. And so, we have been trying very hard  
16 to do that.

17 We've had numerous meetings with a  
18 variety of stakeholders. We actually last week  
19 had a Design LEAN session for about four days  
20 including at our National Quality Conference in  
21 Baltimore to help us think through some of the  
22 more actually operational issues around how

1 physicians interface with CMS to get feedback  
2 reports to report measures and so forth.

3 So, and that really involved many  
4 different stakeholders who were a part of that  
5 process. It wasn't just CMS folks, it was  
6 physicians, physician groups, EHR vendors,  
7 registries, lots of other folks.

8 And, we think we got amazing ideas for  
9 how to improve upon the current state.

10 So, I also think that this -- these  
11 two days and what the Coordinating Committee will  
12 do are critical for us in -- for the quality  
13 measurement and I would say also resource use  
14 measurement component of the program.

15 This is where I think we're going to  
16 be getting some of our most meaningful input.  
17 And, part of that is because of the regular MAP  
18 process that happens every year and we always get  
19 great input.

20 But, I really want us to be thinking  
21 about in the context of what MIPS is trying to do  
22 which is to set physicians up to be able to make

1 the transition into alternative payment models.

2 How do we think about measures? Do we  
3 think about measures any differently in that  
4 context? And, how does that impact how you think  
5 about what measures CMS should include in the  
6 program.

7 So, I think we should be thinking  
8 about it or that would be helpful to us to be  
9 thinking about it in that frame.

10 And then, finally, what I want to do  
11 is read for you a little bit about the principles  
12 that we have defined internally as we have been  
13 doing this work over the past several weeks.

14 When we very first started planning,  
15 which was back in the summer, we started off by  
16 saying, okay, what does success look like? What  
17 have we heard from our stakeholders isn't  
18 working? And, where do -- what is the ideal  
19 state that we want to get to?

20 We certainly think in the first few  
21 years we're going to get to a better state than  
22 where we are now. It's probably not going to be

1 the ideal state in 2017, but it's going to be  
2 better than what we have now.

3 And, it's going to look, I think,  
4 somewhat different from what we have now, which I  
5 think is a good thing.

6 So, we talked about what does success  
7 look like? And then, what are our strategic  
8 goals that we should be working towards for every  
9 policy decision that we're making? What are the  
10 goals that we have to keep in front of us at all  
11 times? And, what are the principles that are  
12 underneath those goals?

13 So, I'm just going to read for you a  
14 little bit what we sort of came up with  
15 internally in terms of our strategic goals and  
16 some of the principles that you'll have to tell  
17 me if you agree or disagree with them.

18 But, much of this is based upon  
19 feedback that we've heard from a variety of  
20 different stakeholders.

21 So, a little bit about what success  
22 looks like, just a brief mention there.

1                   So, we say that a successful MIPS  
2                   program fully equips physicians and other  
3                   clinicians with the tools and incentives to focus  
4                   relentlessly on improved care and health outcomes  
5                   for their patients.

6                   MIPS should also prepare increasing  
7                   number of clinicians over time for a successful  
8                   transition into alternative payment models that  
9                   include acceptance of some greater than nominal  
10                  risk, and to be held accountable for the health  
11                  of their patient population while having the time  
12                  and resources to engage individual patients and  
13                  families in the care that is best for them.

14                  Our strategic goals include using a  
15                  patient centered approach to program development  
16                  that leads to better, smarter and healthier care.

17                  Develop a program that is meaningful,  
18                  understandable and flexible for participating  
19                  clinicians, design incentives that drive movement  
20                  towards delivery system reform principles and  
21                  alternative payment models and ensure close  
22                  attention to excellence and implementation,

1 operational feasibility and effective  
2 communication with stakeholders.

3 And so, some of our high -- I'm not  
4 going to read all of our principles, but some of  
5 our high level principles that I think are  
6 important for this group, obviously, number one  
7 is to improve the health of patients.

8 Number two is meaningful measurement,  
9 so including measures that are meaningful to  
10 patients and clinicians together.

11 Engaging patients, caregivers and  
12 health care professionals in quality improvement.  
13 So, establishing policies that incentivize that  
14 team approach that includes the patients in  
15 improvement.

16 Driving rapid cycle quality  
17 improvement.

18 Minimizing provider burden, or as one  
19 at our LEAN session, one of the providers who was  
20 there said to me, yes, you want to minimize  
21 burden, but it shouldn't be no burden. You just  
22 want the burden to be in the right place. You

1 want the burden to be on what it takes to  
2 actually improve. And, that's exactly right.  
3 Right?

4           Balance simplicity with flexibility.  
5 I think one of the lessons we've learned from the  
6 existing program is that when we think we're  
7 providing a lot of flexibility, we actually make  
8 it more complicated. I know that's not a shock  
9 to people here. So, we're very mindful of that.

10           Advance Health IT with the focus on  
11 improved outcomes of care.

12           And then, align with the National  
13 Quality Strategy and the HHS Delivery System  
14 Reform Goals.

15           So, I think those are the main ones  
16 that I want to highlight.

17           So, I do want to be clear that these  
18 strategic goals and principles are not just words  
19 on paper. They have been right out in front of  
20 us. We talk about them a lot. We talk about  
21 whether or not the policies we're designing, the  
22 in the weeds, nitty gritty policies are actually

1 speaking to those goals and adhering to the  
2 principles. So, we're trying very hard to be  
3 true to them.

4 And so, I wanted you all to hear them  
5 so you can see where we're coming from. Let us  
6 know if you think those are the right ones, if  
7 there's you know, principles or goals that we're  
8 not thinking of as you all are giving us the  
9 input on the measures over the next couple of  
10 days.

11 So, I'll stop there. Thank you very  
12 much.

13 Or, see if anybody has questions. I  
14 don't know if we have time for that or not.

15 CO-CHAIR BAGLEY: That's great.

16 And we have a few minutes for  
17 questions. Anybody have any questions about, you  
18 know, kind of clarifying the program or what  
19 we're trying to accomplish today in terms of the  
20 MIPS?

21 Kate, nice summary.

22 You guys all know this? All right.



1 Well, you know, I had a couple of  
2 comments. You know, I think the hardest part for  
3 us, if you look through all the commentary from  
4 the staff, many of them were encourage further  
5 development. And, if that's the only thing we  
6 send to CMS, we will not have done you guys any  
7 good.

8 So, I think that the conversation  
9 ought to be around how to enrich that  
10 recommendation rather than, you know, just up or  
11 down. You know, we're not just here to do this,  
12 we're here to try to give some guidance about how  
13 that further development should go.

14 DR. GOODRICH: Yes, if I could respond  
15 to that.

16 So, that's very -- I'm glad you said  
17 that. So, you know, our measure under  
18 consideration process starts early. It started  
19 before or right around the time the legislation  
20 passed.

21 And so, we receive, in particular,  
22 from specialty societies, but other developers,

1 suggestions for measures starting in April or  
2 even March of each year.

3 And, we work with the societies  
4 throughout the year and the other developers  
5 throughout the year to give them feedback on the  
6 measures that they're considering.

7 And so, a lot of what you see in front  
8 of you on the calendar is reflective of a lot of  
9 development work that's gone on over the last  
10 couple of years by a number of specialty  
11 societies and we're very glad for that, that  
12 that's happening.

13 We're actually seeing some measures  
14 that you have on the consent calendar that are  
15 earlier in development, that are probably  
16 relatively solidified in terms of numerator,  
17 denominator, but not fully complete.

18 And, I think one thing I would like to  
19 see that would be helpful to us, but I think also  
20 helpful to the developers from the MAP is some  
21 specific strategic direction on some of those.  
22 Because, some of those absolutely, you know,

1       probably got it right, really great for the MIPS  
2       program. Some may be better with some  
3       refinements.

4               And so, that's exactly what I think  
5       would be helpful to us to hear, not just, you  
6       know, like you said, encourage continued  
7       development, but is this generally the right  
8       direction or how could it be made better?

9               What might be, you know, a  
10       modification or a slightly different direction  
11       that would be helpful for us but also helpful for  
12       the developer that would be more appropriate for  
13       the MIPS program?

14              We have a number of societies that  
15       submitted measures to us that never have before,  
16       which I think is fantastic. And so, I think, I  
17       don't want to speak for them, but I would imagine  
18       it could be helpful to hear from this, you know,  
19       august multi-stakeholder group, again, more  
20       specifics around direction, I think would be very  
21       helpful.

22              So, you're right, encourage continued

1 development has the potential to be less helpful,  
2 but I think it's what's underneath that that is  
3 much more helpful.

4 DR. CLARK: Most of the encourage  
5 continued development that, at least I saw,  
6 either they were in -- the measure was in early  
7 development or a field testing was in the process  
8 of ongoing.

9 Are we to assume that these are not  
10 yet complete at this point so that's why they're  
11 on the continuing development?

12 DR. GOODRICH: So, we require, for a  
13 measure to go on the MUC list, it to be a certain  
14 -- at a certain point in development. And, the  
15 reason we've decided to include not fully tested  
16 and developed measures on this list is because we  
17 want that direction from the MAP.

18 Is this the right direction? Should  
19 we continue to invest resources? By the way,  
20 testing is expensive, right? So, should we  
21 continue to invest resources in the testing of  
22 this measure if it's completely the wrong

1 direction?

2 So, that's why we go ahead and put  
3 those on the list. So, typically, these measures  
4 do have what I call sort of stable numerator and  
5 denominator definitions. They have been  
6 specified, the exclusions have been specified.

7 But, they may not be fully tested  
8 within an EMR system or within a registry or what  
9 have you.

10 But, we think it is incredibly helpful  
11 to understand if we're even -- we or the  
12 developer is going in the right direction in the  
13 first place.

14 CO-CHAIR BAGLEY: For instance, a  
15 couple of measures look to me like it'll be a  
16 little hard to objectify the numerator, for  
17 instance, if you see that kind of thing. Then  
18 that's the kind of comment that would be helpful.

19 You know, by what criteria are you  
20 saying it's low, moderate or high? You know, how  
21 you're doing that.

22 DR. GOODRICH: And, you know, we've

1 asked the developers whether they be one of ours  
2 or a specialty society to either be here or on  
3 the phone, if possible, when those measures are  
4 being considered because I think that sometimes  
5 it may just not be clear and having the developer  
6 clarify what the numerator is and how it would be  
7 collected would be helpful for the MAP. But,  
8 also, again, to hear your feedback. So,  
9 hopefully we have or will have people on the  
10 phone or in the room who can help answer those  
11 questions.

12 CO-CHAIR WHITACRE: There was some  
13 discussion last year about development of a  
14 testing center within CMS because one of the big  
15 issues here is once the measures are specified,  
16 as we've seen, it's getting them tested that  
17 really is the hurdle. Is that still on the  
18 table?

19 DR. GOODRICH: So, we weren't really  
20 developing a testing center. What we were  
21 talking about was something we're calling the  
22 National Testing Collaborative.

1                   And so, I think two things to say  
2                   there.

3                   So, that work is still ongoing. It  
4                   isn't fully developed yet. But, I would also  
5                   say, and this is -- I want, you know, Helen or  
6                   Chris or somebody to speak to this, you know, the  
7                   measure incubator that NQF has pulled together  
8                   and is piloting now is another important  
9                   opportunity for finding test beds for some of  
10                  these measures.

11                  We've had the NQF folks working with  
12                  us on the National Testing Collaborative so we're  
13                  not doing two separate things. But, I think  
14                  there's been a tremendous recognition by the  
15                  measurement community of a need for this.

16                  And so, I think what NQF is doing with  
17                  the incubator is going to really advance that and  
18                  we want to be able to build upon that or, you  
19                  know, if there's another niche for it within the  
20                  National Testing Collaborative, be able to do  
21                  that as well.

22                  DR. CASSEL: If I could just respond.

1           If people are not familiar with the  
2           measure incubator, this is a piece of work that  
3           has been ongoing for the last couple of years and  
4           now, really is coming to fruition.

5           Where NQF is not a measure developer  
6           but facilitates bringing together the people with  
7           the concept, the people with the data, the people  
8           with the resources to try to test.

9           We have this hypothesis that the  
10          process could be more efficient and you could get  
11          more rapid testing and maybe even, we hope, less  
12          costly. So, we'll see if that works out.

13          We're in the proof of concept phase  
14          and a couple of these, we had -- there was an  
15          announcement yesterday of the Robert Wood Johnson  
16          funded collaboration. We're engaged with  
17          PatientsLikeMe for a novel approach to cloud-  
18          based crowdsourcing patient reported outcomes on  
19          specific conditions.

20          So, we're very excited about some of  
21          those innovative models.

22          So, anyone who isn't familiar with it,



1 my letter to our NQF members this month was about  
2 the incubator and we'd be happy, Bruce, to send  
3 that to all the members of the committee so they  
4 get kind of the basic information about it.

5 CO-CHAIR BAGLEY: Helen, did you have  
6 any additional comments? You've been immersed in  
7 this work for a long time.

8 DR. BURSTIN: Yes, I mean part of it,  
9 and Kate had said this, I think what we often  
10 hear is the rate limiting step for a lot of  
11 developers to get to the next generation of  
12 measures is testing and not having the available  
13 test beds.

14 So, we have been working to try to see  
15 what to do whatever we can to pull in large data,  
16 big data resources that specialty societies and  
17 others can use.

18 So, we've also got an early  
19 partnership with OptumLabs where we'll be doing  
20 some initial proof of concept testing of a series  
21 of different incubator projects.

22 Again, as Chris pointed out, we are

1 not developing measures, we are simply helping to  
2 facilitate that process, pull together some  
3 interesting bedfellows at times, those with  
4 funding, those with good ideas, those with data,  
5 which I think is really pretty important from the  
6 get go of developing a measure.

7 And finally, those with expertise,  
8 pull in the expertise of the measure development  
9 community about risk adjustment, et cetera, just  
10 to see if, you know, at the start, if you have  
11 data and all those resources, can you more  
12 rapidly develop and finalize and test the measure  
13 and get it to market quicker?

14 And, finally, to fill those national  
15 gaps that MAP has been identifying for years now  
16 and we know it's really difficult. It's great  
17 that CMS is going to have the ability to put more  
18 dollars towards measurement, but we recognize  
19 they can't all be done by CMS. So, we'd like to  
20 ensure there's some ability to bring private  
21 sector funding to those efforts as well.

22 So, thanks.

1 CO-CHAIR BAGLEY: I think I might add  
2 that you're in such a great position to catalyze  
3 harmonization among all the -- everybody comes  
4 with the same idea and it doesn't look quite the  
5 same when it comes out.

6 Any other questions for clarification  
7 for Kate or Helen or Chris?

8 Okay, shall we move on? Andrew?

9 MR. LYZENGA: Thank you.

10 I'm Andrew Lyzenga with NQF.

11 That's great, sort of setting the  
12 stage of the context within which we're going to  
13 be doing this work and the sort of principles and  
14 goals and considerations we should be keeping in  
15 mind as we do this.

16 In terms of our more immediate  
17 objectives here today, we are going to be  
18 reviewing and providing input on the measures  
19 under consideration for federal programs  
20 applicable to clinician settings through a few  
21 different programs that we'll hear about today.

22 To identify high priority measure gaps

1 for each program measure set and we set aside a  
2 bit of time toward the end of this meeting to do  
3 that.

4 And, overall, to finalize our input as  
5 a work group to the MAP Coordinating Committee  
6 who will be making the final decisions on  
7 recommendations for use of measures in the  
8 federal programs.

9 So, just to talk about our approach  
10 here a little bit. This is probably going to be  
11 a little bit of a refresher from what you heard  
12 at our October web meeting.

13 But, just as a reminder, we've revised  
14 our approach a bit. The approach to analysis and  
15 selection of measures is a three step process.

16 First, we developed a program measure  
17 set framework. And, again, that's something that  
18 we did at our October meeting. We reviewed and  
19 finalized the framework.

20 What we'll be doing today is these  
21 second two steps, evaluating the measures under  
22 consideration for what they would add to the

1 program measure sets given that framework, given  
2 the objectives and goals and priorities for each  
3 program.

4 And, to finally identify and  
5 prioritize measure gaps for programs and  
6 settings.

7 We've set out sort of a framework for  
8 making these decisions. We are asking that you  
9 make a decision for each of the measures under  
10 consideration and those decisions categories have  
11 been standardized to allow us for some  
12 consistency across our decisions.

13 Each of those decisions should be  
14 accompanied by one or more statements of  
15 rationale that explains why each decision was  
16 reached and this is where we can provide some  
17 input and feedback to CMS as Kate was talking  
18 about.

19 If we have any thoughts or feedback on  
20 the measures as we make our decisions, we can  
21 give that to us and we can incorporate them into  
22 our recommendations.

1                   For those measures that are accepted  
2                   as part of the consent calendar, NQF staff has  
3                   given some preliminary rationale for those  
4                   decisions as part of our preliminary analysis.  
5                   I'll talk about that a little bit more in a  
6                   moment.

7                   For those that we pull off the consent  
8                   calendar for individual discussion, we'll ask  
9                   that you provide a bit of rationale, again, as  
10                  when we make our decision.

11                  So, just to talk a little bit about  
12                  these decision categories, we have split them out  
13                  into two different kinds of sort of categories,  
14                  those four, fully developed measures, we heard a  
15                  little bit about those that are fully developed  
16                  and those that are at an earlier stage of  
17                  development.

18                  For those measures that are fully  
19                  developed, we have a few different categories for  
20                  decisions, support, conditional support and do  
21                  not support.

22                  We've got some potential examples of

1 the rationale here. I won't go through each of  
2 those.

3 But, these are the potential decision  
4 categories that will be applicable to those  
5 measures that are fully developed and tested.

6 For those measures that are still  
7 under development, not fully tested and  
8 developed, we're going to restrict ourselves to  
9 these three categories.

10 First, to encourage further  
11 development, to not encourage further  
12 consideration or to find that we have  
13 insufficient information to make a final decision  
14 on the measure.

15 So, as we do this, we'll want to keep  
16 these criteria in mind. We have set out these  
17 criteria with input from CMS and with input from  
18 the Coordinating Committee and the MAP and you as  
19 work groups.

20 Non-endorsed or NQF endorsed measures  
21 are required for program measure sets unless no  
22 relevant endorsed measures are available to

1 achieve a critical program objective.

2 I should note that these are not sort  
3 of set in stone. They're just intended to be  
4 guidance really and things that you ought to keep  
5 in mind as we're making our decisions.

6 The rest of these are really sort of  
7 attributes of the program that you should keep in  
8 mind, not necessarily specific to each measure,  
9 but consider whether the measure under  
10 consideration fulfills the aims and goals of the  
11 program, whether it is specific to the goals and  
12 requirements, whether it adds to the program  
13 measure set, whether it contributes to the  
14 program measure set, adequately addressing each  
15 of the National Quality Strategy's three aims,  
16 whether it is helping the program measure set  
17 achieve an appropriate mix of measure types,  
18 whether it is helping the program measure set  
19 enable measurement of person and family centered  
20 care and services, whether it is helping us move  
21 toward consideration for health care disparities  
22 and cultural competency and whether it is helping



1 us more toward a program measure set that  
2 promotes parsimony and alignment.

3 So, as I mentioned, before, to  
4 facilitate this process, we're working with a  
5 consent calendar process. And, as staff at NQF,  
6 we have conducted a preliminary analysis of each  
7 measure under consideration. We've done that,  
8 again, with input from this committee and the  
9 Coordinating Committee.

10 The preliminary analysis is an  
11 algorithm. It asks a series of questions about  
12 each measure under consideration. This is  
13 developed from the selection criteria approved by  
14 the Coordinating Committee and is really intended  
15 to provide MAP members with a succinct profile of  
16 each measure and to serve as a starting point for  
17 your discussions.

18 And, certainly, it is not intended to  
19 be a final decision but to, again, serve as a  
20 starting point. You can choose to pull any  
21 measure off the consent calendar that you would  
22 like to discuss further and potentially consider

1 a different decision than we have recommended as  
2 staff.

3 In terms of the details of the voting  
4 process, I will hand it over to my colleague,  
5 Poonam, to talk about that a little.

6 MS. BAL: Thank you.

7 So, this will be hopefully a refresher  
8 for everyone. We did go over it during the  
9 November all MAP meeting, but we did want to make  
10 sure that everybody understood, it has changed  
11 slightly since last year.

12 So, basically, every measure under  
13 consideration is subject to a vote, either  
14 individually or as part of a consent calendar.

15 With that said, unless a measure is  
16 pulled, we won't specifically vote on it. The  
17 consent calendar, the assumption is that it is --  
18 you are fine with the decisions that were  
19 recommended by the staff and you're okay with  
20 moving forward with that.

21 The work group will be expected to  
22 reach a decision on every measure under

1 consideration. There will be no gray zone or  
2 pushing the measure to the Coordinating  
3 Committee.

4 We did previously have a category of  
5 split decisions, but we will try to avoid that as  
6 much as we can.

7 Again, however the Coordinating  
8 Committee, of course, can continue discussion if  
9 there is an important matter that needs to be  
10 discussed. So, they do still have that option to  
11 bring up that measure.

12 And, staff will provide an overview  
13 for establishing consensus which we are doing  
14 right now.

15 At the start is in person, so moving  
16 forward.

17 So, the method will be that we'll do  
18 an introductory presentation. Staff will present  
19 it and then once you get a quick overview, Chair  
20 will give context to each programmatic discussion  
21 and the voting will start once we have had a  
22 chance to discuss any measures that are pulled.

1                   There will be lead discussants  
2           assigned to each group of measures. That list  
3           was sent out with the email that I sent earlier  
4           this week. I'm sorry, actually, I think that was  
5           last week.

6                   And so, everyone should be aware, your  
7           role is to really respond to the person that's  
8           pulled the measure, give your point of view. It  
9           can be that you agreed with staff, you agreed  
10          with the person that pulled the measure or you  
11          have a completely different view. That's really  
12          up to you as the lead discussant to give your  
13          opinion.

14                   The discussion guide which is this  
15          master -- that's really loud -- master document  
16          that we started last year and we've continued  
17          this year will really contain all the information  
18          you need.

19                   It has all the measures divided into  
20          consent calendars or related groups of measures.  
21          Those groups will have the preliminary analysis  
22          which will have the decision and the rationale

1       that staff have listed.

2               And then, it also includes other  
3       things such as the comment, the specifications.  
4       So, you do have all that background information  
5       all in one master document.

6               So, the voting procedure will go as  
7       forward. So, as I mentioned, staff will review  
8       the preliminary analysis, consent calendar,  
9       present it to the group here.

10              After that's done, all the work group  
11      -- any work group member can pull a measure from  
12      the consent calendar and it's basically  
13      considered a regular agenda item as if we weren't  
14      using the consent calendar system.

15              So, the co-chairs will ask the work  
16      group members to identify them. At that point,  
17      we'll ask the work group member to basically  
18      provide a rationale for why they would like to  
19      either change the preliminary analysis or discuss  
20      the measure further.

21              And then, as long as there's no  
22      objections from the remaining measures, that

1 consent calendar will be considered established.

2 So, you can pull as many measures as  
3 you want from the consent calendar, but if there  
4 are measures remaining on the consent calendar,  
5 those will be assumed that you're okay with that  
6 decision and that will be the established  
7 decision.

8 So, once the measures are pulled, as  
9 I mentioned, the work group member pulling the  
10 measure will give a rationale. The lead  
11 discussants will respond and then all work group  
12 members can provide their input as they feel  
13 necessary.

14 We do ask in the interest of time,  
15 please refrain from repeating points that have  
16 already been made.

17 After the discussion of each MUC,  
18 depending on if it was a fully developed, still  
19 under development or if we're discussing  
20 Physician Compare, your decisions will be  
21 different.

22 So, for a fully developed one, as

1 Andrew mentioned, it'll be support, conditional  
2 support and do not support.

3 For Physician Compare, our decision is  
4 really should it be on the clinician web page or  
5 should it be in a spreadsheet?

6 And then, for under development, the  
7 options are do not -- encourage further  
8 development, do not encourage further development  
9 or we do not have enough information to provide a  
10 rationale.

11 So, to understand how we're tallying  
12 the votes, so, generally, we're not going to --  
13 if the votes are greater than 60 percent for  
14 support, the recommendation is support.

15 However, if the recommendations are  
16 greater than 60 percent for support and  
17 conditional support, the result is conditional  
18 support and then staff will ask to clarify what  
19 the conditions are and announce that before we  
20 move forward.

21 If the MUC receives less than 60  
22 percent for the sum of support and conditional

1 support, the recommendation is do not support.

2 We are using 60 percent as our  
3 majority moving forward. And, while we do not  
4 encourage people to, you know, decide not to  
5 vote, we will count the denominator in deciding  
6 that 60 percent. So, it won't be the full  
7 committee, it's whoever is voting will determine  
8 that 60 percent.

9 So, this is, again, just a kind of  
10 more of a display of what could the options be.  
11 But, I've gone over this so I won't go over it  
12 again. Again, I think everyone kind of  
13 understands if we have 25 committee members and  
14 two abstain from voting or if they're out of the  
15 room or what may be, you can see that if we had  
16 ten conditional -- I'm sorry, ten support, four  
17 conditional support and nine do not support, it  
18 would be at 61 percent and we would move forward  
19 with conditional support.

20 So, along with the voting, we do have  
21 a change with our commenting procedure. As  
22 you're aware, we had early public -- member and



1 public comment that had closed on the 7th of  
2 December. Those comments have been incorporated  
3 in the discussion guide for your use.

4 Along with that, we have a new  
5 procedure for commenting during the meeting.  
6 Before each discussion on the consent calendar,  
7 we will open it up to the general public to see  
8 if they have any comments on the consent calendar  
9 we're reviewing at that time.

10 We do want the comments to be really  
11 focused on the consent calendar that we are about  
12 to speak to. And, there will be a time later on  
13 in the meeting where general comments can be  
14 made. So, that will go first so that way the  
15 full work group can hear any comments that the  
16 members have to make and members of the public.  
17 And then, we'll do all the lists.

18 There will be, also, after the  
19 meeting, we'll have another public commenting  
20 period which will be from December 23rd to  
21 January 12th. And those will be given to the  
22 Coordinating Committee during their

1 consideration. And, again, all comments are  
2 given to CMS for their consideration. So, with  
3 that I'll stop and see if there's any questions.  
4 You have lots.

5 MEMBER FRIEDMAN: So, can you  
6 differentiate between measures that aren't fully  
7 developed and measures that are fully developed,  
8 what is the minimum criteria for a measure to be  
9 fully developed?

10 DR. WINKLER: In general, based on the  
11 information we have that the measure is fully  
12 tested, fully developed and tested. That  
13 actually is one of the questions that's responded  
14 to during the submission process when the  
15 measures are submitted to CMS for consideration.

16 MEMBER FRIEDMAN: Yes, and testing is  
17 subjective, so is there a minimum criteria for  
18 the amount of testing that needs to be done  
19 before they're determined to be fully developed?

20 DR. WINKLER: We don't have that level  
21 of detail.

22 CO-CHAIR BAGLEY: Luther?

1 DR. CLARK: If there's a measure that  
2 is requested to be removed from the calendar, is  
3 that voted on, or is that consensus or how, do  
4 you --

5 DR. WINKLER: Yes.

6 MR. LYZENGA: We'll vote directly on  
7 that measure individually, if it's removed from  
8 the consent calendar.

9 CO-CHAIR BAGLEY: Rachel?

10 MEMBER GROB: Thanks to NQF for the  
11 amazing amount of work during MAP season, much  
12 appreciated. I am wondering back to, Andrew,  
13 your sort of presentation of the MAP process for  
14 arriving at your recommendations to us relative  
15 to each measure. What role, if any, the previous  
16 clinician work group discussions around measure  
17 gaps played in your consideration around -- you  
18 know, we have a set of criteria and then, every  
19 year, we come up with specific measure gap  
20 identification processes. So, how do you mesh  
21 those together?

22 DR. WINKLER: Rachel, if you look in

1 the discussion guide and take the link out to the  
2 full preliminary analysis, you'll see that one of  
3 the questions is around gaps, and, what we used  
4 to address that question is the discussion from  
5 previous years for the gaps identified for the  
6 MAP previously.

7 MR. LYZENGA: So, we had sort of  
8 protocol that we went through for each measure  
9 and it included, among other things, the gaps  
10 that have been previously identified. Did it fit  
11 into those? Some questions around alignment  
12 across programs and a number of other questions  
13 that we considered for each measure.

14 MEMBER FRIEDHOFF: Okay, first  
15 meeting, so apologies if my questions reflect  
16 that, but, one of the early options was do not  
17 encourage further development. Did you  
18 distinguish that from do not support? And also,  
19 what is the spreadsheet option, versus physician  
20 web page?

21 MR. LYZENGA: So, the do not encourage  
22 further development is really only an option for

1 those that are still under development. So, it's  
2 essentially equivalent to do not support for  
3 those measures that are still under development.  
4 The do not support is really for those measures  
5 that are fully developed and tested, in which  
6 case we wouldn't be encouraging or discouraging  
7 further development, they're already developed.  
8 So, that's just a support or do not support.

9 But, for those that are still in that  
10 process of development, sort of your two options  
11 are support further development, do not encourage  
12 further development and then the third option of  
13 we don't have enough information to really make a  
14 final decision. Does that make sense?

15 MEMBER FRIEDHOFF: The spreadsheet?

16 MR. LYZENG: Oh, the spreadsheet.

17 DR. WINKLER: Let me do that one. In  
18 terms of all of the measures, we're going to be  
19 talking a little bit later about the public  
20 reporting vehicle for the clinician measures is  
21 through Physician Compare.

22 And, one of the questions that CMS is

1 asking of us is for measures that are in this  
2 clinician programs, they are all available for  
3 public reporting on Physician Compare. But, they  
4 are looking for feedback, because the plan is to  
5 publically report them in two ways. One is  
6 either on the clinician's individual web page, a  
7 little bit more publically available, a little  
8 bit more out there, if you will, versus a more  
9 downloadable spreadsheet that is available, yet  
10 probably not as visible.

11 And so, CMS asked for our MAPS  
12 feedback on -- for each individual measure where  
13 they think it would be most appropriate. So, we  
14 have drafted, you know, a proposed selection of  
15 those two options, if you will, just, again, to  
16 add to the feedback to CMS on the public  
17 reporting vehicle.

18 CO-CHAIR BAGLEY: Barbara?

19 DR. GOODRICH: I just want to clarify,  
20 why we're -- it seems like two different places.  
21 So, pretty much all of our measure data for every  
22 program goes in a downloadable database, just,

1       you know, so that anybody can have access to.

2       So, pretty much everything will go there.

3               I think the question is, does it only  
4       belong there, or is this something that would be  
5       really meaningful consumers, that we want to have  
6       publically reported on Physician Compare that a  
7       patient could use to, you know, choose providers  
8       or what have you? So, that's really -- and, by  
9       the way, on Physician Compare, they get displayed  
10      as both a percent as well as a star rating, so  
11      just to be clear that that's how that's done.

12              CO-CHAIR BAGLEY: Barb?

13              MEMBER LANDRETH: I think that really  
14      leads to my question and confusion, and I'm new  
15      to the MAP also. When I was going through this,  
16      it seemed like there were quite a few measures  
17      that were very, very clinically detailed that the  
18      average consumer would not be able to use, to  
19      make decisions on the basis of, and yet, there  
20      were some that were very pertinent to the average  
21      purchaser.

22              And so I was a little confused as to

1       should we look at this tool as a QI tool for  
2       clinical practice, as well as a reporting tool,  
3       for patients who are trying to make decisions?  
4       Because I think that's going to really impact how  
5       we vote. There will be very few patients who  
6       will ever download a spreadsheet and make any  
7       sense of it, but, I can certainly understand how  
8       a clinician group would want to do that for their  
9       own QI, internal QI. So, could you help guide me  
10      in that way?

11               DR. GOODRICH: So, Physician Compare,  
12      the primary audience for Physician Compare is  
13      patients and consumers. So, we actually -- the  
14      measures that are up there now which is small  
15      subset of measures, we've been taking sort of an  
16      incremental approach to displaying performance  
17      data for clinicians on Physician Compare. So,  
18      right now, there is our data for ACOs and large  
19      group practices, and that's going to be expanding  
20      over the next year to include individual  
21      clinicians as well.

22               As we decide what goes on there, the



1       number one thing we keep in mind is, is this  
2       measure going to be meaningful to a consumer?  
3       And, of course, we ask consumers and patients.  
4       We have that as part of our testing and our focus  
5       groups, et cetera.

6               So, I agree with you, there are  
7       clearly measures on the MUC list that are  
8       important because there's a performance gap and  
9       it, you know, may be an outcome or appropriate  
10      use or what have you, but that really isn't going  
11      to be very meaningful to a patient, but it's  
12      really important to drive quality improvement.  
13      And, it may even be appropriate for  
14      accountability purposes.

15             But, for Physician Compare,  
16      specifically, what we want input from the MAP on  
17      is for each measure, is this something that's  
18      going to be meaningful to consumers and is  
19      important for improvement? Because, you know,  
20      another major purpose of public reporting is an  
21      incentive to drive improvement.

22             But, I do want to be clear that the

1 patient and consumer is really the primary  
2 audience for Physician Compare. But, we do  
3 strongly believe that we should have transparency  
4 in all measure information, which is why we have  
5 a downloadable database that others can take and,  
6 you know, analyze and so forth.

7 CO-CHAIR BAGLEY: Other comments or  
8 questions? If not, Reva, can we go on to the  
9 next?

10 MS. BAL: Reva, actually, if you don't  
11 mind, I'll do a quick demo of the voting.

12 CO-CHAIR BAGLEY: Yes, we're going to  
13 give you a test, a trial run of your voting  
14 machine.

15 MS. BAL: So, everyone should have a  
16 blue little clicker. Please let us know if you  
17 don't. If you're, obviously, a government  
18 liaison, you will not be having a voting one,  
19 because you're a non-voting member, and Mady also  
20 will not be voting. We do have two people on the  
21 phone that will be voting through chat. And,  
22 Andrew, I will be voting for them as a proxy.

1                   With that said, you'll notice that  
2                   most of the screens have those committee  
3                   guidelines and we'll be posting discussion  
4                   guidelines. But, if you look towards the back of  
5                   the room, the ones to the sides have the voting  
6                   slides on them. Those are just for your  
7                   knowledge so you can see them. It'll show you  
8                   what the different options are, what measure  
9                   you're voting for, what program it is and that'll  
10                  be listed there for you.

11                  There's no need to point at that  
12                  screen. These should work no matter where you  
13                  point. But, if you feel extra cautious, you can  
14                  always point towards Severa, but it should work  
15                  towards -- if you point any way. So, the way  
16                  that you know the voting is happening is if you  
17                  click one of the options that's a valid option,  
18                  so, in this case, one, two or three, if you click  
19                  it, you should get a number show up on your  
20                  screen.

21                  So, if you see the number, that means  
22                  you're good to go, if you see anything else, that

1 means you're not good to go. So, with the screen  
2 there, we'll be having 35 seconds to vote. We'll  
3 tell you when it's open. Please vote then. And,  
4 we'll be looking for a certain number of votes at  
5 that time. Once we get -- either hit the number  
6 of votes or hit the time, we'll stop it and then  
7 we'll let you know the results.

8 On the screen, the percentage will  
9 show, so you'll be able to easily see if we've  
10 hit that 60 percent mark. So, if you guys want,  
11 we can all do a quick test run. So, Severa, I'll  
12 give it to you.

13 MS. CHAVEZ: So, good morning  
14 everyone. So, this is the voting slide for a  
15 measure that would be fully tested and these are  
16 our options. So, this is just an example. Let's  
17 do a test run and I will announce that we are now  
18 voting.

19 And, I guess for the benefit of the  
20 people on the phone, I should read what we are  
21 currently voting on and the options because the  
22 people on the phone would be sending their votes

1 in via chat that only NQF can see. And Poonam  
2 and Andrew here would vote for them with their  
3 own clickers so they are counted, too. Okay?

4 All right, so, this is one of the  
5 measures recommended for the Medicare Shared  
6 Savings Program, MUC ID 15-576, Prevention  
7 Quality Indicators 92 Prevention Quality Chronic  
8 Composite. The voting options are one for  
9 support, two, conditional support and three, do  
10 not support. And we can start voting.

11 MS. BAL: This is only a trial.  
12 Please make sure that when you hit -- you get  
13 some sort -- whatever your number you selected  
14 shows up.

15 MS. CHAVEZ: Right now, I'm seeing 19  
16 responses. I think we have 23 -- 20 in the room,  
17 three on the phone. Oh, okay, all right. So,  
18 okay, so we have 22, and I'm going to stop the  
19 timer.

20 MR. LYZENGA: And, you should be able  
21 to hit it multiple times. It won't register  
22 multiple votes.

1 MS. CHAVEZ: Right.

2 CO-CHAIR BAGLEY: Any questions about  
3 that? That's pretty straightforward.

4 MS. BAL: Okay, go ahead, Reva. We're  
5 going to -- oh, sorry.

6 DR. WINKLER: Okay, I think it's time  
7 to get started on the actual measures under  
8 consideration. We are going to be looking at two  
9 programs primarily. And so, we're going to start  
10 off with the Medicare Shared Savings Program.

11 Because each of these programs have  
12 all of their unique characteristics, we've asked  
13 CMS to provide an introductory presentation on  
14 the program to give you an opportunity to get  
15 yourself in the familiar with the program, its  
16 goals, how it's structured, how it's organized  
17 and how the measures are incorporated into the  
18 program. And so, to start off, Rabia, are you on  
19 the phone?

20 MS. KHAN: Yes, can you hear me?

21 DR. WINKLER: Yes, thank you. Rabia  
22 Khan from CMS is going to give you an overview of

1 the Medicare Shared Savings Program.

2 MS. KHAN: Thank you, Reva. I'm not  
3 sure if everyone can see the slides in the room,  
4 but I'll indicate which slide I'm on if that's  
5 fine.

6 DR. WINKLER: Thank you, Rabia, we do  
7 have the slides projected in the room.

8 MS. KHAN: Great, thanks. So, yes,  
9 I'm Rabia Khan within our Division of Shared  
10 Savings Program, and I'll go over the statutory  
11 authority for the Shared Savings Program as well  
12 as an overview of the program and Performance  
13 Year 2014 results.

14 And then, with a focus on our quality  
15 measurement approach, we'll review our quality  
16 measures, our data collection mechanisms and our  
17 scoring. And then, finally, talk about alignment  
18 of the Medicare Shared Savings Program with other  
19 programs such as PQRS, the value modifier and the  
20 Medicare EHR incentive program.

21 So, on slide three, the Affordable  
22 Care Act Section 3022 mandated the Medicare

1 Shared Savings Program. Program requirements and  
2 policies have been further defined through  
3 various regulations. Largely, the requirements  
4 and updates have been made to the Shared Savings  
5 Program in the 2011 and 2015 Shared Savings  
6 Program rules. We also make annual updates for  
7 quality, and also now assignment updates, in the  
8 annual Physician Fee Schedule Rule.

9 On the next slide, an overview for the  
10 Shared Savings Program, so participation in an  
11 ACO creates incentives for health care providers  
12 to work together voluntarily to coordinate care  
13 and improve quality for their patient population.  
14 ACOs submit an application to CMS to join the  
15 Shared Savings Program. And, if accepted, they  
16 voluntarily enter a three year agreement with  
17 CMS.

18 Each year, the total number of ACOs do  
19 change, due to new ACOs joining the program and  
20 the few who chose to terminate their agreement.  
21 ACOs can enter one of three program tracks, which  
22 are based on their opportunities for savings and



1 the risk of losses. So, most ACOs are in track  
2 one, which provides them with the opportunity to  
3 share in savings, if earned. And tracks two and  
4 three are two sided, so these ACOs also bear the  
5 risk of shared losses, but can earn a higher  
6 percentage of savings if earned. Track three is  
7 a new program track and will begin in 2016.

8 On slide five, we assess ACO  
9 performance annually on their quality performance  
10 and against a financial benchmark to determine  
11 shared savings or losses. In order for ACOs to  
12 be eligible to share in savings, if earned, they  
13 must meet our program's quality performance  
14 standards. And, I'll provide an overview of our  
15 quality performance standards in later slides  
16 here.

17 So, on slide six, we have 423 ACOs who  
18 have been established in the Shared Savings  
19 Program and Pioneer ACO Model. And the number of  
20 ACOs continues to increase. There are 7.9  
21 million ACO assigned beneficiaries, and, the map  
22 here shows that we have Medicare ACO assigned

1 beneficiaries in 49 states, plus Washington, D.C.  
2 and Puerto Rico.

3 For 2015, there are 89 new ACOs  
4 covering 1.6 million beneficiaries assigned to  
5 the program. There continues to be a strong  
6 interest from new and renewing ACOs. And, in  
7 terms of shared savings ACO composition, more  
8 than a half of providers participating in ACOs  
9 are networks of individual practices and group  
10 practices. Approximately a third of ACOs include  
11 hospitals or professional partnerships.

12 So, on slide seven, and in the few  
13 years of the Shared Savings Program, we have  
14 promising results in quality and finance. In  
15 quality, the ACOs who reported in both 2013 and  
16 2014 improved average performance on 27 of 33  
17 measures. ACOs also achieved higher performance  
18 than other fee for service providers on 18 of the  
19 22 Group Practice Reporting Option, or GPRO, web  
20 interface measures.

21 ACOs demonstrated quality improvement  
22 on measures such as patients ratings of

1 clinicians communication, beneficiaries rating of  
2 their doctor, grading for tobacco use and  
3 cessation, and screening for high blood pressure.  
4 Because of alignment between the Shared Savings  
5 Program and PQRS, knowledgeable professionals  
6 participating in ACOs qualified for PQRS  
7 incentives and avoided the 2016 PQRS payment  
8 adjustment when their ACO satisfactorily reported  
9 quality measures on their behalf for the 2014  
10 reporting year.

11 And, on the next slide, in terms of  
12 financial results, in Performance Year 2014,  
13 there was a total net savings of \$383 million.  
14 Twenty-eight percent of ACOs held their spending  
15 of \$806 million below their targets and earned  
16 performance payments of more than \$341 million.  
17 An additional 89 ACOs reduced health care costs  
18 compared to their benchmark, but did not end up  
19 meeting the minimum savings threshold.

20 We note that ACOs with more experience  
21 in the program were more likely to generate  
22 shared savings. 37 percent of ACOs who started in

1 2012 compared, to the 27 percent of those who  
2 started in 2013, and 19 percent of those who  
3 started in 2014. In the first Performance Year,  
4 26 percent of ACOs health spending at \$705  
5 million below their targets and earned  
6 performance payments of more than \$315 million.

7 And on slide nine, so now I'm going to  
8 focus on the quality side of the program or  
9 quality measurement approach. And, the quality  
10 measurement approach for our program is intended  
11 to improve individual and the health of  
12 populations, address quality aims such as  
13 prevention, care of chronic illness, high  
14 prevalence conditions, patient safety, patient  
15 care giver engagement and care coordination, and  
16 these align with our National Quality Strategy  
17 and CMS Quality Strategy goals.

18 We also use our quality measurement  
19 approach to support the Shared Savings Program  
20 goals of better care, better health and lower  
21 growth in expenditures while also aligning with  
22 other quality reporting and incentive programs

1       like PQRS, BM and the Medicare EHR Incentive  
2       Program.

3               And on slide ten, currently we have --  
4       well, for 2015 and in prior years, we have had 33  
5       quality measures that have been separated across  
6       four domains that we use as our basis for  
7       assessing, benchmarking, rewarding and improving  
8       ACO quality performance.

9               So, we have our four domains which are  
10       equally weighted and they are patient care/care  
11       giver experience, care coordination and patient  
12       safety, preventive health, and at-risk  
13       populations. Now, we recently finalized in the  
14       2016 Physician Fee Schedule Final Rule that we  
15       were adding a new measure beginning with 2016  
16       reporting year. So, we will be moving to 34  
17       measures.

18               And then, on slide 11, I'll just  
19       briefly go over the high level -- the measures  
20       within each domain. So, as you can see in our  
21       first domain which is patient care giver  
22       experience, we have eight measures and they come

1 from the Clinician/Group CAHPS Survey and we used  
2 the CAHPS for ACOs survey and it does align with  
3 the CAHPS for PQRS survey.

4 So, these are some eight measures that  
5 we assessed performance for ACOs in terms of  
6 patient and care giver experience. And then,  
7 moving on to slide 12, here's our domain for care  
8 coordination and patient safety. I won't go  
9 through all of the measures in detail or  
10 anything, but these are largely claims based  
11 measures that we have here.

12 We do have other measures in this  
13 domain that are also reported through the GPRO  
14 web interface, but, we have a total of ten  
15 measures within this domain. And, on the next  
16 slide is our preventive health domain. We have a  
17 total of eight measures and this also meets our  
18 aim of better health for a population.

19 There are a lot of screening measures  
20 within this measure set and all of these measures  
21 are reported through the web interface. And  
22 then, on slide 14, this is our clinical care for

1 at-risk population domain. It is five  
2 individually scored measures and a two component  
3 diabetes composite. So, you'll see that ACO-27  
4 and 41 make up for diabetes composite. And,  
5 these are all also reported within the -- through  
6 the GPRO web interface.

7 So, on slide 15, I'll just sort of  
8 briefly go over the mechanisms that we use for  
9 data collection. So, we do use the CAHPS for ACO  
10 survey, which is a patient survey. We also use  
11 claims for our claims based measures. And then,  
12 the EHR Incentive Program attestation data since  
13 we do have a measure which looks at the percent  
14 of primary care physicians who successfully meet  
15 meaningful use requirements.

16 And then, we also use GPRO web  
17 interface in alignment with PQRS. And, on slide  
18 16, so just to go over the quality performance  
19 standard and how ACOs can be eligible to share in  
20 saving when they're meeting that, it changes  
21 based on which performance year an ACO is in in  
22 terms of their agreement.

1                   So, we, at CMS, designate the quality  
2                   performance depending on their performance year.  
3                   So, if you're new to the program, it's their  
4                   first year as ACO, we often refer to that as your  
5                   pay-for-reporting year. And to be eligible to  
6                   share in savings, if earned, the ACO must  
7                   completely and accurately report all quality  
8                   measures and that qualifies them to share in the  
9                   maximum available sharing rate for payment.

10                  Now, we phase in performance measures  
11                  beginning with their second and ongoing through  
12                  their third and subsequent years as part of the  
13                  program. And, we often refer to that as their  
14                  pay-for-performance years. So, when they're  
15                  under a pay-for-performance reporting year, they  
16                  have to meet complete and accurate reporting for  
17                  all quality measures similar to the pay-for-  
18                  reporting year, but they also need to meet  
19                  minimum attainment on at least one pay-for-  
20                  performance measure in each domain.

21                  And, we are encountering ACOs who will  
22                  be entering into their second agreement and we



1 are -- oh, in terms of ACOs who are in their  
2 second agreement, we treat them as an ACO in  
3 their third performance year here. So, they  
4 would fall under pay-for-performance.

5 And, on slide 17, when we do introduce  
6 new measures into the program for the quality  
7 measure set, we finalize that we'll be setting  
8 them a pay-for-reporting two years before phasing  
9 them into pay-for-performance unless we finalize  
10 a measure as pay-for-reporting for all years.

11 We feel maintaining new measures as  
12 pay-for-reporting for two years will help to  
13 ensure that ACOs have adequate time to phase in  
14 their own care processes and infrastructure  
15 before they're held accountable for performance  
16 and that we at CMS also have adequate data to set  
17 benchmarks for these new measures.

18 And, under pay-for-performance which,  
19 again, is the ACO's second or subsequent  
20 performance year, we do phase in an increasing  
21 number of measures into performance.

22 And, you can see at the table below,

1       you can see from those who are just starting  
2       within, you know, with the 2015 reporting year  
3       versus those who started in 2014 or in 2012 and  
4       2013, you'll see the number of pay-for-reporting  
5       measures declines while there's an increase in  
6       the number of performance measures.

7               So, when we talk about ACOs having to  
8       meet the minimum attainment level to receive  
9       points for these pay-for-performance measures, we  
10      define minimum attainment as meeting performance  
11      at 30 percent or the 30th percentile of the  
12      performance benchmark that we establish.

13              Shared savings payments are linked to  
14      their quality performance as compared to  
15      benchmarks based on a sliding scale for scoring.  
16      And, we set our benchmarks for two years to  
17      support ACO quality improvement efforts.

18              And, high performing ACOs receive  
19      higher sharing rates for payment.

20              Next slide?

21              I won't go into this in detail, but  
22      here is -- this shows how we use our sliding

1 scale measures scoring approach where you can see  
2 that the 90th percentile is if an ACO meets that  
3 performance level in the measure, they would get  
4 full points which is two points for that measure  
5 in terms of scoring.

6 We do have one difference for the ACO-  
7 11 EHR measure where it's double weighted. So,  
8 ACOs can earn up to four points for that measure.

9 And, if an ACO falls below the 30th  
10 percentile, it will not earn any points for that  
11 measure.

12 And then, on slide 19, here's an  
13 overview of our 2015 performance year scoring.  
14 So, as you can see, the total number of measures  
15 and those that are used for scoring as well as  
16 the total possible points an ACO can earn for  
17 each domain. And, each domain is equally  
18 weighted.

19 And, beginning with the 2015  
20 performance year, ACOs can earn up to four  
21 quality improvement points in each domain.  
22 However, the total number of points an ACO earns

1 per domain cannot exceed the total possible  
2 points in that domain.

3 So, for instance, an ACO receives four  
4 points for quality improvement in their patient  
5 care giver experience and they had an original  
6 score of 14 points in that domain, they can't get  
7 to 18 points since that exceeds the total  
8 possible points, 16 points, in that domain.

9 So, on the next slide, just an  
10 overview on how the Shared Savings Program  
11 interacts with other programs.

12 When an ACO meets the Shared Savings  
13 Program requirements for quality reporting and  
14 performance, the eligible professional who  
15 participate within the ACO will meet reporting  
16 requirements for other CMS programs,  
17 specifically, PQRS, the Value Modifier and  
18 Medicare EHR Incentive Program.

19 So, on slide 21, in terms of PQRS, and  
20 we'll use 2015 as sort of the standard for how we  
21 align, but if the ACO satisfactorily reports the  
22 quality measures through the GPRO web interface

1 for the 2015 Performance Year, then ACO  
2 participant TINs with PQRS eligible professionals  
3 will not be subject to the 2017 PQRS payment  
4 adjustment.

5 In addition, beginning in 2017, CMS is  
6 applying the VM to physicians in group practices  
7 with two or more EPs and to physician solo  
8 practitioners.

9 Groups and solo practitioners as  
10 identified by their TINs participating in a  
11 Shared Savings Program ACO in 2015 will be  
12 subject to the 2017 VM based on their performance  
13 in calendar year 2015.

14 Previously, TINs participating in that  
15 Shared Savings Program ACO were exempt.

16 So, the VM for shared savings -- TINs  
17 participating within the Shared Savings Program  
18 ACO is determined by calculating a cost and a  
19 quality composite.

20 So, for TINs who are participating in  
21 the ACO, their cost composite will be classified  
22 as average. But, their quality composite will be

1       calculated using ACO-level data reported by the  
2       ACO through the GPRO web interface and the ACO  
3       All-Cause Readmission measure.

4               ACO participants may be eligible for  
5       an upward adjustment based on their ACO's quality  
6       performance. And, if an ACO fails to successfully  
7       report on quality measures, then the participant  
8       TINs under the ACO who are subject to the VM will  
9       be subject to the automatic downward adjustment.

10              In 2017, that automatic downward  
11       adjustment is -4 percent for group physicians in  
12       groups with ten or more EPs and -2 percent for  
13       physicians in groups with between two to nine EPs  
14       and physician solo practitioners.

15              And, on slide 22, in terms of the  
16       Medicare EHR Incentive Program, EPs who  
17       participate in the Shared Savings Program can  
18       satisfy their CQM reporting for the Medicare EHR  
19       Incentive Program if EPs use Certified EHR  
20       Technology to extract their data and the ACO  
21       satisfactorily reports through the web interface.

22              EPs still, though, have to separately

1 attest to all other requirements for the Medicare  
2 EHR Incentive Program to successfully demonstrate  
3 meaningful use and to avoid that program's  
4 adjustment.

5 And, on slide 23, in terms of public  
6 reporting, we do at CMS release and publically  
7 report all the Performance Year results on  
8 data.cms.gov and the link is available there with  
9 our 2014 Performance Year results.

10 And, we do also publically report a  
11 subset of measures that align with PQRS on  
12 Physician Compare.

13 And then also ACOs have to publically  
14 report their quality performance results on their  
15 website according to our Shared Savings Program  
16 Public Reporting Guidance.

17 And then, finally, on slide 24, in  
18 this slide, we wanted to share our considerations  
19 when we were developing this measures under  
20 consideration list and we would like the MAP to  
21 provide input on our MUC list as well as  
22 potential measures for the future of the program.

1                   So, in terms of what we were  
2                   considering, we looked at for measures that  
3                   address National Quality Strategy and CMS Quality  
4                   Strategy goals and priorities.

5                   We also want to maintain alignment  
6                   with other Value-Based Purchasing Programs.  
7                   You'll see in this MUC list, we consider measures  
8                   that align with PQRS and the Value Modifier and  
9                   so, we would also like input in the future, if  
10                  there are other continued alignment as we move  
11                  towards MIPS and other Value-Based Purchasing  
12                  Programs like the SNF Value-Based Purchasing  
13                  Program.

14                  We also need -- we're thinking through  
15                  measures that address population health across  
16                  settings of care and -- largely because ACOs vary  
17                  in composition. So, we need to consider measures  
18                  that can be reported on by all ACOs.

19                  And then, we also are trying to focus  
20                  our attention on patient outcomes. But, where we  
21                  would like input it definitely is around sort of  
22                  this balance of process intermediate outcome and



1 outcome measures that exist within our measure  
2 set.

3 If you experts feel we should move  
4 some -- remove some of these process measures and  
5 replace them with other measures, so really  
6 trying to figure out what is the most appropriate  
7 balance of measures within our measure set.

8 And keeping in mind the sensitivity to  
9 administrative burden for reporting, a lot --  
10 most of these measures are reported through the  
11 GPRO web interface which does require ACOs to  
12 submit the data to CMS. Our claims based and  
13 administrative based measures, we do calculate  
14 and survey vendors that administer the CAHPS for  
15 ACO survey.

16 But, we would like you to keep in mind  
17 sort of when thinking through our measure set and  
18 future measures, the burden for reporting.

19 And, in addition, there may be other  
20 opportunities for us to share data to ACOs. Are  
21 there claims based measures that we could share  
22 in our quarterly feedback reports for ACOs?

1                   So, we do provide ACOs with a  
2                   quarterly expenditure and utilization report  
3                   where we do provide them with raw data on  
4                   readmissions in their reports.

5                   But, we do -- our All-Cause  
6                   Readmission measure is really where we annually  
7                   assess in quality using the risk-adjusted measure  
8                   that we have. But, if there is any feedback or  
9                   suggestions for other claims based measures that  
10                  we could consider providing in the quarterly  
11                  report with raw claims data, that's also  
12                  something we can consider.

13                  All right, Reva, I don't know if there  
14                  are any questions or just to turn it over to you.

15                  DR. WINKLER: Yes, thank you, Rabia,  
16                  very much.

17                  And, I ask any of the work group  
18                  members if you do have any questions for Rabia  
19                  about the program, I think she provided a very  
20                  complete context of the program in which you look  
21                  at the measures under consideration that we'll  
22                  talk about.

1           Before we go to break, I just wanted  
2   to remind the work group that, last year,  
3   discussion around the gaps for the Shared Savings  
4   Program recommendations on the types of measures,  
5   and if you will see that, you know, composite  
6   measures, care coordination, outcome measures,  
7   measures using patient reported data, prevention  
8   in population health that, in fact, that the  
9   recommendations from the MAP last year aligned  
10  fairly well with, again, CMS's considerations for  
11  the future.

12           So, again, we will have the  
13  opportunity to think about and provide more  
14  feedback to CMS around this particular program.

15           But, at this point, we're just a  
16  slight bit ahead of schedule, Bruce, and I think  
17  would be time to go to break.

18           CO-CHAIR BAGLEY: Yes, sure. Thanks,  
19  Reva.

20           And, before we go to break, two  
21  things.

22           First, Cindy Pellegrini has joined us

1 late and Cindy is from the March of Dimes. And,  
2 do you have an organizational disclosure?

3 MEMBER PELLEGRINI: Thank you.

4 I apologize for having a call early  
5 this morning.

6 Cindy Pellegrini and I have no  
7 disclosures.

8 CO-CHAIR BAGLEY: Thank you.

9 I also think it would be appropriate  
10 to ask if there's any public comment questions I  
11 guess might be around the material that's been  
12 presented thus far this morning, any questions  
13 for clarification about the programs or the  
14 procedure.

15 Barbara and then we'll go to public  
16 comment.

17 MEMBER LANDRETH: You mentioned that  
18 many of these measures have been pulled. How do  
19 we know which measures have been pulled and how  
20 do we know who will be addressing those?

21 CO-CHAIR BAGLEY: Okay, the measures  
22 that have been pulled should be on your agenda

1       that was on your table in red. Does everybody  
2       have that?

3               MS. BAL: Actually, that was only  
4       given to you.

5               CO-CHAIR BAGLEY: Oh, I'm the only one  
6       that has that, oh, okay.

7               MS. BAL: So, we will --

8               CO-CHAIR BAGLEY: We'll talk about  
9       that when we're going through the individual --  
10      sorry about that.

11              MS. BAL: Yes, so measures were pulled  
12      in advance.

13              CO-CHAIR BAGLEY: It's right here.

14              MS. BAL: So, we will announce that  
15      measures have been pulled when we go over the  
16      consent calendar and we'll state who was the  
17      person that pulled them as well.

18              CO-CHAIR BAGLEY: For those of you not  
19      familiar with the consent calendar idea, it  
20      really makes you do your homework. In other  
21      words, if you -- you can't kind of wait until it  
22      comes up to have a comment.

1           If it's still on a consent calendar,  
2       you don't get to talk about it. So, just keep  
3       that in mind, if there's something you want to  
4       hear some discussion about, you've got to get it  
5       off the consent calendar.

6           So, that's sort of why we do this.

7           Now, this was very valuable, I think,  
8       last year when we had a lot more measures. And,  
9       I think it's still valuable, but you still have  
10      to pull them off if you want to hear the  
11      discussion.

12          Whether you're for or against it, if  
13      you want to hear discussion around a topic that  
14      might enrich our recommendations to CMS which is  
15      really why we're here, then pull it off and we'll  
16      talk about it.

17          So, let's go -- is there any other  
18      public comment? Yes, go ahead.

19          MS. HANCOCK: Hello, I'm Rebecca  
20      Hancock with the American Academy of  
21      Ophthalmology and my question -- is this working?  
22      Okay.

1 Rebecca Hancock with the American  
2 Academy of Ophthalmology and my question, Andrew,  
3 is on your presentation, you had a slide I think  
4 about guidelines and the first bullet said that  
5 NQF endorsement is required for use of measures  
6 in the program.

7 But, I don't think that's the case, so  
8 I was hoping you could clarify that.

9 MR. LYZENGA: So, they are -- it's  
10 required -- recommended would be a better word  
11 maybe looking to see what the language was  
12 exactly.

13 Required unless no relevant endorsed  
14 measures are available that would fit -- that  
15 would meet the program objectives as part of the  
16 measure set.

17 MS. HANCOCK: I'm not certain that  
18 that's true. Dr. Goodrich, can you speak to  
19 that?

20 DR. GOODRICH: It's more -- well, you  
21 mean statutorily?

22 MS. HANCOCK: Right. Because I know

1       there's a --

2                   DR. GOODRICH: Statutorily, yes, for  
3       most programs, the way the statutes are written  
4       is that we should be using NQF measures, endorsed  
5       measures unless there is not an endorsed measure  
6       for a particular topic area that we want to use  
7       for the program.

8                   Now, the MAP has also separately come  
9       up with its own criteria. I think that's what  
10      Andrew -- I think that may be what you were  
11      speaking to, but I don't want to speak for the  
12      MAP on that.

13                  But, it's -- you guys should clarify  
14      that, I think.

15                  MR. LYZENGA: Yes, so typically as  
16      part of our preliminary evaluation and analysis,  
17      we will not recommend support of a measure unless  
18      it is NQF endorsed. We'll typically make our  
19      recommendation of conditional support with that  
20      condition being NQF review and endorsement.

21                  MS. HANCOCK: Okay, thanks. I just  
22      wanted to clarify that that wasn't a requirement



1 for use in one of the programs because I know  
2 there's lots of measures that aren't endorsed.

3 Thanks.

4 MS. RUBIN: Just a clarification with  
5 Physician Compare because I didn't recall seeing  
6 as part of the preliminary analysis the ability  
7 to comment on individual measures related to  
8 Physician Compare. I only saw the ability for  
9 MIPS or Shared Savings Program.

10 MS. BAL: So, that is correct because  
11 the MUC list was not under review for Physician  
12 Compare. What recommendations we're providing  
13 now is on the request of CMS. It was more of  
14 just we would like the feedback of the clinician  
15 work group and we thought it would be better --

16 MEMBER ORLOWSKI: Actually, we can't  
17 hear you with your head turned.

18 MS. BAL: Oh, I'm sorry. I'm going to  
19 bring this closer to me.

20 So, what I was saying was that the MUC  
21 list is not formally under review for Physician  
22 Compare. The list that was provided, CMS

1 requested that we, you know, get feedback from  
2 the clinician work group to help them as they  
3 further develop that program.

4 And so, we as a -- at NQF decided to  
5 make it a little more of a formal procedure where  
6 it was put on the consent calendars and everybody  
7 have a chance to look over it and change the  
8 decision.

9 So, that's why there was no commenting  
10 because it's not officially part of the MUC list.

11 CO-CHAIR BAGLEY: I see no further  
12 questions. Anybody on the phone have a question?

13 All right, we've earned a 15 minute  
14 break.

15 All right, thank you.

16 (Whereupon, the above-entitled matter  
17 went off the record at 10:31 a.m. and resumed at  
18 10:45 a.m.)

19 DR. WINKLER: Okay, I think that we're  
20 going to get started into the work at hand,  
21 beginning with the Medicare Shared Savings  
22 Program. My slide went away.

1           Okay, we've just had a discussion of  
2   that program. And so on this year's measures  
3   under consideration list, there are five measures  
4   for you to consider. There are two process  
5   measures that are NQF endorsed and already in the  
6   PQRS, MIPS measure set -- clinician measure set  
7   and that is the Falls measure and the Advanced  
8   Care measure. There are also two composite  
9   measures that use the ARHQ PQIs, Prevention  
10   Quality Indicators, for admissions for various  
11   conditions, one for acute and one for chronic.  
12   These two measures have been around for a while,  
13   but they are being revised significantly as well  
14   as additional risk adjustment is being developed  
15   for both of those measures. So these measures  
16   are still kind of in their developing phase.

17           And then there is one measure for --  
18   composite measure for ischemic vascular disease.  
19   All three of the composite measures are also on  
20   the list for MIPS. So with that, as an  
21   introduction to the five measures under  
22   consideration, Eric, back to you.

1 CO-CHAIR WHITACRE: Thank you, Reva.  
2 We'd like to begin by asking for any public  
3 comment on this measure set as part of the  
4 consent calendar. So either members in the room  
5 or people on the phone and we'd ask that the  
6 individuals limit their comments to two minutes  
7 or less.

8 MS. RUBIN: Hi, Koryn Rubin, American  
9 Medical Association. First, we seek  
10 clarification in terms of with the two PQI  
11 composite measures. Whether this is a  
12 replacement to the existing Shared Savings  
13 Program, kind of modified composite measures  
14 given that they are already accountable to a form  
15 of these measures due to the use within the value  
16 modifier because currently it's sending mixed  
17 signals to the ACOs, given that they're being  
18 measured on similar things, but differently. So  
19 that would be helpful and something hopefully the  
20 clinician work group could dive into.

21 But, in general -- so all the measures  
22 that comprise the composite of PQI 91 and 92 are

1 intended to be measured at the metropolitan area  
2 of county level per 100,000 beneficiaries.

3 Depending on the composition and size of the ACO,  
4 this measure may not be feasible to implement in  
5 the Medicare Shared Savings Program due to the  
6 minimum threshold required for the measure to be  
7 considered valid and reliable. If you are an ACO  
8 and you are accountable for costs which they are  
9 per the Shared Savings Program formula, then  
10 using measures of admissions and readmissions is  
11 inappropriate.

12 The ACO has a natural incentive to  
13 reduce avoidable admissions and readmissions  
14 already and we are aware of physician practices  
15 that are part of ACOs telling us that this is  
16 putting them in a weird place in terms of doing  
17 what's best for the patient in terms of treating  
18 them, given that they're held to another -- to  
19 these admission and readmission measures when  
20 they already have that incentive to control  
21 costs.

22 In some cases, the ACO may decide the

1 patient should be hospitalized or readmitted  
2 because that's more efficient than forcing them  
3 to pursue office visits or to provide home care,  
4 but the ACO doesn't have the flexibility to do  
5 that because of a measure that declares  
6 hospitalizations and readmissions bad in all  
7 cases.

8 In addition, information on how the  
9 measures perform at the ACO level has never been  
10 provided for existing measures in the Shared  
11 Savings Program or the value-based modifier. Nor  
12 have they been submitted to NQF for review. We  
13 recommend that the MAP does not support these  
14 measures. And if you look in the Discussion  
15 Guide, you can see some more detailed comments  
16 the AMA provided in terms of the variation of use  
17 with the measure and the level of testing and  
18 analysis that's been performed. Thank you.

19 CO-CHAIR WHITACRE: Thank you. Other  
20 comments? Comments from the phone?

21 OPERATOR: If you'd like to make a  
22 public comment, please press star 1. No, no

1 public comments at this time.

2 CO-CHAIR WHITACRE: Thank you very  
3 much. That means we move on then to the work of  
4 the committee. First, I'd like to remind  
5 everyone of the availability of the Electronic  
6 Discussion Guide. We're working from Version  
7 2.5. It's at the very top left of the Discussion  
8 Guide. You also have available to you the  
9 framework documents, tremendous work by the NQF  
10 staff which helps us look at and review existing  
11 measures for the Shared Savings Program as well  
12 as for MIPS. So two measures have been pulled so  
13 far for discussion.

14 Stephanie, you have pulled two, the  
15 last two, Prevention Quality Indicator 92,  
16 quality chronic composite as well as the ischemic  
17 vascular disease all or none.

18 And Winfred, you also had wished to  
19 pull that last one.

20 Are there other members who would like  
21 to extract measures for discussion? If not, then  
22 the work group would agree to accept staff

1 recommendations for the first three measures.

2 That would be specifically if you review to  
3 support the first two measures and to encourage  
4 further development of the third measure.

5 Yes, Jim?

6 MEMBER PACALA: Does this give us  
7 opportunity to comment on them as well, or once  
8 we vote we're moving on?

9 CO-CHAIR WHITACRE: Well, the purpose  
10 of the consent calendar is to vote and move on.  
11 It doesn't -- did you wish to pull a measure to  
12 comment?

13 MEMBER PACALA: I would like to make  
14 a brief comment on measure 3, the PQI 91.

15 CO-CHAIR WHITACRE: Okay, so that  
16 means we're voting on the first two measures  
17 where there has been recommendations for support  
18 by the staff. If there is no disagreement, then  
19 as part of the consent calendar we will accept  
20 those with a recommendation of support.

21 Terrific. Let's move on to the pulled  
22 measures.



1           Stephanie, we can do this in order of  
2           the measure or we can do it in the order in which  
3           the measure was pulled, but I think Stephanie,  
4           you had some overarching comments and concerns.

5           MEMBER GLIER: Sure, so actually I  
6           have a question for the NQF staff which is why I  
7           pulled PQI 92. And I'd really appreciate a  
8           little more clarification about why you assessed  
9           it as a measure still under development rather  
10          than as a measure that was done, tested, that  
11          sort of was going through modifications. So if  
12          you guys could clarify that for me.

13          DR. WINKLER: Sure. Again, discussion  
14          with CMS and their contractors about these  
15          measures and the information that was provided to  
16          us was that these measures, even though they've  
17          been around, are undergoing substantial change  
18          and the new development of risk models that have  
19          not previously existed. So those elements of the  
20          newness, if you will, is the rationale.

21          MEMBER GLIER: So related, is there  
22          something in the recommendation that I've missed

1 in the Discussion Guide about how we would  
2 encourage further development in a particular  
3 direction that is different from how we would  
4 make a conditional support recommendation pending  
5 these measures coming back to an endorsement  
6 committee and being pre-endorsed, given the new  
7 information?

8 DR. WINKLER: We can certainly add any  
9 of those things that you feel can be put in. If  
10 you noticed the commentary is listed under -- in  
11 the Discussion Guide under the two bullets, the  
12 potential impact of quality of care and  
13 contribution to the measure set, and we can add  
14 whatever you would like in there as well.

15 MEMBER GLIER: I don't have anything  
16 else to add. My recommendation was actually  
17 going to be to move it to conditional support for  
18 these measures pending them coming back after  
19 having been reclassified at the ACO level and  
20 tested at that level with the risk adjustment  
21 model. So I think that the comments that are  
22 included in the Discussion Guide fit. I was just

1 wondering about the specifics of the  
2 recommendation itself.

3 CO-CHAIR WHITACRE: You would be in  
4 agreement for continued -- encourage continued  
5 development for both the third and fourth  
6 measure, the composites. And do not support for  
7 the ischemic vascular because that was pulled as  
8 well.

9 MEMBER GLIER: I thought we could  
10 maybe talk about that one after Jim had a chance  
11 to talk about it.

12 CO-CHAIR WHITACRE: Okay, terrific,  
13 perfect. If you'd like to focus on the quality  
14 indicator.

15 Jim?

16 MEMBER PACALA: I just wanted to make  
17 a comment about the PQI 91. I'm fine with  
18 continued development, but does continued  
19 development mean that the three conditions  
20 listed, dehydration, bacterial pneumonia, or  
21 urinary tract infection will be continued to be  
22 developed? Or would those be under further

1 consideration for perhaps deletion or  
2 modification?

3 I'm concerned about rates of bacterial  
4 pneumonia and urinary tract infection,  
5 particularly in complicated elderly patients.  
6 Bacterial pneumonia, there are frequent cases of  
7 aspiration pneumonia that are really -- I'm  
8 worried about antibiotic over-usage. That's my  
9 bottom line.

10 There are cases of aspiration  
11 pneumonia where antibiotic coverage is not  
12 indicated and they are -- particularly in  
13 patients residing in nursing homes. And I'd be  
14 worried about urinary tract infection rates being  
15 a stimulus for unnecessary treatment of  
16 asymptomatic bacteriuria.

17 So I could just see an inter-  
18 professional team or a group of providers now  
19 reviewing any case of bacteria -- of pneumonia  
20 that's presenting or any possible symptom that  
21 might be a UTI and saying okay, we've got to  
22 check these things and those conditions being

1       overtreated. So I guess I would like that comment  
2       registered if it's under continued development  
3       and I would support for continued development if  
4       that comment was considered and there would be  
5       the option for deletion of certain conditions  
6       such as those two that I mentioned.

7                   CO-CHAIR WHITACRE: Thank you. Janis?

8                   MEMBER ORLOWSKI: First of all, I'd  
9       like to echo the comments on PQI 91 and I think  
10      in particular the urinary tract infection in an  
11      elderly population you have asymptomatic  
12      bacteremia. And so I do think that we need to be  
13      cautious of that.

14                   In regards to number four which is  
15      Prevention Quality Indicator 92, I have three  
16      comments in regards to the encouraged continued  
17      development. The first is that there is  
18      continuing evidence amassing regarding social  
19      demographic factors affecting these quality  
20      indicators of which neither the healthcare  
21      organization or physicians individually can  
22      control. And so I just want to continue to

1 support SES risk adjustment.

2 The second two issues I'd like to  
3 bring up is that they've not -- these measures  
4 have not been tested for a smaller population.  
5 They are listed as an event per 100,000, but most  
6 ACOs do not have 100,000 participants. And so  
7 the question is how does this test in a smaller  
8 population which is more akin to the ACOs that  
9 we're seeing?

10 And then finally we need to have  
11 information on the endorsement for provider level  
12 compare sets and that has not been done yet. So  
13 those are my comments regarding PQI 92. Thank  
14 you.

15 CO-CHAIR WHITACRE: Thank you. A  
16 couple different ways to proceed here. One would  
17 be -- because these are very closely related  
18 measures and we've heard comments on the PQI  
19 measures together, both the acute and chronic,  
20 would be if the committee wishes to vote on those  
21 while the discussion is fresh in our mind and  
22 then move on to the vascular measure which I

1 think is totally separate.

2 CO-CHAIR BAGLEY: Just a process  
3 comment and Stephanie, you kind of reminded me of  
4 this. I suppose probably we were supposed to say  
5 this earlier, but when we vote on a measure,  
6 we'll always have all three options available to  
7 us. So for instance, if you really felt that  
8 this should be conditional support, rather than  
9 -- then your commentary needs to convince the  
10 rest of us that it should be conditional support  
11 rather than just say if I were doing it, I'd --  
12 so somehow that's really what we're looking for  
13 is guidance around how we all should be thinking  
14 about the measure.

15 CO-CHAIR WHITACRE: Yes, Janis?

16 MEMBER ORLOWSKI: If that is available  
17 to all of the committee members, then I would  
18 encourage us to oppose that because these  
19 measures are not ready for use.

20 DR. BRISS: Just some clarification.  
21 You can't -- this measure is under development,  
22 so you only have the under development options.

1 You wouldn't be able to do conditional support  
2 because it's not a fully developed measure, so we  
3 cannot vote in that fashion.

4 However, if this was a fully-developed  
5 measure, you would have the option of support,  
6 conditional support -- so, and do not support.  
7 So unfortunately for these, since they are not  
8 fully developed, we can only have encourage  
9 further development, do not encourage further  
10 development or insufficient information.

11 CO-CHAIR WHITACRE: Thank you. David?

12 MEMBER SEIDENWURM: I had a question  
13 about 92. I don't know if the staff people have  
14 had a chance to think about how this type of a  
15 measure interacts with some of the hospital-  
16 acquired conditions, measures, because you're  
17 sort of putting people a little bit between a  
18 rock and a hard place about identifying the  
19 condition at the time of admission and having  
20 that be part of the admission diagnosis versus  
21 getting blamed for it if it's a hospital-acquired  
22 condition. And it just kind of puts people in a



1 bit of a bind, a little bit along the lines of  
2 the antibiotic overuse concern. So I wonder if  
3 that could be taken into account as development  
4 progresses.

5 CO-CHAIR WHITACRE: Thank you. We  
6 still have to hear from the lead discussants and  
7 if we could perhaps focus on the two issues under  
8 discussion, and I'll leave the vascular  
9 separately.

10 Marci, did you have anything you  
11 wanted to add to the discussion or respond to  
12 what's been said?

13 MEMBER NIELSEN: I did not. I was  
14 waiting for my big opportunity to redeem myself  
15 from last year and the dog ate my homework and I  
16 had prepared a lengthy statement, but all of  
17 these clinicians beat me to punch.

18 (Laughter.)

19 CO-CHAIR WHITACRE: Thank you. That's  
20 terrific. And Kate, I understand is not  
21 available unless she's still on the phone. She  
22 was earlier. Kate? Not there. Terrific.

1                   MEMBER KOPLAN: I'm here. I don't  
2 know if you can hear me. And I am listening  
3 intently to everybody's comments. This is my  
4 first meeting. I'm taking the opportunity just  
5 to listen and learn how the conversations  
6 proceed. But I have heard well what everybody  
7 else's comments are and won't add anything right  
8 now. Thank you.

9                   CO-CHAIR WHITACRE: Yes, Luther?

10                  DR. CLARK: Yes, could you clarify the  
11 distinction between principal diagnosis on  
12 admission and maybe one that's not principal?

13                  DR. WINKLER: We do have the folks  
14 from CMS.

15                  Rabia, are you still on the phone and  
16 would some of your folks that are working with  
17 these measures that could respond to some of  
18 these more technical questions?

19                  MS. KHAN: Hi, this is Rabia. Yes, I'm  
20 still on the line and I believe we also have our  
21 ACO program analysis contractors on as well to  
22 help support this conversation. I don't know if

1 Chris or Rosita, if you're on.

2 DR. BEADLES: Yes, this is Chris with  
3 RTI. The principal diagnosis is usually taken to  
4 be the first diagnosis code for principal  
5 diagnosis. Other diagnosis codes and the claims  
6 data that are 2 through 25 are considered  
7 secondary diagnoses.

8 DR. CLARK: So if this is not the  
9 first diagnosis, one of these diagnoses, then it  
10 would not be part of the measure, is that  
11 correct?

12 DR. BEADLES: Yes. Your understanding  
13 is correct. And these specifications are exactly  
14 the same as what the AHRQ specifications  
15 currently are. So for instance I believe it's --  
16 the COPD and asthma, there are a few places where  
17 it requires a principal diagnosis of COPD and  
18 then a secondary diagnosis of another  
19 accompanying factor that I'm blanking on at the  
20 moment. But there are a few cases where the  
21 specification, as detailed by AHRQ, will also  
22 look at a secondary diagnosis in order to count

1       that admission as COPD admission. I'm just  
2       blanking on what they are at the moment. And I  
3       believe it's the same thing for dehydration. So  
4       if the first diagnosis is for hyponatremia or  
5       hypernatremia, a sodium imbalance, then the  
6       secondary diagnosis somewhere has to also contain  
7       a dehydration to get them into that bucket. But  
8       the specifications are not -- the specifications  
9       for the conditions, be it dehydration, bacterial  
10      pneumonia or a UTI, as well as the chronic  
11      conditions, are not changed at all from what AHRQ  
12      definitions are -- they were originally  
13      specified. I hope that provides some  
14      clarification.

15               CO-CHAIR WHITACRE: Yes. Thank you.

16               DR. WINKLER: Also, Rabia, there were  
17      a couple of comments that Janis made about ACOs  
18      having smaller populations than the measure is  
19      specified for, the population level. And whether  
20      there's been any consideration for the  
21      interaction with the healthcare acquired  
22      conditions measures, I think you may have heard

1 those from David. If you have any comments about  
2 those?

3 MS. KHAN: Yes. This is Rabia. In  
4 terms of the population level that's used for  
5 these measures, both PQI composites are already  
6 used in the Physician Value Modifier Program.  
7 And we feel that since it's been applied at least  
8 and tested and used at a group level for the  
9 value modifier that's appropriate for use at an  
10 ACO level.

11 And in terms of I believe your second  
12 question, interaction with HACs? I am less  
13 familiar with sort of HACs -- I believe it's like  
14 the HAC Reduction Program, but we don't have --  
15 the PSIs that are using that program, so I'm a  
16 little unsure on what's being asked there.

17 DR. BEADLES: This is Chris again. I  
18 can add sort of a brief comment to it. Most of  
19 the time there's a present on admission indicator  
20 in the claims database now. That won't be there  
21 prior to I think it's 2011 or some year. I'm not  
22 exactly sure. But for all of the acute PQIs that

1 would have to be an admitting diagnosis, so it  
2 should not interfere or interact with any of the  
3 hospital-acquired conditions. Most of the time  
4 that we look at -- when we look at data analysis  
5 for admissions for these three conditions,  
6 pneumonia, UTI, the present on admission  
7 indicator is always filled in. I would say  
8 99.9999 percent. In other words, it's indicating  
9 that it's not hospital-acquired condition. And  
10 data analysis, we could look at that and see if  
11 that's something that needs to be taken into  
12 account. But when I look at the claims data, we  
13 haven't seen that.

14 And for the chronic conditions,  
15 because it's an admission for COPD or for asthma  
16 or for heart failure, I don't think that there's  
17 any way that could be misconstrued to be acquired  
18 on admission. I think that comment was mostly  
19 directed at the acute PQIs. Does that add some  
20 clarification for that one?

21 CO-CHAIR WHITACRE: Yes. Thank you.  
22 It does. This is a little confusing because the

1 same indicator measures are being considered  
2 later, tomorrow afternoon, as part of the MIPS  
3 program, so we're balancing between what should  
4 be used to measure individual performance as well  
5 as what should be incorporated into the ACO. So  
6 these are all really very helpful clarifications.  
7 Thank you.

8 Yes, Janis.

9 MEMBER ORLOWSKI: I do want to go back  
10 to the concepts that were present on admission,  
11 that there are times when -- where there is a net  
12 cast to try and capture things present on  
13 admission that may lead to inappropriate  
14 decisions being made. And pneumonia and UTI are  
15 two of those. So the concern is does this set up  
16 behavior that would increase the use of  
17 antibiotics for conditions on admission, for  
18 example, heart failure that is confused. Do we  
19 have a touch of heart failure or do we have a  
20 pneumonia? Do I have asymptomatic bacteremia or  
21 do I have a UTI? And I'm concerned and I think  
22 the comment was made earlier that we want to make

1       sure that we do not put in criteria that leads us  
2       to behaviors and screening that is inappropriate.

3               CO-CHAIR WHITACRE: Thank you. Other  
4       comments? So the staff has recommended for both  
5       the Prevention Quality Indicator measures, both  
6       the acute and chronic measures, encourage future  
7       development. We've heard, I think, one comment  
8       saying that perhaps they should not be  
9       considered. I think if there's no further  
10      discussion, perhaps -- and we need to vote on  
11      these separately because they're in different  
12      phases of development. Perhaps we can proceed to  
13      a vote on those two measures before we proceed  
14      with the vascular measure. That to me is totally  
15      separate.

16             So can we -- this is our first assay  
17      here. Oh please, Jim.

18             MEMBER PACALA: I'm sorry, Eric, but  
19      I did ask a question before and that is if we  
20      were to vote for encourage further development,  
21      does that mean that we're endorsing looking at  
22      pneumonia and UTI or would further development



1 mean that perhaps the designers of the measure  
2 would reconsider those conditions?

3 DR. WINKLER: Jim, essentially the  
4 recommendations from the MAP are the feedback to  
5 CMS measure. You heard Kate say this morning one  
6 of the values of the feedback is to take under  
7 consideration these things. I don't think we can  
8 at this point know where that will take us. Or  
9 take CMS, anyway.

10 CO-CHAIR WHITACRE: Thank you. That's  
11 very helpful. So basically, we're encouraging  
12 further development. This discussion can be a  
13 basis for how the measure developer takes that  
14 back and refines it, but we're not tweaking the  
15 measure on the table.

16 So if we can show -- this will be our  
17 first assay here and using our clickers, if we  
18 can show measure PQI 91 prevention quality acute  
19 composite on the screen. It's slowly coming up.  
20 This will be MUC ID: MUC15-577 for those on the  
21 phone. Our options for this -- remember, this is  
22 the one that sort of fell in between the cracks.

1 It was already being utilized and it was  
2 considered a fully-developed measure for the  
3 purposes of our analysis.

4 DR. BRISS: Sorry, I think we had some  
5 miscommunication. We'll combine them. We'll  
6 vote on the second one while we get that slide  
7 ready. Will that be okay? Give us two seconds  
8 to get that slide ready.

9 CO-CHAIR WHITACRE: I would be in  
10 favor of separating these so there's no ambiguity  
11 later when we review the data. Because one of  
12 these does fall into a somewhat unusual  
13 situation. So the vote would be first, for PQI  
14 91, prevention quality acute composite. MUC15-  
15 577. And our choices are encourage further  
16 development, do not encourage further  
17 development, or insufficient information. Are we  
18 ready to vote?

19 MS. CHAVEZ: Voting is open.

20 DR. BRISS: Terry and Kate, please put  
21 your vote in through the tab feature.

22 MS. CHAVEZ: Okay, 95 percent voted

1 encourage for further development; five percent  
2 did not encourage further consideration.

3 CO-CHAIR WHITACRE: Terrific. Thank  
4 you. If we can move to the next measure, PQI 92.

5 MS. CHAVEZ: Voting is open.

6 CO-CHAIR WHITACRE: This is a vote on  
7 Prevention Quality Indicator 92, prevention  
8 quality chronic composite MUC ID MUC15-576.

9 MS. CHAVEZ: Okay, 95 percent voted  
10 encourage for continued development; five percent  
11 did not encourage further consideration.

12 CO-CHAIR WHITACRE: Great. Thank you.  
13 So if we could move on to discussion to the last  
14 measure which is ischemic vascular disease all or  
15 none outcome measure. This was pulled by  
16 Stephanie and Winfred.

17 Any discussion as to why the measure  
18 was pulled or your concerns?

19 MEMBER GLIER: Sure, I'm happy to  
20 start, unless you'd rather start, either way.

21 DR. WU: Well first off, I just have a  
22 question with respect to NQF 0076 which was cited

1 as a measure that's currently endorsed and  
2 overlaps with this measure. Can you confirm  
3 whether or not statin therapies was included as  
4 one of the requirements to meet the numerator for  
5 that measure?

6 DR. WINKLER: Actually, this measure  
7 is coming up for its maintenance review in the  
8 coming cycle and they have -- and Beth can  
9 probably add to this, but the indication is that  
10 it will have the statin review -- it will have  
11 the statin component at that time.

12 DR. WU: Okay. I mean that was just  
13 my major question. And if, in fact, with NQF  
14 0076 coming up for re-review and the statin  
15 therapy is included, I'm in support of this  
16 recommendation to do not support given that we  
17 want to, you know, utilize existing measures. So  
18 that's reasonable. However, if that is not the  
19 case, I would advise otherwise.

20 MEMBER AVERBECK: This is Beth  
21 Averbeck, Minnesota Community Measurement. Yes,  
22 statin therapy is included. There are some

1 exclusions based on underlying causes, but  
2 otherwise statin therapy is in the revised  
3 measure.

4 CO-CHAIR WHITACRE: Stephanie.

5 MEMBER GLIER: I have a question that  
6 may be best posed for either for Sophia or for  
7 Rabia if they're able to answer it which is about  
8 why 0076 is being pulled from PQRS. I understand  
9 that there are some concerns about duplication  
10 with components of 0076 as well as with the  
11 measure that's actually on the MUC list that  
12 we're actually talking about with the Million  
13 Hearts set. I'm wondering if you guys could say  
14 a little bit more about the thinking behind  
15 pulling the measure -- pulling the composite  
16 measures in favor of the separate measures.

17 MS. AUTREY: I didn't know if Rabia  
18 wanted to speak first.

19 MS. KHAN: Sophia, yes. 0076, my  
20 understanding is the optimal vascular care  
21 measure is not in the Chair's program set, so  
22 I'll just turn it over to you.

1 MS. AUTREY: Okay. So the reason why  
2 we initially proposed to pull it was because it  
3 did not have the statin component included in it  
4 and we did have another measure that was going to  
5 have that statin component. So from our  
6 standpoint, that would be duplicative so we did  
7 want to actually remove it.

8 MEMBER GLIER: So I'm sorry, you were  
9 talking about the decision was to pull the  
10 Minnesota Community Measurement optimal vascular  
11 care measure which is 0076 referenced in the  
12 Discussion Guide, but not actually on the MUC  
13 list, because it did not have a statin component.  
14 And you had a duplicative statin measure already  
15 in the --

16 MS. AUTREY: Well, the reason was  
17 because it didn't have the statin component, but  
18 then it actually was not consistent with the  
19 guidelines. So that's the reason why we wanted  
20 to actually pull it.

21 CO-CHAIR WHITACRE: Amy, you were  
22 next.

1                   MEMBER MOYER: I was initially excited  
2 to see this measure because I thought it was the  
3 Minnesota Community measure which is endorsed and  
4 then I was very confused that we would be  
5 considered an overlapping measure that's not  
6 endorsed when we have one that is. And I know we  
7 probably can't submit measures from the floor,  
8 but I was also frustrated to not see the  
9 corresponding Minnesota Community Measurement  
10 diabetes all or nothing outcome composite,  
11 especially since that was a gap area that was  
12 identified. And in looking at existing measures  
13 in this program, I see two for diabetes. And  
14 there's some real gaps there that aren't being  
15 measured. I probably can't change that now, but  
16 just wanted to point that out.

17                   CO-CHAIR WHITACRE: Beth and then  
18 Janis.

19                   MEMBER AVERBECK: So maybe I'll just  
20 give some background, the history of the optimal  
21 vascular measure because previously it had an LDL  
22 target and then when the guidelines changed it

1 was pulled and went into kind of a year where it  
2 wasn't reported while the group got together and  
3 looked at the revised guidelines and then made a  
4 new measure that had -- a revised measure that  
5 then had the statin component in it. So it was  
6 on hiatus for a bit while the guidelines were  
7 being reviewed and the measurement group got back  
8 together again. So that's just the history of  
9 why the vascular measure didn't have a statin in  
10 because it had the previous LDL target and then  
11 it was revised.

12 CO-CHAIR WHITACRE: Janis.

13 MEMBER ORLOWSKI: So I'm going to make  
14 a general statement about outcomes measures and  
15 I'll just say ditto as we roll through them. I  
16 think that when we take a look at outcomes  
17 measures, we need to take a look at our risk  
18 adjustments, specifically, we need to look at the  
19 social demographic factors. And if there's not a  
20 comment in them, then we have to understand if --  
21 is there the ability for the physician, for the  
22 providers, or for the hospital to impact that



1 outcome or are there factors beyond their  
2 control?

3 So as we take a look at outcomes --  
4 and again, there's amassing literature that there  
5 are SDS factors that cannot be ameliorated by the  
6 provider. And so we can't hold people  
7 accountable for outcomes measures if they cannot  
8 affect specific -- if they cannot affect the  
9 factors that lead to that outcome.

10 So again, I support -- let me say this  
11 this way, I do not support this measure which is  
12 the staff recommendation, but for a different  
13 reason.

14 CO-CHAIR WHITACRE: Peter, did you  
15 have a comment?

16 DR. BRISS: Just to tie up the  
17 previous discussion on the optimal diabetes care.  
18 Maybe Beth can clarify on that one, too. I think  
19 it's a substantially similar story to the optimal  
20 vascular care one. The statin component also  
21 needed to be updated on that one, too, right?

22 MEMBER AVERBECK: Yes, so there was a

1 peer with optimal diabetes that had LDL targets  
2 and that on a revision went to statin resource  
3 specific LDL values based on age and  
4 recommendations.

5 CO-CHAIR WHITACRE: Amy.

6 MEMBER MOYER: I just had one  
7 additional thing. We looked at alignment across  
8 pairs, both at optimal diabetes and the optimal  
9 vascular care measure from Minnesota Community  
10 Measurement. They are part of the priority list  
11 that was put together from the catalyst for  
12 payment reform for purchasers. I know we used  
13 these in our pay for performance program. We  
14 used them in a lot of our other programs. So  
15 there's an opportunity for some real alignment  
16 there and asking the same thing from providers.  
17 We're all asking for that same measure.

18 MEMBER PELLEGRINI: So cardiovascular  
19 isn't something where I spend a lot of time. Can  
20 someone explain what the overlap is, if it is  
21 exact with the Million Hearts measure and which  
22 of the programs, if any, that measure is

1 incorporated into already? Because we're saying  
2 it's duplicative. Part of the reason for the do  
3 not support is that it's duplicative of the  
4 Million Hearts measure?

5 DR. WINKLER: That was actually taken  
6 as the rationale for removing it from PQRS by CMS  
7 this year in the most recent final rule.

8 MEMBER PELLEGRINI: But is that  
9 because that Million Hearts measure is also in  
10 PQRS?

11 DR. WINKLER: Correct.

12 MEMBER PELLEGRINI: Okay. But that  
13 would not disqualify it from being in the Shared  
14 Savings Program.

15 MS. AUTREY: So one of the things that  
16 we tried to do with Shared Savings Program and  
17 PQRS is align the measure set. And so the reason  
18 why when we removed it from PQRS, we wanted to  
19 make sure that we aligned with ACO. And that's  
20 why.

21 MEMBER PELLEGRINI: Thank you.

22 CO-CHAIR WHITACRE: Any comments from

1 the -- oh, excuse me. Barbara?

2 MEMBER LANDRETH: Just a quick comment  
3 on the statins. I'm assuming the reason that  
4 statins were -- or the LDL target was replaced  
5 was simply the documentation that a person was on  
6 statins was based on the new guidelines. But if  
7 you look carefully at the new guidelines, they  
8 have very clear indications for high intensity,  
9 medium intensity, low intensity statins. And I  
10 want to make sure because that is truly an  
11 approximation for an LDL target. High intensity  
12 statins will reduce your LDL by 50 percent or  
13 more. So I think that that's really important  
14 that we look at -- if we're taking away the LDL  
15 target, I think it's really important that we  
16 look at which statins are actually being given.  
17 Because if you're giving Pravachol 20 milligrams  
18 to somebody with an LDL of 200, is that going to  
19 meet your target?

20 CO-CHAIR WHITACRE: Peter?

21 DR. BRISS: If I understand it, so two  
22 things. A Million Hearts has relevant measures

1 that HHS has been working really hard at and  
2 aligning across programs on hypertension, tobacco  
3 use cessation, appropriate aspirin use, and  
4 cholesterol management. So all of those issues  
5 are addressed currently in Million Hearts  
6 measures.

7 About the last point about cholesterol  
8 measures, it's actually harder than one would  
9 expect to know what those statins people are  
10 actually on from current EHR, so my understanding  
11 is you can get a reasonable -- you can know what  
12 size pill a person is on, but you can't actually  
13 know what dose of statin somebody is on easily.  
14 And so I think most of the current statin  
15 measures aren't trying to determine intensity of  
16 statin use because it's hard to pull out of an  
17 EHR.

18 CO-CHAIR WHITACRE: Beth?

19 MEMBER AVERBECK: I'll make a comment.  
20 We did discuss whether or not we would try and do  
21 dosing of statins, but there are a number of  
22 initiatives around pill splitting for cost

1 savings and other things. So it was ideal,  
2 averse, and feasibility and so after the  
3 discussion it was around statin use. But to try  
4 to get to the, I think, hugest point, absolute  
5 dosing was really hard through an EHR.

6 CO-CHAIR WHITACRE: I think this is a  
7 great discussion for developers of other  
8 measures.

9 Stephanie?

10 MEMBER GLIER: To go back to my -- the  
11 reason I originally pulled this measure which was  
12 actually sort of related to the conversation  
13 we've been having here. I think generally -- I'm  
14 not sure what the right recommendation is for the  
15 MAP work group to make to have this outcome. But  
16 in general, it would be really lovely to have  
17 high quality outcome measures, composite measures  
18 to the extent possible.

19 I like the Million Hearts measures.  
20 I think Million Hearts is doing great things.  
21 Keep doing it. But I'm not sure that having  
22 those components of the Million Hearts measures

1 is worth getting rid of a really high value  
2 composite measure. And so I would like to  
3 encourage CMS to consider using composite  
4 measures wherever possible, especially for things  
5 like optimal care when we have this kind of a  
6 robust set of information together. So whether  
7 we decide that the Wisconsin IVD all or none  
8 measure or the Minnesota Community Measurement  
9 measure when it's done going through the  
10 guidelines review or some other approach is the  
11 best approach, I think my message -- and I hope  
12 that the work group members will support me on  
13 this. We'd really like to have this type of a  
14 composite outcome measure that can tell us a lot  
15 of information easily.

16 CO-CHAIR WHITACRE: Thank you. We'll  
17 be voting specifically on this measure, but I  
18 appreciate your comments.

19 Bruce.

20 CO-CHAIR BAGLEY: My comments are  
21 similar. I think the rationale used by the staff  
22 is that if it's part of the Million Hearts, then

1 we don't have to have another measure. However,  
2 what's the mechanism to make sure that measure is  
3 in the set I guess is what I want to know, just  
4 to say we don't support it because it's done  
5 somewhere else is not addressing the fact of  
6 whether it should be here or not, to me.

7 DR. WINKLER: Just to comment. If you  
8 look at the measures that are currently in the  
9 Shared Savings Program, the aspirin component and  
10 the statin component are already individual  
11 measures in the Shared Savings Program.

12 CO-CHAIR BAGLEY: My second comment is  
13 about composite measures. I agree. Composite  
14 measures are very high leverage for improvement  
15 because they force you to have a systematic  
16 approach to all four things as opposed to -- so  
17 if your organization does 75 percent on each of  
18 four measures, that's your average, then if you  
19 multiply those all together, you get 32 percent.  
20 And that makes providers very nervous. They get  
21 twitchy like this, they go what? Thirty-five  
22 percent? I'm used to getting 100 percent. So



1 they're very good for quality improvement.  
2 They're a little tough on the troops for payment  
3 and judgement.

4 So I agree that this is the kind of  
5 thing that's going to make the most difference  
6 for improvement. So I hope we're not going to  
7 abandon composite measures because they're not  
8 popular.

9 CO-CHAIR WHITACRE: Thank you. Any  
10 discussant contributions? Marci or Kate?

11 MEMBER NIELSEN: No comments on this  
12 end. I do think it's worthwhile to point out two  
13 things though that would underscore some of the  
14 concerns that have been addressed. One is the  
15 shift toward outcomes measures which is a  
16 balancing act with some of these performance  
17 measures, acknowledging that the goal is going to  
18 be outcome measures, but recognizing until we  
19 have solid measures, it's difficult to get there  
20 and I think that's the sort of needle that we're  
21 trying to thread. Yes, that's it. I'm not  
22 mixing metaphors.

1           The other point around risk adjustment  
2   for SES is another important one, not just from  
3   the provider perspective who may be in an  
4   academic medical center taking care of a lot of  
5   very sick --- and folks who are high risk, but  
6   from the perspective of patients. As we start to  
7   report patient-reported outcomes, I think it's  
8   important for us to realize that patients want to  
9   know who's taking good care of high-risk  
10   populations. And so we just want to go on the  
11   record underscoring the same kinds of concerns,  
12   but maybe from a different angle.

13           CO-CHAIR WHITACRE: Kate, did you have  
14   a comment?

15           MEMBER KOPLAN: This is Kate also. I  
16   am still trying to figure out the redundancy  
17   issue. And so it's a little bit -- you know, you  
18   can't tell from this analysis and none of us can  
19   probably memorize all of the different places  
20   where we see the measures. So in the future if,  
21   for example, redundancy is one of the concerns,  
22   it may be helpful to sort of list it out.

1 Million Hearts -- and these are the kind of  
2 people that participate there. What is currently  
3 in different kinds of ACOs you see in -- and  
4 that's the PQRS and other places for some of the  
5 composites, if that's the group's concern.

6 But I do also support that the  
7 composite measures represent how well we're doing  
8 for each individual patient, even though for the  
9 separate measures we do well. So we also like  
10 composite measures and KP uses a lot of them. So  
11 I do agree generally with the concept of them.  
12 And I do -- whoever mentioned the statin concern,  
13 it kind of does become a process measure if  
14 you're just on a statin rather than if you're on  
15 an effective statin. So whereas the hypertension  
16 control is really a quote unquote outcome, it's  
17 a more robust measure, just the fact whether or  
18 not you're on a statin makes me a little bit  
19 nervous because it doesn't represent clinical  
20 effectiveness. So that would be my concern with  
21 that one part, as opposed to the aspirin and  
22 blood pressure and the tobacco-free pieces feel

1 really good.

2 CO-CHAIR WHITACRE: Thank you. Yes?

3 DR. ALEMU: My concern is about one of  
4 the components of the measure about statin use.  
5 And as you know, after the new guideline, I'm not  
6 aware of any measure which speaks to that  
7 guideline. And the HHS is trying to develop a  
8 measure which is simple and can be used for  
9 Million Hearts initiative, but in this case I am  
10 really not aware of a measure that is currently  
11 developed related to the new guidelines. So I  
12 just want to point out that concern.

13 CO-CHAIR WHITACRE: Thank you. Any  
14 other discussion? This is just a great example  
15 of how we can take one measure which in the end  
16 we may not feel very strongly about, generate  
17 this great discussion about composite measures,  
18 outcomes, patient-reported experience, risk  
19 adjustment, and try to refine some other measures  
20 which aren't even on the table. So that's really  
21 wonderful. That's the value, I think, of this  
22 committee.

1                   So I think if there are no other  
2                   comments, it would be time to vote and it looks  
3                   like -- oh, excuse me, Barbara.

4                   MEMBER LANDRETH: Please clarify for  
5                   me again if we do not support this, does this  
6                   mean that there will not be a composite  
7                   cardiovascular initiative in this round?

8                   DR. WINKLER: You're making a singular  
9                   decision on this particular measure for the  
10                  Medicare Shared Savings Program.

11                  MEMBER LANDRETH: So the fact that  
12                  it's in Million Hearts doesn't really matter?

13                  DR. WINKLER: The way they talk about  
14                  Million Hearts measures are the measures  
15                  themselves which as Peter said were the aspirin,  
16                  smoking, blood pressure, and statin use. There  
17                  are -- there's already a measure of aspirin and  
18                  statin use in the Shared Savings Program.

19                  CO-CHAIR WHITACRE: Yes, Winfred.

20                  DR. WU: Could I just make one  
21                  suggestion? Since this is going to come up to be  
22                  one of these re-options, maybe the conditional

1 support could be one whereby if NQF 0075 does not  
2 have its re-review completed with statin therapy  
3 listed in the revised measure that we might  
4 conditionally support this Wisconsin proposed  
5 measure otherwise?

6 DR. WINKLER: I was going to say just  
7 realize 0076 is not in the Shared Savings Program  
8 either. It previously was in the PQRS program.

9 CO-CHAIR WHITACRE: Yes, Peter.

10 DR. BRISS: I thought when we looked  
11 at the Shared Savings Program's measures this  
12 morning that, in addition to the two that you  
13 said, that blood pressure and smoking measures  
14 were also in Shared Savings.

15 DR. WINKLER: I think you may be  
16 right, but was the blood pressure just for  
17 hypertensive patients or was it for everybody?

18 DR. BRISS: It's both a screening  
19 measure that essentially applies to everyone and  
20 a controlled measure that applies to people who  
21 need to be controlled. So all four of the  
22 components -- I guess it depends on -- some of

1       you have said that you feel strongly about a  
2       composite measure, but at least all four of the  
3       components that are reflected in this composite  
4       are already reflected in the program as it  
5       stands.

6                   DR. WINKLER:  Thanks for the  
7       correction, Peter.

8                   CO-CHAIR WHITACRE:  Janis.

9                   MEMBER ORLOWSKI:  A comment regarding  
10      the politics of voting.  I am concerned about  
11      disagreeing with the measure, but holding it open  
12      for further work, like a placeholder to dump  
13      other bills into so to speak.

14                   I think that we should say yes or no  
15      on this measure or it needs more work, but we  
16      also have the opportunity to send strong messages  
17      back.  We want a measure that does X, Y, or Z.  
18      So rather than holding a bad measure open, we  
19      should vote on the measure, but then send strong  
20      messages about what we want to come forward.

21                   CO-CHAIR WHITACRE:  Thank you.  That's  
22      my understanding as well.  We're voting on this

1 specific measure, not the concept, not other  
2 relevant measures that could be very applicable.

3 Thank you.

4 Yes?

5 MEMBER KOPLAN: Can you clarify what  
6 the choices are?

7 CO-CHAIR WHITACRE: We're not quite  
8 ready to vote. Our choices we'll go over.  
9 There's still a comment.

10 Stephanie?

11 MEMBER GLIER: It's another clarifying  
12 question for CMS. Since we are not, in fact,  
13 talking about 0076, but 0076 has been in PQRS  
14 before, would that measure need to come back to  
15 the MAP on the MUC list in the future for  
16 inclusion in the future program or would it be  
17 okay as is?

18 MS. AUTREY: If there were changes to  
19 0076, then yes, it would need to come back  
20 through the MAP.

21 CO-CHAIR WHITACRE: Jim.

22 MEMBER PACALA: Quick and philosophical



1       retort to Bruce's endorsement of composite  
2       measures. I do think we need to be careful  
3       because it would be great to pair -- and I know  
4       this is very difficult logistically, but to pair  
5       a composite measure with a patient-centered,  
6       goal-oriented outcome or process measure.

7               I've got a lot of patients who don't  
8       like to take drugs. And if we start going whole  
9       hog on this, and I've got 75 percent of each of  
10      the -- and that's what they want. They don't  
11      want to take a statin. And if we start doing  
12      SPRINT -- if we start following SPRINT, we're  
13      going to be pushing blood pressure medicines on  
14      these people like crazy. I mean the average  
15      SPRINT subject needed three anti-hypertensives to  
16      get down to 120.

17              So just a philosophical comment for  
18      general purposes that I do think we need to  
19      balance the rigor of the composite measure with  
20      some kind of patient or goal-oriented outcome as  
21      well. And with some kind of waiver if the  
22      patient doesn't want to take all those drugs.

1 CO-CHAIR WHITACRE: Please.

2 CO-CHAIR BAGLEY: I think that's a  
3 classic physician retort in the sense that 100  
4 percent must be the best. And we don't even know  
5 really what optimal -- you guys are beginning to  
6 know what optimal performance is and it might be  
7 50 percent that might be optimal performance.  
8 And that's perfectly okay. So it's not the  
9 composite that makes that a problem, it's the  
10 individual measures and patients and stuff that  
11 make that a problem. But everybody will be  
12 measured on the same approach. And a composite  
13 measure makes you have a checklist. If you want  
14 to do well on a composite measure, you've got to  
15 have a checklist. So it makes you put some  
16 process in place that's going to get better  
17 outcomes on that, regardless of the patient  
18 population by the way.

19 MEMBER PACALA: I know that. I live  
20 in Minnesota and you know, I get together with my  
21 panels -- with my team and panels and we've got  
22 now statin. That's one of the -- you know, so

1       who's on a statin, who's not? And we get after  
2       them. We force the statins on them to get our  
3       composite up.

4                   CO-CHAIR WHITACRE: Barbara.

5                   MEMBER LANDRETH: Jim, I think you're  
6       lucky to live in Minnesota. I live in Oklahoma.  
7       So we have some of that worst health statistics  
8       --

9                   MEMBER PACALA: Better football team.

10                  MEMBER LANDRETH: Well, that's true,  
11       but that's all we can do. So unfortunately, it's  
12       very true, patient compliance is nowhere factored  
13       into any of these measures and I'd like to see  
14       future measures being developed that would have  
15       in your checklist, Bruce, the physician or the  
16       provider has the opportunity to say patient is  
17       not compliant. Or patient refuses to exercise.  
18       I've counseled until I'm blue in the face. They  
19       will not change their diet. So I think that  
20       those kinds of things need to be factored in  
21       because patient compliance -- we're not acting on  
22       widgets. We're not acting on inert subjects.

1 They have free will.

2 CO-CHAIR WHITACRE: Cindy and then  
3 Janis.

4 MEMBER PELLEGRINI: Barbara, I really  
5 actually agree with you. And I think that there  
6 are a lot of cases -- the only place I'm going to  
7 disagree is that we shouldn't just be classifying  
8 patients as a recalcitrant because in some cases  
9 they're actually making very carefully considered  
10 decisions.

11 And I think it's one thing to talk  
12 about cardiovascular care, but in the maternal  
13 and child health world, we put a lot of choices  
14 in front of people and we may encourage one, but  
15 we accept others, whether it's things like C-  
16 section or scheduled deliveries and things like  
17 that. So I'd love to see us all get into that  
18 and say either -- how can we quantify the kinds  
19 of choices that patients are making because there  
20 have been a couple of cases in my own medical  
21 history where my doctor said I think you should  
22 do this. And I said thank you very much, but you

1 know what, I'm not going to. And here are my  
2 reasons why and we're just going to agree to  
3 disagree. Teasing that out is, of course,  
4 incredibly difficult, but I'd love to see us go  
5 in that direction.

6 CO-CHAIR WHITACRE: Janis.

7 MEMBER ORLOWSKI: Not to prolong this  
8 too long, but since we're being philosophical, I  
9 completely agree. I think that we need to have  
10 an opportunity to indicate patients' preference,  
11 whether it's the preference or noncompliance.  
12 But I also think that when we take a look at  
13 certain measures that we need to first of all  
14 understand those people who choose not to be  
15 compliant, but then we need to compel providers  
16 to try to push that percentage. And I'll give  
17 you an example.

18 I recently visited a hospital where  
19 I'm sure they had 100 percent compliance with the  
20 influenza vaccine documentation on admission to  
21 the hospital. Ninety percent of people chose to  
22 refuse the vaccine. I don't believe that. And

1       so I think that what they have is they have 100  
2       percent compliance with the measure. And I would  
3       say since we know from a public health point of  
4       view, it's probably one of the most important  
5       things that we can do is to vaccinate. And once  
6       we have the measure and they drive it in there  
7       100 percent, the next thing is that if you're at  
8       90 percent refused, that there has to be some  
9       target of improvement so that the next year  
10      you're at 80 percent improvement or 70 or  
11      whatever, so that I do believe that there should  
12      be patients' indication of choice. But it is  
13      also our responsibility as physicians is to  
14      educate our patients and their families to what  
15      is absolutely rock solid, scientific information  
16      regarding vaccination. And that is the  
17      responsibility we have.

18               So again, I'm speaking philosophically  
19      of where you go from process measures to outcomes  
20      or whatever. And there will be patients who  
21      refuse vaccinations. That's fine. But we have  
22      some role to play in that.

1 CO-CHAIR WHITACRE: Thank you. We're  
2 going vascular to vaccination. That's terrific.

3 Peter.

4 DR. BRISS: I want to support that  
5 general thrust, too. I don't want to give a sort  
6 of too uniform view of us needing to endorse  
7 blaming the patient, so think about -- one of my  
8 hats is I'm still a working stiff internist and  
9 so I know how hard this can be. But you know,  
10 think about smoking cessation is still always the  
11 right thing. And think about how many times you  
12 have to talk to somebody 16 times before they  
13 actually quit, but they eventually do quit. And  
14 so I'm real reluctant to give providers the  
15 patient just won't go there on the first time you  
16 say it. And we know that you won't bat a  
17 thousand all the time, but it's still -- there  
18 are still some things that are the right thing  
19 and we ought to be trying to do better.

20 CO-CHAIR WHITACRE: Marci.

21 MEMBER NIELSEN: I'm so sorry. I  
22 can't help but listen to this conversation and of

1 course, we all know that language matters. So  
2 I'm a little sensitized to compliance language.  
3 In many, many cases when patients are making  
4 decisions about care they don't want that we  
5 believe as clinicians is in there better  
6 interest, it's because there are other issues at  
7 play, often behavioral health.

8 And so I recognize this is a measures  
9 conversation, but given that we've got a public  
10 record here, I would just want to point out that  
11 engaging patients in real and substantive ways  
12 often gets us the improvements in those measures  
13 that are critically important and so behavioral  
14 health, absolutely critical, often left out.

15 CO-CHAIR WHITACRE: Yes, Rachel.

16 MEMBER GROB: I just wanted to throw  
17 out a not very well considered yet by me, idea  
18 that we sort of marry the idea of the composite  
19 measures and the idea that when we look at  
20 outcomes related to specific kinds of  
21 recommendations and want to also take into  
22 account the behavioral health issues and the



1 patient's own decision making and autonomy that  
2 we think about composites that measure sort of  
3 patient experience and shared decision making  
4 along with some of these outcomes. I don't  
5 really know how that's done because I'm not a  
6 technical measure developer, but I know that we  
7 have these issues kind of in the field with does  
8 patient experience -- high patient experience  
9 scores actually potentially indicate poorer  
10 clinical quality. And I think it's a good debate  
11 to follow further with evidence and measure  
12 developments.

13 CO-CHAIR WHITACRE: Beth.

14 MEMBER AVERBECK: So good suggestion.  
15 Actually, when we looked at the optimal vascular  
16 and optimal diabetes, there was a lot of  
17 discussion around could we incorporate a shared  
18 decision metric in there and then there was more  
19 discussion on how there weren't really good  
20 definitions nor metrics around shared decision  
21 making, so I wonder if with that thought we might  
22 want to consider that as a measurement gap in the

1 discussion tomorrow around shared decision  
2 making. It's hard to put a -- when it's not yet  
3 fully developed into a composite, although over  
4 time that would be ideal and then maybe some  
5 steps to get there.

6 CO-CHAIR WHITACRE: Very nice. We'll  
7 start to keep a check list for that. Mady?

8 DR. CHALK: Those issues of shared  
9 decision making out of behavioral health issues  
10 have been a particular focus on the Duals Work  
11 Group in thinking about measures and assuring  
12 that those were included as factors in how these  
13 measures are applied. So I think we really need  
14 to keep that in mind.

15 CO-CHAIR WHITACRE: Well, this has  
16 been a great discussion. If there's nothing  
17 further about this measure.

18 MEMBER KOPLAN: I have one more  
19 comment. This is Kate on the phone.

20 CO-CHAIR WHITACRE: Yes.

21 MEMBER KOPLAN: Just about the  
22 medication adherence conversation and so I don't

1 see medication adherence as part of this,  
2 although that was obviously part of the previous  
3 conversation. And obviously, in CMS stars, for  
4 the stars quality measurement, there are at least  
5 three med. adherence measures if not more and  
6 there are other adherence measures. But in CMS  
7 stars, those are weighted very heavily, so  
8 they're obviously recognizing the importance of  
9 those measures.

10 It would be nice if that is something  
11 that we wanted to proceed with. Those are kind  
12 of like standalone med. adherence measures with  
13 different specs than what we're used to. If we  
14 were to sort of help develop some similar kind of  
15 things along those lines to help speak to the  
16 patient side, non-adherence, and a real outcomes-  
17 based approach. So those are things we're  
18 pursuing in KP. Thanks.

19 CO-CHAIR WHITACRE: Thank you.

20 Rachel?

21 MEMBER GROB: I'll be quick, but I  
22 just -- Mady, thank you for that comment and I

1 wonder if there's a time that would be  
2 appropriate for us to hear more about how your  
3 work group coped with these discussions or  
4 specific recommendations that you made. I  
5 realize that we have to vote now and it's not the  
6 time, but that was a very intriguing introduction  
7 and I just wanted to acknowledge it and ask for  
8 follow up.

9 CO-CHAIR WHITACRE: Thank you. If  
10 there are no other comments, we'll proceed to  
11 vote on the measure which is on the screen,  
12 ischemic vascular disease, all or none outcome  
13 measure, optimal control, MUC ID: MUC 15275.  
14 Our choices are support, conditional support, or  
15 do not support.

16 MS. CHAVEZ: Voting is open.

17 DR. BRISS: Kate, Terry, please enter  
18 your votes.

19 MS. CHAVEZ: We had 20 votes, 10  
20 percent voted support, 40 percent voted  
21 conditional support, 50 percent voted do not  
22 support. So this measure does not pass.

1 CO-CHAIR WHITACRE: Thank you. Great  
2 discussion. I hope we will continue through  
3 lunch.

4 DR. WINKLER: Okay, I think we're  
5 pretty much ready for lunch at this point.

6 CO-CHAIR BAGLEY: We have another  
7 housekeeping item. How many people might be  
8 interested in a dinner this evening, especially  
9 for those who are out of town? Could you raise  
10 your hand so we can get a count? It's yet to be  
11 determined where and when, but --

12 MEMBER NIELSEN: Are you cooking,  
13 Bruce? That sounded like you were cooking.

14 CO-CHAIR BAGLEY: No.

15 MEMBER NIELSEN: Okay, just checking.

16 CO-CHAIR BAGLEY: I'm too far from my  
17 kitchen.

18 DR. WINKLER: Okay. We'll reconvene  
19 at 12:30. Lunch. Be back here, as you can hear.  
20 And we reconvene at 12:30. Thanks a lot.

21 (Whereupon, the above-entitled matter  
22 went off the record at 11:51 a.m. and resumed at

1 12:29 p.m.)

2 CO-CHAIR BAGLEY: All right. It's  
3 12:30, so we're going to go ahead and get  
4 started. And we're starting out the afternoon  
5 talking about the MIPS Program, and sort of the  
6 context by which we're supposed to be thinking  
7 about these measures. So, Reva, do you want to do  
8 the intro?

9 DR. WINKLER: Sure. Thanks, everybody.  
10 I'd like to introduce Molly MacHarris from CMS  
11 who is going to introduce and describe the MIPS  
12 Program, particularly to set the context for the  
13 work that this workgroup is going to do over the  
14 next day and a half. Molly.

15 MS. MACHARRIS: Thank you, Reva, and  
16 thank you for having me here today.

17 So, my role within CMS, I will be  
18 leading the new MIPS Program, so we are busily  
19 working on everything we need to do over the next  
20 few months and years to come. So, thank you all  
21 for your input today.

22 Okay. So, I know that when Dr.

1 Goodrich spoke this morning she talked at a high  
2 level on some of the principles and goals that we  
3 have for the Merit Based Incentive Payment  
4 System, or MIPS Program. So, these are some of  
5 the principles that we have developed so far.  
6 These are not final. These are draft principles,  
7 so if folks have any comments or feedback related  
8 to these, we'd be more than happy to take those.  
9 But before I go over these in more detail, I did  
10 just want to set the stage a little bit for the  
11 MIPS Program.

12 So MACRA, the Medicare Access and CHIP  
13 Reauthorization Act passed this year in April. It  
14 did a couple of things. Most importantly for the  
15 conversations today and tomorrow are that it  
16 repealed the sustainable growth rate, and it  
17 authorized two new programs. The first is the  
18 MIPS Program, and the second is incentives for  
19 participation in an alternative payment model.

20 Additionally, what MACRA did was that  
21 it really tied nicely into some of the delivery  
22 system reform goals that the Secretary issued

1 earlier this year. And just for those of you who  
2 may not have those memorized, the two delivery  
3 system reform goals that the Secretary issued  
4 were that, for the first is that in 2016 we would  
5 like to see 30 percent of all of Medicare  
6 payments tied to quality or value through  
7 participation in an alternative payment model. We  
8 hope to see that increase to 50 percent by the  
9 end of 2018. And that goal ties really  
10 specifically into the alternative payment models.

11 The second goal which ties into the  
12 MIPS Program, is that we want to have Medicare  
13 fee-for-service tied to quality or value having  
14 85 percent of those payments associated with that  
15 by the end of 2016, and then to have 90 percent  
16 of those payments tied to quality or value by the  
17 end of 2018.

18 So, these goals really set the stage  
19 for what MACRA did. And I did just want to level  
20 set with everyone on those, because while that  
21 sets internal goals for HHS, we know that we  
22 cannot do this alone. We have to work with the



1 private payers to actually get us there.

2 So, just to look at some of the  
3 principles that we have. Again, I know that Kate  
4 went over these today, but some of the ones I do  
5 just want to highlight are that we are really  
6 trying to focus on policies that remove as much  
7 administrative burden as possible from eligible  
8 professionals and their offices. Most  
9 importantly, we really want to be using a  
10 patient-centered approach. We want to develop a  
11 program that is meaningful to professionals, and  
12 that we have metrics and activities that are  
13 meaningful to providers. And then we also really  
14 want to insure that we have excellence in  
15 implementation.

16 Let's see. Okay. So, MIPS is a new  
17 program. MIPS will begin in 2019. That is when  
18 professionals adjustments will start to be  
19 addressed under MIPS. The first year of MIPS  
20 there will be a 4 percent payment adjustment.  
21 MIPS also sunsets the three existing programs  
22 that providers typically deal with, so that

1 includes the PQRS Program, the Physician Value  
2 Modifier, and the Medicare EHR Incentive Program  
3 for Eligible Professionals. Those adjustments  
4 will end in 2018.

5 And what MACRA does under MIPS is it  
6 consolidates and aligns those programs, and now  
7 we have four performance categories. Those  
8 include quality, which for the first year will  
9 account for a provider's -- of their total  
10 composite performance score it will account for  
11 50 percent of their score. Resource use, which in  
12 the first year will account for 10 percent of  
13 their score; clinical practice in proven  
14 activities, this is a new area for us. This will  
15 account for 15 percent of their total composite  
16 performance score. And then, lastly, the  
17 Meaningful Use of certified EHR technology that  
18 will account for 25 percent of their total  
19 composite performance score. And the concept over  
20 total composite performance score we will be  
21 assigning to each provider this specific score,  
22 and it will be based on a zero to 100 point

1 scale.

2 Some of the other things that MIPS  
3 does specifically related to the quality  
4 component and specifically related to measures,  
5 so we're not required to actually go through the  
6 MAP process, but as Kate mentioned earlier this  
7 morning, we have found through the past years  
8 that the feedback we receive through the MAP  
9 process is particularly valuable, so that's why  
10 we have presented our measures here today and  
11 tomorrow.

12 The other thing that we have to do  
13 specifically related to the quality measures is  
14 that we are required by law to submit all of the  
15 measures to a peer review journal. The law  
16 doesn't say that they have to be published, but  
17 they have to be submitted to a peer review  
18 journal prior to the final measure list being  
19 posted. So, that's a process that we're still  
20 working through. We're really excited about it.  
21 That's a joke.

22 So, who is MIPS -- who can participate

1 in this? So, under MIPS there's going to be three  
2 main ways that people can participate. The first  
3 is as an individual eligible professional. The  
4 second is as part of a group practice. And the  
5 third is as part of a virtual group. Virtual  
6 groups, that's another new concept that we have  
7 under MIPS. This is an area where providers that  
8 are either solo practitioners or practices of up  
9 to 10 provides, they can band together and form a  
10 virtual group.

11 And then who can actually within those  
12 areas, who is actually eligible? So, for the  
13 first two years, it's a little bit narrower than  
14 who can currently participate in the PQRS  
15 program, and it's a little broader than who can  
16 participate in the Meaningful Use program. So, we  
17 have our physicians, PAs, Nurse Practitioners,  
18 CNSs, and CRNAs. For the third year forward we  
19 can expand that list to those that are currently  
20 eligible to participate in the PQRS program.

21 One thing to note is that on the APM  
22 side of things, for the first year of APMs, those

1 that can participate is the entire list, so what  
2 I have covered in those two bubbles, the  
3 physicians, PAs, Nurse Practitioners, and then as  
4 well as the occupational therapists, et cetera.

5 We do have a couple of exclusions from  
6 MIPS. The first is if you are part of a  
7 qualifying APM, you are completely excluded from  
8 MIPS. You would be receiving the 5 percent lump  
9 sum incentive payment that is associated with  
10 APMs.

11 Additionally, an exclusion is if you  
12 are part of a partially qualified APM. The  
13 statute gets into a level of detail that talks  
14 about different thresholds of whether you are a  
15 QP, a Qualified Participant, or if you're a  
16 partial QP. If you are a partial QP, you can  
17 either elect to participate in MIPS, or you can  
18 choose to be excluded.

19 And then the last exclusion we have is  
20 based off of low volume thresholds, which we will  
21 establish through rulemaking. They can be based  
22 either on number of patients, number of

1 encounters, or volume of services, or potentially  
2 a hybrid of those.

3 The one other exclusion that we have  
4 which isn't noted on the slide is that if you are  
5 a newly enrolled Medicare doc, you are excluded  
6 from MIPS for the first year.

7 Okay, so some of the adjustments. I  
8 mentioned earlier that we have the concept of a  
9 composite performance score. We've abbreviated it  
10 as CPS. We love to abbreviate things at CMS. That  
11 covers the four domains of performance. Again,  
12 it's quality, resource use, clinical practice  
13 improvement activities, and meaningful use.

14 I touched on earlier the percentage  
15 amounts for the first year. Please note that  
16 those do change over time. In 2020, quality gets  
17 reduced to 45 percent and resource use gets  
18 raised to 15 percent. And then in 2021 and future  
19 years, quality will account for 30 percent, and  
20 resource use will account for 30 percent. The  
21 adjustments under MIPS must be budget-neutral,  
22 similar to the Physician Value Modifier program.

1                   So, when we are assigning the  
2                   performance score, it gets a little complicated,  
3                   but at a high level we will be assigning to each  
4                   EP regardless of how they participate, whether  
5                   it's as an individual, a group, or a virtual  
6                   group, a composite performance score which will  
7                   be based off of a scale of zero to 100. We will  
8                   then compare that composite performance score to  
9                   an overall MIPS performance threshold that we  
10                  will define through rulemaking.

11                  Depending upon where that provider  
12                  compares to that performance threshold, they will  
13                  receive either a positive, neutral, or negative  
14                  adjustment. So, if they are above or at the  
15                  performance threshold, they would either receive  
16                  a positive adjustment, or a neutral adjustment.  
17                  If they are below that threshold they would  
18                  receive a negative adjustment.

19                  One other thing to note related to  
20                  MIPS is that by law we must develop the payment  
21                  methodology using a linear sliding scale, so  
22                  we're still working through exactly what that

1 means. But what we anticipate is that we will not  
2 be seeing quite as much bunching at the neutral  
3 point that we see today under the Physician Value  
4 Modifier. Rather, we would see a broader range of  
5 scores that could be applied.

6 In future years when the data is  
7 available, we will also need to take into  
8 consideration the assessment for achievement and  
9 improvement. And then, also, for the first five  
10 or six years of MIPS, we have to establish an  
11 exceptional performance threshold. And there is a  
12 separate pool of money outside of the budget  
13 neutrality for those providers who have met  
14 exceptional performance. And this is just a brief  
15 timeline that talks about the SGR updates for  
16 MIPS, and then the APM side of things.

17 The last thing I'll note is just some  
18 process pieces. We do anticipate going through  
19 rulemaking in the spring to summer of next year,  
20 and then publishing a final rule towards late  
21 summer/early fall of next year. We did issue an  
22 RFI earlier this fall. We received a lot of



1        comments on that. Thank you for everyone who  
2        commented, and we are still working through those  
3        comments and applying those, as much as possible.

4                So, at this point I'll pause and I  
5        guess turn it back over to you, Reva.

6                DR. WINKLER: I think at this point, if  
7        there are any questions from the workgroup to  
8        clarify, it is a new program. There are a lot of  
9        changes in terms of perhaps the way to think  
10       about measures to be recommended by the MAP. And  
11       we just want to be sure that you have all the  
12       clarity that we can provide as you move through  
13       the rest of the agenda.

14               CO-CHAIR BAGLEY: Janis, go ahead.

15               MEMBER ORLOWSKI: Thanks very much for  
16       the overview. I have three specific questions.  
17       The first not a question, it's a comment. It  
18       regards this particular slide which reviews the  
19       Physician Fee Schedule. And just a note that this  
20       is not the Physician Fee Schedule. This is the  
21       part that comes from MIPS, but there's another  
22       law on the books. And the physician update this

1 year is actually a negative, so I think we have  
2 to be careful about presenting that this is the  
3 current Physician Fee Schedule, because it's not  
4 what has been proposed.

5 The second is -- my question is  
6 regarding threshold. What are your thoughts  
7 currently regarding a threshold, either time in  
8 practice, number of patients, or some other  
9 threshold for these measurements?

10 And then the third question that I  
11 have, and I understand that you need to get this  
12 program in place, so this is probably a minor  
13 point. But I was wondering what the thoughts were  
14 for new in practice, so someone who is graduating  
15 from a residency program new to practice who is  
16 just in what I would call a couple of ramp-up  
17 years? If there's been any thoughts about those  
18 individuals?

19 CO-CHAIR BAGLEY: Before you answer, is  
20 there somebody on the phone that could put their  
21 phone on mute so we don't have to listen to the  
22 background? Thank you.

1 MS. MACHARRIS: Sure. So, thank you for  
2 the comments and the questions. I'll address the  
3 last one first. So, as I noted just briefly, we  
4 do have the ability under MIPS similar to what  
5 exists today under the Medicare EHR Incentive  
6 program, that if are a brand new doc, if you're  
7 brand newly enrolled to Medicare, you are  
8 excluded for the first year.

9 MEMBER ORLOWSKI: For just one year.  
10 But no ramp-up after that?

11 MS. MACHARRIS: So, by law you're  
12 excluded for the first year. The ramp-up for new  
13 docs, that is a concept that we are still working  
14 through internally of any policies we would  
15 potentially want to institute related to that.  
16 So, thank you for the feedback.

17 For the second question related to the  
18 performance thresholds. So, under MIPS, and it  
19 gets a little complicated because there's a lot  
20 of terminology that we use, and we will try to  
21 clarify this as much as possible through  
22 rulemaking and then through future

1       communications.

2               So for MIPS overall for the entire  
3       program, we will establish one performance  
4       threshold, in addition to -- well, we have one  
5       performance threshold, and then we will also have  
6       an exceptional performance threshold. And then  
7       within each of the categories, we have the  
8       ability to establish benchmarks related to  
9       specific measures or activities as much as we  
10      have data available to them. But we will have one  
11      performance threshold which we will then be  
12      comparing all providers against.

13             MEMBER ORLOWSKI: And I'm sorry, I did  
14      use the word "threshold." That probably was  
15      confusing. I was referring to minimum volume of  
16      patients seen by a physician, is there a  
17      threshold below which -- and I'll try to use a  
18      different word. Is there a barrier below which  
19      you would not be measured in this program?

20             MS. MACHARRIS: Yes. So, that is an  
21      exclusion that we have the ability of  
22      implementing. That's another area we're still

1 working through, what the policy will be. But we  
2 do have the ability to set a certain low volume  
3 threshold that if you bill, or if you see less  
4 patients or less encounters, or any hybrids of  
5 those, that you would be completely excluded from  
6 the MIPS program.

7 MEMBER ORLOWSKI: Okay. So, working on  
8 that still.

9 MS. MACHARRIS: Yes.

10 MEMBER ORLOWSKI: Thank you.

11 CO-CHAIR WHITACRE: I would like to ask  
12 just as a practicing surgeon, is where the QRURs  
13 would come in in terms of the feedback reports?

14 MS. MACHARRIS: Yes, great question.  
15 And I apologize that I didn't talk about feedback  
16 reports, which is another important component of  
17 the MIPS program. So, additionally what MACRA  
18 does, is it sunsetted a lot of things, and we use  
19 the term "sunsetting," but it could be equated to  
20 ending. So, the Physician Feedback program, the  
21 QRURs, that separate piece as an existing outside  
22 of MIPS will end. Those feedback reports, we're

1 required by law to issue feedback reports to  
2 eligible professionals. The first feedback report  
3 has to be issued July 1st, 2017, and then we --  
4 the next feedback report by law we are required  
5 to issue is July 1st, 2018. And in that second  
6 report we have to provide information on items  
7 and services related to your patients for other  
8 physicians.

9           The other piece related to the  
10 feedback reports is that while there are those  
11 two statutory dates we have to meet, there is a  
12 clear intent that we need to provide feedback  
13 timely, and Congress went ahead and defined that  
14 for us a little bit in more detail, such as  
15 quarterly. So, it's an area that we know, we have  
16 been working on for years of trying to provide  
17 feedback in a more timely fashion. So, we do  
18 anticipate that the QRUR reports as a separate  
19 concept will end, and the aspects of the QRUR  
20 reports that we feel are meaningful we would want  
21 to continue under the MIPS program.

22           DR. CLARK: You mentioned that the

1 program is patient centric. I was wondering, was  
2 there patient input into development and how you  
3 may have incorporated patient values?

4 MS. MACHARRIS: So, I can't speak to  
5 whether or not patient input was developed in the  
6 actual constructing of the law, but we have been  
7 trying to work with as many patients and  
8 providers as possible as we have been developing  
9 the MIPS program. Some of the things that we have  
10 done and we will continue to do is, we issued the  
11 RFI which we know not really most patients will  
12 be reviewing that. But one of the things we did  
13 have is, just last week we held a LEAN event that  
14 correlated with the QualityNet conference, and we  
15 were able to receive some feedback from patients  
16 and providers there. We also have been working  
17 closely with the QIOs and QINs that CMS has in  
18 our regional offices to try to engage as many  
19 patients as possible to work through what would  
20 really be meaningful to them.

21 CO-CHAIR BAGLEY: Cindy, you're next.

22 MEMBER PELLEGRINI: So, coincidentally,

1 I spent half the day yesterday in a meeting on  
2 potential changes to maintenance of  
3 certification. So, that's top of mind for me, and  
4 I'm looking at the clinical practice improvement  
5 activities element. Just curious, obviously, this  
6 is still in the developmental stages, but are you  
7 thinking about harmonizing some of that with  
8 those kind of maintenance of certification  
9 activities to reduce burden on providers?

10 MS. MACHARRIS: Short answer, yes. I  
11 probably won't get into more detail than that  
12 because it kinds of starts talking about what our  
13 potential policies will be, but that is an area  
14 specifically in the clinical practice improvement  
15 activities that we are exploring, working with  
16 the Boards of what that could potentially look  
17 like.

18 CO-CHAIR BAGLEY: David.

19 MEMBER SEIDENWURM: Well, having just  
20 sat for MOC that was top of mind for me, as well.  
21 So, I was wondering if you were going to  
22 harmonize some of the practice improvement



1 activities with some of the other measurement  
2 domains?

3 MS. MACHARRIS: So, for the clinical  
4 practice improvement activities, since this is a  
5 new area for us, we've been really trying to work  
6 through what is the existing landscape for  
7 quality improvement activities. We know that  
8 quality improvement has been occurring for years  
9 and years, but really more at either a regional  
10 level or within specific practices. So, we'll  
11 talk about this more through future meetings, and  
12 through the regulation, but we've been working  
13 through what is the current landscape for quality  
14 improvement? And which activities that local  
15 practices have been doing, or activities that  
16 have been occurring at the local level could  
17 really be implemented at the national level?

18 So with all that being said, that's  
19 kind of our initial process of trying to create  
20 an inventory of what all of these QI activities  
21 could be. We do foresee that in the future there  
22 would be harmonization potentially across the

1 QIs, so the clinical practice improvement  
2 activities and then also potentially across some  
3 of the quality measures, so that is an area that  
4 we are definitely looking at and hoping to  
5 explore further in future years.

6 CO-CHAIR BAGLEY: Stephanie.

7 MEMBER GLIER: This is probably a  
8 clarification from NQF. Is the MIPS framework  
9 spreadsheet the current physician piece, the fee  
10 schedule measures that were finalized for 2016?

11 MR. LYZENGA: Yes. I believe that's the  
12 finalized -- the most recent rule in July or  
13 September, whatever it was.

14 MEMBER GLIER: Okay. So, then a  
15 question for Molly or Sophia that you may not  
16 actually be able to answer since I know this is  
17 getting into policy making. To what extent are  
18 you considering rolling over or streamlining the  
19 measures that are currently used in PQRS into the  
20 MIPS program?

21 MS. MACHARRIS: So, we are taking a  
22 hard look at all of the measures that we have in

1 existence in the PQRS program and, you know,  
2 looking -- let me go back to our principles. So,  
3 we're taking a hard look at all of those measures  
4 and really trying to work through based off of,  
5 you know, some of our draft principles which  
6 measures really make sense for us to continue  
7 under the MIPS program.

8 One of the key things that we want to  
9 try to do under the MIPS program is not just have  
10 a PQRS 2.0, a VM 2.0, or an EHR Incentive program  
11 2.0. I know I said this numerous times at other  
12 presentations, and I'm sure for those of you that  
13 hear presentations from other CMS staff, you will  
14 hear that as a common theme. We do not want to  
15 just repackage those existing programs, stick a  
16 new label on it and say this is MIPS. So with  
17 that, we are really trying to take a look at  
18 those measures and work through which of those  
19 are really quality quality measures, and which of  
20 those are measures that we feel can really be  
21 meaningful to the various specialties.

22 So, I'll pause there. And, Sophia, if

1       you want to add anything, feel free.

2               MS. AUTREY: I completely agree, which  
3       actually brings us back to one of the additional  
4       requests that Kate had earlier today when we  
5       received feedback from the MAP and looking at the  
6       measures that we have on the table on the  
7       calendar, not just the blanket recommendation or  
8       support, but actually give us some type of  
9       substantive information so that if there are  
10      additional requests or additional development  
11      that needs to happen for those measures, you're  
12      more specific in that guidance. So, that would  
13      help us a lot, because we are specifically  
14      looking at making sure that the measure set for  
15      MIPS is more robust.

16              CO-CHAIR BAGLEY: Robert, you're next.

17              MEMBER KRUGHOFF: This is a little  
18      tangential to what we're supposed to be focusing  
19      on here, but could you give us a little sense of  
20      what's happening to Meaningful Use, the sort of  
21      trajectory of requirements, standards, et cetera,  
22      and incentives for Meaningful Use from now

1 through, you know, the long-term development of  
2 these -- long-term implementation into 2022 and  
3 beyond?

4 MS. MACHARRIS: Sure. So, I'm sure  
5 that all of you are aware we recently -- CMS  
6 recently issued the Stage 3 final rule I think a  
7 month or so ago, which laid out the remaining  
8 groundwork for Meaningful Use, the program as a  
9 whole. So, that includes the Medicare side for  
10 both EPs, and then EHRs for hospitals. And then  
11 also for Medicaid. So, we have that kind of  
12 groundwork already laid out.

13 What MIPS does specifically is, it  
14 folds in the Medicare side for professionals into  
15 the MIPS framework. So, it also -- let me think  
16 of how I want to frame this. MIPS also does  
17 provide to us more flexibility than we feel  
18 exists today in the Meaningful Use program. So,  
19 without getting into policy, which I,  
20 unfortunately, can't talk about right now, we are  
21 taking a hard look at the Meaningful Use program,  
22 the policies we set forward in the Stage 3 rule.

1 And then also how we want to implement MIPS as a  
2 whole where it really comes across to  
3 professionals as a complete program, not four  
4 disparate categories, and what changes we would  
5 potentially need to make to the Meaningful Use  
6 component. So, I hope that helped answer  
7 somewhat. I know it was a little vague.

8 CO-CHAIR BAGLEY: Marci.

9 MEMBER NIELSEN: I might just offer one  
10 example where CMS isn't, in fact, recreating the  
11 four programs and rolling them up to be, you  
12 know, Meaningful Use. I guess this would be the  
13 equivalent of 4.0, and that is under the clinical  
14 activities, and as an example of a new way in  
15 which you're going to recognize quality  
16 improvement is that patient-centered medical  
17 homes for those practices that are certified  
18 patient-centered medical homes. Right off the  
19 bat, you get the full score, that full 15 percent  
20 is rated on behalf of that clinician and their  
21 practice as meeting all of those requirements.  
22 So, that was in statute, but it's a terrific

1 opportunity, I think, to look to primary care to  
2 help drive what you're trying to do systemwide  
3 for those practices that have embraced that  
4 model.

5 MS. MACHARRIS: Thank you.

6 CO-CHAIR BAGLEY: Jim, go ahead.

7 MEMBER PACALA: Thanks for your  
8 presentation. Could you just talk a little bit  
9 more about clinical practice improvement? Do you  
10 envision the measures to be mostly process  
11 measures, or if there are outcome measures  
12 envisioned, how are they -- how will they be  
13 distinct from quality and resource use measures?

14 MS. MACHARRIS: Sure. So, the clinical  
15 practice improvement activities performance  
16 category, within the law it calls out six  
17 specific subcategories. Those include patient  
18 safety, patient experience, care coordination,  
19 and a couple of others. Within that, there are  
20 some examples of what some of those activities  
21 could look like. We also, additionally, have the  
22 ability to expand beyond those six subcategories,

1 if we so chose to do so. That was an area we  
2 specifically sought comment on, on the most  
3 recent RFI that we issued, and we're still  
4 working through those comments and trying to  
5 determine are there activities that could fit  
6 into any of the additional subcategories.

7 So, when we -- as we've been working  
8 through our inventory process of the existing QI  
9 work that has been done to date, we have been  
10 categorizing the measures and activities into  
11 different areas, you know, kind of looking at  
12 areas that are more process as in, you know, was  
13 there after-hours care available, versus other  
14 areas where it could be more outcomes-based.

15 Since we know this will be new under  
16 MIPS, we are still working through exactly what  
17 that category should look like. So, I think I'll  
18 pause there. Does that help answer?

19 CO-CHAIR WHITACRE: If I could ask  
20 again as this is -- not as a co-chair, but  
21 practicing surgeon. Would there be thresholds for  
22 reporting quality? Right now among the different



1 programs those thresholds very widely in the  
2 various PQRS registries, via claims, via QCDRs.  
3 Do you have that envisaged or proposed threshold?

4 MS. MACHARRIS: So, we do anticipate  
5 that in the various categories we will have to  
6 set forward some sort of criteria of what success  
7 looks like. We're still working through what that  
8 should be. Again, kind of taking into  
9 consideration all of the feedback we've received  
10 over the years, and then also through the RFI of,  
11 you know, what should be the appropriate number  
12 of measures? Should we still allow providers to  
13 select from a broad set of measures? Could we  
14 introduce a core set of measures which we know is  
15 something that we have struggled with to a  
16 certain extent really looking at the physician  
17 realm because trying to define a distinct set of  
18 core measures that would apply to all physicians  
19 is a little bit more difficult on the provider  
20 side than on the hospital side. So, we do  
21 anticipate specifically calling out per category  
22 what success will look like, and what you would

1       need to do to get either the full percentage  
2       points allowable, or a portion of those  
3       percentage points. And we'll, of course, talk  
4       about that in more detail in the reg.

5               DR. WINKLER: Yes. Just to clarify, the  
6       measures that are under consideration that we  
7       have before us, are those all for the quality  
8       portion of the MIPS program?

9               MS. MACHARRIS: Yes.

10              CO-CHAIR BAGLEY: Any other questions  
11       from the workgroup about the MIPS program, in  
12       general? Okay. Seeing none, I think we'll move  
13       on. And what I'd like to do is open up for public  
14       comment.

15              No? Reva, you're going to lead us  
16       through the Physician Compare?

17              DR. WINKLER: Because public reporting  
18       is an important part of quality measurement, and  
19       Physician Compare is truly ramping up for the  
20       publication of measure results for clinicians, we  
21       don't want to overlook, I'm just going to skip  
22       through these, the Physician Compare aspect and

1 the fact that CMS is asking for some feedback.

2 So, we've asked -- again, this is Alesia Hovatter  
3 from CMS, and she's just going to go over what's  
4 happening with public reporting of physician  
5 measures for Physician Compare.

6 MS. HOVATTER: Great. Thanks so much,  
7 Reva. This is Alesia Hovatter. So, at CMS, I am  
8 the Physician Compare lead, and thank you so much  
9 for having me today. So, I wanted to provide a  
10 bit of background on where we are with Physician  
11 Compare and our goals, so that could help inform  
12 you as you go through this process the rest of  
13 today and tomorrow.

14 Okay. So, for Physician Compare, you  
15 know, we think about public reporting and how can  
16 we help consumers make informed decisions when  
17 making health care decisions, and motivate health  
18 care professionals to improve their performance?  
19 So, this is really the two-fold purpose that we  
20 have displaying on the screen now for Physician  
21 Compare.

22 As most of you are aware, CMS was

1 required by Section 10.3.3.1 of the Affordable  
2 Care Act, also known as ACA, to establish the  
3 Physician Compare website. So, this two-fold  
4 purpose is really to provide more information for  
5 consumers to encourage informed health care  
6 decisions, and to create explicit incentives for  
7 physicians to maximize their performance. The  
8 site was launched on December 30th of 2010, and  
9 based on consumer testing and stakeholder input,  
10 the site was redesigned in 2013.

11 So what is Physician Compare? Most of  
12 you have probably been on our website, and this  
13 is a screenshot from the website, so this is on  
14 Medicare.gov. Physician Compare allows consumers  
15 to search physicians and other health care  
16 professionals who are actively participating in  
17 Medicare and Fee-for-Service. At this moment in  
18 time, the site includes general information about  
19 physicians, health care professionals, group  
20 practices including name, address, specialty,  
21 hospital affiliation, and clinical training  
22 information.

1 All eligible professionals which we  
2 like acronyms, so that's known as EPs, currently  
3 provide Fee-for-Service, Medicare services are  
4 included. This includes physicians, advanced  
5 practice nurses such as nurse practitioners, and  
6 physician assistants and other health care  
7 professionals, such as physical therapists and  
8 social workers. A complete list of those who are  
9 included on Physician Compare can be found under  
10 the Physician Compare resources pages under  
11 "Specialty Definitions," if you all wanted to  
12 have any questions about that. Information about  
13 physicians and other health care professionals  
14 who satisfactorily participate in CMS quality  
15 programs, and quality measures for group  
16 practices and ACOs.

17 So as you know, for Physician Compare  
18 we've really used a phased approach, so we  
19 started with a small set of measures and we are  
20 growing that over time. So, this slide represents  
21 in February of 2014, the first quality measures  
22 were publicly reported on Physician Compare. So,

1 as a quick synopsis of this slide, that was a  
2 subset of the 2012 Physician Quality Reporting  
3 System, also known as PQRS, Group Practice  
4 Reporting Option, also known as GPRO, measures  
5 collected by the web interface for groups of 25  
6 or more EPs and accountable care organizations.  
7 So, that's what was available for public  
8 reporting.

9           There was -- also a subset of these  
10 measures was published for 66 group practices,  
11 and 141 ACOs that successfully reported the  
12 measures. So, that's where we started.

13           So then last year in December of 2014,  
14 the second subset of group practice and ACO  
15 measures were reported for 2013 data. And that  
16 was a subset of diabetes and heart disease  
17 measures that were reported for 139 group  
18 practices of 25 or more EPs, and 214 shared  
19 savings program, and 23 Pioneer ACOs. So now in  
20 the current state where we are right now in late  
21 December of 2015, Physician Compare will continue  
22 the phased approach in additional quality

1 measures over future years. We will continue to  
2 report group practice-level measures reported by  
3 the web interface. This year we are reporting  
4 measures for approximately 275 group practices.

5 The first individual EP data will be  
6 reported on Physician Compare very soon, which  
7 will be right now in December of 2015 by the end  
8 of the year. That will include a subset of six  
9 measures reported via claims, and that will be  
10 for approximately 40,000 eligible professionals.

11 Also, the first patient experience  
12 measures for group practices will be publicly  
13 reported. This will include a subset of eight  
14 CAHPS for PQRS measures. It will also again be  
15 including data for ACOs, approximately 333 shared  
16 savings program ACOs, and 20 Pioneer ACOs. And  
17 they will have clinical quality of care and  
18 patient experience data publicly reported. So,  
19 this is an exciting year since we have a bunch of  
20 new things going up this year.

21 So, as Molly indicated, MACRA was  
22 recently passed on April 16th of 2015. So, Molly

1 went over the first couple of bullets that are  
2 listed here. What I really want to put emphasis  
3 on now is that this increases the data available  
4 for public reporting on Physician Compare, so  
5 there will be a lot more data that is available  
6 which will provide opportunities to give  
7 consumers even more information to enhance their  
8 decision making.

9           So, here's where I really want to  
10 focus on the presentation today; the challenges  
11 to public reporting individual-level measures.  
12 Consumers really want individual EP measure data,  
13 but it is important that public reporting  
14 accurately reflects individual health care  
15 professionals' performance. Physician Compare  
16 will only publicly report valid, reliable, and  
17 comparable quality data that resonates well with  
18 consumers. Those are our public reporting  
19 standards that we have now. We have stated those  
20 each year that we have put something in  
21 rulemaking in the Physician Fee Schedule rule, so  
22 that still holds true now.



1           A particular challenge is the small  
2       sample sizes that are associated with individual  
3       EPs. Analysis to date show that data are  
4       reliable, though, and individual EP reporting is  
5       viable. So, we really want to engage consumers  
6       throughout this process.

7           Public reporting can serve many  
8       purposes. On Physician Compare, public reporting  
9       is for the public. It is for consumers. The goal  
10      is to, again, help consumers make informed  
11      decisions about their health care so they need  
12      data that means something to them, and they need  
13      data that they can understand.

14          Not every measure is a good measure  
15      for public reporting. Data are collected for a  
16      variety of reasons, and some very clinically  
17      sound measures are wonderful for informing  
18      clinical practice, but other measures are best  
19      for aiding consumers. The perfect measure,  
20      ideally, would have something on both categories.

21          To start, what do consumers want?  
22      Consumers want data from other consumers.

1 Ideally, they'd like narrative reviews, something  
2 like Yelp; however, these data present many  
3 challenges. Consumers do really value the CAHPS  
4 data and regularly request this type of patient  
5 experience data on the individual EP level.

6 Understanding the concerns of small sample sizes  
7 and measure attribution it would be valuable to  
8 evaluate the opportunities in this area.

9 Consumers also really value clinical  
10 quality of care measures, the types of measures  
11 generally part of PQRS as valuable when they  
12 resonate with them, and make sense to them.

13 Consumer engagement with quality  
14 starts with measure development. We need to  
15 develop measures that better meet the needs of  
16 consumers and can help them make informed  
17 decisions about the care that they receive.  
18 Physician Compare is actively working with the  
19 measure development contractor to build more  
20 engagement options and information into the  
21 measures blueprint. To help facilitate this, the  
22 goal is to get consumers more meaningfully

1 involved early and often, but this group has a  
2 lot more intermediate role to play. We can look  
3 to include measures in existing programs and  
4 programs soon to come on line that are meaningful  
5 to consumers. We can think about the kinds of  
6 measures consumers are looking for, we can think  
7 about the types of information most important to  
8 consumers, and we can work to include measures  
9 that focus on things that matter most to  
10 consumers and present data in a way that is most  
11 easy to understand and interpret. That will be  
12 things like outcome measures, composite measures,  
13 and are measures being risk-adjusted?

14 Through consumer informed measure  
15 development and measure selection, ultimately, we  
16 can work together to insure that Physician  
17 Compare is a resource for sound quality data that  
18 helps consumers make those informed decisions  
19 about the care they receive through Medicare.

20 That's all I have today. Here's my  
21 information, and as many of you know, we have a  
22 Physician Compare Support Team, so if you have

1 any questions in the future, you can either  
2 direct them to me, Alesia Hovatter, or the  
3 Physician Compare Support Team at  
4 PhysicianCompare@Westat.com. So, I know we're  
5 running short on time, but I'll take any  
6 questions.

7 MEMBER MOYER: Related to what is going  
8 to be reported on Physician Compare, I thought I  
9 had heard that not all groups that submitted data  
10 were going to have results reported, that there  
11 were some where there were questions about  
12 comparability of results. Could you talk a little  
13 bit about what will actually be out there, and  
14 what will not?

15 MS. HOVATTER: Sure. So, where we are  
16 now, again, those public reporting standards are  
17 still going to resonate. So just for instance  
18 this year for December of 2015 when the measures  
19 go up, there were -- what we had stated and you  
20 all had probably received information on, the  
21 registry and EHR will not be available. And we do  
22 have specific information on which measures we

1 met our public reporting standards, resonate well  
2 with consumers. And that information is actually  
3 available on the Physician Compare Initiative  
4 page, and we have helpful documents that actually  
5 list out those exact measures. So I can show you  
6 where those are, if that would be helpful.

7 CO-CHAIR BAGLEY: Any other questions?  
8 Janice.

9 MEMBER ORLOWSKI: Just a comment. I  
10 think that -- I do understand that the public  
11 wants to see an individual physician, and that's  
12 understandable. And I do understand the logic  
13 behind that, but there's very good information  
14 out there that we should be looking at people  
15 within care teams. And there are highly -- high-  
16 quality care teams, and if you take a physician  
17 out of a high-functioning care team and put him  
18 or her into another situation, that quality does  
19 not always follow them without the development of  
20 a team.

21 Secondly, we are spending a lot of  
22 time talking about and developing the concept of

1 inner professional teams. So, I just want to note  
2 that this big ramp-up in physician-specific data  
3 is contrary to what is a trend that is moving us  
4 away from physician-specific, captain of the team  
5 type work, and moving us towards care teams that  
6 are more effective. And I know in many of the  
7 places that I visit when you take a look at let's  
8 say primary care. Primary care now is -- primary  
9 care is given within care teams. Teams become  
10 responsible for panels with patients, and so I'm  
11 concerned that we have this ramp-up at CMS when  
12 the rest of the field is moving in a different  
13 direction.

14 CO-CHAIR BAGLEY: Robert.

15 MEMBER ORLOWSKI: If you have a comment  
16 on that?

17 MS. HOVATTER: No. Thank you for that,  
18 but --

19 MEMBER KRUGHOFF: I guess I have a  
20 counter point to that, and I think what makes  
21 sense at the individual physician level really  
22 depends on the measure -- the type of measure

1       itself. There's a whole lot of evidence then on  
2       communication skills, or communication  
3       performance. Most of the variation takes place  
4       and still takes place at the individual physician  
5       level. You can have groups and some do much  
6       better than others, also, and that's a patient  
7       experience-type measure. Also, patient experience  
8       measures you don't have the kind of sample size  
9       issue that you have with a lot of clinical  
10      measures. So, I think you need to have a nuanced  
11      approach to which measures you focus at which  
12      level on. And I think you will find that there  
13      are some measures patient -- for instance, we've  
14      just done something on surgeon ratings and the  
15      surgeons are not greatly excited about what we've  
16      done, but we actually have found a lot of  
17      variation among surgeons in terms of outcomes  
18      even at the individual surgeon level, but faced  
19      with real sample size issues there. So, I just  
20      think that has to be nuanced, and I do think that  
21      consumers do care that, you know -- rightly or  
22      wrongly they care about variation at the

1 individual physician level. And beyond that I  
2 would say in many cases it's rightly. Okay? They  
3 really are right to focus at that level. Okay,  
4 I'll stop for now.

5 CO-CHAIR BAGLEY: Other comments or  
6 questions? Did you have anything to add to that?

7 MS. HOVATTER: No, no. Thank you for  
8 that, and thank you, Reva.

9 CO-CHAIR BAGLEY: Alesia, thank you  
10 very much.

11 MS. HOVATTER: Yes.

12 CO-CHAIR BAGLEY: So, now we will move  
13 on.

14 (Pause.)

15 CO-CHAIR BAGLEY: Yes. We're going to  
16 move on to the derm measures, and invite public  
17 comment before we have the lead discussers talk.

18 DR. WINKLER: Let me just -- yes, on  
19 the measures under consideration list we have  
20 five process measures that we've grouped together  
21 in the first consent calendar. These measures  
22 were submitted by the American Academy of



1 Dermatology, and they address non-melanoma skin  
2 cancers. All five of those measures are still in  
3 development. The testing results are expected in  
4 the summer or fall of 2016. They've indicated  
5 that the data source will be claims and registry,  
6 and the registry that they are intended for is  
7 their -- is AAD's clinical data registry that  
8 will be launched in January of 2016.

9           So, I'd also just want to call your  
10 attention to the spreadsheet that we shared with  
11 you over the last several months of the current  
12 measures in the clinician measure set. There are  
13 over 300 of those measures. We've tried to  
14 categorize them in a way that would be easy for  
15 you to look at them to ask what's currently  
16 available for dermatology as you look at the new  
17 set. So, there are five existing measures for  
18 melanoma and psoriasis, but none for the non-  
19 melanoma skin cancers, so these are a new topic  
20 area. There is one related measure around biopsy  
21 follow-up, though it is not the same measures  
22 that you see on these measures under

1 consideration. So, Bruce, I think --

2 CO-CHAIR BAGLEY: Now I'm going to open  
3 it up to the public comment. Introduce  
4 yourselves.

5 MS. CARTER: Thank you. Can everyone  
6 hear me?

7 CO-CHAIR BAGLEY: Stay close to the  
8 mic.

9 MS. CARTER: I'm going to be close to  
10 the mic. So, hello, everyone. My name is  
11 Stephanie Carter. I'm with the American Academy  
12 of Dermatology.

13 I just wanted to say that we're  
14 pleased that five measures of the skin cancer  
15 measures are under consideration. Including these  
16 measures in this would help to fill two gaps  
17 primarily with having measures that address  
18 patient care, as well as providing more measures  
19 for dermatologists to be able to report.

20 These measures focus primarily or all  
21 on non-melanoma skin cancer which are basal cell  
22 carcinoma and squamous cell carcinoma, which 4

1 million new cases are diagnosed each year in the  
2 U.S. So, including with these five measures, two  
3 of them address appropriate use criteria for --

4 I'm sorry. Of these five measures, two  
5 of them address appropriate use criteria for most  
6 surgery, two for timely reporting of skin cancers  
7 and receiving biopsy results, and one with skin  
8 cancer prevention measure. All of these measures  
9 are part of a long term effort for the Academy to  
10 build a portfolio of performance measures that  
11 will be important to dermatology care topics of  
12 skin cancer. These measures have been specified  
13 and they are currently in field testing, and have  
14 been specified for the clinical registry data  
15 from that the Academy will be launching next  
16 month. So, thank you for your consideration.

17 CO-CHAIR BAGLEY: All right. I don't  
18 see any other public commentary. Can we go on --  
19 anybody on the phone? Sorry, thank you.

20 OPERATOR: If you want to make a public  
21 comment, please press star 1.

22 CO-CHAIR BAGLEY: Please go ahead.

1 OPERATOR: There are no public comments  
2 at this time.

3 CO-CHAIR BAGLEY: Okay. We have lead  
4 discussants. We're going to go to Scott and  
5 Steve. We'll have the discussion first? Okay. I'm  
6 getting direction from my partners up here. Okay.  
7 So far we have -- there's -- let me just point  
8 out. There's five bullets on your agenda, and  
9 there's 10 items on your discussion list, so each  
10 one of the bullets is for consideration under  
11 MIPS and under Physician Compare. That's why  
12 there's two times as many discussion points.

13 So, so far we have had extractions on  
14 the first, second, and fifth bullet, so that  
15 would be those corresponding discussion items.

16 DR. WINKLER: And those are for MIPS.

17 CO-CHAIR BAGLEY: Right. Are there any  
18 additional extractions at this time? Steve?

19 MEMBER FRIEDHOFF: Four.

20 CO-CHAIR BAGLEY: Okay.

21 MEMBER FRIEDHOFF: For 9 and 10, the  
22 preventive screening for transplant patients.

1 CO-CHAIR BAGLEY: Okay. So, the only  
2 one that's not been extracted is 3. Is that  
3 right?

4 MEMBER PACALA: I'm confused. When you  
5 say 1, 2, and 5, do you mean --

6 CO-CHAIR BAGLEY: I'm talking about the  
7 bullets on your agenda.

8 MEMBER PACALA: So, that's --

9 CO-CHAIR BAGLEY: Right.

10 MEMBER PACALA: Right. So, that's 1-4  
11 and 9 and 10.

12 CO-CHAIR BAGLEY: Correct.

13 MEMBER PACALA: Thank you. Okay. So, we  
14 have -- the only one we have left is the third  
15 bullet which would be 5 and 6. Okay.

16 CO-CHAIR BAGLEY: Okay, thank you.  
17 Sorry for that. I think we can go ahead, and if  
18 there's no objection to accepting what would be  
19 bullets 3 and 4, which would correspond to  
20 discussion items 6-10, 6-8. We'll go ahead and  
21 accept them.

22 5-8.

1                   Right, that's really -- that's the  
2                   best way to look at it. They have not been  
3                   pulled. Any objection to accepting the Staff  
4                   recommendation? I don't see any, so let's go  
5                   ahead. Now, Scott and Steve.

6                   MEMBER FRIEDHOFF: So, for the  
7                   clinician reporting time, just a couple of  
8                   comments, and I think my ultimate conclusion is  
9                   recommendation is encourage continued development  
10                  with a few caveats.

11                  I think that most would agree that we  
12                  want to insure that biopsy results are  
13                  communicated in a timely fashion, but by  
14                  communicating an average I'm not sure, do we have  
15                  an understanding of what the patient as a  
16                  consumer expects when they're looking at this  
17                  kind of data? And is it meaningful for a patient  
18                  to compare whether they get results back in two  
19                  weeks, three weeks, or four weeks as long as it's  
20                  communicated, you know, within a reasonable time  
21                  frame, whatever that might be?

22                  So, for that reason, I was thinking

1       that maybe average isn't necessarily the best way  
2       to measure this. That can mean a lot of good and  
3       a lot of bad, whatever that means, with the  
4       average being somewhere in the middle, that could  
5       suggest a lot of variation. So, one thing perhaps  
6       to consider might be a targeted time frame and  
7       the percentage that meet that time frame, as  
8       opposed to an average as part of the continued  
9       development.

10               And then my third comment is that the  
11       core of this measure is communicating critical  
12       results back to the patient. And I guess I was  
13       questioning why would we isolate this to  
14       pathology, as opposed to other critical lab  
15       results, PAP smears, mammograms, other imaging.  
16       It feels a little myopic in that way.

17               MEMBER FURNEY: I would echo that, and  
18       just add, what causes the patient the most  
19       anxiety is the fear of the unknown. So, the fact  
20       that we're specifying certain pathology types to  
21       be reported instead of all biopsy reports, I  
22       think we could simplify as we develop the

1       measure, simplify that all results need to be  
2       communicated within a period of time, whether we  
3       decide it is more practical to do it based on  
4       median and standard deviation or a critical time  
5       frame. But if we're focusing on the patient  
6       communication, it is knowing when the result is  
7       back regardless of pathology that's important to  
8       the patients.

9                   CO-CHAIR BAGLEY: Go ahead, David.

10                  MEMBER SEIDENWURM: One thing I was  
11       concerned about, and I think this applies more  
12       broadly to just, you know, the current clinical  
13       situation is, I don't think that we want to  
14       encourage the dissemination of the wrong  
15       information quickly. I think we'd rather also  
16       have some measurement that would get at the  
17       accuracy of the information or standards around  
18       the performance of the test that we're reporting.  
19       So, I think if we're going to have a standard  
20       like this, it ought to be married with some other  
21       richer data sources about the actual accuracy of  
22       the biopsy, whether appropriate standards for --



1       and that's just in this one example. It would  
2       apply to other procedures, as well; you know,  
3       whether the procedure was done in the correct  
4       way, whether the biopsy was necessary in the  
5       first place. You know, and you could go on from  
6       there.

7                   CO-CHAIR BAGLEY: Stephanie, did you  
8       have a comment since you're the one who extracted  
9       these?

10                  MEMBER GLIER: I did, and I actually  
11       want to respond first to Steve. I think -- maybe  
12       I misunderstood the specs, but it looks to me  
13       like the numerators have a specific number of  
14       days in which the response has to get back either  
15       to the patient or to the biopsying clinician. Is  
16       that -- did you read it differently than I did?

17                  MEMBER FRIEDHOFF: I think I was  
18       focused more on, you know, the length of time  
19       taken. It's -- maybe I was reading that  
20       incorrectly, simply implying an average rather  
21       than a threshold.

22                  MEMBER GLIER: In the measure

1 specifications for both of them? So, for the  
2 biopsying time, biopsy reporting time, clinician  
3 which is the first -- measures 1 and 2, or bullet  
4 1, depending on how we're counting these, it's --  
5 the number of cutaneous biopsies where the final  
6 biopsy pathology findings were communicated  
7 within 15 business days from when the biopsy was  
8 performed, and for the pathology measure it's  
9 within 5 business days from when the biopsy was  
10 submitted from the clinician to the pathologist.

11 I'm okay with those as a general  
12 threshold. I don't have any evidence to suggest  
13 that that's the wrong number of days. My concern  
14 with these measures is that I don't see value in  
15 separating the pathologist measure from the  
16 clinician measure overall. I think what we're  
17 trying to measure here is how well a clinician  
18 who performs the test is able to get those test  
19 results back to a patient who is concerned about  
20 a finding. Back to this question about fear of  
21 the unknown. I think we want to make sure that  
22 patients are being informed about their health

1 conditions as quickly and as accurately, but as  
2 quickly as we can to alleviate the fear of the  
3 unknown in the meantime. And I don't see a lot of  
4 value for an accountability program to separate  
5 the what happens behind the scenes from a  
6 patient. So, if a patient gets a biopsy and the  
7 clinician takes that sample and sends it to a  
8 pathologist, and the pathologist does whatever  
9 the pathologist does, and then sends something  
10 back to the clinician, before the clinician can  
11 get back to the patient, that's fine. The  
12 workflow is fine, but I don't think that the  
13 measure of what happens behind the scenes is  
14 useful for us as an accountability measure. I  
15 think it would be great to have that as a QI  
16 measure. If the dermatologists want to include it  
17 in their registry more power to them, but I think  
18 I have some concerns about having it as a  
19 separate measure for use in MIPS.

20 CO-CHAIR BAGLEY: Amy next.

21 MEMBER MOYER: I guess I don't know  
22 what the evidence is behind the 15 business days

1 notification. That felt a little generous to me.  
2 It doesn't really feel like we're pushing the  
3 envelope there. I mean, at a minimum that's three  
4 weeks to let a patient know about a result. And  
5 the other thing that I'd like to see that I  
6 didn't see at least called out in the specs  
7 attached was, what do we mean by communication?  
8 Did you drop a letter in the mail? You had a  
9 conversation with the patient? You know they  
10 received the results, just maybe a little bit --  
11 something a little bit more definitive about  
12 what does it mean to communicate those results to  
13 a patient.

14 CO-CHAIR WHITACRE: If I could just  
15 take off my co-chair hat for a minute and speak  
16 as a practicing breast surgeon. I deal with this  
17 every day, so if I could just add a level of  
18 granularity to some of these points, because  
19 they're all important, but there's really more  
20 behind the scenes.

21 First of all, we may not control the  
22 length of time it takes for a pathologist to get

1 us a printed report, and the final printed report  
2 is what matters because if you get a preliminary  
3 verbal report that says it's benign, but they  
4 don't tell you about the atypia, the discussion  
5 you're having with a patient much later is  
6 completely different, it really results in a lack  
7 of confidence, and disruption of flow, and  
8 disappointment, not good care.

9 What happens is, in terms of reporting  
10 the pathology reports, local takeover by another  
11 group, the hospital now, the secretaries can't do  
12 overtime. This is happening in Tucson right now.  
13 I don't get printed reports. It can take two  
14 weeks for things that used to take five days, so  
15 I tell the patients five days and it's coming  
16 back in two weeks. So, while I agree that in a  
17 systems environment where the system controls  
18 everything, that's fine, but where you're dealing  
19 with independent contractors, which is still a  
20 good part of medicine, separating the pathology  
21 time generated report versus the clinician time  
22 allows you to separate where the flaw may be. And

1       how the data is communicated is also very  
2       important, but it's going to vary based on  
3       pathology type, patient. I don't know how that  
4       can be better specified in the measure.

5                   CO-CHAIR BAGLEY: Jim, you're next.

6                   MEMBER PACALA: Well, I wanted to pick  
7       up on Amy's point. I mean, does notify mean that  
8       you've attempted to notify, or that you have  
9       actually spoken to the patient? And those are --

10       I think those are important. We have a number of  
11       patients in our own clinic who you try to get a  
12       hold of them and you have to send in the Marines,  
13       basically, to eventually -- you know, or tackle  
14       them on the street to be able to talk to them.  
15       Even with serious news, so that's one issue. And  
16       I don't know if somebody who's an expert in  
17       communication quality measures would care to  
18       address that and enlighten us.

19                   The second thing is, was there  
20       consideration of an allowance for interpreters?  
21       We have sometimes difficulty lining up an  
22       interpreter to convey complicated news to

1 patients.

2 CO-CHAIR BAGLEY: Janis.

3 MEMBER ORLOWSKI: Just to --

4 CO-CHAIR BAGLEY: Janis, hold on.

5 MEMBER ORLOWSKI: Yes.

6 CO-CHAIR BAGLEY: There's a direct  
7 response.

8 MS. AUTREY: So, we did receive actual  
9 substantive changes to this measure maybe a week  
10 or so ago, so we were not able to provide them to  
11 the Committee. But it actually addressed some of  
12 the concerns regarding how to communicate, and  
13 they specifically identify directly speaking with  
14 the patient as one of those criteria. Another  
15 one, documenting a telephone message or voicemail  
16 regarding availability of the lab results, and  
17 mail fax sent to the patient indicating  
18 availability of lab results. And then any HIPAA  
19 secure electronic communication with the patient  
20 discussing the diagnosis.

21 CO-CHAIR BAGLEY: Thank you for that.

22 Janis.

1                   MEMBER ORLOWSKI: I was going to  
2                   comment on notifying, but I think it's been  
3                   handled in regards to that. The second thing is  
4                   just to add on to Eric's comments.

5                   There are some specimens where the  
6                   pathologic manipulation and review of it takes  
7                   more than that amount of time. And I'm a  
8                   nephrologist, and I can tell you that we can get  
9                   -- for those who are not doctors, I apologize,  
10                  but we can get light microscopies with the  
11                  initial reading within a couple of days, but  
12                  electron microscopy will easily take three weeks  
13                  for processing and for it to be done in a final  
14                  report. So, I think that what we have to do in  
15                  this is we have to take a look at when the  
16                  treating physician receives the final report and  
17                  put timeliness around that, rather than starting  
18                  the clock at a pathologist time that -- where it  
19                  actually may take more than two weeks for the  
20                  pathology work to be completed, especially as we  
21                  look sort at some of the new markers and the gene  
22                  sequencing, and the PCI that we're doing on some



1 of this tissue, I think we have to use the final  
2 report as the clock-setting event.

3 CO-CHAIR BAGLEY: Are there other  
4 questions? Yes, go ahead, Stephanie.

5 MEMBER GLIER: I'm actually wondering  
6 if there's somebody here who is a dermatologist  
7 who can speak to these tests, because I think  
8 your points are totally valid. If there are  
9 pathology tests that are going to take longer  
10 than the five days that are in the pathology  
11 measure, that will affect the 15 day total window  
12 that is currently in the measure. Yes, please.

13 MEMBER ORLOWSKI: Well, I can tell you  
14 melanoma is one of those tests. And there is  
15 atypia in cells.

16 No, I understand that but I'm giving  
17 an example. I'm giving an example that there are  
18 a number of dermatologic lesions that are  
19 difficult because you're looking at atypia, and  
20 it needs to go through a sequence and review.

21 CO-CHAIR BAGLEY: So, I'm hearing that  
22 -- by the way, Staff recommendation is encourage

1 continued development. I'm hearing that it should  
2 -- CMS should work to make it more patient  
3 centered, I think would be the first thing. And,  
4 secondly, maybe more generalizable, because if  
5 you stop and think about this, if you have one  
6 measure for each different diagnosis, you have  
7 1,000 measures for every diagnosis. So, can we  
8 have a measure that's just about, you know,  
9 reporting to patients that would apply to, you  
10 know, a whole raft of diagnoses. Amy, go ahead.

11 MEMBER MOYER: Recognizing this was  
12 submitted by a specialty society for measurement  
13 of their members, I guess really hearing this  
14 sounds like a -- like one of those measures where  
15 it is the system, and the totality of the team. I  
16 mean, it's one thing if we're measuring from  
17 okay, the physician got the measure and didn't --  
18 or got the results and didn't do anything with  
19 them. I'm okay with holding the physician  
20 accountable for that, but it really feels like  
21 this is one of those interactive, you know, how  
22 does everything get handed off, how does

1 everything play well together? I mean, I'd be  
2 interested in doing this for a system, but I  
3 would find it challenging to, I think, hold a  
4 physician accountable for this, I'm not a  
5 physician, but --

6 CO-CHAIR BAGLEY: It certainly does get  
7 to clinical integration, doesn't it? Peter, you  
8 were next.

9 DR. BRISS: Yes, I was thinking about  
10 -- maybe this is piling on, but I'm inclined to  
11 say that this kind of a measure is never going to  
12 move the system in an important way. It's too  
13 narrow. And, you know, the truth is, I'd like to  
14 see them make one measure -- to the extent that  
15 timeliness is a problem, I'd like to see one  
16 measure that said -- that was patient centered  
17 that said did you get all your relevant results  
18 in some reasonable amount of time? And you could  
19 do that with one measure, and that would incent  
20 the system to solve some of the problems that  
21 Eric was talking about.

22 CO-CHAIR BAGLEY: Comments?

1 DR. WINKLER: We actually wanted to  
2 invite the measure developer to sit at the table  
3 to discuss and answering questions that the  
4 Committee had.

5 MS. CARTER: If anybody had a question  
6 they would like me to address as a developer on  
7 the measure, they're more than welcome. If  
8 anybody wants to repeat -- I said if anybody has  
9 a question about the measures that they would  
10 like answered, and would like to repeat, then  
11 I'll be more than happy to answer.

12 CO-CHAIR WHITACRE: I have a question.  
13 Do you have adequate measures for your members to  
14 report to participate in quality reporting  
15 programs, or is this necessary to complete that  
16 set?

17 MS. CARTER: It would be -- currently  
18 we only have six measures on PQRS.

19 CO-CHAIR BAGLEY: Other questions? Are  
20 we ready to vote? Okay, it looks like the answer  
21 is yes. Do we have a voting option ready for  
22 that?

1           MEMBER GLIER: Are we voting on just  
2           the clinician measure, or are we voting on both  
3           the clinician and the pathologist measures?

4           CO-CHAIR BAGLEY: They're two separate  
5           ones.

6           MEMBER SEIDENWURM: Are we voting for  
7           both programs, or --

8           CO-CHAIR BAGLEY: You're only voting  
9           for MIPS.

10          MS. CHAVEZ: Okay. Now getting ready to  
11          vote on MCU15-215. The voting options are 1,  
12          encourage for continued development; 2, do not  
13          encourage further consideration; 3, insufficient  
14          information. Voting is open.

15          CO-CHAIR BAGLEY: Go.

16          MS. CHAVEZ: For those on the phone,  
17          please submit your votes via chat. Thank you.  
18          Okay, 77 percent encourage for continued  
19          development, 23 percent do not encourage further  
20          consideration, zero insufficient information. The  
21          vote is for encourage for continued development.

22          CO-CHAIR BAGLEY: Okay, let's go on to

1 the pathologist. You want to read it?

2 MS. CHAVEZ: Okay. Now voting on MCU15-  
3 216. Same options, 1 encourage for continued  
4 development; 2 do not encourage further  
5 consideration; 3 insufficient information. Voting  
6 is open. Okay, 59 percent encourage for continued  
7 development, 41 percent do not encourage further  
8 consideration, zero insufficient information.

9 CO-CHAIR BAGLEY: You'll note that  
10 that's 1 percent lower than 60 percent.

11 MS. CHAVEZ: Yes.

12 CO-CHAIR BAGLEY: Did you get votes  
13 from the phone?

14 MR. LYZENGA: We did, so that -- just  
15 to clarify, Reva, that means do not encourage  
16 further consideration, the final decision?

17 CO-CHAIR BAGLEY: Cindy.

18 MEMBER PELLEGRINI: Just a quick  
19 question for our guest from EED. Just -- it just  
20 occurred to me as we're looking at this, did EED  
21 develop the pathology measure in consultation or  
22 partnership with pathologists?

1 MS. CARTER: So, it was in consultation  
2 -- well, we have workgroups that we work with to  
3 help develop the measures, so on those we have  
4 dermatologists and most surgeons that in some  
5 cases they could -- most surgeons do do their own  
6 pathology, but we didn't have like a pathologist.

7 CO-CHAIR BAGLEY: Go ahead, Scott.

8 MEMBER FURNEY: There were a couple of  
9 comments submitted on this measure. One was from  
10 the College of American Pathologists, and they  
11 were not supportive of this for many of the  
12 reasons we've already discussed. Interestingly,  
13 the American Society of Dermatopathology was in  
14 support. Both of them commenting that the number  
15 of measures for pathologists is very limited,  
16 which is what I believe was behind part of the  
17 development of this. So, if we don't continue  
18 with this, we'll have a continued gap to close as  
19 we recommend new measures. Pathologists having  
20 very few, unfortunately, at this point will have  
21 to consider others.

22 CO-CHAIR BAGLEY: CMS has heard your

1        comments. Okay. Are we ready to go on to the next  
2        one? So, the next -- the last one is the use of  
3        preventive screening protocol for transplant  
4        patients. Go ahead.

5                MEMBER GLIER: Me again?

6                CO-CHAIR BAGLEY: Yes, please.

7                MEMBER GLIER: So, my concern with this  
8        measure is that it is a documentation measure,  
9        and it seems very unlikely to me to actually  
10       achieve the stated goals which are to insure  
11       health promotion using three tiers to increase  
12       knowledge screenings and protective methods to  
13       limit the morbidity and mortality that can result  
14       from non-melanoma skin cancer. So, I find it hard  
15       to believe that documentation is going to achieve  
16       that. If there is a way to develop the measure  
17       further to be more closely tied to those  
18       outcomes, it would be great to see that, but I'm  
19       skeptical about its current format.

20               CO-CHAIR BAGLEY: Steve, go ahead.

21               MEMBER FRIEDHOFF: This is a little bit  
22       of a picky point, but if we're thinking of this



1 in the context of dermatology measures it seemed  
2 to me that this was more of a transplant measure.  
3 I mean, the analogy might be, you know, a dilated  
4 retinal exam being considered an ophthalmology  
5 quality metric as opposed to a diabetes care  
6 quality metric. So, it seemed a stretch to  
7 include this in dermatology for that reason.

8 CO-CHAIR BAGLEY: Are there other  
9 comments? It would seem -- to your point, it  
10 would seem like there's a whole raft of things  
11 that a transplant patient should have, and this  
12 ought to be on it, as opposed to the other way  
13 around. Right? Other comments or -- do you have  
14 comments about the measure?

15 MS. CARTER: So, for this measure it  
16 was looking to -- or sun protection or prevention  
17 -- or skin cancer prevention for transplant  
18 patients who are at a higher risk of getting  
19 cancer, skin cancers because of transplant and  
20 lower immunity. So, we did think this was  
21 important. We were not -- I think by making a  
22 measure that would encourage the education of

1 skin cancer, to be more hyper vigilant in, you  
2 know, doing some protective activities, clothing,  
3 or sunscreen, or things like that, and just  
4 making that a part of practice for dermatologists  
5 would help to lower that risk of skin cancer. So,  
6 we did -- but we did want to --- we did support  
7 the measure in the hopes that it would lower skin  
8 cancers for transplant patients who are just at  
9 higher risk of getting them. So, were there any  
10 specific questions?

11 CO-CHAIR BAGLEY: Beth, why don't you  
12 go ahead.

13 MEMBER AVERBECK: Was an intended group  
14 to be measured dermatologists, or anyone seeing a  
15 patient who is a transplant patient?

16 MS. CARTER: With the measure as  
17 written, it was for dermatologists, so they're  
18 more likely to -- I guess they would be more the  
19 specialty that would be looking at skin cancers,  
20 or be doing this, but it could be for any  
21 provider, actually. So, as long as they, you  
22 know, know that the patient is a transplant

1 patient they can give them education about sun  
2 protection since they are high risks.

3 CO-CHAIR BAGLEY: Scott.

4 MEMBER FURNEY: If the denominator is  
5 all transplant patients there would be no way to  
6 hold dermatologists who haven't been consulted to  
7 that metric, so it would have to be a transplant  
8 team metric to work, has already been discussed.  
9 There would have to be a checklist.

10 As far as a measure, I think as a  
11 process measure it is reasonable, but the  
12 attribution will have to be to their transplant  
13 surgeon.

14 CO-CHAIR BAGLEY: Other comments? Yes,  
15 Peter.

16 DR. BRISS: If you were going to  
17 address this issue, I agree with Bruce, it ought  
18 to be a component of a composite measure about  
19 what are the most important things to do for  
20 transplant patients? It doesn't seem to make  
21 sense as a standalone measure.

22 CO-CHAIR WHITACRE: And surgeon comment

1 just in terms of knowledge, I was not aware how  
2 important this was. But when I touched base with  
3 my transplant colleagues, this is apparently a  
4 big deal. And they do address it as a team, so  
5 I'm not -- I can't speak to the measure, but  
6 clinically this is actually very important, and  
7 it needs to be assessed in the system.

8 CO-CHAIR BAGLEY: I don't see any other  
9 comments. Anybody else? Okay. Are we ready to  
10 vote? Okay, let's do it.

11 MS. CHAVEZ: Okay. Now voting on MCU15-  
12 177 for MIPS. So, options are 1 encourage for  
13 continued development; 2 do not encourage further  
14 consideration; 3 insufficient information. Voting  
15 is open. For those on the phone, please submit  
16 your votes via chat. The results for MCU ID  
17 MCU15-177, 50 percent encouraged for continued  
18 development; 45 percent do not encourage further  
19 consideration; 5 percent insufficient  
20 information. So, vote is for do not encourage  
21 further consideration.

22 CO-CHAIR BAGLEY: Okay. That concludes

1 the dermatology section. Now, we have an option  
2 to go for a break, or press on. How many want to  
3 press on? Okay. You're late voters, huh? Okay.  
4 Looks like we ought to press on, so let's do  
5 that.

6 DR. WINKLER: Okay. Our next topic area  
7 is in eye care. And what we have are 12 new  
8 outcome measures for various eye conditions  
9 submitted by the American Academy of  
10 Ophthalmology. These measures are still in  
11 development, they're still undergoing testing  
12 which is expected to be completed in the spring  
13 of 2016.

14 These measures are currently specified  
15 for registry-based reporting and electronic  
16 capture from EHRs for use in AAO's IRIS registry.  
17 And these measures are included in their QCDR for  
18 PQRS reporting in 2015 for eye care. So, there  
19 are currently about 14 measures for eye care in  
20 the clinician set, five of them address some of  
21 the conditions that you see here, both diabetic  
22 retinopathy, glaucoma, and macular degeneration,

1 but those others were process measures, so this  
2 provides some new outcome measures. But in  
3 addition, seven of the measures address new eye  
4 care conditions that are not in the existing set.  
5 So, with that --

6 MEMBER GLIER: Oh, right. I was going  
7 to say, we're on to public comment.

8 MS. HANCOCK: Hi, Rebecca Hancock with  
9 the American Academy of Ophthalmology. I just  
10 wanted to share a few points on the eye care  
11 measures that are up for discussion now. All of  
12 these measures were developed by the Academy in  
13 conjunction with the major sub-specialty  
14 societies. They're fully specified and were  
15 submitted to and accepted by CMS as qualified  
16 clinical data registry measures, and they are  
17 currently in use this year by physicians using  
18 the Academy's registry, IRIS registry, qualified  
19 clinical data registry option, QCDR option to  
20 participate in PQRS.

21 At the end of this calendar year, we  
22 will have a full year's worth of data, and are

1 hoping to wrap-up testing and have the measures  
2 fully completed by early spring next year, so  
3 they will be ready for use in MIPS in 2017. These  
4 are all important patient outcome measures, and  
5 we encourage MAP to offer their support for them.  
6 Thanks.

7 CO-CHAIR WHITACRE: Are there any other  
8 -- is this questioning for the --

9 MEMBER GLIER: Sorry. Amy, would you  
10 stay for a second? My question is if these are  
11 already accepted by the QCDR program and being  
12 reported that way, and you're hoping to finalize  
13 testing in the spring, if we offer  
14 recommendations for encouraging continued  
15 development in a particular direction, is the  
16 Academy open to those suggestions?

17 MS. HANCOCK: Yes.

18 CO-CHAIR WHITACRE: Are there other  
19 comments, other public comments either on the  
20 floor or on the phone?

21 OPERATOR: At this time, to make a  
22 comment please press star 1. There are no public

1        comments from the phone line.

2                    CO-CHAIR WHITACRE: Great. Thank you  
3        very much. So, a couple of measures have already  
4        been pulled, and I think the simplest way to do  
5        this is probably to use the agenda with the  
6        bullet points because it's really unwieldy in the  
7        discussion document because of the public  
8        reporting issues.

9                    So, I went ahead and in my mind and on  
10       paper went every third measure, so the first  
11       number 3 was Exudative Age-Related Macular  
12       Degeneration. If I counted correctly, six was  
13       Corneal Graft Surgery - Postoperative  
14       Improvement. Number 9 was Acute Anterior Uveitis  
15       - Post-treatment visual acuity. This is just for  
16       reference later. And number 12 is Chronic  
17       Anterior Uveitis. Saying each one of these each  
18       time is going to be difficult, so I thought going  
19       through these -- so, the measures that have been  
20       pulled are number 3, which is Exudative Age-  
21       Related Macular Degeneration, loss of visual  
22       acuity. Stephanie, that's you. Then number 7,



1 which is Surgery for Acquired Involutional  
2 Ptosis: Patients with an improvement of marginal  
3 reflex distance. And that's pulled by Bruce. And  
4 then the one following that, Acquired  
5 Involutional Entropion: Normalized lid position  
6 after surgical repair. Again, I think, Bruce, you  
7 pulled these as a pair. And then number 10, which  
8 is Acute Anterior Uveitis: Post-treatment Grade 0  
9 anterior chamber cells, by Stephanie. And number  
10 12, Chronic Anterior Uveitis: Post-treatment  
11 Grade 0 anterior chamber cells. I think I'm ready  
12 to sit for my ophthalmology boards after doing  
13 this. Holy smokes! I would either have pulled  
14 none or all of them, but anyway. So, are there  
15 any other measures which the members would like  
16 to extract from this group? Yes, David.

17 MEMBER SEIDENWURM: In the new  
18 taxonomy, number 12, intra ocular Pressure  
19 Reduction following Laser Trabeculoplasty. Number  
20 2, I mean. Did I say 12?

21 CO-CHAIR WHITACRE: Number 2? Oh, that  
22 helps. Okay.

1 MEMBER SEIDENWURM: Sorry.

2 CO-CHAIR WHITACRE: Okay, David. All  
3 right. Any other measures to extract? Terrific.  
4 Stephanie, shall we start with you? I assume you  
5 had a method here.

6 Oh, sorry. I guess we should -- we can  
7 accept the consent calendar which would include  
8 Measures 1, Glaucoma, Intra ocular Pressure  
9 Reduction; number 4, Non-Exudative Age-Related  
10 Macular Degeneration loss of visual acuity; the  
11 one following that, Diabetic Macular Edema, loss  
12 of visual acuity; number 6, Corneal Graft Surgery  
13 Post-operative Improvement in visual acuity; then  
14 number 10, no, excuse me, number 11, Chronic  
15 Anterior Uveitis: Post-treatment visual acuity.  
16 Sorry. And number 9, Acute Anterior Uveitis:  
17 Post-treatment visual acuity. Gosh, yes.

18 MEMBER KRUGHOFF: Can you give us some  
19 sense of the implications and the reasons to care  
20 about knocking anything off this list? I mean,  
21 the reasons I could imagine wanting to knock  
22 things off a list would be that they're -- well,

1 one would be that they don't seem to be valid,  
2 but beyond that, you know, if they're too  
3 burdensome and the number of patients impacted  
4 are too small, you might not want to do these  
5 things. On the other hand, if the society has  
6 already built these things into its registry  
7 program and stuff, you know, that wouldn't -- it  
8 wouldn't be very compelling to me as a reason to  
9 get rid of it. It might be compelling to not put  
10 the results on the Physician Compare website, but  
11 even then to have it in the database doesn't seem  
12 like a bad idea, because somebody else who's  
13 really focusing on this particular field could  
14 make it available to patients in a patient forum  
15 setting or something like that, drawing on the,  
16 what you call the spreadsheet, what we call the  
17 spreadsheet here. So, I don't have a very good  
18 way of deciding why to get rid of any of these  
19 things if the society is doing it, and the data  
20 are coming in.

21 CO-CHAIR WHITACRE: Well, we think  
22 alike and this is the challenge for the members

1 who extracted the measures. Stephanie, go ahead.

2 MEMBER GLIER: I have two comments, one  
3 is a logistics, which is really that I meant to  
4 pull 3 and 4 together as a pair. So, before we do  
5 the consent calendar, I didn't tell you that, so  
6 there's no way you could have known. That was on  
7 me, not on you.

8 My second comment is sort of a  
9 response to Robert, and I'm wondering if instead  
10 of pulling up the discussion guide on the screen  
11 that we're all seeing, if we could go back to the  
12 slide with CMS' principles for MIPS, because I  
13 think it would be helpful for everyone to be  
14 looking at what it is that CMS is trying to build  
15 in this program as we're thinking about the  
16 measures that are currently proposed, and using  
17 that as a bar to say are these measures -- do the  
18 measures we're looking at here, even if the  
19 ophthalmologists are already using them in their  
20 registry, they can use them in their registry for  
21 many purposes, including quality improvement,  
22 including benchmarking, including peer

1 comparisons, but are they a fit for MIPS? Are  
2 they going to add meaningful information for this  
3 accountability program? And if the answer is no,  
4 then I would urge us to use our judgment and take  
5 a little bit more of a conservative approach  
6 about recommending more time and money put into  
7 developing these measures for accountability  
8 purposes if they don't seem like they're going to  
9 be useful for that purpose.

10 CO-CHAIR WHITACRE: If we can first  
11 agree on the consent calendar with the slight  
12 change of Measure 4 being pulled, as well. Is  
13 everyone in agreement that we can accept the  
14 other measures? Beautiful. Please, Stephanie.  
15 You'd like to go through where specifically the  
16 MIPS principles you think these measures do not  
17 satisfy, or may not satisfy those?

18 MEMBER GLIER: Oh, and I did not  
19 actually mean to do a crosswalk specifically to  
20 that.

21 CO-CHAIR WHITACRE: Oh, okay.

22 MEMBER GLIER: I just thought this

1 would be a good reference point for people to be  
2 able to look at --

3 CO-CHAIR WHITACRE: Okay.

4 MEMBER GLIER: -- as we're going  
5 through the discussion.

6 I think I'd like to take more of a  
7 questioning approach for the measures that I  
8 pulled. Your name is Amy. Right?

9 MS. HANCOCK: No, my name is Rebecca.

10 MEMBER GLIER: Rebecca. I'm sorry.

11 MS. HANCOCK: And Dr. Friedman is an  
12 ophthalmologist, and he's representing the  
13 Academy, so he hopefully can help me in answering  
14 any of the clinical-type questions.

15 MEMBER GLIER: Thank you. Well, then a  
16 question to both of you is, is there a reason to  
17 separate the wet and dry macular degeneration  
18 measures from each other?

19 MEMBER FRIEDMAN: Okay, my area of  
20 expertise. So, the answer is yes. We -- macular  
21 degeneration is the most common cause of vision  
22 loss in Medicare patients and patients over 75.

1 And, basically, we generically categorize it wet  
2 versus dry. Wet is more common, wet turns into  
3 dry, dry is more serious. We have more treatments  
4 for wet.

5 So, basically, we do have some --  
6 there is some evidence that giving AREDS2,  
7 giving patients with dry macular degeneration,  
8 which is very, very common, if you treat them  
9 with vitamins and it's level 1 evidence, you can  
10 slow down the progression of wet macular  
11 degeneration and save vision. So, we have  
12 separate measures for dry because there is a  
13 treatment for dry. And then once they develop  
14 wet, we have different treatments for wet. We  
15 give them injections, typically. So, they're two  
16 slightly -- although it's the same area of  
17 pathology, we can separate them out basically  
18 into wet and dry, and they do have different  
19 treatments; therefore, we have two different  
20 measures to accomplish that.

21 MEMBER GLIER: And perhaps this is not  
22 as nuanced a question as I meant it to be, but

1 would it be possible to consider essentially like  
2 an optimal macular degeneration measure that  
3 included both treatment courses appropriate for  
4 the type of patient you were looking at? So, sort  
5 of a compound measure to say for both of these  
6 are you doing the appropriate care as determined  
7 by the guidelines that the Academy uses?

8 MEMBER FRIEDMAN: I suppose you do, but  
9 I think there's enough difference between the two  
10 disease processes and the treatments to separate  
11 them out.

12 CO-CHAIR WHITACRE: Yes?

13 MEMBER KRUGHOFF: Could somebody  
14 explain a little more what the implications are  
15 from MIPS of having a whole lot of measures in  
16 one field of medicine and a smaller number of  
17 measures in another field of medicine? It would -  
18 - my understanding is that the MIPS people would  
19 still be able in some way to weight those  
20 different -- maybe I'm wrong. Could they still  
21 weight those measures in the overall MIPS scoring  
22 and say well, these are more significant, affect



1 more people; therefore, we're really going to put  
2 priority on that. And so it's the MIPS people  
3 who, you know -- CMS who decides how to use all  
4 these measures and the weighting of all those  
5 measures, but not something that we really need  
6 to worry much about except that that's another  
7 thing that they might want to get some feedback  
8 on when they do it. But it's not -- I'm not --  
9 it's not clear to me what the advantage is in  
10 getting rid of some of this information that CMS  
11 could have in scoring people.

12 CO-CHAIR WHITACRE: David.

13 MS. AUTREY: We had a large number for  
14 the larger specialties, but some of the sub-  
15 specialties, some of those measures aren't  
16 relevant for them. So, you will see in some  
17 aspects where there are a large number, but not  
18 all of the people in the sub-specialty actually  
19 can report all of those measures, so we do have a  
20 larger number. But then there are some  
21 specialties in which we just have fewer measures  
22 because fewer measures have been submitted. So,

1       it is not as if we have actually said that's how  
2       we want it, but that's just how it has occurred.  
3       So, we are looking for more measures so that more  
4       providers can have a plethora of measures that  
5       are relevant for their specialty, and sometimes  
6       their sub-specialties.

7                   CO-CHAIR WHITACRE: David was, I think,  
8       first.

9                   MEMBER SEIDENWURM: Sure. So, it's  
10       great to have an ophthalmologist here to answer  
11       these questions because we're getting into some  
12       highly technical areas.

13                   My questions were around the questions  
14       regarding separating the glaucoma measures into  
15       the surgical and the non-surgical. Why not just  
16       have a general measure for how well you're doing  
17       with the intra ocular pressure? You know, why  
18       would those be -- why would those need to be  
19       separate? And then the other family of questions  
20       that I had, had to do with why one would select  
21       an intermediate metric other than visual acuity?  
22       I understand for intra ocular pressure it takes,

1     you know, quite a while for the visual acuity to  
2     deteriorate, so that makes sense. But I didn't  
3     have the knowledge base to judge the inflammatory  
4     cells in the other examples, so if you could  
5     address some of those questions in a way that  
6     some of us non-ophthalmologists could understand,  
7     that would be great.

8             MEMBER FRIEDMAN: Sure. So, one quick  
9     comment on the last thing that was stated,  
10    ophthalmology. So, there's some ophthalmologists  
11    -- there's a lot of specials in ophthalmology.  
12    For example, some ophthalmologists maybe limit  
13    their practice to retina, which is what I do. So,  
14    a lot of these measures wouldn't be applicable to  
15    me. For example, I don't treat glaucoma, so I  
16    couldn't report any of the glaucoma measures.  
17    There are some ophthalmologists that just limit  
18    their practice to uveitis, so we need to have a  
19    large group of measures that traverses the whole  
20    practice of ophthalmology, so for people that  
21    don't do glaucoma, don't do retina, there needs  
22    to be measures if they just limit their practice

1 to uveitis, for example, so they can report on  
2 that particular disease set.

3           Glaucoma, so the first question about  
4 glaucoma. Glaucoma, again, you can differentiate  
5 from a very common cause of vision loss, most  
6 common cause of vision loss in older age  
7 Americans, the Medicare population. You can  
8 separate that into medical versus surgical. And I  
9 think there's enough distinction between those  
10 two, if you -- that you can take the patients  
11 that are doing well, and you want to certainly  
12 have some guidelines or criteria for looking at  
13 treatment outcomes based on medical treatment.  
14 And then once they advance to that, we do  
15 procedures, surgical procedures or invasive  
16 procedures. And then at that point you can look  
17 at treatment outcomes based on surgery, so they  
18 get Procedure A. What was the result of that? So,  
19 we're looking at outcome measures now which we  
20 didn't before. We looked at -- our initial  
21 measure was reduction in LP, but now we're  
22 looking at -- we have more robust measures

1 looking at outcome measures seeing that now the  
2 patients that do have to go to surgery, what  
3 percent of those eyes do well? And I think  
4 there's enough -- you could, again, lump them in  
5 together, but I think there's enough distinction  
6 between the medical and the surgical to have  
7 separate measures for that.

8 And the other thing is that we do have  
9 -- general ophthalmologists treat a lot of early  
10 glaucoma, and so they can report on the -- most  
11 of the eyes that they're being treated with  
12 drops, but then we have glaucoma specialists, and  
13 they get the eyes that are doing poorly. And  
14 maybe they're doing surgery on the majority of  
15 the patients, and they're not seeing the easy  
16 glaucoma patients. And they need outcomes that  
17 they can actually report on, because they're  
18 specializing, they're limiting their eyes to the  
19 eyes that aren't doing well. And they get  
20 referrals from general ophthalmologists that are  
21 seeing the simple eyes, so they need measures  
22 that they can report on, because their patient

1 population is somewhat biased, because they have  
2 the worst cases.

3 CO-CHAIR WHITACRE: Barbara.

4 MEMBER LANDRETH: What this seems to me  
5 is that you may be risk-adjusting patients by  
6 developing additional measures, whereas in some  
7 other measures risk-adjustment is part of the  
8 measure. Do you see what I mean? In other words,  
9 is there a way that we can risk-adjust these  
10 patients so that you can look maybe not at so  
11 many measures, but look at the people who have --  
12 you know, can easily be medically managed and  
13 their glaucoma is not at a severe level in the  
14 same bucket as you look at the more severe cases,  
15 but risk-adjust them.

16 CO-CHAIR WHITACRE: Robert.

17 MEMBER KRUGHOFF: Yes, I think that's  
18 a very good point. In a sense, you know, I'm --  
19 without knowing what would happen, I'm prepared  
20 to sort of send all these measures to CMS to do  
21 whatever scoring it wants to do. But that does  
22 require some sort of weighting, and it requires

1 both risk-adjustment, which I assume they would  
2 do. But once you've risk-adjusted, you then have  
3 to weigh the measures and decide, you know, what  
4 the overall aggregate measure is in terms of, you  
5 know, quality and reimbursement, et cetera. And  
6 somebody is going to have to do that, and I don't  
7 have a picture of how that's done. On the other  
8 hand, I don't mind having a lot of them to work  
9 with. I'd like to have more confidence that  
10 they'll do a good job doing that part putting  
11 these measures together into some composite  
12 thing. But, you know, that's sort of a -- and one  
13 could combine them all with every procedure and  
14 every type of case being risk-adjusters, and have  
15 one overall measure for quality. And, of course,  
16 you'd have a lot more clinical information if you  
17 did it at that level rather than sending them off  
18 as end measures to CMS. But can anybody give us  
19 any feedback? Maybe nobody else needs the  
20 feedback. I need the feedback as to how CMS is  
21 going to behave with this stuff.

22 CO-CHAIR WHITACRE: Peter, and then

1 Cindy, and then Beth.

2 DR. BRISS: It seems to me that the  
3 strong format that Robert sort of -- I mean, if  
4 you really pushed that to its logical conclusion,  
5 then there's no sense of having a MAP. Right? So,  
6 it seems to me that our reason for being is to  
7 give CMS some advice about what things are  
8 relatively higher, and what things are relatively  
9 less high priority. And CMS can always take it or  
10 leave it. Right? They've been good historically  
11 about taking advice from the MAP, but it hasn't  
12 been 100 percent, so they can still do their  
13 internal decision making, but we can at least  
14 give them some advice about priority.

15 And the rest of your argument is that  
16 part of the problem is that we have an  
17 embarrassment of riches. Part of the problem is  
18 that it's impossible for even technically skilled  
19 people to sort through hundreds of measures and  
20 make any sense out of them. So, I would generally  
21 say having a smaller set of higher value measures  
22 would be a good thing. And it's not universally



1 true that more information is always better.

2 CO-CHAIR WHITACRE: Cindy.

3 MEMBER PELLEGRINI: I hope this isn't  
4 going to sound like I'm getting into semantics  
5 here, but I think we've got a nuance between what  
6 I'm going to call risk versus relevance. And  
7 there is that issue if the patients have  
8 different risk levels, which may refer to their  
9 degree of health, their capacity, their  
10 resources, their health literacy, et cetera, but  
11 then we've got the relevance of the measures to  
12 the physicians. And this came up at the  
13 certification meeting I mentioned I was at. In  
14 that context where they're saying, you know, if  
15 you're an orthopedic surgeon you may be an  
16 orthopedic surgeon who says, you know, I only do  
17 knees. Don't test me on elbows, don't test me on  
18 spines because I don't touch them. Right? So, I  
19 think we're running into that kind of problem  
20 here, and it's a very tempting thing to conflate  
21 those risk and relevance things looking at these  
22 measures. And we have to look at it from both the

1 patient side, and the physician side. This may be  
2 something that CMS has already kind of parsed out  
3 for themselves, I'm not sure.

4 CO-CHAIR WHITACRE: Beth.

5 MEMBER AVERBECK: Thanks. I was one of  
6 the reactors on this group, and so I think as a  
7 physician but not as an ophthalmologist, I was  
8 very encouraged that we were moving in the  
9 direction of outcome measures from the Academy,  
10 so thank you for that. And these are -- and I  
11 think, David, to your point earlier, these are  
12 new topics, new areas, moving some measures more  
13 towards outcomes. I'm encouraged that they're  
14 being field tested and that, hopefully, once  
15 they're field tested that they might be able to  
16 go through the NQF endorsement process, and  
17 continue to move down that path. So, that's just  
18 a general comment on the measurement set.

19 DR. GOODRICH: Well, since CMS has been  
20 referenced about what we'll do so often, I feel  
21 like I should respond. So, a couple of points to  
22 make.

1           I think what I was hearing was the  
2   issue of combining some of these measures and the  
3   need possibly for risk-adjustment. So, just as  
4   generally how this works, we didn't develop these  
5   measures, so I think AAO would take this  
6   feedback, and should they decide that it makes  
7   sense for some of these measures for them to be a  
8   composite, which is what you're talking about, I  
9   think, and risk-adjust them, they can do that.  
10   And then that measure would come to CMS to be  
11   implemented in that way. We don't risk-adjust on  
12   the back end or anything like that within CMS. We  
13   don't combine measures that don't come to us as  
14   composites. The developer really has the  
15   stewardship over those measures. We might  
16   encourage that as we work with the developers to  
17   do exactly that. They're getting that  
18   encouragement from you now, so that will be up to  
19   AAO as to whether or not they want to do that.  
20   We'll have ongoing conversations with AAO.

21           Around the issue of, you know, a  
22   plethora of measures because there's such a

1 variation in scope of practice, and all of that.  
2 That is a true thing that we are definitely  
3 seeing reflected here. I'll be honest. I do worry  
4 about some of the societies that haven't had many  
5 measures that are just getting into the  
6 measurement game that need measures that are  
7 relevant for them, and relevant for their  
8 patients for them to be evaluated on for  
9 accountability purposes for these programs.

10 Many of them want to participate these  
11 programs. They see a lot of Medicare patients,  
12 and so having measures that are relevant to them  
13 is really important. And I think it's a balance  
14 between having some measures that -- and having  
15 the right measures, and maybe over time getting  
16 to better measures. It is a balance definitely  
17 because, you know, you don't want to have -- as  
18 this group has worked hard with us over the past  
19 four years to get us to a place where we're  
20 seeing more outcome-based appropriate use  
21 measures and so forth, and we've made a lot of  
22 progress in that direction, not enough, but we've

1 made a lot of progress in that direction. So, we  
2 continue, especially as we see these specialty  
3 societies that are starting to get into the  
4 measurement development world sending measures to  
5 us to try to encourage moving in that direction.  
6 I think some have moved further than others, is  
7 essentially what I'll say.

8 CO-CHAIR WHITACRE: Thank you very  
9 much. Stephanie, I hope that helped address some  
10 of the concerns you have with the measures you  
11 pulled, because I know Bruce had pulled some  
12 measures, as well. So, if we could perhaps ---  
13 oh, other -- I'm sorry, I missed. Yes.

14 DR. ALEMU: Yes. When you have a large  
15 number of measures, I mean, we have to be  
16 selective. We know that there are a large number  
17 of measures out there, but there are different  
18 conditions which need to be looked at, the pre-  
19 balance of the condition is, you know, one of the  
20 most important factors in addition to relevance  
21 and other issues. But when it comes to, you know,  
22 these measures which we are talking about, there

1 are cases where you cannot make composite  
2 measures. The individuals will not -- you know,  
3 we cannot get them together in order to have one  
4 composite measure. So, we have to see it case by  
5 case and, you know, we have to look at in order  
6 to make it shorter, composite measures are not  
7 always the solution. So, it's -- you have to look  
8 at them case by case. And in this case, I don't  
9 see that making a composite measure solves the  
10 problem.

11 CO-CHAIR WHITACRE: Thank you. Scott,  
12 did you have a comment?

13 MEMBER FURNEY: I would encourage as  
14 these measures are further developed, the closer  
15 we can get to measuring patient-specific outcomes  
16 being visual preservation, visual acuity or  
17 preservation. It sounds like just in reading the  
18 measures we have intermediate outcome measures  
19 that should lead to that, and I think barring a -  
20 - to Janis' point earlier, barring a really good  
21 risk-adjustment system that would potentially be  
22 a bias against those that do secondary referrals

1 or tertiary referrals. So, I think the measures  
2 make sense to me now that they've been explained.

3 CO-CHAIR WHITACRE: Okay, thank you.  
4 Luther.

5 DR. CLARK: Was my understanding  
6 correct that these measures were developed by the  
7 Academy in conjunction with CMS, in consultation?  
8 Right? They were just submitted.

9 DR. GOODRICH: The Academy developed  
10 them. As we have with other specialty societies,  
11 along the way of development we'll connect and  
12 talk about it, and all that, but we were not  
13 involved in the development at all.

14 DR. CLARK: But you've had  
15 conversations as they developed.

16 DR. GOODRICH: Yes, and we talk with  
17 AAO a lot, gladly so.

18 CO-CHAIR WHITACRE: Scott.

19 MEMBER FRIEDMAN: I appreciate that  
20 point. So, some of these measures look at  
21 surrogates for visual function, so ultimately  
22 we're trying to prevent patients from going blind

1 and improve their vision. So, for example, the  
2 cell and flare, if we have one has persistent  
3 cells, if left untreated that will lead,  
4 ultimately, to vision loss, so we do have two  
5 measures and they kind of say the same thing,  
6 looking different ways of saying the same thing.  
7 Obviously, ultimately, we want to preserve  
8 vision. If you have persistent cells and if left  
9 untreated, you're probably going to lose --

10 there's a reasonable chance you're going to lose  
11 vision. Intra ocular pressure, if it remains high  
12 you're going to lose peripheral vision,  
13 eventually, and go completely blind, so that is  
14 somewhat of a surrogate for visual function. But  
15 I do agree with you. I appreciate that point.

16 CO-CHAIR WHITACRE: Yes, Robert.

17 MEMBER KRUGHOFF: Okay, I'll stop after  
18 this one. The -- I guess I'm wondering if we say  
19 encourage further development, could there be a  
20 way to amplify that a little bit and say see if  
21 you can come up with something that is more of a  
22 composite out of these things, because that



1 message doesn't get across by just saying don't  
2 encourage further development. If there's a  
3 potential for a composite, we might want to get  
4 that across, but also say encourage further  
5 development means to try and get a composite.

6 The other thing I guess I'd like to  
7 express is that I can imagine that consumers who  
8 have one of these conditions might be very  
9 interested in a rather narrow measure that really  
10 has to do with the particular condition I have,  
11 unless we know that there's a very high  
12 correlation between success in one versus  
13 another. But from a Physician Compare database  
14 website, the spreadsheet website level, why not  
15 make that information available? If the society  
16 is moving forward with this anyway, why not make  
17 that available so I could actually find out how  
18 this doctor does with my particular condition  
19 assuming there's adequate sample size. And sample  
20 size, you know, has to be a test here.

21 CO-CHAIR WHITACRE: Peter, and then  
22 Steve.

1 DR. BRISS: Scott, I'm another  
2 specialty that needs an education. So, I think I  
3 get the logic model for this, so the Uveitis will  
4 sometimes lead to vision loss. And what I can't  
5 get my mind around is why we need both measures.  
6 So, it might be that Uveitis is -- if you mean  
7 that they're both getting essentially the same  
8 conceptual thing and we might be able to choose  
9 one or the other, so you might -- if Uveitis  
10 isn't something you really want to treat, and  
11 vision loss is relatively rare or far in the  
12 future, you might choose the one. If vision loss  
13 happens commonly enough that what you're going to  
14 treat is the Uveitis, but what you really care  
15 about is the vision loss, you might be able to  
16 get away with the vision loss. I can't quite get  
17 my head around why we need both measures, and why  
18 we couldn't choose one as preferable over the  
19 other.

20 MEMBER FRIEDMAN: Sure. I think when  
21 you look at them -- so, again, Uveitis,  
22 inflammation cells, if you get rid of the cells

1 in theory you prevent vision loss. The other one  
2 looked at baseline visual acuity prior to the  
3 onset, so it's slightly different. So, if someone  
4 has developed Uveitis and they develop vision  
5 loss, you want to make sure they get their  
6 baseline vision back, so they're slightly  
7 different looking at the same thing, looking at  
8 it from two slightly different approaches. And I  
9 think there's enough difference between the two  
10 that we should probably include both of them.

11 CO-CHAIR WHITACRE: Well, thank you  
12 very much. That's a great discussion. Steve?

13 MEMBER FRIEDHOFF: Thanks. You know, I  
14 think when I first saw the list, I had similar  
15 concerns about the sheer volume, but as I heard  
16 your feedback, I think it all -- you know, it  
17 started to make sense as to why that they were  
18 separated both for, you have different clinical  
19 presentations to be in some specialization, et  
20 cetera. And I think as I think about it, again,  
21 I'm not sure what CMS' perspective is on this,  
22 but I would think that it's actually perfectly

1 fine for some specialties to have a lot more  
2 measures than others based on the volume of  
3 Medicare beneficiaries being seen, the potential  
4 for, you know, very good or very bad outcomes,  
5 the cost to the system. So, I feel like I'm a  
6 little bit less hung up on whether we have a lot  
7 for one specialty and few for another, especially  
8 if they're meaningful, they meet the MIPS  
9 principles. And, particularly, they're things  
10 that I think patients are going to be looking  
11 for. And if you think about if a patient may be  
12 looking -- I don't know that they would  
13 necessarily be shopping for a pathologist, and  
14 they might have a much narrower scope if they're  
15 searching for a dermatologist, but they had a  
16 very discrete ophthalmologic concern they might  
17 want this level of granularity.

18 MEMBER ORLOWSKI: So, the 50,000-foot  
19 view, it's been interesting to listen to the  
20 conversation. The way I view it is the  
21 ophthalmologists came forward and said measure us  
22 on these because they're important. You know

1       what? Measure them. And I think the rule is now  
2       is to link for the public why these measures are  
3       important. So, what we have to do is have  
4       verbiage that says the ophthalmologists know  
5       about cells and inflammation, and all this other  
6       stuff, but in the end, this links to loss of  
7       vision. And so I would say measure the  
8       ophthalmologists on these parameters. They're  
9       well thought out, they have, you know, sort of  
10      national association that's backed behind, and  
11      they're raising their hands and saying measure us  
12      on this. And they're not easy, they're not  
13      nonsense. And then what CMS needs to do is  
14      translate that into something that becomes  
15      understandable to the public of why you would  
16      want to know about these measures with your  
17      ophthalmologist.

18                   CO-CHAIR WHITACRE: Great, thank you.

19      Bruce, would you like to mention why you  
20      extracted the measures, I think 7 and 8. One more  
21      hand. Sorry, gosh.

22                   MEMBER SEIDENWURM: So, the

1 conversation that's been going on here has been  
2 great, and I think that several of the physicians  
3 who sat around the table in previous years have  
4 made analogous statements that have not carried  
5 the day. So, I'm very glad that this perspective  
6 is seen as valuable as we move forward in these  
7 programs. And I think that was very well  
8 expressed, and thank you.

9 CO-CHAIR BAGLEY: Okay. I extracted  
10 these measures, this would be 7 and 8, because I  
11 wanted to hear -- I don't want to focus too much  
12 on the measures themselves. I want to hear some  
13 discussion from the workgroup about what I might  
14 call expected outcome measures. So, let me take  
15 it away from ophthalmology for a minute. If you  
16 have a measure about an appendectomy, and the  
17 measure is that the thing that goes to the  
18 pathology lab ought to be an appendix. That seems  
19 like that's an expected outcome, and unless  
20 there's some pretty big gap that we don't  
21 identify it every time, it's kind of a ludicrous  
22 measure.

1                   So, Scott, forgive me. I'm going to  
2                   oversimplify this, but for ptosis, that means lid  
3                   hangs down, gets in the way of your vision, and  
4                   if you do an operation the marginal distance  
5                   should be greater. In other words, it ought to  
6                   get farther away from the center of the cornea.  
7                   So, that's kind of an expected outcome, so unless  
8                   there's a failure rate of, you know, 80 percent,  
9                   or 20 percent, or something like that, it doesn't  
10                  seem like a reasonable outcome.

11                  And I applaud the fact we're trying to  
12                  get to outcome -- please bear with me for a  
13                  minute. The other one, Entropion, for those of  
14                  you -- that means that the lower lid, usually in  
15                  older people tips in. And the patient-oriented  
16                  problem is that tears run down their face all day  
17                  long, any time they're upright. So, the measure,  
18                  if you really want an outcome measure, not  
19                  whether we put the lid back where it belongs, is  
20                  do the tears no longer run down my face. You  
21                  know, that's the better approach to a patient-  
22                  oriented outcome. So, I don't want to focus too

1 much on these two measures because I want to  
2 applaud the idea that we're trying to move  
3 towards outcome measures. But I want to hear a  
4 general discussion about what is an expected  
5 outcome versus a gap in care that measures might  
6 drive a reduction of?

7 CO-CHAIR WHITACRE: Yes.

8 DR. WINKLER: Can I make a comment?

9 Yes, and when we were going through these in the  
10 preliminary analysis, one of the challenges we  
11 had was exactly this question, because what we  
12 did not have was really any information, any data  
13 on what current performance is. And that made it  
14 very challenging to understand really, you know,  
15 is this going to have an impact on patients,  
16 because if performance is currently wide-eyed,  
17 well, there's not much this measure is going to  
18 do to improve that. And that lack of information,  
19 I think, underpins some of the comments that  
20 you're making right now, and is problematic not  
21 with just these measures, but we found it  
22 pervasive through a lot of the measures. So, just



1 to tell you, I found that extremely challenging  
2 in looking at the measures.

3 CO-CHAIR WHITACRE: Luther.

4 DR. CLARK: Yes. Bruce, I think that's  
5 actually a really great point, and it goes back  
6 to a couple of the questions I asked earlier,  
7 because one can have a clinical outcome which is  
8 a measure of success, but then when you think  
9 about, you know, what's important to the patient,  
10 it may be something different, although related.  
11 And I think those two examples you gave are  
12 really excellent ones. And maybe an approach to  
13 that is just thinking about them in terms of  
14 outcomes that really patients value versus  
15 outcomes that reflect a clinical success. And I  
16 think when we say that measures are patient  
17 centric or in that category, it's an important  
18 distinction.

19 CO-CHAIR WHITACRE: Robert.

20 MEMBER KRUGHOFF: I promised I was  
21 finished, but I think when you look at all these  
22 things you're wondering about the incidents and

1 the variability in outcomes. These may all be  
2 topped out measures, which is the reason we get  
3 rid of measures all the time here, so we really  
4 do need to know that kind of thing. This is just  
5 an uncomfortable sort of voting situation for us  
6 here because we don't know those things, and to  
7 say -- to not vote in favor of further  
8 development seems to me to be kind of too bad,  
9 because I really want to know more. Right? And so  
10 I'm just not quite sure what our -- whether  
11 there's some way to supplement a negative vote on  
12 some of these things by saying but yes, if  
13 there's big variation and there's a high  
14 incidence of this thing, we'd like you to go on.

15 My attitude has been, hey, this sounds  
16 like a freebie. The doctors want to do it, so I'm  
17 all in favor of all the data you can get out  
18 there, and then anybody who's going to end up  
19 reporting on it -- yes, I wouldn't put -- we have  
20 a choice. Should we put it on the visible  
21 Physician Compare website, or should we put it in  
22 a downloadable database, and if it's not very

1 important, we only put it on the downloadable  
2 database. And if anybody wants to take it and use  
3 it, I think that's the best role for the  
4 government, anyway, in all of these measures, is  
5 to make more data available so that the patient  
6 group that's trying to figure out what they want  
7 to do with a particular kind of eye condition,  
8 can go in and look at it. So, it's all good to  
9 have this stuff, unless it's too big a burden on  
10 the doctors to do it, relative to the benefit.

11 MEMBER FRIEDMAN: So a couple of  
12 things. So with the question of the ptosis, I  
13 agree. You hope the patients are getting better  
14 and not staying the same or even more  
15 importantly, getting worse; but unfortunately,  
16 you'd be surprised. So we think this is  
17 significant enough to where we'd like to measure  
18 it, and if 99 percent of them are getting better,  
19 then maybe we can do away with this measure. But  
20 again, it's what Rebecca said, we don't have the  
21 data yes for this and the other measures, if our  
22 other measures are also topped out, we certainly

1 don't want to use those, but until we get the  
2 data and have a reasonable amount of data to look  
3 at what's going on, we think that we shouldn't  
4 move forward.

5 And again, the analysis is encourage  
6 continued development, so the measures, at least  
7 our particular measures aren't done, they're not  
8 ready for prime time, but we're working forward  
9 with them and we think we should continue to move  
10 forward. Stephanie?

11 MEMBER GLIER: Yes, I guess I want to  
12 respond to Robert's point here a little bit,  
13 which is a little philosophical and it maybe goes  
14 back to a question he was sort of asking earlier,  
15 which I think is to CMS, about whether it's  
16 possible in the mixed program to weight measures  
17 differently so that people could get a higher  
18 score for a more important measure or the  
19 equivalent. So if there are measures that we  
20 think are just sort of okay, but we need them to  
21 fill gaps or we need them to make sure that all  
22 subspecialists are able to report something that

1 is very relevant to their practice, maybe CMS is  
2 able to do some program design to weight them  
3 more heavily or less heavily based on their  
4 relevance to these principles, based on how  
5 important they are to consumers. And Kate, you  
6 can weigh in on that if you want. Do you want  
7 to? I have one other comment to make, but--okay.

8  
9 But I think we--I agree with you that  
10 more information is going to be useful, but I  
11 think our role here at the MAP is to tell CMS  
12 what measures we think are going to be valuable  
13 for accountability. NIPS is going to be a--is an  
14 incentive program, it's a 4 percent bonus or 4  
15 percent ding based on your performance, and if we  
16 say yes to every measure that comes in, and I'm  
17 not--this is not about the ophthalmology  
18 measures; I think actually you guys have done an  
19 incredible job moving towards outcomes, and I  
20 really appreciate all the work you've done  
21 thinking about what is important to patients and  
22 their function and trying to turn those into

1 things that are related to care. But in some of  
2 the other measures, you guys are going to hear  
3 from me a lot today--it's going to be just The  
4 Stephanie Show for most of the afternoon too--I  
5 think there's some places where the measures are  
6 really--they really are standard of care; they  
7 really are did you do a surgery and did the  
8 surgery do the thing that you were supposed to be  
9 doing the surgery for?

10 That's not useful information in terms  
11 of an accountability. We shouldn't be rewarding  
12 you for succeeding at the very basic function  
13 that you were trying to do. If it is very high  
14 quality, great, and maybe we can talk about  
15 performance gaps then. But without that data, I  
16 think we have to be a little bit more critical of  
17 the measures we're looking at. So that's--

18 CO-CHAIR WHITACRE: So Kate, then  
19 Scott, then Jim, then Rachel.

20 DR. GOODRICH: So on MIPS, we do have  
21 the flexibility within the parameters of the  
22 MACRA statute to do that kind thing. I will tell

1       you in our request for information, we got  
2       comments from some who said we should weight  
3       measures differently, and some who said we  
4       shouldn't, so there's obviously a variety of  
5       opinion on that. I would also like to say that  
6       when we develop measures at CMS, part of our  
7       initial process is to do something called  
8       building the business case for the measure, which  
9       has a number of criteria to it, but a big one is  
10      performance variation; that goes for process or  
11      outcome. And so I will say with a lot of the  
12      measures on here, as we were reviewing them when  
13      they came in to us, you know, I just want to sort  
14      of re-emphasize what Reva said, we had the same  
15      bit of a frustration of, you know, this looks  
16      like a great outcome measure, but is there a  
17      variation? Is it--we didn't know, and sometimes  
18      people don't know; you don't really have good  
19      data, so you have to talk to the professionals  
20      who really know the world better than you do to  
21      understand it, but I will say that has been a  
22      frustration.

1           But one of our core principles--those  
2   of you who have heard me talk about our core  
3   principles for measure development at CMS--is  
4   that there be performance variation. So that is  
5   something I think we would want to know before  
6   implementing a measure, and we don't always know  
7   it, quite frankly, in time for the MAP; sometimes  
8   we know it a little bit later, so to the extent  
9   we can get that information, that'll be helpful  
10  for us as well.

11           MS. HANCOCK: Yes, and I think we  
12  could get you some information after we get data  
13  when the year concludes.

14           MEMBER FURNEY: Just a quick comment  
15  as a non-ophthalmologist about these two  
16  measures, the surgical measures for both ptosis  
17  and entropion. It seems like we're really  
18  looking, we're trying to define an outcome from  
19  the surgeon's perspective; it would be  
20  interesting as the measure is developed to have a  
21  patient outcome. So patient satisfaction  
22  obviously, most physicians do not want to be



1 measured by that, but that's ultimately, have you  
2 satisfied the patient's need with the surgery is  
3 probably better than the anatomic outcome..

4 MEMBER FURNEY: I'll just react  
5 quickly by saying that we have plans to continue  
6 measured development efforts in the future and  
7 patient reported outcomes and outcomes around  
8 what patients want is definitely something that  
9 we plan to focus on.

10 MEMBER PACALA: Yes, just adding on or  
11 continuing Bruce's point about really the  
12 distinguishing ability of a measure. I'd like to  
13 ask Scott, Dr. Friedman, about the macular  
14 degeneration measure. So from your experience,  
15 the outcome is being defined as a loss of less  
16 than .3logMAR of visual acuity; I don't know what  
17 that is, but first of all, is that a good  
18 distinguishing cut point? That would be number  
19 one; two is it clinically meaningful, and then I  
20 guess the third question would be is there a  
21 potential downside to this, of setting up adverse  
22 selection? In other words, would a patient who

1 perhaps should be operated on for macular  
2 degeneration or get VGF agents perhaps could  
3 there be a disincentive for the practitioner to  
4 say oh boy, this person is likely to lose than  
5 .3logMAR because of other features, and so if I  
6 actually do what I think should be done, I'm  
7 going to get dinged for it.

8 MEMBER FRIEDMAN: Sure, so to address  
9 your first thing, I believe we were told to go by  
10 our first names, so you can call me Scott and  
11 I'll call you Jim. So logMAR is, you know, not  
12 to belabor the point or waste time, is a way to  
13 convert the known acuity, 20/30, 20/200, to a way  
14 you can do statistical analysis. So basically--  
15 yes, basically it doesn't mean anything to you;  
16 don't worry about it. It's just a way that we  
17 can look at change in visual acuity. So if  
18 you're talking about the wet AMD, we give shots  
19 to not only to prevent vision loss, but also to  
20 improve it; on average, about a third of the  
21 patients see two lines better, significantly  
22 better after treatments. So we certainly want to

1 test whether patients are--making sure the  
2 patients aren't getting worse, and again, if your  
3 patients are getting worse being treated,  
4 probably not doing something correctly; you need  
5 to do something else. And then with all these,  
6 at least with ophthalmology and presumably with  
7 all measures, there's going to be some issues  
8 with risk adjustment. In other words, we're  
9 going to have patients who are going to have a  
10 worse prognosis not only with acute macular  
11 degeneration or with glaucoma, for example, so  
12 they need to be risk adjusted. Are the people, I  
13 guess in my opinion the people that have the  
14 worst--they have a worse macular degeneration,  
15 and we can separate out eyes that maybe are going  
16 to have a poorer prognosis, and do you want to go  
17 ahead and refer those out so you don't get dinged  
18 for that. But I think if your N is large enough,  
19 that's going to be sorted out, and if enough  
20 people want to have enough patients, they're  
21 still going to have a favorable outcome doing the  
22 worst cases, but I think the savvy

1 ophthalmologist and maybe the savvy physician is  
2 going to consider I'm not treating that patient  
3 and sending that patient off somewhere else  
4 because it's going to adversely affect them,  
5 presumably financially.

6 CO-CHAIR WHITACRE: Rachel, I think  
7 you were on the list.

8 MEMBER GROB: I wanted to go back to  
9 the question of what is useful to patients to  
10 have reported versus being able to do that drill  
11 down, and although I can read through what NQF  
12 recommended with respect to what's on the  
13 spreadsheet and what's reported on Physician  
14 Compare, I'm wondering if you could give us an  
15 explanation of how as a group you considered  
16 these measures and then the patient's perspective  
17 and made your recommendations for one or the  
18 other.

19 DR. WINKLER: I didn't--I skipped  
20 through the slides; in fact, I might be able to--  
21 no, it's not set up. Actually, the Clinician  
22 Work Group had established their guiding

1 principles for the various clinician programs,  
2 including Physician Compare, and there were  
3 listed a group of measures that--the types of  
4 measures, if you will, that you had established  
5 as the type of measures you wanted to see on  
6 Physician Compare. We use that as the guidance;  
7 we tried to match that with the type of measure  
8 that we saw here, again realizing that these were  
9 drafts and your feedback on did we get it right  
10 or did we get it wrong is appropriate discussion  
11 for us today, but if you look--let's see--no, we  
12 need to go farther--yes, it's under Physician  
13 Compare--it's going to be after Alicia's  
14 presentation. Yes. Those were the work group  
15 guiding principles, so we tried to match that, so  
16 that's where the draft came from.

17 MEMBER GROB: Thanks for that  
18 reminder. I'm just wondering if you had any  
19 concerns about the number that are there, because  
20 I think we do know that there's sort of a  
21 cognitive information overload that can happen  
22 sometimes; some people are looking at it, and I

1 don't know which ones that I might say this  
2 shouldn't be reported, but because we're talking  
3 about sort of balancing parsimony and this  
4 particular measure set with comprehensiveness and  
5 the kind of granularity that we've heard so well  
6 described here, it seems to me that in addition  
7 to these, there's sort of a question about what  
8 it would be like from the patient's perspective,  
9 because the majority of them I think there's 20-  
10 -you know, we're reporting--we're recommending to  
11 report a lot of them on Physician Compare. So  
12 I'm just wondering if anybody has thoughts about  
13 that. I don't have a recommendation of a  
14 particular one that should be on the spreadsheet  
15 versus not, but I do have sort of a concern about  
16 Physician Compare getting so big that you know,  
17 people looking for an ophthalmologist look at it  
18 and go like oh my God I have no idea what to  
19 focus on here.

20 CO-CHAIR WHITACRE: Mady, did you have  
21 a comment?

22 DR. CHALK: I just wanted to follow up

1 on Rachel's comment. I don't know how a patient  
2 sitting there looking at those particular  
3 measures would use them. Now, if somebody is  
4 going to take these measures, if they're there,  
5 and CMS is going to take them or somebody else  
6 is, NQF, and translate them into language that a  
7 consumer might understand so that they could say  
8 okay, if my ophthalmologist measures well on X,  
9 here's what it means to me, I should go to that  
10 ophthalmologist, I should not, you know, he's a  
11 specialist in, or she is in something in  
12 particular. But just looking at the measure as a  
13 measure that is going to be out in public, I just  
14 don't understand how a consumer would use it.

15 CO-CHAIR WHITACRE: Would you like to  
16 respond to that? Sure.

17 DR. GOODRICH: So yes, so for the  
18 measures that we currently have on Physician  
19 Compare, they've been translated into English.  
20 So--and we've worked with patients to make sure  
21 that they can understand what is the way we've  
22 translated and have modified wording; so that's

1       called consumer testing, right? But it's work  
2       with actual patients to try to help--to make sure  
3       that we actually display a measure and what the  
4       measure means in a way that a lay person could  
5       understand. We also, you know, I think we try  
6       for the seventh grade reading levels, I think  
7       that's a yes; I'm getting the thumbs up from  
8       Alisa. So we can always make it better, but some  
9       of these I also think would be very difficult to  
10      translate, so I want to acknowledge that. So  
11      that's part of the input we're looking for, is  
12      you know, they're all going to go on the  
13      spreadsheet; let me just be clear about that  
14      again. Everything goes in the spreadsheet;  
15      that's just for total transparency. But how do  
16      we prioritize the ones that are translatable and  
17      meaningful to patients? That's what we really  
18      want to know from you all.

19                   CO-CHAIR WHITACRE: David?

20                   MEMBER SEIDENWURM: Well, I think that  
21      CMS has done a good job in translating the  
22      metrics out there now into English, and so I



1 think we can rely on them to do a good job going  
2 forward. So I think that's one point, but I  
3 think that each patient is going to look at this  
4 in their own way for the conditions that are  
5 relevant to them. So if there does seem to be a  
6 proliferation of metrics out there, the people  
7 are only going to look at the ones that are  
8 relevant to them, just like one doesn't look at  
9 the whole array of cars out there on the consumer  
10 things, you know, you kind of know if you want a  
11 SUV or a sports car or whatever, so you're just  
12 going to look at the ones--you know what your  
13 budget is, for example, in that analogy. So I  
14 think that we can trust the patients; the other  
15 thing is remember a big consumer of this  
16 information is the doctors themselves, and I  
17 think that if the doctors are going to be looking  
18 at this and motivating themselves. So again, the  
19 wide variety of metrics that are relevant to the  
20 physicians I think also drives the quality of  
21 care. So you know, I don't think we want to  
22 necessarily mush it up and dumb it down too much.

1 And so I think that we're going in the right  
2 direction today, so let's not lose momentum.

3 CO-CHAIR WHITACRE: Scott, then  
4 Robert, then Marcy.

5 MEMBER FURNEY: Just a very quick  
6 point, and just an analogy from my world. We  
7 might have said 15 years ago that patients won't  
8 understand an HIV viral load in CD4, yet all of  
9 my patients that I see can quote that. So I  
10 think we need to be careful; there will be a  
11 process of patient education and there will only  
12 be a subset that will use the site, but I think  
13 if we're being careful about translating these,  
14 that patients who care about looking for  
15 information will actually know what to do with  
16 it.

17 MEMBER KRUGHOFF: I think this is sort  
18 of highlighting our problem, and it may come up  
19 with the other measures also, that it really does  
20 make a difference if you're talking about what  
21 measures we'd like to see go forward in the  
22 Physician Compare spreadsheet as opposed to what

1 measures we'd like to go forward on the Physician  
2 Compare website itself, where you're only going  
3 to, you know, you maybe only want to see a few of  
4 them, versus what you want to have go forward for  
5 MIPS purposes. They really are different uses,  
6 and I can--and they would affect patients at  
7 different times in their lives. If I were  
8 choosing an ophthalmologist, I might want to have  
9 something that was at quite a summary level, and  
10 would make it fairly simple to choose--I don't  
11 have anything wrong with my eyes, but I want to  
12 choose one who's going to be a good  
13 ophthalmologist.

14 On the other hand, if I have a  
15 particular condition and I'm looking for somebody  
16 to do a particular therapy for me, I might be  
17 very interested in having it drilled down later.  
18 And trying to put all these things in this same  
19 process that we have here, I don't know how I'd  
20 solve the process problem, but I do think the  
21 process doesn't sort of fit all of those  
22 objectives very well.

1 CO-CHAIR WHITACRE: Reva, would you  
2 like to respond?

3 DR. WINKLER: Yes, I just want to  
4 respond to Robert, just to be sure everyone's  
5 clear. All of the measures in MIPS are the  
6 measures that are our primary agenda items  
7 because they are on the measures under  
8 consideration given to us by CMS. Realize though  
9 that any of those measures that are used in those  
10 programs become available for Physician Compare.  
11 So it's the downstream, so then it can bifurcate  
12 spreadsheet versus--so it's not three choices,  
13 all right. Your choice around the measure around  
14 MIPS is the primary choice; it's the secondary  
15 how is the vehicle for public reporting carried  
16 out secondarily. So keep--just--it's not three  
17 independent choices.

18 MEMBER NIELSEN: Although I have  
19 worked around clinicians my entire career, it  
20 always makes me nervous because I was never good  
21 enough at math to go to medical school, so let me  
22 own that right up front before I ask my friends

1 at NQF if this is what we're really trying to do.  
2 Dr. Cassel told us this morning that this is one  
3 of the rare occasions in Washington, D.C. where  
4 we have truly different stakeholders come  
5 together and have to collaborate, and I do think  
6 that that's true. But one other place would be  
7 right down the street at the Patient-Centered  
8 Primary Care Collaborative, where everything we  
9 do goes into a Venn diagram, and it's just three  
10 circles, which is why I can understand it. It's  
11 patients, and then it's providers or clinicians,  
12 and it's payers. And everything we work on  
13 really, if it doesn't fit in the middle of that  
14 circle, we can't really work on it because then  
15 it's quickly lopsided, and suddenly we're not the  
16 Patient-Centered Primary Care Collaborative.

17 I recognize that you all have to color  
18 outside of the middle of the Venn diagram for the  
19 purposes of Congress told you to, CMS has told  
20 you to, all the advocacy groups are telling you  
21 to, but isn't our job to help you shrink what is  
22 a huge universe of possible things to consider,

1 using data, using advocacy groups and other  
2 professional associations' advice, to shrink the  
3 number of things we're focused on, and in  
4 reality, although I think we think not everyone  
5 else understands our perspective, we're all  
6 basically in agreement. I mean, we've got to  
7 shrink the number of measures, and the measures  
8 need to be more valuable. The end. Like, that's  
9 all we're doing here.

10 So I guess I share people starting to  
11 sound like they're having philosophical  
12 disagreements with one another, and we really  
13 aren't. Like I think, in my opinion, some of  
14 this stuff is mandated that CMS review. Congress  
15 told them to; they don't have a choice, Kate sits  
16 and smiles nicely at us, and pretends like it was  
17 her idea. It wasn't her idea. She doesn't  
18 measure this any more than I want to measure it,  
19 but you know what I mean? Like, we're all on the  
20 same team.

21 So I think if we took a deep cleansing  
22 breath, and thought about we all want a smaller

1 set of measures, but they need to be valuable and  
2 downstream, they have to have meaning to  
3 patients. Upstream, I wish they could all have  
4 meaning to patients, but that is unrealistic  
5 given where we are in the world of measurement  
6 and in the world of process shifting to outcomes.  
7 Nobody would like outcomes more than me. So  
8 anyway, I say go team, we're all on the same  
9 team, and do a little yoga, and have a snack, and  
10 then we'll get all the rest of this work done.

11 CO-CHAIR WHITACRE: Helen, please.

12 DR. BURSTIN: It's hard to follow  
13 that. The snack sounds really good actually; I'm  
14 not sure about the yoga. You know I think in  
15 principle, you're right, Marcy. I do think  
16 though that for a lot of specialties, there are  
17 subspecialties and again, I'm not sure that the  
18 number of measures is really the issue. I think  
19 it's not every measure is used for every purpose.  
20 Actually at our recent board meeting, one of our  
21 consumer members said you know, does anybody  
22 complain when the library has too many books? I

1 mean at some level, if these measures are not all  
2 going to be used at the same time for every  
3 purpose, but they serve a purpose and they in  
4 fact meet the needs of clinicians and patients,  
5 so be it. I just don't think--and again, this  
6 is to advise CMS on their selection. So make  
7 your recommendations, Kate will ultimately take  
8 those and CMS and make their final  
9 determinations. But I wouldn't get so hung up on  
10 the numbers thing I guess.

11 CO-CHAIR WHITACRE: Rachel.

12 MEMBER GROB: I would never complain  
13 that there are too many books in the library or  
14 too many notes in a Mozart concerto, though he  
15 was once told there were. But I do think that to  
16 some degree, consumers are sort of voting with  
17 their feet with respect to things like the  
18 Physician Compare website, and that they are  
19 going to other places in the private sector, you  
20 know, something that's more like Yelp or like  
21 Trip Advisor or Amazon where it is sort of boiled  
22 down, it speaks to them more loudly. So I'm here



1 representing patients, I'm the last one who wants  
2 to be condescending towards them, but I think  
3 there's a concern there that we should take  
4 seriously as a work group when it comes to that  
5 part of the decision about which things in MIPS  
6 show up on Physician Compare and give this  
7 feedback to CMS because I know nobody more than  
8 CMS wants Physician Compare to actually be  
9 really, really useful, and it's that validated  
10 data scientifically generated in a way that a lot  
11 of the anecdotal stuff out in the public domain  
12 doesn't have. But I think we have a job here to  
13 make sure that what we represent is as meaningful  
14 as possible to as many consumers as possible, and  
15 I love the post it on Physician Compare, you  
16 know, versus spreadsheet because some consumers--  
17 I couldn't agree more with you, Robert--will want  
18 to drill down because they have macular  
19 degeneration that is dry, and they need that  
20 information, and other people are going to be  
21 like hey, I need to pick an ophthalmologist, and  
22 they're going to look at it and just go like

1       whoa, I'm going to look on Yelp. We don't want  
2       that to happen.

3                   CO-CHAIR WHITACRE: Well this has been  
4       just a brilliant discussion as before, and I  
5       would like to pick up on the deep cleansing  
6       breath motif, and make a proposal to the group.  
7       We're ahead of schedule, but it's been a great  
8       discussion and we haven't yet voted, so I'm  
9       proposing that we take a brief break now, let  
10      everyone refresh, think of what they want to  
11      think, any additional final comments, and then  
12      work our way through the five measures that have  
13      been pulled. Before I do that, however, David I  
14      did quickly move over, and apparently you had  
15      pulled Measure 2, if I understood correctly? I  
16      wanted to make sure I wasn't mistaken, and did we  
17      address any concerns in the course of the  
18      discussion if it was Measure 3.

19                   MEMBER SEIDENWURM: I did, and they  
20      were well addressed.

21                   CO-CHAIR WHITACRE: Is everyone  
22      agreeable to that? I think it would give us a

1 chance all to refresh, rethink. This is such a  
2 great discussion; we may have final comments  
3 before the vote, we'll still have time for that.  
4 Well if everyone is in agreement, let's do that,  
5 15-minute break and we'll meet back here.

6 (Whereupon, the above-entitled matter  
7 went off the record at 2:54 p.m. and resumed at  
8 3:14 p.m.)

9 CO-CHAIR WHITACRE: So I thought  
10 because this discussion--and I'm sure you've  
11 heard this before--has been a real eye-opener,  
12 had to say it, this--I thought we would take any  
13 last comments or thoughts. This has been such an  
14 important discussion, not just obviously about  
15 the ophthalmology measures, which honestly I  
16 admit I don't completely understand at a medical  
17 or surgical level, but it's been important in our  
18 understanding of balancing parsimony of measures  
19 versus granularity and where that balance lies;  
20 it's been very important in understanding how we  
21 evaluate measures for MIPS versus Physician  
22 Compare and how there the translation not just of

1 language but of scoring needs to occur to be  
2 meaningful to patients. So we have a number of  
3 measures which have been pulled, and my thought  
4 is that we'd have any final discussion, thoughts,  
5 before we proceed and then sequentially go  
6 through each measure. We've had some close  
7 votes, so I wanted to make sure every measure  
8 receives an individual vote, and then we'll move  
9 on to the next section. And if that's agreeable,  
10 I'd open the floor to any last comments,  
11 observations, concerns. Wow. That's great.  
12 Okay, let's go through measure by measure.

13           So measure number one, just while  
14 we're voting, we voted on the consent, so it's  
15 just--I'm sorry, we begin with measure number  
16 two, which was the first pulled measure, Glaucoma  
17 - Intraocular Pressure Reduction following Laser  
18 Trabeculoplasty; MUC ID MUC15-374, which is on  
19 the screen. Our choices for all of these  
20 measures that have been pulled will be the same;  
21 encourage for continued development, do not  
22 encourage for further consideration, and

1       insufficient information.

2                   MS. CHAVEZ:   Now voting for MUC15-374;  
3       voting is open.   And for those on the phone,  
4       please submit your votes via chat.   Thank you.  
5       Okay, the results for MUC15-374 for MIPS are 95  
6       percent encourage   for continued development; 5  
7       percent do not encourage further consideration;  
8       zero for insufficient information.   So vote is  
9       for encourage for continued development.

10                   CO-CHAIR WHITACRE:   So the next  
11       measure for vote is measure number three,  
12       Exudative Age Related Macular Degeneration:   Loss  
13       of Visual Acuity.   So this is MUC ID MUC15-379.

14                   MS. CHAVEZ:   And same options, one,  
15       encourage for continued development; two, do not  
16       encourage further consideration; three,  
17       insufficient information.   Voting is open.   For  
18       those on the phone, please submit your votes via  
19       chat.   Okay, and the results for MUC15-379 for  
20       MIPS are 100 percent encourage for continued  
21       development; zero do not encourage further  
22       consideration; zero insufficient information.

1 CO-CHAIR WHITACRE: So the next  
2 measure is number 4, Nonexudative Age Related  
3 Macular Degeneration: Loss of Visual Acuity.  
4 This is MUC ID MUC15-392.

5 MS. CHAVEZ: Voting is open. Okay,  
6 the results for MUC15-392 for MIPS are 100  
7 percent encourage for continued development; zero  
8 do not encourage further consideration; zero for  
9 insufficient information.

10 CO-CHAIR WHITACRE: The next measure  
11 is number seven, Surgery for Acquired  
12 Involutional Ptosis: Patients with an  
13 improvement of marginal reflex distance. This is  
14 MUC ID MUC15-375.

15 MS. CHAVEZ: Voting is open. Okay the  
16 results for MUC ID 375 for MIPS are 95 percent  
17 encourage for continued development; 5 percent do  
18 not encourage further consideration; zero  
19 insufficient information.

20 CO-CHAIR WHITACRE: Number eight,  
21 Acquired Involutional Entropion: Normalized lid  
22 position after surgical repair.

1 MS. CHAVEZ: Voting is open.

2 CO-CHAIR WHITACRE: This is for MUC ID

3 MUC15-377.

4 MS. CHAVEZ: Okay, the results for  
5 MUC15-377 for MIPS, 95 percent encourage for  
6 continued development; 5 percent do not encourage  
7 further consideration; zero insufficient  
8 information.

9 CO-CHAIR WHITACRE: The next measure  
10 is number 10, Acute Anterior Uveitis: Post-  
11 treatment Grade 0 anterior chamber cells; it's  
12 MUC ID MUC15-396.

13 MS. CHAVEZ: Okay, voting is open.  
14 Okay the results for MUC15-396 for MIPS, 91  
15 percent encourage for continued development; 9  
16 percent do not encourage further consideration;  
17 zero percent insufficient information.

18 CO-CHAIR WHITACRE: And the last  
19 measure, Chronic Anterior Uveitis: Post-  
20 treatment Grade 0 anterior chamber cells, MUC ID  
21 MUC15-399.

22 MS. CHAVEZ: Voting is open. MUC ID

1 15-399. Okay, the results for MUC15-399 for  
2 MIPS, 86 percent encourage for continued  
3 development; 14 percent do not encourage further  
4 consideration; zero insufficient information.

5 CO-CHAIR WHITACRE: Thank you  
6 everyone; great discussion.

7 DR. WINKLER: Okay. Take a deep  
8 breath. All right, we're going to move on to our  
9 next and last topic area for today, and that's  
10 the topic area for cancer. We have a group of 10  
11 process managers that have been submitted  
12 pertaining to cancer. We have one new eMeasure  
13 from CMS that is still under development around  
14 PSA screening; this measure received a large  
15 number of comments, so we don't--make sure  
16 everyone notices those. There is one NQF  
17 endorsed end of life measure, and I will point  
18 out that this was a--end of life care was a gap  
19 identified by the MAP last year. And then we  
20 have eight measures that are in development that  
21 were submitted by the Society of Gynecologic  
22 Oncology, which introduces the first measures for



1 endometrial, cervical and ovarian cancers that  
2 we've seen. These are also some of the first  
3 measures for that particular specialty as well;  
4 these measures are still being developed with  
5 testing expected to be completed in 2016, and  
6 they are being collected in the SGO clinical  
7 outcomes registry. So, opportunity for public  
8 comment?

9 CO-CHAIR BAGLEY: Okay. Let's ask for  
10 public comment about these measures, this would  
11 be the cancer set. Is there anybody who would  
12 like to make any public comments? Well I see no  
13 one in the room, how about the phone?

14 MR. LYZENGA: Operator, could you ask  
15 for public comment?

16 OPERATOR: At this time, to make a  
17 public comment, please press star one. We do  
18 have a public comment from Dan Barocas.

19 CO-CHAIR BAGLEY: Dan, please go  
20 ahead.

21 DR. BAROCAS: I'm Dan Barocas, I'm an  
22 associate professor of urologic surgery at

1 Vanderbilt University and a member of the  
2 American Urological Association. I'm a prostate  
3 cancer doctor, a researcher, and a patient  
4 advocate. Regarding the PSA testing measures,  
5 the key point is that the USPSTF Grade D  
6 recommendation against PSA screening is highly  
7 controversial. Other prominent national  
8 organizations, including the American College of  
9 Physicians, the American Society of Clinical  
10 Oncology, The American Cancer Society, the  
11 National Comprehensive Care Network, and our own  
12 organization advocate for some form of shared  
13 decision-making to guide screening practices at  
14 the individual level. In order for a national  
15 measure on over-use to have value, there should  
16 be wide agreement on the recommendation, and this  
17 is not the case in PSA-based screening for  
18 prostate cancer, which in some studies has  
19 reduced prostate cancer mortality by over 20  
20 percent.

21 There were over 350 comments submitted  
22 during the CMS public comment period from a

1 variety of stakeholders; only one comment stood  
2 in favor of the measure, and this was from an EMR  
3 vendor that sells a product to collect data for  
4 such measures. The remainder were uniformly  
5 against the measure, and cited data regarding the  
6 mortality benefits of screening, alternative  
7 methods for reducing the harms of screening, and  
8 the potential harms of halting screening for all  
9 men in terms of delayed diagnoses and missed  
10 diagnoses, which is of particular concern for  
11 African-American men and those with a family  
12 history who are at higher risk for prostate  
13 cancer diagnosis and mortality.

14 In summary, many view the USPSTF  
15 recommendations against prostate cancer screening  
16 as severely flawed; at best, they are highly  
17 controversial and should not be the basis of a  
18 quality measure. Indeed, the measure is  
19 currently under review and possible revision, and  
20 the USPSTF process itself is under scrutiny, as a  
21 bill to expand oversight and stakeholder input  
22 has been introduced into Congress. We strongly

1       urge MAP not to encourage further consideration  
2       of this controversial measure.

3                   CO-CHAIR BAGLEY: Thank you, Dan. Any  
4       other comment, public comment from the phone.

5                   OPERATOR: There are no further  
6       comments.

7                   CO-CHAIR BAGLEY: Reva, do you want to  
8       give an overview, and then we'll hear from--well,  
9       okay, then we're ready to hear from our lead--  
10      well, I'll take Eric's lead and ask you to number  
11      your bullets if you didn't do that already, and  
12      forget about the numbers on the discussion guide  
13      because that was just more confusing than it was  
14      worth. I have number one pulled, number two,  
15      number five, number seven, eight, nine, 10 and  
16      11. It might be easier to name the ones that  
17      weren't, but that's okay. So that--are there any  
18      additional requests for--Janice? I'll do it one  
19      more time, and then I'll do the ones that are  
20      still on the consent calendar; that might be  
21      easier. So I have number one, number two, number  
22      five, number seven, number eight, number nine, 10

1 and 11. In my view, that leaves only three and  
2 four still on the consent calendar. It's going  
3 to be a good afternoon here. Ah, thank you for  
4 that. I can't hear you.

5 MEMBER GLIER: I meant to pull six if  
6 you didn't pull six. I pulled five through 11 as  
7 a block.

8 CO-CHAIR BAGLEY: Okay. Do we have  
9 commentary from the lead discussants? Yes,  
10 there's been a suggestion that we think about  
11 separating out number one and number two, right,  
12 and then consider the rest as sort of en bloc.  
13 So that might be a little easier to manage in  
14 terms of the discussion, so let's try to do that.  
15 Amy, go ahead.

16 MEMBER MOYER: Okay. Well generally  
17 speaking, in looking at the number of measures  
18 that were in here for the different kinds of  
19 cancer, I found myself wondering, you know, I  
20 know we've had this philosophical discussion  
21 about lumping versus splitting out, and one of  
22 the concerns that I'm not sure we specifically

1 raised yet is the ability to have a large enough  
2 denominator to end up with reliable measurement  
3 that, you know, you can trust. And so you know  
4 the more we split things out, the more difficult  
5 that becomes. And so in general, I--when we're  
6 talking about individual physician level or  
7 eligible provider level measures, where we can  
8 lump it and where we can increase reliability is  
9 useful, and I think that's also useful from a  
10 patient perspective to not be looking at all  
11 these little minutiae, but instead to have a  
12 broader picture.

13 MEMBER ORLOWSKI: Yes, as a  
14 discussant. So as we talked about--first of all,  
15 it's the PSA, it's the hospice, and then it's the  
16 urogynae issues. In regards to the PSA, I am--I  
17 would suggest that when we pick a measure to  
18 measure everyone, that we should not be picking  
19 those that are in the midst of a widespread  
20 medical controversy. And I would say that this  
21 falls within it; for years there was a  
22 recommendation for screening, there's been a

1 recent change within, just within the last 18  
2 months, two years, I don't know how long it's  
3 been, and what I would say is that there's been  
4 much discussion, both publicly as well as within  
5 the academic community, regarding the  
6 recommendation. And just on the basis of that  
7 alone, whether we fall on one side or the other  
8 of the debate, I would say that it is unwise to  
9 choose it as a measure until the standard of care  
10 in the community has been established. And I  
11 would suggest that the standard of care has not  
12 been established. And--so that's my comment on  
13 number one, and I do have an opinion on which  
14 side of the debate, but I don't think that that's  
15 relevant.

16 In regards to the hospice, I was going  
17 to say it seems like a pretty straightforward, so  
18 I'll be interested in the discussion; I have no  
19 further comments about the hospice. In the last,  
20 which I'll bunch into the urogynae group,  
21 urogynae, I would have two comments. There are I  
22 believe three measures that have a non-response

1 from ACOG where they have responded to all of the  
2 other measures, and I am looking for a reason for  
3 the non-response. I can tell you that  
4 personally, I am reading that there's either  
5 controversy within their community for the  
6 support of that measure, or they're not  
7 supporting it but they chose only to make  
8 positive comments. But I would, rather than  
9 having me guess, I would like to have further  
10 information about why there's a non-response.

11 The second question, or the second  
12 issue that I would like to address, when we have  
13 specific days, which are 42 days, a very unusual  
14 number, 42 days for something, 60 days for  
15 something else, that I believe that when we have  
16 looked at measures previously in other programs,  
17 that the absolute number of hours or absolute  
18 number of days sometimes moves people to make  
19 decisions that are not appropriate. And I would  
20 tell you that having practiced my life in two  
21 large cities and with an urban and  
22 socioeconomically--low socioeconomic group of



1 individuals, that helping individuals arrive at  
2 specific days, 42 days or whatever, is difficult  
3 and it should be done, and there should efforts  
4 made to stay within certain days. But unless  
5 there's a specific scientific reason why 43 days  
6 is worse than 42, I think that we have to be  
7 careful about aligning the number of days.

8           And so as I take a look at it, if the  
9 recommendation is for radiation to occur in the  
10 first four weeks, then I would suggest that for a  
11 national measure, five weeks or six weeks would  
12 be the outer limit, unless we're going to risk  
13 adjust it in some way. And so I think by the  
14 days, what we're trying to do is to link  
15 sequentially different treatments, where you have  
16 a hysterectomy followed by brachytherapy or  
17 something like that. And I, unless someone can  
18 explain a scientific reason for being as precise  
19 as they are with the days, I think that we need  
20 to say that this care needs to occur timely, but  
21 have that timeliness be within a reasonable  
22 period.

1 DR. WINKLER: I just want to respond,  
2 Janice, because I actually looked up all of the  
3 treatment protocols for all these different types  
4 of cancers. I am a gynecologist by training, so  
5 at least I could understand what they were  
6 saying. But the--it's actually the evidence that  
7 states those specific days, and those are  
8 actually specified, those treatment time frames  
9 are specified in the treatment guideline  
10 protocols. So based on the evidence--

11 MEMBER ORLOWSKI: I understand.

12 DR. WINKLER: --so that's where  
13 they're coming from, so I can tell you that part.

14 MEMBER ORLOWSKI: I believe that, I  
15 believe that the guideline says 42 days; what I'm  
16 asking is a slightly different question. Is  
17 there a reason to suspect that it's poor care if  
18 it's at 45 days?

19 DR. WINKLER: I think you'd have to go  
20 back and read the studies, because actually, they  
21 really were fairly discriminating on some of  
22 these time frames.

1                   MEMBER ORLOWSKI: So again, I think  
2                   that--again, based on experience, these time  
3                   frames push people sometimes to make decisions to  
4                   hit specific times, and I would be cautious is my  
5                   only comment about that.

6                   CO-CHAIR BAGLEY: Okay, before we dive  
7                   in, I think we have to vote on, or at least if  
8                   anybody wants to take number three off the  
9                   consent calendar; if not, we'll accept that one,  
10                  and then we can move on. Do I hear any appetite  
11                  for--number four has been withdrawn apparently;  
12                  that's no longer on the list. Okay, so number  
13                  three is the only one we have to do, then. I  
14                  don't see any rousing--okay. So let's go back to  
15                  number one, and try to talk about that as a  
16                  standalone before we move on to some of the other  
17                  controversy, and Janice and Amy, thanks for the  
18                  set up on this one. So do we have any comments  
19                  from the work group about number one? That would  
20                  be the non-recommended PSA based screening. I'm  
21                  looking for--pardon? Yes, please do. Why don't  
22                  you start it off. Thank you.

1                   MEMBER LANDRETH: I think that  
2           everything that needs to be said about this  
3           measure probably already has been said, and the  
4           number of public comments is really very clear,  
5           and I agree with all of them except perhaps the  
6           physician who wanted to take this to the Supreme  
7           Court if we passed it. But I can talk--I'm  
8           talking today from a purchaser perspective, and a  
9           patient perspective. My husband is 56 years old  
10          right now; at age 50, his PSA, which his  
11          physician was monitoring, this was back when the  
12          guidelines were lower than the four that they  
13          currently are for a threshold, he was having  
14          serial PSAs every year that were going up just  
15          minimally, and his physician said you know, you  
16          can have a biopsy, it really doesn't matter, but  
17          if you want to, that would be great.

18                   I took him in for a biopsy--he had 20  
19          milligrams of Valium so he needed me there--they  
20          biopsied; his Gleason score came back on all  
21          biopsy sites as an eight. He had a Gleason score  
22          eight malignancy, and he's 50 years old. So at

1       that point, we're starting to try to determine  
2       what do we do. Robotic surgery was really what  
3       was recommended; he had the robotic surgery, he  
4       went through serial PSA screenings after that  
5       point, and his PSA for six years now has been  
6       0.01. So the fact that the physician who was his  
7       primary care doc didn't even really recommend  
8       that he have the biopsy, but was smart enough to  
9       at least measure and give him that option saved  
10      his life. And I think it would be criminal if we  
11      were to disincentivize providers of any kind from  
12      doing the only test that we have that's available  
13      right now to prevent the second most leading  
14      cause of death, of cancer death, in men. So  
15      that's why I pulled it.

16                   CO-CHAIR BAGLEY: Other comments?

17      Sepheen, do you have a comment or do you want to  
18      introduce yourself and--

19                   DR. BYRON: Hi, I'm Sepheen Byron, I'm  
20      with the Measure Development Team that developed  
21      this measure, and I do want to thank you for  
22      sharing that story, I think it is very important

1 for us to hear. I recognize that this is a very  
2 controversial topic, and I recognize that there  
3 are some issues with disagreements with the U.S.  
4 Preventative Services Task Force. So just to  
5 explain a little bit about the rationale, this  
6 measure is based on that U.S. Preventative  
7 Services Task Force recommendation that is  
8 actually pretty squarely in the D recommendation  
9 space, and I think that for the stories that show  
10 that it is a useful test, there are also stories  
11 to remember that show that there were harms from  
12 the test, and that is where the task force was  
13 looking at the bulk of the evidence across all of  
14 the studies that were done, and it is a  
15 systematic evidence review that we do base our  
16 measure on.

17 Now, this is just to explain our  
18 process, so we wanted to make it clear that we  
19 are basing the measure on an evidence review that  
20 was done in a way that is recommended by the  
21 Institute of Medicine in terms of a trustworthy  
22 guideline. You know it is a very rigorous

1 process; I actually attend all of the discussions  
2 and I know that there are hard choices to make in  
3 medicine, and it is difficult. And so you know,  
4 whether or not the Committee feels this is a good  
5 measure for this purpose, I think we are very  
6 interested in hearing. One thing that was  
7 pointed out is that we are still in development,  
8 and in terms of where we place the age ranges for  
9 this measure, we still have some play around; we  
10 wanted to make it more inclusive versus less  
11 because we wanted to be able to put it through  
12 testing in that way, and because the  
13 recommendation does say that, you know, the issue  
14 of over-diagnosis and the issue of harms from  
15 treatment that didn't need to happen are very  
16 real.

17 I do not want to diminish your story  
18 in any way, and I do think that there are many  
19 cases where it turned out to be helpful, but when  
20 we look at the bulk of the evidence and look at  
21 it in a systematic way, that is where the  
22 guidelines emerged, and that is what we're basing

1 the measure on, and the intent is really to make  
2 sure that a screening test is not applied to a  
3 general population in a way that could  
4 inadvertently result in more harm than good. And  
5 so you know I think we're very lucky to have the  
6 task force stepping in on controversial issues  
7 like this and trying to give guidance around  
8 where it makes sense from a general population  
9 perspective, and if doing something like  
10 specifying the age range in a different way might  
11 make this measure more palatable, then this is  
12 something that, you know, as I said, we have just  
13 seen our public comment, there were 350 comments,  
14 we have read every single comment, and we want to  
15 make sure we do the right thing in terms of this  
16 measure. So thank you.

17 CO-CHAIR BAGLEY: David, go ahead.

18 MEMBER SEIDENWURM: Well I'll start  
19 the ball rolling because I'm too dumb to keep my  
20 mouth shut, but I'm going to speak strongly in  
21 favor of this measure, and I'd like to disagree  
22 slightly with what Janice said earlier, and I



1 think it's precisely in some areas where there  
2 might be some controversy where we might need  
3 some leadership from payer groups to help move  
4 the ball, because sometimes the physician  
5 community is a little bit high bound sometimes in  
6 the way we practice. You know, we know it takes  
7 17 or some number like that years for something  
8 new that works to work its way into the system  
9 and we don't know how to measure how long it  
10 takes for something that doesn't work to leave  
11 the system because it never happens. So I think  
12 that this is exactly the type of leadership that  
13 we do need from consensus groups like the task  
14 force, and from payer groups like CMS, and I  
15 think that adjusting the age range and being  
16 very, very careful about the parameters is going  
17 to be critical, and I'm not going to want to be  
18 sitting in Kate's chair when this--if this is  
19 promulgated as a formal policy, but I'd like to  
20 encourage people to stand up for the scientific  
21 method here and really try to encourage the  
22 practice of evidence-based medicine in our

1 country.

2 MEMBER PELLEGRINI: David I really  
3 appreciate those comments, because I was thinking  
4 along the same lines, you know, what--we're  
5 talking about measures as a tool to drive change  
6 in practice, and this is I think a classic case  
7 of driving it really hard really fast, right? So  
8 this is a case where we've had a dramatic change  
9 in the recommendations, and now this measure is  
10 being developed to say all right, we're going to  
11 do all in on that change in the recommendations,  
12 we're going to try to push everybody to take that  
13 up as quickly as possible. And so what I'm  
14 turning over in my mind is what is the role of a  
15 group like ours in deciding does there need to be  
16 a kind of cooling off period of some kind, where-  
17 -and it's not just the physicians who are  
18 resistant; a lot of times, it's the patients too,  
19 right? Does society, does the patient community,  
20 does the physician community need a little time  
21 to process this before we ought to start  
22 measuring everybody on it, and I don't think I've

1 got an answer right off the top of my head, and  
2 that's just why we get paid the big bucks here.

3 CO-CHAIR BAGLEY: Introduce yourself.

4 MS. CRAWFORD: Sure. So my name is  
5 Alyssa Crawford, I'm from Mathematica Policy  
6 Research, and I'm part of the team that Sepheen  
7 is on developing this measure. So I just want to  
8 thank you for bringing that up, because I want to  
9 emphasize that this measure is actually very  
10 early in the development process. So what I mean  
11 by that is that there's still a lot of work we  
12 have to do before it's a measure that's ready for  
13 use in a program, and I want to emphasize that  
14 the guidance you give us, regardless of your  
15 decision, is something we'll take into  
16 consideration not only in terms of whether we  
17 move this measure forward for development, but  
18 how we move this measure forward for development.  
19 So we're very aware of the work that's going on  
20 with USPSTF to update their guidelines, we're  
21 very aware that there's a lot of ongoing work in  
22 the evidence for this measure, and so I don't

1 think necessarily--I just wanted to emphasize it-  
2 -continuing development of this measure does not  
3 necessarily mean developing it in the absence of  
4 taking that information into account; it's saying  
5 that this information and that this concept is  
6 worth potentially measuring, and it's worth  
7 spending some time thinking about how to measure  
8 right so that CMS can make a decision about  
9 whether or not it's worth measuring in a few  
10 years when the measure is ready. So just wanted  
11 to emphasize that aspect and that sense of where  
12 the measure is in the general development  
13 process.

14 CO-CHAIR WHITACRE: I'm taking off my  
15 co-chair hat again. This is breast surgeon  
16 speaking, and I can't help compare this to the  
17 mammography controversy. Now the mammography  
18 controversy happened sort of as a two-step thing.  
19 The first time USPSTF recommendations came out,  
20 revolt, act of Congress, yadda yadda said no you  
21 can't do that; that's the cooling off period. I  
22 mean, that's what happened, and so when the

1 recommendations came a second time, and now we  
2 actually have three different sets of  
3 recommendations of screening the average risk  
4 woman, it helped to have the cooling off, it  
5 helped to have the multiplicity of  
6 recommendations because it made clear it's not  
7 all black and white. I mean, it's not one truth;  
8 this is not written in stone.

9           The thing that helped us in breast is  
10 that during the time that this controversy first  
11 started to where we are today, they developed and  
12 validated, at least partially, some very powerful  
13 statistical risk assessment tools. We have a  
14 number of risk models that allow us to stratify  
15 lifetime and five-year risk of developing breast  
16 cancer. So individualizing recommendations  
17 suddenly made sense, not just for mammography.  
18 Whether or not it's still real, I don't know, but  
19 at least it makes sense.

20           We have some sense of the scientific  
21 method saying we are applying specific screening  
22 tools according to relative risk. Do those tools

1 exist for assessing risk of prostate cancer?  
2 Something--the Gail model, Tyrer-Cuzick model,  
3 Claus model, I mean BRCAPRO, we can go on and on  
4 with the risk models we use. So these are  
5 recommendations that are across the board for  
6 everyone.

7 DR. BYRON: Well the recommendations  
8 focus on a general non at risk population, and  
9 that's for across all of U.S. Preventative  
10 Services Task Force.

11 CO-CHAIR WHITACRE: Risk being family  
12 history?

13 DR. BYRON: Whether or not--family  
14 history gets taken into account, but if somebody  
15 is considered part of the general population,  
16 then the recommendation--

17 CO-CHAIR WHITACRE: We used to screen  
18 --in women, it was male versus female. All women  
19 were the same. We know that's not true; we  
20 screen differently. The reason I bring that up  
21 is because you know, I just--it's hard to believe  
22 with the presentations we've seen that reality is

1 black or white, but it's also hard to believe  
2 that this is not, because of a controversy, a  
3 somewhat useful tool. We could go the route of  
4 Switzerland and not do any mammography, but that  
5 doesn't make sense to anyone either. So it may  
6 be a timing issue, not just in terms of cooling  
7 off, because you don't want something to damage  
8 the value of the program that we're interested in  
9 making recommendations for. At the same time, it  
10 may require further science to stratify risks to  
11 know how to use this tool best. Just analogy.

12 CO-CHAIR BAGLEY: Beth, you're next,  
13 and then you.

14 MEMBER AVERBECK: Yes, I would be  
15 supportive of looking into the measure, and part  
16 of it might be what's our opportunity to pace the  
17 change given the current conversation. Is there  
18 an age range that could be considered as sort of  
19 a first step where there's general agreement that  
20 screening beyond a certain age does not provide  
21 benefit and we get more consensus around that? I  
22 mean, like diabetes, you know, having an A1C

1 below 7, below 8 in someone who's 85 is no longer  
2 clinically appropriate and so is there some way  
3 that we might be able to take a look at age  
4 ranges as a way to start down this path of a  
5 potential measure where we're trying to prevent  
6 harm by doing a screening test?

7 CO-CHAIR BAGLEY: Barbara, you're  
8 next.

9 DR. BYRON: And that is actually built  
10 into our testing plan, because we are aware that  
11 the age range is a question for this.

12 MS. CRAWFORD: This is Alyssa again  
13 from Mathematica. I think you're right that we  
14 can probably try to identify some ways to measure  
15 this; it may not cover all of the scenarios in  
16 which it is appropriate to recommend or to work  
17 with a patient to decide whether a PSA test is  
18 appropriate, but I think we can try to--there is  
19 going to be a way that we can measure whether  
20 certain types of patients are getting tests that  
21 are supported by evidence, and I think that's  
22 something that we would be interested in doing



1 and are looking for your feedback in terms of  
2 whether that's an appropriate next step.

3 MEMBER LANDRETH: I think probably  
4 part of the reason that you had so many outraged  
5 people responding was the way that the measure  
6 was written. It was looking at all patients  
7 regardless of age. High risk, low risk didn't  
8 really matter, and also I think that it was  
9 basically saying you can't do a PSA, you're going  
10 to be penalized if you do a PSA rather than if  
11 your patient asks for a PSA or if you have a  
12 collaborative discussion with your patient  
13 recommending or not recommending a PSA,  
14 regardless, you are going to be dinged if you  
15 ordered a PSA. So I think that's the real reason  
16 that you're seeing so much outrage right now, and  
17 my concern is that if we as a committee,  
18 understanding your good intentions of moving  
19 forward and doing the right thing, what's going  
20 to happen to the physician who's going to take us  
21 to the Supreme Court? I mean, I think there has  
22 to be some kind of an explanation or caveat that

1 says we support the concept, we know you've got a  
2 lot of work to do, so we don't get individually  
3 sued.

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

5 DR. BRISS: So I agree. As a guideline  
6 develop our work agendas with the Preventative  
7 Services Task Force, I'm generally sympathetic--

8 CO-CHAIR BAGLEY: Closer to the  
9 microphone, please.

10 DR. BRISS: --sorry. I'm generally  
11 sympathetic--my read of the evidence is like  
12 theirs personally and professionally. Now having  
13 said that, I tend to agree with Janice about  
14 given the level of controversy in the field and  
15 given the extent to which informed decision  
16 making is a very important fact of life in this  
17 subject matter, I think a quality--I feel like a  
18 quality measure that generally dings people for  
19 ordering one of these tests is premature, even  
20 for somebody like me who generally agrees with  
21 the direction that they're trying to go.

22 CO-CHAIR BAGLEY: Rachel, you're next.

1                   MEMBER GROB: Even though I know we're  
2 not talking about the public reporting side yet,  
3 I want to bookmark that for a measure like this,  
4 were it to be brought all the way forward, and  
5 for low value care measures in general, we need  
6 more evidence about how consumers comprehend  
7 those, and what kind of action they take, because  
8 the goal of CMS and the measure developer and the  
9 MAP and us is to help consumers make quality  
10 decisions. I'm concerned that given controversy,  
11 public awareness and so on, that public reporting  
12 of a measure like this will actually drive people  
13 in the opposite direction, and I think we just  
14 need a strategy for that. I don't think we can  
15 withhold information, but I really think that  
16 that's a conversation for CMS and eventually for  
17 the MAP when we look at public reporting, what  
18 does it mean to interpret this for consumers who  
19 are going to have their own interpretation,  
20 otherwise--

21                   CO-CHAIR BAGLEY: Go ahead.

22                   MEMBER FURNEY: So the consumers will

1 certainly have their opinions, but to some degree  
2 I think it is our responsibility to help them  
3 form them. So in this measure, the intent is to  
4 not uniformly screen average risk individuals  
5 routinely with the test. And I agree that's--  
6 part of my concern about it is how it's written;  
7 we don't have the same level of evidence and risk  
8 prediction to be able to say who--which of the  
9 high risk candidates might benefit. So race,  
10 family history, history of prostatitis, and then  
11 honestly what we need is actuarial tables. How  
12 long will this person live? It's likely if there  
13 is benefit it is 15 years after their found and  
14 intervened, if there is benefit. And so I agree  
15 there's enough uncertainty in the science; I  
16 think what we need to do is encourage the  
17 development of the measure to discourage, but not  
18 prohibit, the use of testing in the average risk  
19 patient.

20 And the idea of a cooling off period,  
21 having lived as chair of a quality committee  
22 through the breast cancer thing for the last few

1 years, I'm finally--my armor is dented, but I'm  
2 okay. I'm not sure that we can realistically  
3 take forward a do not test measure, but I so  
4 think we can say that the evidence does not  
5 suggest that the routine screening of average  
6 risk individuals is a good idea in general, and  
7 the absence of evidence does not mean that there  
8 is not evidence of harm; there's clearly evidence  
9 of over-testing and over-treatment, and we have  
10 to weight that in our decision-making.

11 MEMBER FRIEDMAN: For those of us that  
12 are not urologists, so basically you're saying is  
13 that any screening is unnecessary at this point,  
14 because aren't--don't the specialty societies  
15 recommend screening at this point, and you're  
16 saying that that's unnecessary?

17 DR. BYRON: So I do want to point out  
18 that the measure does exclude people--it pulls  
19 out people who are higher risk, so anyone who has  
20 a diagnosis of prostate cancer or a history of a  
21 diagnosis of prostate cancer, those taking  
22 certain medications that are associated with that

1       there the 5-alpha reductase inhibitors, and also-  
2       -I can't remember the last one--

3               MEMBER FRIEDMAN:   So if you already  
4       know that you have prostate cancer, one does need  
5       to be screened for it.   That goes without saying.

6               DR. BYRON:   Right, and those with an  
7       elevated PSA test are also pulled out of the  
8       measure.

9               MEMBER FRIEDMAN:   Again, if one  
10      already knows your PSA is elevated, you don't  
11      need to be screened for that as well.   So we're  
12      looking at people that are asymptomatic that  
13      reach a certain age, and you're suggesting that  
14      they don't need to be screened at this point?

15              DR. BYRON:   So the recommendation from  
16      the U.S. Preventative Services Task Force that  
17      the harms outweigh the benefits for screening in  
18      the general population for those who are not at  
19      risk.   There are--the American Urological  
20      Association does encourage shared decision making  
21      and potentially screening at a younger age.   So--  
22      but the Task Force recommends against it for all

1       ages, so that is the recommendation.

2                   MS. CRAWFORD: And can I just add on  
3       to that. So this measure as you've heard is  
4       based on USPSTF guidelines, and it is the  
5       starting point for our development process. So  
6       the exclusions that Tina's mentioning are the  
7       exclusions that are there currently; that doesn't  
8       necessarily mean that we can't consider other  
9       exclusions to, as you've said, make sure that the  
10      right patients are --that providers are  
11      incentivized to have the conversations with  
12      patients for whom PSA testing is appropriate, and  
13      some of that is talking about the age range;  
14      we've already mentioned that that's part of our  
15      testing process and something that we're  
16      exploring. Part of that is continuing to talk  
17      with stakeholders like you and the American  
18      Urological Association and others to get their  
19      input about other exclusions and new evidence  
20      that would help to support other instances in  
21      which it's appropriate for patients to be  
22      screened. So that's the current state of the

1       measure; that doesn't mean that we can't take  
2       additional feedback and reconsider those  
3       exclusions and identify whether there are other  
4       ones that are appropriate and evidence based to  
5       add.

6               But I did want to just quickly note  
7       that the--just for the reference to the exclusion  
8       for patients with a prior elevated PSA, this was  
9       put in because we obviously do not want to  
10      expect that providers would ignore a prior high  
11      result, and to speak to the situation earlier, if  
12      there was a decision earlier to test, even though  
13      the evidence according to the USPSTF guidelines  
14      do not support it, if there was a shared decision  
15      making process, and the provider works with the  
16      patient, and the patient and the provider  
17      together come to the decision to screen that  
18      patient, if there is an elevated test, we want to  
19      recognize that that is appropriate in that  
20      situation for the providers to continue to follow  
21      up and make sure the PSA levels, to monitor them  
22      over time. So that's the reason for that



1 particular exclusion, but the exclusions  
2 themselves are still very much under development  
3 and can definitely be further expanded or  
4 refined based on the information we get  
5 throughout the testing process.

6 CO-CHAIR BAGLEY: Peter, you were  
7 next.

8 DR. BRISS: To try to clarify, so all  
9 task force recommendations, their chapter and  
10 verse says these apply to asymptomatic people at  
11 average risk, right? And so the exclusions that  
12 you were talking about was trying to  
13 operationally define what those word strings  
14 mean. There's some things that might happen in  
15 the interaction, like I don't know what the  
16 answer is to Eric's question about does a family  
17 history take you out of the average risk category  
18 in this context. There's all kinds of complexity  
19 about what average risk might--does being  
20 African-American take you out of the average risk  
21 category? There are all kinds of things that  
22 would be operationally complicated, and so

1       there's--you know, and the other thing that  
2       given the frequency about--at which people still  
3       come in asking for a PSA, right? You know, I  
4       think you might think about how do we define  
5       patient preferences and shared decision-making in  
6       this subject matter as you're thinking forward  
7       about this; I think it's really hard.

8                   CO-CHAIR BAGLEY: Robert.

9                   MEMBER KRUGHOFF: I'm afraid I've  
10       missed something; what does encourage continued  
11       development mean? What are the implications if  
12       we say that? Does it mean that--

13                  DR. WINKLER: The words speak for  
14       themselves; the implication is whatever the--  
15       whoever is listening takes them.

16                  MEMBER KRUGHOFF: Will it always have  
17       to come back through this process again before it  
18       gets supported? So is it just a matter of  
19       saying, you know, keep thinking about this; is  
20       that what it is?

21                  DR. GOODRICH: So this is Kate. So if  
22       the measure undergoes significant changes from

1 where it is now, which I suspect that it's likely  
2 to do, then yes it comes back through this  
3 process.

4 MEMBER KRUGHOFF: So it is to say re-  
5 evaluate in a sense. I mean that's what I'm--  
6 that doesn't seem so problematic.

7 MEMBER KRUGHOFF: Kate caveated it, so  
8 I wouldn't assume that all of your  
9 recommendations are exactly that. In this  
10 particular case, we're talking about some  
11 significant issues around the measure, and in  
12 this particular measure, that may apply. But I  
13 don't think that's how you should interpret that  
14 across the board.

15 CO-CHAIR BAGLEY: I have my own name  
16 on the list, and then you Janice. So you know,  
17 stepping aside from my chair role for a minute, I  
18 just want to make some observations. I think  
19 this is very complex as we can tell because there  
20 doesn't seem to be any agreement, but it actually  
21 is very parallel to the DCIS discussion in breast  
22 cancer. You know the pathologists don't really

1 think that's cancer, and that has led to a fair  
2 amount of over treatment, which is part of what's  
3 caused the harm that makes the risk, you know the  
4 harm benefit balance out of balance. And I think  
5 we have exactly the same phenomenon here. It's  
6 not so much that the test is the problem, it's  
7 what we do with the test result that's the  
8 problem, and we're attacking it at the wrong  
9 place. So I would suggest we consider re-framing  
10 this whole discussion around finding a measure  
11 that would address over treatment and not over  
12 testing. So I really think that, to you point  
13 Robert, and if we are truly are kind of headed  
14 down the wrong direction, somebody's got to say  
15 halt, and I think this might be a case where  
16 we're actually attacking a systematic thing at  
17 the wrong place in the system in my view. So  
18 maybe to rethink how we might approach this is  
19 one thing.

20 Another thing is, and this comes from  
21 a long history of sitting at these kinds of  
22 tables is that this is basically a consensus

1 group, and this entire discussion screams lack of  
2 consensus. So for us to decide there's a  
3 consensus around something where the entire  
4 discussion screams lack of consensus is a little  
5 bit over-reaching in my view. So now I'm the  
6 chairman again; Janice.

7 MEMBER ORLOWSKI: Just a point of  
8 information. I went and Googled the  
9 recommendations, just so that I was very  
10 comfortable, and on the U.S. Preventative Service  
11 Task Force website, under prostate cancer  
12 screening, was a big note saying that the topic  
13 is in the process of being updated, and they do  
14 have an update section with a new research. And  
15 so I think it's a different--I agree with you  
16 that we don't have a standard of care, that's the  
17 term that I would use. There's not a standard of  
18 care. I think that this is different than people  
19 who order a test that leads to a lot of over-  
20 utilization; that I believe we need to stop.  
21 From my point of view, that may or may not be  
22 what's going on here once we have an agreed-upon

1 recommendation, and I think that it is something  
2 that needs to be studied, I think there's a lot  
3 of concern that there is over-utilization in this  
4 area, and overutilization often leads to patient  
5 harm, unintended patient harm.

6 We don't know even from USPSTF, you  
7 know, from the task force, we don't have a  
8 recommendation they're standing by. Their  
9 website says hold on, don't use this information,  
10 we're going to be updating it. And so they may  
11 come out with an even stronger message that says  
12 yes, we're standing by our original  
13 recommendation, or they may have involved a whole  
14 group of people and they may have some  
15 modification. So again, I think that you can't  
16 hold physicians, providers--I hate that word--but  
17 you can't hold them accountable for something  
18 that is going to be measured and which will  
19 affect a certain validation score of them on a  
20 public website, and will end up affecting the  
21 payment that they receive with the measure that  
22 is right now going through, you know, a standard

1 of care assessment of whether the United States  
2 Preventative Services and the community at large  
3 will stand by this recommendation.

4 MEMBER FURNEY: I think we'd be doing  
5 a disservice if we didn't encourage CMS to  
6 continue to address this important topic, to  
7 develop data, to refine the models, to look at  
8 what can be seen, and then perhaps if the task  
9 force changes its recommendations or if it re-  
10 affirms its recommendations or if it doesn't,  
11 that the data can be interpreted, the metric can  
12 be refined, can be brought back for further  
13 review. I assume that a topic like this would go  
14 through extensive review, both through this type  
15 of a process, internal processes performed in  
16 good faith at CMS, and you know doubtless with  
17 some political guidance as well, depending upon  
18 whatever's happening at that moment in history.

19 So I think that to say that we can't  
20 talk about this would be kind of anti-science,  
21 and just like every article you ever read says,  
22 you know, we need more research on the topic,

1       yes, and let's keep doing it.

2                   CO-CHAIR BAGLEY:  You know the absence  
3       of hands means it's time for a vote; is that  
4       right?  Any other final comments?

5                   DR. WINKLER:  I just want to say that  
6       we have captured and, you know, we have both  
7       recording and transcript to capture all the  
8       richness of your conversation.  All the caveats,  
9       all the input.  So even though your votes seem to  
10      have, you know, just a couple of little words,  
11      they will be modified with all of the richness of  
12      the conversation that you've just had.  So it  
13      isn't just that, there is another section that  
14      goes with it that explains the discussion.

15                  MS. CHAVEZ:  Okay.  We are now voting  
16      on MUC15-1019 for MIPS, and for those on the  
17      phone, the options are one, encourage for  
18      continued development; two, do not encourage  
19      further consideration; and three, insufficient  
20      information.  Voting is open.  Okay, the voting  
21      results for MUC15-1019 for MIPS are 52 percent  
22      encourage for continued development; 33 percent



1 do not encourage further consideration; 14  
2 percent insufficient information.

3 CO-CHAIR BAGLEY: So it doesn't pass  
4 our 60 percent threshold.

5 MS. CHAVEZ: Yes, so the vote is for  
6 do not encourage further consideration.

7 CO-CHAIR BAGLEY: All right, let's  
8 move on to number two.

9 MR. LYZENGA: And just for my own  
10 curiosity, it's for CMS, does a vote like that  
11 mean that--Kate, does a vote like that mean that  
12 you will not bring it back through the MAP  
13 process, or is there still a prospect that you  
14 may? Just curious. A vote to not encourage  
15 further consideration, for example, I'm just  
16 curious how CMS interprets that, and if that  
17 means that you will not bring a revised measure,  
18 should such a thing occur, back through the  
19 process.

20 DR. GOODRICH: If we continue to  
21 revise it, it would definitely come back. I mean  
22 this is a little odd, right? A majority of

1 people voted encourage continued development, it  
2 just doesn't meet the 60 percent threshold. So  
3 I'm not sure what message that sends us about  
4 what we should do. So we're going to obviously  
5 have to talk through it, but if we do decide to  
6 continue developing it with all the input and  
7 everything, then yes, it would come back through.  
8 Yes.

9 CO-CHAIR BAGLEY: Okay, we're going  
10 to move on to the hospice measure. I actually  
11 was the one that pulled this because I wanted to  
12 hear some conversation around the three-day  
13 stipulation and hospice. I know that a lot of  
14 the lightning rod issues around people being in  
15 hospice right in the last few days of life is  
16 really what drew attention to this; I'll buy  
17 that. But if we're really going to try to  
18 improve that situation, we have to measure far  
19 sooner than three days. So why aren't we doing,  
20 you know, two weeks, six weeks, five months, I  
21 mean, why aren't we looking at maybe multiple  
22 dates so then we could study later to see which

1 one made a difference, you know, instead of three  
2 days as just sort of well, we've obviously waited  
3 too long, let's not do that anymore. So I guess  
4 I'm interested in the conversation about that.

5 Peter?

6 DR. BRISS: I suspect that I guess it  
7 would be good to have more data. This isn't an  
8 actual data question, but I suspect that there  
9 are a lot of people that are currently dropped  
10 into hospice in their last six hours of life, and  
11 three days would be a significant improvement.  
12 So for the purposes of the quality measure, if we  
13 could figure out something that was an  
14 improvement from wherever we are.

15 CO-CHAIR BAGLEY: No Jim, you were  
16 next.

17 MEMBER PACALA: Yes Bruce, my  
18 recollection of this is that Peter's right, that  
19 three days, there's a huge bimodal distribution  
20 of hospice enrollment and less than three days is  
21 a huge spike, and then it tails off, and then it  
22 sort of is a very broad, normal distribution. So

1 I think that--I suspect that that's what's behind  
2 the three-day.

3 CO-CHAIR BAGLEY: But let me ask for a  
4 clarification; is that just sort of an  
5 observational bell-shaped curve or is that an  
6 effectiveness bell-shaped curve?

7 MEMBER PACALA: Observational.

8 CO-CHAIR BAGLEY: Answer the question.  
9 Let's answer the question.

10 MEMBER PACALA: But I'm answering the  
11 question.

12 CO-CHAIR BAGLEY: Why do you think  
13 they chose three days? If this were a medicine,  
14 and you know applying it at three days is  
15 useless, you wouldn't be doing it.

16 DR. WINKLER: Bruce?

17 CO-CHAIR BAGLEY: So I guess that's  
18 really what the genesis of my question was, is  
19 how do we sort of get this--if we're going to  
20 really look for improvement, what's a better way  
21 to examine this than just the ones that clearly  
22 aren't going to work?

1 DR. WINKLER: Bruce, I'd just point  
2 out that this actually is an endorsed measure,  
3 and the summary of the endorsement review is  
4 available in your discussion guide, and this was  
5 a question that was raised by the committee that  
6 evaluated the measure during its last review, and  
7 as it says that members question why three days  
8 was selected as the numerator; the developer  
9 responded that three days was really their  
10 minimum; that perhaps seven days might be a  
11 better indicator of quality, but that the current  
12 reality was such that there were so many patients  
13 that weren't getting to hospice at all. But  
14 anyway, the summary of the endorsement review is  
15 available in your discussion guide; I just wanted  
16 to be able to make that out to you.

17 CO-CHAIR BAGLEY: Beth, you were next.  
18 Go ahead, please.

19 MEMBER PACALA: So I think also this  
20 deals with the trajectory of a malignancy, and so  
21 you know, there are different trajectories of  
22 death, and the trajectory of advanced malignancy

1 is probably the most predictable, and that is  
2 when you lose ADL function, I think about 90  
3 percent of people with cancer, end stage cancer,  
4 when they lose ADL function, are dead within two  
5 months. And so maybe two months is the right  
6 number for looking at cancer, but I would support  
7 this measure particularly as a starting point for  
8 looking at appropriate hospice enrollment in a  
9 special population, or in a sub population in  
10 which the outcome and the trajectory is much more  
11 predictable.

12 MEMBER MOYER: I will preface this  
13 comment with I was voted most cynical at the NQF  
14 Conference last year by my table. This really  
15 short term, hey we're really, really sure this  
16 patient is dying, let's trip them on to hospice  
17 so they don't hit our mortality care measure, I  
18 think this could be a balancing against that as  
19 well, avoiding, you know, exclusion of those  
20 patients because you've managed to get them on  
21 hospice even though it's, you know, more than two  
22 days out.

1 CO-CHAIR BAGLEY: Go ahead.

2 MEMBER FURNEY: One concern that I  
3 had, I would favor a longer interval of time just  
4 as been mentioned, but I think you know, we  
5 should stick with the three days if that's what  
6 the society gave us, and it certainly would move  
7 the ball somewhere. But is there any chance that  
8 we would deny people the supportive services of  
9 hospice type care in their last days of life by  
10 doing this, and I'm wondering if that could be--  
11 it's probably a small number, but could that be  
12 an unintended consequence?

13 CO-CHAIR BAGLEY: Other comments?  
14 What do people think about having multiple time  
15 periods as--multiple numerators if you will?

16 MEMBER AVERBECK: So I wonder if  
17 there's an opportunity in the comments because  
18 since it is NQF endorsed or NQF staff just said,  
19 some of those comments around the timing could go  
20 back to the developers for the next time that  
21 it's due for review, since it is NQF endorsed.  
22 I'm just curious, because it seems like that's

1 the conversation around what are the intervals  
2 and could we get that feedback back.

3 DR. WINKLER: Absolutely. In fact,  
4 one of our biggest pushes right now at NQF is  
5 integrating all the information flow between MAP  
6 and the endorsement process, and feedback from  
7 MAP will definitely feed into the next evaluation  
8 of this measure, and so we definitely are taking  
9 note and we'll do that.

10 CO-CHAIR BAGLEY: Peter, go ahead.

11 DR. BRISS: And I'd love to,  
12 especially if we're talking about lengthening the  
13 time, if we could have the developer think about  
14 the unintended consequences, the possibility  
15 which may be the most repulsive example of gaming  
16 I've ever heard of actually.

17 DR. CLARK: Yes, this would seem to be  
18 one of those situations where you really would  
19 benefit from some input from patient care giver.  
20 I mean, they're--as I mean we'll all recognize,  
21 these are very difficult decisions and the  
22 dynamic as to when one decides to go to hospice



1 is not an easy one on the part of the family as  
2 well as perhaps the provider; certainly on the  
3 part of the care givers.

4 CO-CHAIR BAGLEY: I don't see any  
5 hands, so--oh okay, go ahead Sam.

6 MEMBER FURNEY: I have just a  
7 question; in looking at the measure, the  
8 attribution of the measure is the provider making  
9 the referral, so presuming this is likely an  
10 oncologist? Okay. I think three days seems  
11 very, very short, and I'm not sure how to revise  
12 the measure to reflect what I think this group--  
13 it sounds like the consensus is longer is better,  
14 and if three days is considered too short of a  
15 threshold, then we want to measure that initially  
16 and just hopefully, we'll move that number, and  
17 over time if the optimal--I don't know if the  
18 optimal is 30 days or 60 days, but I think we  
19 should eventually move that number as we  
20 hopefully top out the measure, that three days is  
21 a rare occurrence, because longer than three days  
22 is certainly beneficial

1 DR. WINKLER: From just a timing  
2 perspective, actually NQF has an upcoming cancer  
3 project that's starting for the spring, and we  
4 can certainly bring this subject to be discussed  
5 for them on this NQF endorsed measure as part of  
6 the feedback from the MAP.

7 CO-CHAIR BAGLEY: Barbara, go ahead.

8 MEMBER LANDRETH: Just a quick  
9 comment. My personal experience has been that  
10 the oncologists are often the last ones to refer  
11 to hospice, and I don't know why that is. I  
12 suspect that it might be because they want to  
13 continue some sort of treatment or give them some  
14 hope that additional treatment will work, but  
15 from a primary care perspective, I think you're  
16 going to see hospice being referred to much, much  
17 sooner than three days. So although this is a  
18 cancer measure, it would also apply across the  
19 board to other providers as well.

20 CO-CHAIR BAGLEY: But you have both  
21 brought back to mind one of the other reasons I  
22 wanted to see this pulled out; is there any

1 reason that this shouldn't apply to all hospice  
2 referrals rather than only cancer patients?

3 DR. GOODRICH: So we'd have to ask the  
4 developer, I don't know if ASCO is here on the  
5 phone, but typically with these measures, the way  
6 they're coded, they're not necessarily coded for  
7 a specific specialist, but they are intended for,  
8 you know, I'm sure ASCO is developing it  
9 primarily for oncologists, but it is likely that  
10 it would be possible for primary care physicians  
11 or pathologists or whoever else to use this  
12 measure if they could select the measure. We'd  
13 have to confirm that with ASCO, but it's likely.

14 CO-CHAIR BAGLEY: It's just an  
15 opportunity to point out that there are other  
16 things that you die from, you know? Go ahead,  
17 Steve.

18 MEMBER FRIEDHOFF: As I started  
19 thinking about the length of stay discussion,  
20 I've done some part time hospice and palliative  
21 care in the past, and I was trying to pull up  
22 some of the numbers that the NHPCO organization

1 utilizes for their own patient-oriented outcomes,  
2 and it's things like you know, pain control,  
3 symptom control within 48 hours, family self-  
4 reported, knowing what to do at the time of death  
5 and other similar types of measures. What I was  
6 trying to do is find out if there's any  
7 correlation between, you know, length of time in  
8 hospice versus those measures, and I couldn't  
9 find anything public, but I have to believe that  
10 there's probably some information out there so if  
11 it's something that's being reconsidered in  
12 another work group, that may be worth bringing  
13 into this dialogue, because three does seem  
14 short, I mean I agree with Jim's statement that  
15 you've got to start somewhere, but if there  
16 really is an optimal patient oriented outcome  
17 driven length of stay, it's something we should  
18 probably understand.

19 DR. BRISS: You know, we've had  
20 several conversations today that were sort of  
21 about could a measure be generalized beyond the  
22 population for whom it was initially specified;

1 and so if we did that more systematically, you  
2 know we would solve some of our problems about  
3 small numbers and about lack of measures for  
4 certain specialties and about signal to noise  
5 ratio and proliferation of measures. If there  
6 were a way to feed back general guidance that  
7 said every measure ought to be specified as  
8 broadly as it can be, if patient populations and  
9 provider groups I think that would help a lot of  
10 our problems.

11 CO-CHAIR BAGLEY: Great. Great point.  
12 Jim.

13 MEMBER PACALA: I still think this is  
14 at the right spot, and it's the right target  
15 population and the right parameters. I think we  
16 need to start at a point where we have the most  
17 solid data and the most predictability of the  
18 trajectory of the patient. And so while it is a  
19 low ceiling--is it a low floor--whatever the rate  
20 metaphor is, I think this is the correct one.  
21 Even with hospice referral criteria out there for  
22 dementia, you know, stage 7 and advanced multi-

1 morbidity and advanced severity of chronic  
2 illness, all of those criteria are not nearly as  
3 predictable as an end-stage malignancy is. And  
4 so I think that does muddy up the precision of  
5 the instrument, and I think this would be a good  
6 place to start, and I'm endorsing--I'm going to  
7 vote yes.

8 MEMBER FRIEDMAN: So if this measure  
9 is NQF-endorsed, is there data showing the  
10 results of it, and I suspect it's very, very  
11 high.

12 DR. WINKLER: The information that's  
13 available at the time was limited to the testing  
14 that they'd one, so it was a very small amount of  
15 information provided during the last review.  
16 Let's just say we're going to have a lot more  
17 information on it coming up in its next review in  
18 the spring, and so the question is where the  
19 measure is potentially being used right now, and  
20 are they collecting data.

21 MEMBER FRIEDMAN: So if the number is  
22 50 percent or something obscene like that, maybe

1 it is a good measure the way it's written right  
2 now, so maybe we just need more data on it.

3 DR. GOODRICH: I expect ASCO has this  
4 measure in their registry, so they--it's a QCDR?  
5 Okay. Yes, so they probably do have that, so.

6 CO-CHAIR BAGLEY: Stephanie?

7 MEMBER GLIER: Just to add a quick  
8 comment that in NQF's review of this measure in  
9 the endorsement summary materials, it does note  
10 that the measure is of use; ASCO's quality  
11 improvement initiative actually using a modified  
12 version of the measure with a seven-day window.  
13 So I'm certain that you will have a lot more data  
14 when this comes back in the spring. I agree with  
15 Jim; I think we should support this measure as it  
16 is now and ASCA will be updating the measure. If  
17 they see a different data guided number of days,  
18 then I'm sure they will update the measure  
19 accordingly.

20 CO-CHAIR BAGLEY: Thank you for that;  
21 I see a lot of heads shaking, so maybe we should  
22 vote. Let's vote.

1 MS. CHAVEZ: Okay, now voting on  
2 MUC15-415 for MIPS. The options are one,  
3 support; two, conditional support; three, do not  
4 support. Voting is open. Okay. So the results  
5 for MUC15-415 for MIPS are 90 percent support; 10  
6 percent conditional support; zero percent do not  
7 support. So the vote is support.

8 CO-CHAIR BAGLEY: Okay, we'll go on to  
9 number five, bullet number five. Stephanie, do  
10 you want to have the first whack at this, since  
11 you pulled it?

12 MEMBER GLIER: Sure. So as I  
13 mentioned at the beginning of this consent  
14 calendar, I actually pulled five through the rest  
15 of the consent calendar as a bloc. I don't want  
16 to talk about any one of them in particular; if  
17 other people have specific comments on an  
18 individual measure, I'm happy to defer to that.  
19 My concern about these--and it is a concern--is  
20 that these appear to me to be standard of care  
21 measures and it's unclear that there's much of a  
22 performance gap in this space, and I am not



1 excited about the prospect of having an  
2 accountability program run by CMS where we're  
3 just asking people to do the very basic  
4 expectation of their practice.

5 Back to sort of the comment that Bruce  
6 had made earlier about--I'm not sure what--if I  
7 remember the exact example you used, but I think  
8 standard of care is too low a bar here, and I  
9 think I'd like to see these measures either  
10 combined into a single composite that says yes,  
11 we are meeting the standard of care on all of  
12 these measures, or we're not, or improved  
13 individually to be more closely tied to the  
14 outcomes that patients need. These are--I think  
15 actually one of the things that really caught my  
16 eye was that against recommendation on the second  
17 listing for each of these measures for the  
18 Physician Compare spreadsheet or webpage was  
19 spreadsheet for all of them because they are so  
20 technical as to be fairly meaningless to most  
21 patients. If you are a cancer patient undergoing  
22 one of these treatments, perhaps you do want to

1 know that your doctor is doing this, but again,  
2 if it's standard of care measure, I'm not sure  
3 that that's telling you what you need to know,  
4 either to choose a doctor or to help you guide  
5 your treatment. So I was pretty underwhelmed by  
6 this whole bloc; I would very much like to see  
7 good measures in this space, and if these  
8 measures can be improved, I'd love to have them  
9 improved and come back. If they are going to  
10 stay this way, I am not as excited about moving  
11 them forward.

12 CO-CHAIR BAGLEY: And I also was  
13 wanting to ask these to be extracted for a  
14 similar reason. I mean, this comes under maybe  
15 the heading of compliance with treatment  
16 protocols, and is that an appropriate level to  
17 set, you know, national standards about. So  
18 that's kind of the nature of the discussion I  
19 wanted to hear, similar to what Stephanie asked.  
20 I have Beth and David, so Beth you're next.

21 MEMBER AVERBECK: So I'm going to  
22 direct my question to Reva, because I know this

1 is some of your clinical background. Is part of  
2 the measure related to the type of hysterectomy,  
3 though as to try and have choice of hysterectomy  
4 where there are less complications? So some  
5 vaginal instead of abdominal; maybe I was  
6 misreading the specs--

7 DR. WINKLER: If you're talking about  
8 the specific measure that's minimally invasive  
9 surgery performed for endometrial cancer, you  
10 know the studies have basically showed that it's  
11 perfectly fine to use minimally invasive  
12 techniques to get the same outcomes for cervical  
13 cancer of a certain stage and grade, which is  
14 defined in this measure. And so that's what--the  
15 measure would encourage the use of the more  
16 minimally invasive surgeries because the outcomes  
17 are similar.

18 MEMBER AVERBECK: So just to clarify,  
19 I wasn't--I haven't pulled that minimally  
20 invasive surgery. I think we had actually  
21 already--that was the only measure on the set  
22 that we did not pull.

1                   MEMBER GLIER:   So Beth if you wanted  
2                   to talk about it, I didn't want to stop you, but  
3                   just to clarify, my concerns are with performance  
4                   of radical hysterectomy in patients with 1B1-IIA  
5                   cervical cancer on down.

6                   DR. WINKLER:   Okay.

7                   CO-CHAIR BAGLEY:   David, you were  
8                   next.

9                   MEMBER SEIDENWURM:   Yes, I'm not sure  
10                  that we really know what proportion of cancer  
11                  patients with these diagnoses received the  
12                  standard of care, and I think that that is  
13                  something that we ought to encourage inquiry  
14                  into.   I also think that if I understand the way  
15                  that these programs are going to function,  
16                  there's going to be sort of a gradation on this,  
17                  you know, linear scale that was explained to us  
18                  earlier, so that the people who excel and are  
19                  able to achieve higher rates might be rewarded  
20                  compared to the people who weren't able to  
21                  achieve higher rates   or had practice patterns  
22                  that were otherwise aberrant.   So I think it's

1 kind of self-scaling, and I think that if we're  
2 going to look at these metrics as quality  
3 improvement tools, you know first you've got to  
4 make all your Toyotas the same, you know, then  
5 you can make a Lexus, but you've got to even find  
6 out if you're even making a Toyota, and I'm not  
7 sure that we know that yet. So for those  
8 reasons, and also for the reasons that we talked  
9 about earlier today about some practitioners who  
10 restrict their practice to some of these narrower  
11 areas, again, we'll have a greater participation  
12 and a greater ability to influence their  
13 practices in a positive way.

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

15 DR. BRISS: Yes, I was going to say I  
16 wish it were otherwise, but ever since Beth  
17 McGlynn, you know people only do the right things  
18 about 50 percent of the time. Every time I look  
19 at another area, it's another--the batting  
20 average is always 50 percent, and even on stuff  
21 that I know the most about, like blood pressure  
22 control, which I think is a completely simple

1 clinical problem, you know, for which we have  
2 easily used effective medications, it's still 50  
3 percent. So I--this isn't my area, and so if  
4 everybody's batting 1,000 in this area, I'll be  
5 delighted but surprised.

6 CO-CHAIR BAGLEY: Winfred.

7 DR. WU: Yes, I just wanted to clarify  
8 my understanding. I mean, out of all the  
9 measures, I thought the brachytherapy measure,  
10 there was some documentation of a pretty  
11 significant performance gap, so I just wanted to  
12 clarify that. I think on the order of 40 percent  
13 of women who should get brachytherapy aren't, so.

14 DR. WINKLER: Yes, that was the only  
15 measure for which we had any hard data on current  
16 performance, and it was really disappointing I've  
17 got to say.

18 CO-CHAIR BAGLEY: I don't see any  
19 other hands. Now we're kind of talking about  
20 this whole set at the same time, so if you stop  
21 talking or raising your hands, we're going to  
22 vote on them all if that's okay with you guys.

1 Anybody object to that approach? We might make  
2 it. Okay. We're going to start with--that was  
3 number five, right? And that's the radical  
4 hysterectomy? No, I don't think--we can't do  
5 that.

6 MS. CHAVEZ: Okay, so we'll start with  
7 MUC15-465. The options: one, encourage for  
8 continued development; two, do not encourage  
9 further consideration; three, insufficient  
10 information. Voting is open. For those on the  
11 phone, oh we have one left voting via phone--okay  
12 we got it, thank you.

13 CO-CHAIR BAGLEY: Next.

14 MS. CHAVEZ: The results for MUC15-465  
15 for MIPS are 76 percent encourage for continued  
16 development; 24 percent do not encourage further  
17 consideration; zero insufficient information. So  
18 vote is for encourage for continued development.  
19 Next.

20 Okay, sorry about that. Now voting  
21 for MUC15-460 for MIPS. Options: one, encourage  
22 for continued development; two, do not encourage

1 further consideration; three, insufficient  
2 information. Voting is open. Okay, the voting  
3 results for MUC15-460 for MIPS are 95 percent  
4 encourage for continued development; 5 percent do  
5 not encourage further consideration; zero  
6 insufficient information, so vote is for  
7 continued development.

8 CO-CHAIR BAGLEY: I would, after  
9 seeing these, I'd entertain a motion to vote for  
10 the rest of them as a bloc. Does anybody object  
11 to that? Any single person can object to that.  
12 All right, so let's do that; I don't know how  
13 you're going to do that with. Just put up the  
14 next one, and we'll say it applies to all of  
15 them.

16 MS. CHAVEZ: Here's the list of MIPS.

17 CO-CHAIR BAGLEY: Okay that's perfect.  
18 Okay, that'll make it official. It may just take  
19 a little time, but we'll get it.

20 MS. CHAVEZ: Okay, yes. So now we're  
21 voting en bloc for MUC IDs 15-461, 15-466, 15-  
22 463, 15-454, 15-450 for MIPS. Options are one,



1 encourage for continued development; two, do not  
2 encourage further consideration; three,  
3 insufficient information. Voting is open. Okay,  
4 we have the results for MUC15-461, 466, 463, 454,  
5 450 for MIPS, and the voting results are 86  
6 percent encourage for continued development; 14  
7 percent do not encourage further consideration;  
8 zero percent insufficient information. So the  
9 vote for all of these are continued development.

10 CO-CHAIR BAGLEY: Okay, we have one  
11 more item, and that is the opportunity for public  
12 comment. Is there any--I'm not sure there's  
13 anything to comment on, but is there any  
14 additional public comment? Anybody on the phone?

15 OPERATOR: Once again, to make a  
16 comment, please press star one.

17 CO-CHAIR BAGLEY: We of course will  
18 have public comment on the individual measures;  
19 that's tomorrow.

20 OPERATOR: And at this time there are  
21 no public comments from the phone line.

22 CO-CHAIR BAGLEY: Okay, you've done

1 great work; we're finished ahead of schedule.  
2 Dinner, for those of you who are attending,  
3 that's going to be at 5:30 at Mio. Are we going  
4 to just meet there, or are we going to go en  
5 bloc?

6 MS. BAL: So it's up to all of you to  
7 decide; it is only a block up, so not very far at  
8 all. You can choose to walk over there together,  
9 or you can choose to meet people there. It's up  
10 to you.

11 CO-CHAIR BAGLEY: Okay, what's the  
12 address?

13 MS. BAL: I will announce it shortly.

14 CO-CHAIR BAGLEY: Okay great. Thank  
15 you. Thank you all for your patience and your  
16 lively conversation. We'll see you tomorrow.

17 (Whereupon, the above-entitled matter  
18 went off the record at 4:39 p.m.)  
19  
20  
21  
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