

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
CLINICIANS WORKGROUP

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THURSDAY
DECEMBER 10, 2015

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The Work Group met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 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
CONSTANCE DAHLIN, MSN, ANP-BC, ACHPN, FAAN, Individual Subject Matter Expert
STEPHEN FRIEDHOFF, MD, Anthem
SCOTT FRIEDMAN, MD, American Academy of Ophthalmology
SCOTT FURNEY, MD, FACP, Carolina's HealthCare System
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

GAYLE LEE, JD, Association of American Medical
Colleges

AMY MOYER, The Alliance

MARCI NIELSEN, PhD, MPH, Patient-Centered Primary
Care Collaborative

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:

ELISA MUNTHALI, MPH, Vice President, Quality
Management

MARCIA WILSON, Senior Vice President, Quality
Measurement

POONAM BAL, Project Manager

SEVERA CHAVEZ, Project Analyst

WUNMI ISIJOLA, Senior Project Manager

ANDREW LYZENGA, Senior Project Manager

REVA WINKLER, MD, PhD, Senior Director

ALSO PRESENT:

SOPHIA AUTREY, CMS

JEREMY COLLINS, MD, Society of Interventional
Radiology*

AMY MULLINS, MD, American Academy of Family
Physicians

KORYN RUBIN, American Medical Association*

JILL SAGE, MPH, American College of Surgeons

RHONDA TALLER, American College of Cardiologists

* present by teleconference

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

2 (8:31 a.m.)

3 CO-CHAIR WHITACRE: Good morning
4 everybody. I think we're about ready to start.
5 We have a couple Committee Members who will be on
6 the line on and off and I know Kate will be in
7 and out during the course of the meeting. So I
8 hope everybody had a good night. I think we had
9 a great day yesterday and the thought moving
10 forward today will be to continue in the same
11 vein with a very spirited, but collegial
12 discussion of some of the Measures. I think
13 that's, as we've discussed, the real value of the
14 Committee, not just our voting recommendations.
15 Bruce, did you have any additions to yesterday's
16 meeting?

17 CO-CHAIR BAGLEY: Yes. I thought that
18 the meeting went extremely well yesterday. And
19 just I always like to pause once in a while, is
20 there anything that you really liked about how
21 the meeting went yesterday and is there anything
22 we could do better today, I guess is the real

1 question? So, any comments on the food, the
2 temperature of the room --

3 (Laughter.)

4 CO-CHAIR BAGLEY: -- the conduct from
5 the front of the table? I mean, how did it go?

6 DR. BRISS: I have one. So, remember
7 that we should do this early and often, so the
8 Staff is to be complimented again, I would say.
9 So remember that they got the MUC list the
10 Wednesday before Thanksgiving. And so this is --

11 CO-CHAIR BAGLEY: At about 5:45, I
12 think, yes.

13 DR. BRISS: Yes. I heard it was 3:30.
14 So, don't underestimate how fast we Feds are,
15 Bruce. But the Staff is to be complimented for
16 the quality of the materials given the time, of
17 course, that these things were put together.

18 CO-CHAIR BAGLEY: Thank you for that.

19 MEMBER FRIEDHOFF: So, just one
20 housekeeping thing that's slightly confusing. We
21 talk about the Measure numbers and we're going by
22 this sheet and not the online list, and that's

1 somewhat confusing. And I've kind of been
2 following the online stuff, which is really,
3 really well thought out and nice and laid out for
4 me. So if you could -- I mean, the common
5 dominator is the Measure number. If you could
6 just also state the Measure number, I can stay in
7 sync with what's happening.

8 DR. WINKLER: Obviously, I think our
9 experience is we'll re-think how we do the
10 numbering. The fact that there were two entries
11 on the discussion guide for each Measure is where
12 we've got to re-think that. But we appreciate
13 it. Okay. Unless anybody else has any comments,
14 we might as well get started. The first topic
15 this morning is interventional radiology. We
16 have seven new Measures that were submitted by
17 the Society of Interventional Radiology.

18 There is one Outcome Measure that is
19 fully developed, and that's the 30 Day Stroke and
20 Death Rate for Symptomatic Patients undergoing
21 carotid stent placement. Just of note, this is
22 closely related to a Measure that is already in

1 the clinicians set for asymptomatic patients, so
2 it's really just the other group of patients.
3 The remainder of the Measures are still in
4 development, testing is ongoing and will be
5 completed later in probably the fall/September is
6 the estimate at this point. And most of these
7 Measures are planned to be incorporated into the
8 National Interventional Radiology Quality
9 Registry and data captured through their
10 Structured Reporting Initiative, so, similar to
11 the other specialty societies. I guess we're
12 looking for public comment at this point?

13 CO-CHAIR WHITACRE: We'll be following
14 the same pattern that we did yesterday, so we'll
15 begin with inviting any public comments, either
16 from people here in the room or, if there are
17 none, from anyone on the phone.

18 OPERATOR: At this time, to make a
19 comment, please press Star 1. And there are no
20 public comments at this time.

21 CO-CHAIR WHITACRE: There are no public
22 comments? Okay. Well, if I could ask then, we

1 have -- let me just review quickly that a couple
2 Measures have already been pulled by Committee
3 Members. And those are, on the printed sheet,
4 Number 5, 6, and 7. Bruce is listed, as well as
5 Stephanie, but, David, I know you also had a
6 concern about those Measures. Are there any
7 Committee Members who would like to pull
8 additional Measures from the list?

9 If not, perhaps we can begin with the
10 discussion, either Bruce -- oh, forgot, I have to
11 do the consent calendar. So that means the
12 Committee would accept Measures, again on the
13 printed list, 1, 2, 3, and 4 with the Staff
14 recommendations. If there's no objection, then
15 we'll consider those accepted on the consent
16 calendar and then focus on Measures 5, 6, and 7.
17 And it would be for Bruce, Stephanie, and then
18 David.

19 MEMBER SEIDENWURM: So the first thing
20 I want to do is thank you guys for helping us to
21 recognize the development of interventional
22 radiology as a almost a surgical sub-specialty as

1 well as a radiologic sub-specialty. And helping
2 to allow my colleagues to develop their
3 discipline in a rigorous way. And I think as the
4 American College of Radiology, Society of
5 Interventional Radiology, Society of
6 Neurointerventional Surgery, the other groups
7 that are practicing in this domain, are really to
8 be commended for trying to go forward with
9 structured evaluation of procedures that even a
10 few years ago weren't ever being done. And so I
11 think that we want to assist them in that
12 endeavor.

13 The reason that I was concerned about
14 Numbers 5, 6, and 7 on the sheet was because the
15 procedure itself is, and I'm not quite sure
16 whether these are positive things about including
17 them in the program or negative, because they
18 really cut both ways, they're uncommon
19 procedures. They're related, obviously, to the
20 outcomes, but they're not the only things that
21 are related to the outcomes. They might be the
22 tip of the iceberg or the flagship procedure in a

1 multidisciplinary system of care for these kind
2 of complicated, difficult patients.

3 And then there was the same discussion
4 we had last time about how detailed we wanted to
5 get in the analysis of uncommon procedures. So
6 the best compromise that I could kind of come up
7 with to square that circle was to retain for
8 further development the patient reported
9 outcomes, because patient reported outcomes for
10 iliofemoral venous stenting would actually wind
11 up being a proxy for patient outcomes for severe
12 post-thrombotic disease and that's an important
13 problem.

14 And then the improvement in the
15 clinical severity score, which again would be a
16 marker for this kind of interdisciplinary
17 approach to this problem, I wasn't sure if just
18 the assessment of the post-thrombotic syndrome
19 raised the bar quite high enough and if that
20 wasn't subsumed in the others, because we already
21 had an Outcome Measure of improvement. So my
22 recommendation would be to include 5 and 7 and

1 maybe not so much to go forward with Number 6.

2 CO-CHAIR WHITACRE: Other comments?

3 CO-CHAIR BAGLEY: My comments were
4 similar. I wanted to focus a little bit on the
5 idea of, well, first of all, small numbers you
6 already mentioned, but the objectifying and
7 having comparison data for this outcome. I love
8 patient reported outcomes, don't get me wrong,
9 but how do we kind of make sure that this can be
10 objectified and have enough comparison data to be
11 meaningful, I guess was my concern.

12 MEMBER GLIER: This is Stephanie. My
13 concern was very similar. You actually said what
14 I was hoping to say better than I could have.

15 MEMBER SEIDENWURM: I doubt that.

16 MEMBER GLIER: I don't, the way my
17 voice is going this morning. I'm wondering about
18 whether it actually makes sense to move forward
19 with all three of them as some type of a single
20 Measure. Is there a reason that the Venous
21 Clinical Severity Score should be measured
22 separately or is there a way that we could have a

1 single Patient Reported Outcome or Outcome
2 Measure that includes a patient reported outcome
3 assessment and a clinical assessment using either
4 the Villalta Score or the other score? Do you
5 know enough?

6 MEMBER SEIDENWURM: Just on the face of
7 it, it seems like if you already were measuring
8 improvement that just measuring the frequency
9 with which assessment was performed would be
10 redundant. So I think that, that might be
11 superfluous. And then the other half of your
12 question, I'm sorry?

13 MEMBER GLIER: So I'm looking at MUC ID
14 15-413, which is 13 on the website or 7, I think,
15 on our list this morning, Improvement in the
16 Venous Clinical Severity Score after iliofemoral
17 venous stenting. Does that add substantial value
18 on top of the Patient Reported Outcome Measure or
19 is there a way that we could combine those two
20 into a single Measure with two different scales
21 that both would show improvement?

22 MEMBER SEIDENWURM: Sure. So, the one

1 metric is how the patient feels about it, the
2 other is more an objective measure of clinical
3 success. Now obviously, ultimately the goal is
4 to make the patient feel better about their leg
5 and their life, but you also have to know if the
6 procedure itself was successful and if the
7 desired tissue changes were occurring. So I
8 think that they're both important and measuring
9 separate domains of the success of the procedure.

10 MEMBER GLIER: I agree. I think from
11 a consumer end participant perspective, it would
12 be nice to see those married together so you can
13 say --

14 MEMBER SEIDENWURM: As a composite?

15 MEMBER GLIER: As a composite. So
16 there is clinical improvement, but you also see
17 improvement in the functional status and the
18 experience of the patient themselves.

19 DR. WINKLER: We can add those to the
20 comments for each of them.

21 CO-CHAIR WHITACRE: Scott?

22 MEMBER FURNEY: So analogous to our

1 conversation yesterday about the ophthalmology
2 Measures, this actually is what we asked for
3 yesterday, or at least I did, is assessment of
4 clinical success combined with patient assessment
5 of success, but by validated instrument. So I
6 have a good amount of content expertise in DVT
7 prevention treatment, less in the invasive side,
8 but all of these are subject to very good
9 assessment instruments. So I think having both,
10 can they be combined in a composite, would that
11 be meaningful, I think that it's difficult to do,
12 but they should correlate together. I think they
13 could be redundant at worst, but I'm very happy
14 to see both.

15 CO-CHAIR WHITACRE: May I make a
16 comment as a Committee Member, just step out of
17 the chair for a minute? One of the issues I see,
18 because I have it in my specialty and I see it
19 happening again and again in different
20 specialties, is saying, well this is great, we've
21 described all the components and possible
22 complications of these either frequent or rare

1 problems and we should combine patient reported
2 outcomes, and then, we stop.

3 So, we've made a little bit of a list
4 of things that we might measure and talk about
5 later today and I want to be respectful of
6 everyone's time, I know people have planes to
7 catch, but it seems to me unless we offer some
8 advice to someone about how to overcome that, how
9 do we get from these fragmented multiple small
10 Measures to a more composite clinician/patient
11 reported Outcome Measure, we're maybe not helping
12 the Measure Developers as much as we possibly
13 could. Not that I have the answer, but to me,
14 that's the next step as we move past this, we
15 recommend it be done, but, okay, how? Give me an
16 example, show me how it works, show me how we'd
17 report it. So in, perhaps later at 2:00 or so,
18 when we have the CAHPS discussion, we can revisit
19 that. End of comment. David?

20 MEMBER SEIDENWURM: Well, not to wax
21 too philosophical here, but I think that the
22 point is that there's a hierarchy of metrics and

1 they come in layers, right? The patient reported
2 outcomes at the top are for everything and
3 they're comparable and they're validated, but
4 somehow we need to give the physicians, the whole
5 treatment team, the tools to get there. And I
6 think that, notwithstanding the particular use of
7 these metrics and the different payment programs
8 and all that, we need to provide people with the
9 tools that we think are the stepping stones to
10 get them to the whole thing. Because if you just
11 throw this whole big metric at them and say, have
12 at it, we haven't helped and we've abdicated our
13 responsibility in a certain way. So by providing
14 the more detailed tools along the way, maybe
15 we're giving people some help.

16 CO-CHAIR WHITACRE: My thought was
17 simply that we ask in the future if Measure
18 Developers come with these fragmented tools that
19 they be combined, perhaps with a separate Measure
20 saying, okay, I've got a patient reported outcome
21 for this as well. So it's fine to have three or
22 four Measures, one of them being the Patient

1 Reported Outcome. I mean, we need that
2 desperately in our field, that's why I bring it
3 up. Reva?

4 DR. WINKLER: Yes. I'm just wondering
5 if anyone is from the Measure Developers from the
6 Society that had wanted to comment on -- anybody
7 on the phone maybe? I don't see anybody in the
8 room. Just give them an opportunity to comment.
9 Okay. Thanks.

10 CO-CHAIR WHITACRE: Other comments?
11 This is great, we're going to be way ahead of
12 schedule. Well, if there are no other comments,
13 I think we can proceed with a vote. The first
14 would be on Measure Number 5, this is on the
15 printed sheet. That would be MUC15-411. Scott?
16 Oh, we have to distribute our clickers. Okay, if
17 we can display, then, Measure Number 5. This is
18 Patient reported outcomes following iliofemoral
19 venous stenting, MUC ID MUC15-411. And our
20 choices are Encourage for Continued Development,
21 Do Not Encourage Further Consideration,
22 Insufficient Information.

1 MS. CHAVEZ: Thank you, Dr. Whitacre.
2 Voting is now open. Terry and Kate, please send
3 your votes via chat and Staff in the room will
4 vote for you via the voting tool. Thank you.
5 Okay. The results for MUC15-411 for MIPS are 100
6 percent Encourage for Continued Development, zero
7 Do Not Encourage Further Consideration, zero
8 Insufficient Information. So this Measure is
9 recommended for continued development.

10 CO-CHAIR WHITACRE: So Measure Number
11 6 on the printed agenda, this is Assessment of
12 post-thrombotic syndrome following iliofemoral
13 venous stenting. That's MUC ID MUC15-412.

14 MS. CHAVEZ: Okay. Voting is open.
15 Okay. The results for MUC15-412 for MIPS are 56
16 percent Encourage for Continued Development, 44
17 percent Do Not Encourage Further Consideration,
18 zero Insufficient Information.

19 CO-CHAIR WHITACRE: The next Measure is
20 number 7 on the printed agenda, Improvement in
21 the Venous Clinical Severity Score after
22 iliofemoral venous stenting, MUC ID MUC15-413.

1 MS. CHAVEZ: Voting is open. I
2 apologize, it was the wrong slide, so let's start
3 over. Okay, we get a fresh 35 seconds, voting is
4 open. Okay. Voting results for MUC ID 413 for
5 MIPS are 94 percent Encourage for Continued
6 Development, six percent Do Not Encourage Further
7 Consideration, zero Insufficient Information.

8 CO-CHAIR WHITACRE: Reva?

9 DR. WINKLER: Yes. I just noticed that
10 in terms of the folks that pulled these, they
11 mentioned it both for MIPS and Physician Compare.
12 And we really hadn't focused in on that, but it
13 would be worthwhile or would be helpful for us,
14 if indeed you do have disagreements with the way
15 we characterize the recommendation for the
16 Physician Compare, the web page versus in the
17 spreadsheet, and as Kate said, everything's in
18 the spreadsheet, but in the web page
19 specifically, please let us know because we will
20 be providing that information to CMS and we want
21 to represent the recommendation of the work here
22 accurately. Obviously, any Measure that isn't

1 recommended won't have a recommendation for
2 Physician Compare.

3 MEMBER SEIDENWURM: So, just along the
4 same lines as yesterday, philosophically, this
5 should be available to people who want to look
6 for it, so as long as it's broken down into a
7 form that a sixth grader can understand.

8 DR. WINKLER: Yes.

9 CO-CHAIR WHITACRE: Terrific. We'll
10 move on to the next section.

11 CO-CHAIR BAGLEY: Okay. We're
12 scheduled for a break, but I hope you guys can
13 press on through. We next are going to consider
14 the pre-rulemaking input for MIPS and PC Measures
15 under urogynecology.

16 CO-CHAIR WHITACRE: It turns out, I
17 guess, we're tallying the votes from the phone
18 and I guess there was a bit of a delay and this
19 is for Measure, it's on the last group, Measure
20 Number 6 on 412. So, MUC15-412, which is Measure
21 6 on the printed agenda, that came in at 56
22 percent, apparently with the addition of the

1 outside votes, that changed the percentages.
2 Would it be reasonable to ask everybody to revote
3 on that Measure and make sure we tally the
4 telephone votes at the same time? So if we can
5 proceed with a revote of Measure Number 6 on the
6 printed agenda, which I'll read to make sure
7 we're clear, Assessment of post-thrombotic
8 syndrome following iliofemoral venous stenting,
9 MUC ID MUC15-412. And we'll make sure that we've
10 tallied, as we move forward, the telephone
11 respondents as well.

12 MS. BAL: Kate, Terry, and Robert,
13 please go ahead and just chat your votes now
14 while we're getting this ready. Thank you.

15 MS. CHAVEZ: Okay. We're now ready to
16 vote for MUC15-412, 1 Encourage for Continued
17 Development, 2 Do Not Encourage Further
18 Consideration, 3 Insufficient Information. Okay.
19 The votes are in and the results for MUC15-412
20 for MIPS are 52 percent Encourage for Continued
21 Development, 48 percent Do Not Encourage Further
22 Consideration, zero Insufficient Information.

1 CO-CHAIR WHITACRE: Thank you. I
2 apologize for the glitch.

3 CO-CHAIR BAGLEY: Okay. In that case,
4 we'll go on to the agenda item marked 10:30 and
5 we're going to look at the Measures for
6 urogynecology. We're going to start with an
7 opportunity for public comment. Is there anyone
8 on the phone with a public comment? I realize
9 that there's a slight disadvantage for somebody
10 who is following the agenda, specifically we're a
11 little ahead of schedule, but I don't know,
12 unless we just sit here and wait an hour, that
13 probably is not going to work. So any other
14 general comments about this -- Reva, do you want
15 to give an overview?

16 DR. WINKLER: The next group of
17 Measures is around urogynecology. There are five
18 Measures from the American Urogynecologic
19 Society. There is a combination of Process and
20 Outcome Measures that are all still in
21 development.

22 CO-CHAIR BAGLEY: All right. Well,

1 just to note, on your agenda, Number 4 has
2 actually been pulled. So, yes, there are six
3 listed, but 4 is pulled. Just so there's no
4 confusion there. And so far we have already
5 pulled 1, 3, 5, and 6 on your agenda. That
6 leaves only 2 that hasn't been. Is anybody
7 interested in hearing a discussion about 2?
8 Seeing none, I'll ask if there's any objection to
9 accepting 2 as a consent calendar? I see none,
10 so let's move on. Stephanie, the Stephanie Show
11 continues.

12 MEMBER GLIER: The Stephanie Show
13 continues, but I'm wondering if our Lead
14 Discussants also wanted to weigh in on their --

15 CO-CHAIR BAGLEY: Okay, sure. Thank
16 you for that.

17 MEMBER LANDRETH: I'm supposed to be
18 talking about Physician Compare, but I actually
19 had some questions about this. Maybe, Reva, you
20 can answer this. It's been 30 years since I've
21 worked in GYN, but when I saw the colposcleiosis, I
22 had never even heard of this. So, I went back in

1 and looked it up on Up to Date and now I
2 understand what it is. I was concerned because I
3 was wondering about how common is this? And I
4 noticed that the Developers didn't really have an
5 indication of how common it was.

6 So I went into the database that we
7 have, claims database from all of the St. Louis
8 area, and looked for the last four years for this
9 procedure, the CPT Code 57120, and there were 42
10 cases. But it was, obviously, a primarily under
11 65 population, so it might not have been
12 representative, because we don't have the
13 Medicare data in there. So it might give you an
14 idea, but for four years, 42 cases is really not
15 that many. And so, how prevalent is this?

16 DR. WINKLER: I would counter this with
17 the fact that it's most common done in the very
18 elderly --

19 MEMBER LANDRETH: Right.

20 DR. WINKLER: -- women who have
21 significant pelvic prolapse who are really not
22 great surgical candidates for more significant

1 surgery. And this is just done for symptom, to
2 control the prolapse. So, if you didn't have
3 representative numbers from a Medicare
4 population, I don't think it's particularly
5 meaningful, because that's where you're going to
6 see all these patients. This is done strictly
7 for symptom relief in elderly patients who are
8 not good candidates for more definitive surgery.

9 MEMBER LANDRETH: I was --

10 DR. WINKLER: And I couldn't find any
11 data on it either.

12 MEMBER LANDRETH: I was just wondering,
13 there are so many other things that I think that
14 ACOG could be looking at, like what's the
15 incidence of pap smears that are done
16 unnecessarily? What's the incidents of vaginal
17 pap smears that are being done on post-
18 hysterectomy women with no cervixes? To focus on
19 something that I'd never even heard of, and I'm
20 ignorant, but to the exclusion of some of the
21 other things I think that are much more common,
22 it didn't seem to make much sense to me.

1 DR. WINKLER: I will just point out
2 that these are from a sub-specialty, the
3 urogynecology --

4 MEMBER LANDRETH: Okay.

5 DR. WINKLER: -- so they have a very
6 narrow, narrow focus and it is not the breadth of
7 gynecology in terms of their particular interest.

8 MEMBER LANDRETH: Okay. That makes
9 more sense.

10 CO-CHAIR BAGLEY: Luther or Jim?

11 DR. CLARK: No, I was just going to
12 point out that the Urogynecologic Society was in
13 fact in support of these Measures. There was
14 some question in terms of the route as to what
15 the baseline was in terms of what proportion of
16 women really would not be eligible for vaginal
17 hysterectomy. And that was a question, but they
18 were in support. That was my only comment.

19 MEMBER PACALA: I had a couple of
20 comments in general to tee up discussions. For
21 Number 1 on route of hysterectomy, I just wanted
22 to note that, as you can see, there's wide

1 variability in the numbers of vaginal versus
2 abdominal versus laparoscopic. And so, while the
3 Measure Developers admittedly say that they're
4 not sure what the right percentage is, I still
5 think it has utility in comparative data and I
6 think even as a practitioner, a practitioner
7 would want to know how I compare to the rest of
8 my peers in terms of the frequencies of these
9 procedures I'm doing.

10 In that sense, I think it is somewhat
11 parallel to C-Section. And there are C-Section
12 rates and there's wide variability of C-Section
13 rates within practices and across practices. And
14 I think, obviously, within practices it's
15 probably a little bit more significant than
16 across practices because practices see different
17 populations of people. But I ended up thinking
18 about the Measure that way and I thought that if
19 I were a practitioner doing those procedures, I
20 would want to know. And so, I thought
21 encouraging further development of that Measure
22 was a good idea.

1 In terms of the Number 3, the
2 obliterative procedures, I think we just covered
3 that fairly well. I'm a geriatrician, it's not
4 the most common condition, but it's also not
5 terribly uncommon and it's a patient safety
6 Measure that seems pretty straightforward. So I
7 didn't see too much controversy in that one. And
8 then in 5 and 6, both of those were offering
9 trials of conservative management before a
10 surgical procedure, in the first one, to correct
11 fecal incontinence and in the second one, to
12 correct urgency urinary incontinence. Both of
13 those are interesting in that I think most of the
14 research has shown that conservative treatment
15 can be effective and, obviously, it's safe, so
16 that's a good idea.

17 I did have some issue with thinking
18 about these conditions, because there are certain
19 conditions, particularly with prolapse, where the
20 prolapse, these conditions can get to a point
21 where it's so severe that conservative treatment
22 is not very useful. So it's sort of like with

1 BPH, if the AUA score is 15 or 20 in somebody
2 with BPH, then you realize that drug therapy is
3 probably not going to help their symptoms and
4 that they probably need some type of surgical
5 intervention. And so, there might be some
6 colorectal surgeons who specialize in fecal
7 incontinence surgery who only see the worst
8 cases.

9 So in lots of those cases, they may
10 not have a trial of conservative management
11 because that's already been done or it's just not
12 worth it. So, again, they're going to further
13 develop, it's encourage further development, I
14 think those are good ideas because trying a
15 conservative treatment first is probably a good
16 idea in general. So that's the end of my
17 comments. There wasn't too much disagreement in
18 the few public comments that were received, but
19 ACOG said these things represent good practice
20 and we support them.

21 CO-CHAIR BAGLEY: Now Stephanie.

22 MEMBER GLIER: Jim, you teed up my

1 comments so perfectly, thank you. My first
2 response on the conservative therapy Measures,
3 which also happen to be Documentation Measures,
4 really line up with what the NQF Staff had
5 offered in their preliminary analysis and I think
6 I totally agree with you that we would want to
7 make sure that conservative therapy is
8 appropriate. And even beyond the sort of patient
9 reported outcomes that's indicated here in the
10 NQF Staff response, it would be really fantastic
11 to have a Functional Status Measure here so that
12 you could actually say, this is a candidate,
13 based on the functional status, this is a
14 candidate for conservative therapy, and have a
15 Measure that demonstrates that before you go into
16 something that's more intensive.

17 Similarly, I think -- I had actually
18 pulled these Measures specifically for the
19 Physician Compare recommendations and when I was
20 thinking about it, it was because I don't think
21 these Measures would be useful for a patient as
22 they are now and I think you guys had recommended

1 that they go on the spreadsheet, not on the
2 individual clinician website because what is a
3 patient going to do with this information if we
4 don't have something like a Patient Reported
5 Outcome or a Functional Status Measure?

6 So, to my mind, I think further
7 developing these as they are is not particularly
8 useful, but if we are able to recommend if the
9 Society is able to do some work on a functional
10 status assessment or on a patient reported
11 outcome that could do some shared decision making
12 based on the evidence along with the
13 documentation of conservation therapy as
14 appropriate, that would be very valuable for
15 patients. And, in that case, I would want to see
16 that Measure on an individual clinician website.
17 But if it ends up being something that is not
18 particularly useful for patients, I'm not sure
19 that we should support further development. So
20 that's where my comments lie on those Measures.

21 CO-CHAIR BAGLEY: Go ahead, Jim.

22 MEMBER PACALA: Could I ask, there was

1 a recommendation for the route of hysterectomy
2 that, that be on the clinician webpage and I
3 actually think that's a good idea. I agree with
4 that recommendation, although without some kind
5 of adjustment for case mix, that could be
6 misleading, but I do think that is something that
7 a consumer would want to know.

8 MEMBER GLIER: And you're doing a great
9 job teeing it right back to me on that one. My
10 comment on that was actually that I think if
11 there's a way, and I know I'm sort of grasping at
12 straws here, but if there's a way to incorporate
13 some shared decision making into that Measure,
14 because we don't know what the right case mix is,
15 I think having some patient preference indicated
16 in the way that the Measure displays would be
17 really valuable and could help us make something
18 presented on the clinician website more useful,
19 to say, yes, my doctor listened to me about what
20 my preferences were, whatever it is, about
21 recovery from surgery or basic risks or the
22 equivalent.

1 CO-CHAIR BAGLEY: Mady?

2 DR. CHALK: From the Duals perspective,
3 I wanted to support what Stephanie just talked
4 about. Given that some of these Measures have to
5 do with elderly patients, the shared decision
6 making issue is a very big issue and was
7 identified by the Duals group as a major gap in
8 the way we're thinking about Measure development.
9 So, just wanted to support what you said.

10 CO-CHAIR BAGLEY: Thank you for that.
11 Other comments? Go ahead, Cindy.

12 MEMBER PELLEGRINI: So from a purely
13 practical perspective, I'm not sure I'm seeing
14 how the route of hysterectomy Measure is useful
15 to CMS for MIPS because they would have to say,
16 here's how you are going to be judged as
17 successful, right? We're going to have to set a
18 threshold or something like that and if we don't
19 know, if we have really no idea what the right
20 threshold is, how do they do that, right? So how
21 do you even know if you're doing well on this
22 Measure or not? So I do agree that I think it

1 would be great for the Physician Compare
2 clinician webpage.

3 And then just a note on the rest of
4 the Measures. I found it really interesting that
5 the ACOG comments were all that this is good
6 gynecologic practice, which, to me, maybe I'm
7 overthinking it, but to me sounded like damning
8 them with faint praise. Sort of, again, are we
9 just measuring normal baseline good practice that
10 everybody ought to be doing or are we actually
11 measuring high quality care?

12 CO-CHAIR BAGLEY: Kate, did you have
13 any comment about that? Nothing to say about
14 true, true, and related. Go ahead, Scott.

15 MEMBER FRIEDMAN: I'm obviously not an
16 OB/GYN, maybe we have some people that have
17 expertise, so in 2010, most hysterectomies were
18 not performed vaginally, yet that's the preferred
19 treatment. Can someone elaborate on why we're
20 looking at this Measure at all? Is vaginal
21 hysterectomy the best way to treat this disease?
22 And, if so, why in 2010 are most docs not doing

1 it that way? My understanding is, it's not
2 necessarily the best way in talking to my
3 colleagues.

4 DR. WINKLER: Yes. Anybody from AUGS
5 or ACOG on the line? I don't want to preempt
6 that. Okay. I actually just read the recent
7 literature, Scott, so that I can answer it, not
8 from my personal experience, but from what I'm
9 recently reading, is in fact the data does show
10 that there is decreased complications and
11 improved recovery time for the non-abdominal
12 route, whether it's a LAVH or a vag hyst.

13 The current data actually is the
14 problem and there are concerted efforts by ACOG
15 to promote greater use of vaginal hysterectomy
16 and assisted vaginal hysterectomy. All of the
17 journals I've been getting and only glancing at,
18 I've started reading more detail and you see that
19 this is because of the benefit to patients. And
20 so, this is something they are promoting and
21 supporting and the data does show that it is
22 better outcomes for patients in most cases.

1 MEMBER FRIEDMAN: Vaginal's better
2 than, not to get in details, is better than
3 laparoscopic, for example, LAVH?

4 DR. WINKLER: I think the laparoscopic
5 and vaginal are together versus a straightforward
6 laparotomy with hysterectomy.

7 MEMBER FRIEDMAN: So based on what you
8 just told me, this Measure is incorrect, that
9 vaginal isn't the preferential way to do this?

10 DR. WINKLER: No, no, evidence base is
11 one thing, current performance is --

12 MEMBER FRIEDMAN: Well, is vaginal
13 hysterectomy associated with better outcome than
14 laparoscopic, for example?

15 DR. WINKLER: Those two, I think, are
16 fairly comparable.

17 MEMBER FRIEDMAN: So should the Measure
18 be rewritten to state that?

19 DR. WINKLER: We can certainly ask.
20 Like I say, I glanced at the data.

21 CO-CHAIR BAGLEY: Amy?

22 MEMBER MOYER: So, I've been trying to

1 find some data to support this, but I know I've
2 heard this come up as a conversation with
3 clinicians throughout our state about the
4 appropriateness of the hysterectomy in the first
5 place. And, so, we're talking about how to do
6 the procedure, but I'm looking at the Measures in
7 the program and what's out there and I'm not
8 seeing anything that talks about, should the
9 procedure have happened in the first place? And
10 I think that's a question I'd want to answer
11 before talking about how we did the procedure.
12 So it would be nice to see a Measure like that.
13 I did see a lot of kind of more anecdotal news
14 story type things come up, but it feels like
15 there's a perception at least that this is a
16 potentially overused procedure.

17 CO-CHAIR BAGLEY: Barbara?

18 MEMBER LANDRETH: Reva, maybe you can
19 help me. Robotic procedures, that seems to be
20 the way that a lot of clinicians in Tulsa are
21 going for hysterectomies. So would those be
22 considered laparoscopic?

1 DR. WINKLER: In all honesty, I'm
2 looking at the specifications and they've only
3 specified it using the various codes and I just
4 don't know the codes off the top of my head, so I
5 can't answer your question. I mean, we'd have to
6 look those up to see what gets captured.

7 MEMBER LANDRETH: I can see that the
8 Measure Developers may be wanting to evaluate the
9 use of robotic because presumably it's more
10 expensive. And, again, that's a good question, I
11 don't know, because robotic surgery is now being
12 used much more and is that even necessary?

13 CO-CHAIR WHITACRE: If I can just ask
14 a question, again, this is just as a Committee
15 Member, does the group of either GYN specialists
16 or urogynecologists or anybody have a registry
17 that's looking at this? The reason I ask that is
18 I'm struck by the way different Measures have
19 been brought to the Committee, we've had what I
20 gather with the ophthalmologists, a registry-
21 based, hey, we've got some data, here's numbers,
22 we've got clinicians engaged, and we're throwing

1 these Measures forward. And I get a sense that
2 here MIPS is being used as a registry to collect
3 data, which may or may not be inappropriate, I'm
4 just trying to understand how the Measure came
5 forward.

6 DR. GOODRICH: This is Kate. First of
7 all, Sophia, do we know if they have like a QCDR?
8 They don't, do they? They don't. Okay. So the
9 way these would be used would -- I think they're
10 submitted as registry Measures, what that means
11 for us if we decided to propose them and if we
12 finalize them, they would be then coded into many
13 of what's called the traditional registries,
14 these are the registries that have been run, CE
15 City, there's lot of others, this is even pre-
16 QCDR. So they would be available by probably
17 multiple different registries. There's a lot of
18 registries out there that basically have all the
19 PQRS and would probably have all the future MIPS
20 Measures in there, so clinicians could chose to
21 work with a registry to submit that, that's how
22 that would end up working.

1 CO-CHAIR BAGLEY: Amy?

2 MEMBER MOYER: I sit on the Surgery
3 Committee and they recently brought several
4 Measures to that Committee and my understanding
5 from what they said there is they're working very
6 hard to get a registry in place and it sounded
7 like maybe in the next year they hoped to have
8 that up and running.

9 CO-CHAIR BAGLEY: Other comments? Yes,
10 go ahead, Dave.

11 MEMBER SEIDENWURM: So it sounds like
12 the way forward here would be to encourage
13 further development with particular attention to
14 the other less invasive routes and, dare I say
15 it, the ones that are the most cost effective.

16 CO-CHAIR BAGLEY: Jim, go ahead.

17 MEMBER PACALA: Yes. Perhaps just a
18 consideration of a different numerator. The
19 numerator here was percentage of vaginal, maybe
20 we want to find out what the percentage of
21 abdominals is since that seems to be the one that
22 they're discouraging.

1 CO-CHAIR BAGLEY: Lower is better.

2 MEMBER SEIDENWURM: Oh and one other
3 point, just to amplify what Amy said earlier, I
4 think this would be another example of where when
5 we touch on one aspect of a procedure, we ought
6 to look at whether it was indicated, how it was
7 done, what the outcomes were, as well as just the
8 frequency, for example. That we really need to
9 have this kind of pyramid of Measures rather than
10 just look at one snapshot.

11 CO-CHAIR BAGLEY: Eric?

12 CO-CHAIR WHITACRE: I would add to
13 that, but I would add cost as well because I
14 think that's very important in discriminating the
15 cost effectiveness of these procedures.

16 CO-CHAIR BAGLEY: I have kind of a
17 question around that to Kate. To what extent
18 have you seen real appropriateness Measures
19 offered up? Across the board, I mean.

20 DR. GOODRICH: Yes. We've definitely
21 seen an increase in Appropriate Use Measures over
22 the last couple of years, especially that the

1 specialty societies are starting to develop and
2 sending in to us. So we are seeing more.

3 CO-CHAIR BAGLEY: You've let it be
4 known that those would be welcome from anyone?

5 DR. GOODRICH: We've been pretty clear
6 about what our priorities are, I think we've been
7 clear, you tell me if we're not, and Appropriate
8 Use is always on that list of Measure types we
9 are interested in.

10 CO-CHAIR BAGLEY: Great. Additional
11 comments on any of these Measures under
12 consideration? Any public comment or comment
13 from the phone on these?

14 OPERATOR: At this time, to make a
15 comment, please press Star 1. There are no
16 public comments.

17 CO-CHAIR BAGLEY: Okay. Rachel?

18 MEMBER GROB: I just wanted to make an
19 observation, with all due respect to everyone,
20 that it's very useful to have the Measure
21 Developers here for some of these questions and
22 I'm just reflecting on the sort of substantive

1 value of the MAP's deliberations relative to who
2 ends up being in the room. So, I mean, frankly,
3 I'm looking at this vote and I'm thinking, I feel
4 like personally I have insufficient information,
5 but I don't really know whether that means
6 there's insufficient information out there or
7 not. So just as sort of a process point, maybe
8 to hang on to for later, whatever we can do to --

9 DR. WINKLER: Rachel, let me just make
10 two observations. All the Developers were
11 notified and invited and encouraged to attend.
12 But one of the problems of us being so far ahead
13 of schedule that I'm a little bit concerned about
14 is they weren't expecting it to come up on the
15 agenda until a little bit later. That, I think,
16 is ---

17 MEMBER GROB: Well, that's kind of
18 worth, that's actually really worth considering.
19 And, again, I don't mean it as a criticism at all
20 of --

21 DR. WINKLER: Yes.

22 MEMBER GROB: -- NQF or the MAP or CMS

1 or even the Developers, but just a reflection as
2 a work group member who doesn't have substantive
3 expertise in a lot of these areas, that it's very
4 helpful to have that dialog because it produces a
5 richer understanding of what the Developer was
6 thinking of.

7 CO-CHAIR BAGLEY: Let me offer this.
8 If, and then I'll ask the Staff to help us, if
9 someone comes on the line later that we told what
10 time to come on, I'd be pretty open to a
11 reconsideration of things like this. So, I don't
12 think we have to -- we'll be easy about a motion
13 to reconsider, let's put it that way. So if you
14 guys would be on the lookout for them when they
15 come on, or contact them separately if you have
16 that option, that would be great. Okay. Are we
17 ready to vote? Anybody else have any comments?
18 I guess we're ready to vote. The first Measure
19 will be 15-437, route.

20 MS. CHAVEZ: Now voting for MUC15-437
21 for MIPS. Voting options, 1 Encourage for
22 Continued Development, 2 Do Not Encourage Further

1 Consideration, 3 Insufficient Information. For
2 those on the phone, please submit your votes via
3 chat. Thank you. Okay. And the voting results
4 for MUC15-437 for MIPS are 84 percent Encourage
5 for Continued Development, 11 percent Do Not
6 Encourage Further Consideration, five percent
7 Insufficient Information.

8 CO-CHAIR BAGLEY: Okay. Number 3 on
9 your agenda is MUC15-439, Testing for uterine
10 disease prior to obliteration.

11 MS. CHAVEZ: Okay. Voting is now open.
12 Okay. The voting results for MUC15-439 for MIPS
13 are 86 percent Encourage for Continued
14 Development, 14 percent Do Not Encourage Further
15 Consideration, zero Insufficient Information.

16 CO-CHAIR BAGLEY: The next one will be
17 MUC15-440 and this is Documentation of trial of
18 conservative management prior to fecal
19 incontinence surgery.

20 SSS: Okay. Now voting for MUC15-440,
21 1 Encourage for Continued Development, 2 Do Not
22 Encourage Further Consideration, 3 Insufficient

1 Information. Voting is open. The voting results
2 for MUC15-440 for MIPS are 90 percent Encourage
3 for Continued Development, 10 percent Do Not
4 Encourage Further Consideration, zero
5 Insufficient Information.

6 CO-CHAIR BAGLEY: And the final one
7 will be MUC15-441, Trial of conservative
8 management prior to urgency incontinence surgery.

9 MS. CHAVEZ: Voting is open. Those on
10 the phone, please submit your votes via chat. The
11 voting results for MUC15-441 for MIPS are 86
12 percent Encourage for Continued Development, 14
13 percent Do Not Encourage Further Consideration,
14 zero Insufficient Information.

15 CO-CHAIR BAGLEY: Okay. Well, thank
16 you very much. It's almost time for lunch, Eric.

17 (Laughter.)

18 CO-CHAIR BAGLEY: Let's keep on
19 trucking. I mean it's up to you.

20 CO-CHAIR WHITACRE: Do we have a
21 mechanism either to contact the Developers for
22 the subsequent sections so they know we're way

1 ahead of schedule? And maybe we should take a
2 couple minutes to do that and see if that's
3 successful? If so, let's take a little break and
4 see if we can resolve the discrepancy in the
5 schedule and planned call-ins.

6 (Whereupon, the above-entitled matter
7 went off the record at 9:24 a.m. and resumed at
8 9:37 a.m.)

9 CO-CHAIR WHITACRE: So, because we were
10 way ahead on the agenda, it turns out that the
11 group from interventional radiology is on the
12 line. Just to let them know, all of the Measures
13 were recommended for further development, except
14 for MUC ID 15-412, which was Assessment of post-
15 thrombotic syndrome following iliofemoral venous
16 stenting. But certainly we would invite you to
17 make any additional comments about that Measure
18 set.

19 DR. COLLINS: Sure. This is Jeremy
20 Collins with the SIR. So let me just take a
21 quick look at my notes here. That's 412 -- yes,
22 so that Measure was looking specifically at the

1 Villalta Score, I think, to evaluate the patient
2 reported symptoms and clinical findings that are
3 related to post-thrombotic syndrome. There is a
4 bit of overlap, I admit, with the Measure 413,
5 the Venous Clinical Severity Score.

6 In our discussions, which included our
7 venous service line, I apologize, the one
8 gentleman who was able to make it from the venous
9 service line had to step into a case and stepped
10 off the phone, they were thinking that combining
11 this in some way with 413 would be reasonable.

12 And we can certainly, once things progress
13 through the process here and we're maybe looking
14 to evaluate the Measure in more detail and
15 specify it, come up with either a combined
16 Measure that has both the Villalta Score and the
17 Venous Clinical Severity Score, or leave as-is
18 based on the comments.

19 CO-CHAIR WHITACRE: I think that
20 reflects discussion that also occurred at the
21 Committee level. That seemed --

22 DR. COLLINS: Okay.

1 CO-CHAIR WHITACRE: -- very reasonable.

2 DR. COLLINS: Great. Okay.

3 CO-CHAIR WHITACRE: Super. Were there
4 any other comments that you would like to make?

5 DR. COLLINS: I had -- yes. One other
6 comment, I noticed that there was a concern that
7 one of the quality of life surveys, the uterine
8 fibroid symptoms score, was something that one
9 had to pay for institutions to use outside the
10 research setting. I just wanted to reassure the
11 group there that individuals who would want to
12 use it for the purposes of quality reporting
13 would have access to it free of charge.

14 CO-CHAIR WHITACRE: Terrific. Thank
15 you. Well, that's great. Well, thank you very
16 much. I'm sorry that the agenda was a little bit
17 off timing, but we appreciate you calling in.

18 DR. COLLINS: Great. Thanks so much.
19 Appreciate it.

20 CO-CHAIR WHITACRE: Thank you.

21 DR. WINKLER: Is anybody on the phone
22 from the American Urogynecologic Society?

1 Operator, do you know?

2 OPERATOR: I don't see anyone online at
3 this time.

4 DR. WINKLER: Okay. Would you please
5 let us know if anyone does call in from that
6 organization?

7 OPERATOR: Yes, ma'am.

8 CO-CHAIR WHITACRE: Well, the thought
9 was that we could change the agenda by taking
10 some of the afternoon items and inserting them at
11 this point, but the feeling was, when Bruce and I
12 talked about it, that our thought processes will
13 be a little bit different and we'll be on a
14 different level, so that it made sense to move
15 ahead with the agenda and to invite the outside
16 groups to make comments, being very willing to
17 reconsider our votes if there are substantive
18 comments. If that's okay with everybody, we'll
19 move on to the next section then. This is the
20 gastroenterology Measures under consideration.
21 And, as always, we begin with public comment.
22 Are there -- oh, excuse me.

1 DR. WINKLER: Just in terms of the ten
2 Measures for gastroenterology, they're a little
3 bit different even though they're a group of
4 specialty Measures. They are from a practice in
5 Eugene, Oregon and not the specialty society per
6 se. These do address new condition areas,
7 particularly liver disease, and there are several
8 new endoscopy Measures. I think we should take
9 note of the comments that have been submitted by
10 the societies on these Measures.

11 CO-CHAIR WHITACRE: Please, Kate?

12 DR. GOODRICH: So I'd like to make a
13 comment, not specifically about these Measures,
14 but Amy reminded me that I should have mentioned
15 this yesterday and I failed to, I'm sorry. So,
16 many of you know that CMS and America's Health
17 Insurance Plans have been working together with
18 some of the professional societies and consumers
19 and practitioners to develop consensus around
20 core sets of Measures in particular areas. The
21 idea being that once we have consensus in these
22 areas -- and these are for existing Measures, by

1 the way, so we sort of tabled or put in a parking
2 lot thinking about specific gaps and priorities
3 for development just yet. And so there's been a
4 lot of work done over the last 18 months on this.

5 And the reason I'm bringing it up now
6 is because one of the topic areas that we have
7 developed consensus around is around liver
8 disease. So, particularly hepatitis C, sort of
9 we have it combined with HIV Measures. So, I
10 just wanted to recognize that and have people be
11 aware that, that has happened. We do plan, by
12 the way, to make these lists public. We're
13 aiming for the end of the year, so that's very
14 soon, but our goal is to do that.

15 And so the idea is that CMS would
16 include these core sets in our relevant programs,
17 MIPS would be a relevant program. I will say
18 that the vast majority of the Measures that are
19 in these core sets are already in our PQRS
20 program and that private payers would similarly
21 use these core sets in their contracts with
22 provider organizations as they come up for

1 renewal or if there's an opportunity to modify a
2 contract. We have about 70, 75 percent of
3 covered lives represented around the table. So,
4 anyway, a lot of great work that's gone on. NQF
5 has been at the table as well as this has
6 happened.

7 So, again, number one, I'm bringing it
8 up because I forgot to yesterday in my opening
9 remarks and, number two, given that we're at a
10 topic now that does include an area where we had
11 consensus around core sets, I just wanted to let
12 you know. It doesn't mean that we couldn't
13 consider some of these, we still want the MAP's
14 input, doesn't mean that we're not going to take
15 the MAP's input, but I will also say this process
16 with the private payers and CMS and the other
17 groups is going to be an iterative ongoing
18 process, it doesn't stop now, and so we know that
19 new and better Measures are going to come along
20 down the pike that we'll want to include and may
21 even replace some of the ones on the core set.
22 So it doesn't stop what we're doing now, but I

1 wanted the group to be aware that this has
2 happened. And happy to take any questions about
3 it, but, again, just apologize for not talking
4 about this yesterday.

5 CO-CHAIR WHITACRE: Thank you. I have
6 a question, if I could begin? What are the other
7 core sets?

8 DR. GOODRICH: Sure. So ACO primary
9 care medical home, which really tends to be
10 mostly primary care Measures. Hepatitis C/HIV
11 was one set that was sort of together. GI
12 Measures. And then OB/GYN, medical oncology,
13 cardiology. We also did orthopedics, but there's
14 so few orthopedics Measures, we ended up really
15 just talking about the hospital level Measures,
16 which this is really intended for ambulatory
17 care, the work that we've been doing. So those
18 are the ones. Oh, and pediatrics is happening
19 now, it hasn't -- we're not going to be releasing
20 pediatrics because it's much earlier in its
21 process than the others.

22 CO-CHAIR BAGLEY: To what extent does

1 the gastroenterology core set overlap with these
2 recommendations?

3 DR. GOODRICH: So, I think the
4 gastroenterology core set does not include these
5 on here, I don't believe, and, Amy, you can keep
6 me honest here. I can pull it up, I just don't,
7 in fact I will pull it up, I just don't have it
8 front of me. So these are different from what's
9 in the core set currently.

10 CO-CHAIR WHITACRE: Other questions?
11 Well, thank you very much, that's very helpful.
12 So if we can get back -- David?

13 MEMBER SEIDENWURM: Would now be the
14 time to pull for --

15 CO-CHAIR WHITACRE: Public comment
16 first.

17 MEMBER SEIDENWURM: Oh, sorry about
18 that.

19 CO-CHAIR WHITACRE: Reva did quick
20 overview. I'm sorry, we're getting this down.
21 I'm not quite, I'm a slow learner.

22 (Laughter.)

1 CO-CHAIR WHITACRE: So now it's time
2 for public comment on the gastroenterology
3 Measures. Is there anyone either in the room or
4 on the phone who would like to make a comment
5 about these Measures?

6 OPERATOR: Once again, to make a
7 comment, please press Star 1. There are no
8 public comments from the phone line.

9 CO-CHAIR WHITACRE: Thank you.

10 DR. MULLINS: So, Amy Mullins, AAFP.
11 And of the Measures that were proposed, nine were
12 on the core set and I appreciate Kate bringing
13 that up. I did have a note in my notes that the
14 MUC Number 230, but I don't know that it is in
15 this section, maybe it's not in these, so that
16 one was on the core set, but I don't see it
17 listed here. Oh, in the next batch? Okay. So
18 that one was in the core set in the -- but none
19 of the ones in this section were listed in the
20 core set. And I have a copy of those, Kate, if
21 you need them.

22 CO-CHAIR WHITACRE: Thank you. So if

1 there are no other public comments, I'd like to
2 let the Committee know that several Measures have
3 already been pulled. This is off the printed
4 agenda. And that is Measure Number 2, Number 3,
5 and Number 4, where once again Stephanie will
6 have the floor. Are there other Members who
7 would like to pull any other Measures? David?
8 Peter?

9 DR. BRISS: I'd also like to pull
10 Number 1, please, in addition --

11 CO-CHAIR WHITACRE: Number 1?

12 DR. BRISS: -- to the ones that
13 Stephanie has pulled.

14 CO-CHAIR WHITACRE: David?

15 MEMBER SEIDENWURM: I'd like to also
16 pull Number 1, Number 9, and Number 10. Yes.

17 CO-CHAIR WHITACRE: Terrific. Other
18 Members? Yes, Peter?

19 DR. BRISS: Yes, without pulling any
20 more off, because I don't think it's necessary, I
21 wanted to hear a conversation, much like I asked
22 for yesterday, about this entire set being sort

1 of compliance with treatment protocols kind of
2 Measures or standard procedures, standard care,
3 to see whether these really are robust enough to
4 move forward as something that really would
5 advance quality. So sort of a general
6 discussion, I suspect we'll hit that on talking
7 about any of these.

8 DR. WINKLER: Again, I will just note
9 that as we -- sort of the chronic problem across
10 the whole set of Measures, there was really very
11 little data on current performance to really know
12 what the current problem is or isn't among these
13 topic areas.

14 CO-CHAIR WHITACRE: Jim, are you
15 pulling a Measure or do I hand it over to
16 Stephanie? Stephanie, I think you're up.

17 MEMBER GLIER: Do we want to start with
18 the Barrett's Esophagus folks?

19 CO-CHAIR WHITACRE: We can start with
20 Number 1, if I was, I think Peter. We'll just go
21 down the list rather than order in which they
22 were pulled.

1 DR. BRISS: Yes. So briefly on these,
2 there were a number of issues with the whole
3 suite of endoscopy Measures. And, so, it appears
4 that not a lot is known about current
5 performance, not a lot is known about variation
6 in performance. And, so, there are issues if
7 these Measures go forward that need to be -- that
8 could be further sort of addressed on the science
9 side. On the specification side, a number of the
10 people that commented on these Measures noted
11 correctly that they could be better specified to
12 discourage overuse as well as encouraging
13 appropriate use of endoscopy.

14 So many of these Measures are
15 specified, I won't get into the Measure specs,
16 details, but they're things like, have you had an
17 endoscopy within the last year? And the
18 endoscopies aren't actually recommended that
19 often, it's often three to five years or
20 something like that. And so you could specify
21 the time courses more precisely to both encourage
22 appropriate use and discourage some overuse.

1 CO-CHAIR WHITACRE: Stephanie?

2 MEMBER GLIER: Yes, I'd like to echo
3 that. And I think to the extent that there is
4 the potential for the Society to consider
5 respecifying this as a single Measure of
6 surveillance for these conditions, I think we
7 could still get the data we need to understand
8 better how this is going forward without having
9 many discrete Measures that are not particularly
10 useful in addition to each other.

11 I wanted to thank the NQF Staff again
12 for their very thoughtful review on the hepatitis
13 Measures later in this set. I really strongly
14 agreed with your comments about how these
15 Measures could be made better, so I did not pull
16 some of those Measures because you had already
17 said the comments that I wanted to. So just
18 verbally endorsing what you had already said.
19 The specific comments that I wanted to make about
20 the Measures were to potentially combine the
21 Measures, but also on the Non-selective beta
22 blocker use, which is Measure 4 on our list --

1 oh, I'm sorry, one last comment for the Staff.
2 Listed on our agenda, Number 2 and Number 3 are
3 both titled MUC15-221, the second one is 212.
4 You got that already?

5 DR. WINKLER: That should be 212, the
6 third.

7 MEMBER GLIER: Yes. So, Number 4
8 though, the Non-selective beta blocker use in
9 patients with esophageal varices, I think NQF's
10 recommendations already were right on. It's
11 unclear to me how large the performance gap is
12 and I'm wondering again whether it would be
13 possible to develop this as a Patient Reported
14 Outcome Measure or a Functional Status Measure of
15 some sort? And, like I said in the last section,
16 if it is developed that way, I think it would be
17 really useful on Physician Compare. If it is not
18 developed that way, I would recommend against
19 further development.

20 CO-CHAIR WHITACRE: David?

21 MEMBER SEIDENWURM: So, this is kind of
22 a general comment about the endoscopy

1 surveillance colonoscopy. I think that,
2 particularly with respect to Measure Number 1,
3 the endoscopy for Barrett's Esophagus, I think
4 that we could do a lot of mischief here if we
5 went forward with a Measure like this unless it
6 were coupled with an overuse Measure for
7 endoscopy for GERD to begin with, because I think
8 that the problem is that, for many people, the
9 Barrett's Esophagus is a finding with not 100
10 percent inter-observer reproducibility among
11 endoscopists and pathologists, let's say.

12 And then the people who -- it also
13 occurs sort of somewhat in the asymptomatic
14 population, the screening population. So then,
15 you start with maybe a procedure that wasn't
16 indicated to begin with, you get to a finding
17 that's of uncertain significance, then you follow
18 it in order to detect a disease that we don't
19 know the treatment helps. So you kind of set up
20 a cascade here. So I'm kind of -- I'm
21 overstating the case a little bit for rhetorical
22 purposes, but not by a whole ton I don't think.

1 So I think if we were going to do this, we would
2 want to couple it with an overuse metric for GERD
3 endoscopy.

4 CO-CHAIR WHITACRE: Yes, Jim?

5 MEMBER PACALA: In Measures 1 through
6 3, again, the endoscopy Measures, I struggled
7 with this because it seems to me that the
8 American College of Gastroenterology states that
9 these are recommended procedures, yet the
10 comments from the American Gastroenterological
11 Association didn't support them. They didn't
12 specify why they didn't support them. And then
13 the society for the endoscopists themselves
14 didn't support it for the reasons that David's
15 talking about.

16 And I thought, well, that's pretty
17 powerful. If the endoscopists are saying, this
18 isn't quite settled and this could lead to
19 overuse of what we do, I thought that was a
20 pretty powerful statement. But I really, I'm not
21 a gastroenterologist, so I just had trouble
22 resolving or reconciling what appears to be

1 differences between the ACG, AGA, and AGSE or
2 whatever. I mean, it was tough for me. Does
3 anybody, can anybody shed any light on that or is
4 it what it appears to be, an internal conflict?

5 CO-CHAIR WHITACRE: Peter?

6 DR. BRISS: I can only interpret the
7 text of the comments. It didn't look to me like
8 people necessarily had issues with the Measure
9 concept, they did have issues with implementing a
10 Measure today sort of in a program, given that we
11 don't know much about current performance and the
12 Measures aren't necessarily specified to deal
13 with overuse, for example. So it didn't sound to
14 me like -- I didn't read the comments as being
15 opposed to further development of the Measure, I
16 thought that they did raise some issues that
17 would need to be addressed as the Developer goes
18 forward.

19 CO-CHAIR WHITACRE: Yes?

20 MEMBER AVERBECK: So I had a comment
21 about actually one of the comments on the Non-
22 selective beta blocker use. And one of the

1 comments was, because of the side effects,
2 patients don't take the medication. And I'm
3 unaware of any other Measure where we have used
4 the fact that there are side effects or patients
5 not choosing to take a medicine as a reason not
6 to have the Measure.

7 CO-CHAIR WHITACRE: Yes, Peter?

8 DR. BRISS: On that Measure, the issue
9 that one of the commenters raised that I thought
10 was perhaps most germane is that there are
11 multiple equivalent therapies that one could
12 choose and this one is picking one winner out of
13 a stable of appropriate therapies. And so that
14 would have been the primary issue on that one
15 that I'd like the Developers to actually think
16 hard about.

17 CO-CHAIR WHITACRE: Scott?

18 MEMBER FRIEDMAN: Again, from a non-GI
19 perspective, is the problem that there aren't
20 enough endoscopies being done or are there too
21 many or we just don't know? And then the other
22 issue is that, do the specialty societies, and

1 I'm sure there's some overlap, is it that they
2 don't agree with the recommendations and how do
3 you resolve that issue?

4 CO-CHAIR WHITACRE: Yes, Scott?

5 MEMBER FURNEY: So, as an internist
6 that deals with gastroenterologists, so I'm not a
7 gastroenterologist, the discussion of Barrett's
8 is a question of overuse. So within the GI
9 community and both reading the comments and from
10 my colleagues, that Measure is something that is,
11 without a Measure of overuse as many have said,
12 is potentially concerning to include as a
13 Measure, could actually increase inappropriate
14 use. The other Measures, I'm a bit more puzzled
15 and the comments are more mixed.

16 So in evaluating dysplasia for
17 Ulcerative Colitis and Crohn's is an important
18 condition and in reading the comments, it's not
19 clear what the contention is, one society would
20 support, one would not. And that for me, because
21 we don't know the gap in those Measures, I think
22 those two, referring back to the Developers and

1 actually having them work with the specialty
2 societies makes sense to me. And so my question
3 for the group is, can we get the people who
4 proposed the Measure and are developing the
5 Measure to actually work in a collaborative way
6 with the specialty societies to determine if the
7 Measure can be developed in a more appropriate
8 way?

9 CO-CHAIR WHITACRE: Yes?

10 MEMBER FRIEDHOFF: If I take off my
11 primary care hat for a second and put on my payer
12 hat, in terms of potential for underutilization
13 for things like Barrett's for example, sometimes
14 if the recommendation is over a multi-year
15 period, it's a little hard for us to tell because
16 individuals may not have the same insurance over
17 that period of time. But I can tell you that for
18 things like Barrett's and certainly for GERD, we
19 definitely see significant overutilization, and
20 it's very variable, significant regional, even
21 within a region, variation as you'd probably
22 expect for something like that. So I would also

1 encourage potentially looking at additional
2 Measures around overutilization. And one other
3 quick question, I noticed that AGA seemed to not
4 endorse anything on this list, including the
5 vaccines, which seemed fairly straightforward to
6 me, and I'm curious if there was a hidden message
7 in there somewhere in terms of the development
8 process?

9 MEMBER PELLEGRINI: So, kind of using
10 your comment as a starting point, I have a more
11 general comment about the public comments that
12 we've gotten here. And I'm wondering, it seems
13 to me, first of all, that it's in some ways
14 wonderful that we get any comments at all because
15 the MUC is open for 15 minutes I think for
16 comment, right, to file. But they are incredibly
17 helpful when we do get them, but some are, of
18 course, much more helpful than others. And I'm
19 wondering if there's any way that, I don't know
20 if this would necessarily be appropriate from
21 NQF, but if even we as a Committee could put out
22 a very brief statement to would-be commenters

1 about what is.

2 So for example, a long letter where
3 your position is buried somewhere in about the
4 twelfth sentence is less helpful than a two or
5 three sentence, we support or we oppose and this
6 is why. And from the AGA perspective, saying
7 that they oppose this is kind of helpful, but
8 knowing why would be a lot more useful in, is
9 this an internal conflict? Is this a lack of
10 evidence? Is this the fact that they actually
11 really hate this, but they don't want to say so
12 to some of their members who developed these
13 Measures? I mean, okay, they're not going to say
14 that. But it seems like maybe some very brief
15 parameters would benefit everybody.

16 CO-CHAIR WHITACRE: Just listening to
17 the discussion, it seems, and speaking just as a
18 member of the Committee, these seem to be
19 nascent, incompletely defined Measures where
20 there's not strong society support where we've
21 had an opportunity to learn how it might be
22 better for them to proceed if indeed these are

1 important Measures.

2 One is, we need substantive comments,
3 we need some sense of consensus, we need a sense
4 that perhaps the Measure Developers, if these are
5 a little controversial, need to be here. And
6 perhaps there's a way we would, and I again don't
7 know if this is our role, we have to stay within
8 our lanes of responsibility and so forth, but it
9 would be incredibly helpful to have these people
10 here to help us and it would be very helpful to
11 have more structured comments.

12 Comments are great, but we could say,
13 they will be easier for the Members to review,
14 and it has to do with simple time constraints,
15 these are part of the Committee. We get the
16 Measures, we have only a certain amount of time,
17 if we're going to digest your point of view, we
18 need it in a structured fashion. I think this is
19 incredibly valuable. I think some of our best
20 discussions are about some of the Measures that
21 we're least comfortable with, so it's always good
22 to have some like this on the list. If they're

1 all slam-dunk, we don't learn anything. Sorry,
2 end of discussion.

3 DR. WINKLER: Yes. Just in response to
4 that, Wunmi's over in the back room nodding, it's
5 certainly something we can add to the
6 introduction when we put the MUC list up for
7 comment to give little bit more directive. And
8 that feedback I think is very useful and we
9 welcome it, but I think we can --

10 CO-CHAIR WHITACRE: Yes, David?

11 MEMBER SEIDENWURM: Another area that
12 we could encourage the Measure Developers, I
13 think, with respect to these types of things is,
14 if we're going to have a Measure for a procedure
15 in which we're quite sure there's variation in
16 the way the procedure is performed, we know that
17 objectively for colonoscopy and I don't know as
18 much about the data for upper endoscopy, it would
19 also be good to include these and perhaps include
20 a composite with respect to the way the procedure
21 is performed. Was the terminal ileum reached?
22 Was the -- what was the withdrawal time?

1 I mean, all of the metrics that are
2 employed where there's a lot of variation and we
3 know that there's correlation with intermediate
4 outcome anyway. So I think if we are going to
5 have a metric that talks about some aspect of a
6 procedure and encourages people to do a
7 procedure, we ought to encourage people to do it
8 well. I mean, we don't want people to do more
9 bad anything, we want people to do more good
10 whatever it is.

11 CO-CHAIR WHITACRE: Luther?

12 DR. CLARK: Just a point of
13 clarification, did someone say earlier that these
14 Measures were put together by a group of
15 practitioners? And I guess my question there and
16 that may be the source of some of the
17 disagreement, how common is that? I mean, this
18 is a group practice that is submitting Measures
19 that would then be broadly applied and one would
20 assume that there are processes within the
21 structured organizations for which they belong.

22 DR. WINKLER: I mean, we don't have a

1 lot of information on who they are, the Eugene
2 Gastroenterologic Consultants and the Oregon
3 Endoscopy Center. The call for Measures that CMS
4 does is open to anyone and so I don't believe
5 there are any particular limits on who could
6 develop. This could be a very large group with a
7 large data structure. It's hard to -- I don't
8 think we know enough about it to say one way or
9 the other.

10 CO-CHAIR WHITACRE: Yes, Peter?

11 DR. BRISS: And Measures in general
12 come from all kinds of places, so there are some
13 Measure Developers that do huge numbers of
14 Measures and sometimes there are small boutique
15 shops that kind of own one Measure and there's
16 everything in between.

17 CO-CHAIR WHITACRE: David?

18 MEMBER SEIDENWURM: Well, I think that
19 we should evaluate the metrics on their own and
20 the source isn't as important. I mean, I think
21 politically of course, it's to be preferred if
22 the broader community of patients and other

1 stakeholders, doctors, whatever, approve a
2 Measure and like it, but I think a good Measure
3 wherever it comes from, is something that
4 deserves to be considered.

5 CO-CHAIR WHITACRE: Yes, Marci?

6 MEMBER NIELSEN: This may not be the
7 right place to offer these comments, but as we
8 spend so much time giving Reva and her team
9 advice about additional information we'd like and
10 maybe a little bit more of this and maybe a
11 little bit more of that, I'm drawn to the fact
12 that we are creating more problems for ourselves
13 in some regard because we have so much data in
14 front of us to evaluate these Measures that we
15 have become Measure Developers ourselves.

16 And my suggestion might be, every time
17 we, and maybe we need to have some consensus
18 about this, every time we ask for some sort of
19 new means by which NQF could help us evaluate a
20 Measure, we take something off their list that we
21 didn't find particularly useful because there's
22 such disparity in what we know as we sit here and

1 evaluate a Measure. If you're not a clinician,
2 I'm telling you, there is medical terminology
3 galore. If we did all of our homework, we non-
4 clinicians, to get to speed, we'd all be doctors.

5 (Laughter.)

6 MEMBER NIELSEN: And, as I said before,
7 I'm not good at math.

8 (Laughter.)

9 MEMBER NIELSEN: I am good at
10 statistics though, I pointed that out to somebody
11 yesterday. My other point would be, I can't
12 imagine that Reva's not sitting here going,
13 really, you know what, if you had just done A, B,
14 and C, you would be able, you any of us, to
15 better evaluate a Measure. So one thing I'd
16 maybe invite you all to do, is to say, to
17 maximize your participation on the MAP, our
18 suggestion is, and not just like, you guys give
19 us so much information, it is astounding what a
20 terrific job you do on that front and I am so
21 grateful for it, but I think you should start
22 bossing us around.

1 If you want to maximize your time at
2 a MAP meeting, here are the three things you must
3 do, here are three additional things that would
4 be of help, particularly if you are doing the
5 facilitation, because I can now talk about
6 advanced directives until the cows come home, but
7 did you notice we didn't even talk about it, that
8 was the thing I studied up most on. So I don't
9 know, Eric, I know you asked us to have some like
10 brainstorming and we're in the middle of the
11 Measure discussion, but because I have a flight
12 at 3:00, I wanted to make sure I got that in
13 there. Thank you, thank you, thank you to NQF
14 Staff for the job you do. Let's take some stuff
15 off your plate as we're putting stuff on and then
16 start bossing us around. The end.

17 CO-CHAIR WHITACRE: So we have on the
18 gaps list, lighter load, better instructions, and
19 little math, before we come to the meeting.

20 (Laughter.)

21 CO-CHAIR WHITACRE: Yes, Peter?

22 DR. BRISS: For the endoscopy Measures

1 in particular, I suspect we might be ready for
2 some decision making. And I would say that it's
3 sort of separate from the issue of the Developer.
4 These are kind of specialized Measures for
5 certain kinds of procedural people, but we
6 haven't thrown out Measures previously in this
7 meeting because they're kind of specialized for
8 certain kinds of procedural people. But we've
9 identified a number of things that if these
10 things went forward for further development, the
11 Developers would have to deal with. So they're
12 all sort of issues about how the Measures are
13 specified and how they would need to get a little
14 bit broader input so that we didn't have such a
15 hung jury and so we could probably try to get
16 some decision making on it.

17 CO-CHAIR WHITACRE: Do you have comment
18 first, Sophia?

19 MS. AUTREY: Yes. So I wanted to go
20 back to the question about the people that
21 actually submit the Measures to CMS. And really,
22 Reva, answered the question beautifully. This is

1 exactly what we do, we receive information and
2 Measures from a number of organizations and
3 societies. What we would hope is that those
4 societies or those organizations would work with
5 the specialists before submitting the Measure,
6 but we have received Measures in the past from
7 educational institutions and they did not talk to
8 the specialists that actually do it and so when
9 we have the Measure in front of us, the
10 specialists are like, no. So, that's why we
11 bring it here.

12 (Laughter.)

13 CO-CHAIR WHITACRE: That's a great
14 explanation, thank you. I agree with Peter --
15 oh, sorry. Yes, Gayle?

16 MEMBER LEE: I just had a real quick
17 question for Sophia. Because I am confused about
18 what the dynamic and what's going on between the
19 specialty society and the Measure Developers, did
20 the specialty society come to CMS directly at all
21 and raise any issues or can you shed any light on
22 what's going on here between the Developers and

1 the society?

2 MS. AUTREY: Well, if the Measure
3 Developer didn't contact the specialty society
4 prior to developing these Measures, then the
5 first time that the specialty society saw it
6 would have been when the MAP actually put it out
7 for comment. So, we have no idea what those
8 conversations were prior to the submission.

9 CO-CHAIR WHITACRE: Well, I tend to
10 agree with Peter that we've sort of come to a
11 mind on the endoscopy Measures and if it would be
12 okay with everyone, before we address the
13 hepatitis Measures, that we move ahead with a
14 vote on the first four Measures. So if there's
15 no objection, if we can go ahead and prepare to
16 do that. Sorry, Stephanie?

17 MEMBER GLIER: Can I just clarify? I
18 agree, I think we came to a consensus. I want to
19 be clear what I think that consensus is, which is
20 that the Measure either needs to be revised to
21 include an overuse component or it needs to be
22 paired with an overuse Measure.

1 CO-CHAIR WHITACRE: We have limited
2 choices on how we vote.

3 MEMBER GLIER: No, I agree. I'm not
4 saying --

5 CO-CHAIR WHITACRE: Yes.

6 MEMBER GLIER: -- we should change the
7 voting, I just want to be clear so that when the
8 Developer is looking at our feedback or when CMS
9 is going back looking at our feedback, it's clear
10 that even if this Measure is continued developed
11 as it is, if we say Encourage for Continued
12 Development, that's not what we mean, we mean it
13 has to include overuse.

14 CO-CHAIR WHITACRE: I think hopefully
15 the comments will reflect exactly what you have
16 said. I think that's where we have to come to
17 some agreement in how we send that message back.
18 Yes, Scott?

19 MEMBER FURNEY: So, as relatively new
20 to this Committee, it's not clear to me, and I've
21 had discussions with a number of people, what
22 happens to the recommendation to encourage

1 continued development? Because if that does not
2 return here and our comments are -- so what I'm
3 hearing is, this needs to be substantively
4 revised or abandoned. So, I guess what I'm
5 looking for is guidance on if we all believe that
6 the Measures in their current state are flawed
7 and we vote 1, Encourage for Continued
8 Development, that doesn't reflect the discussion.
9 If it's continued in the current vein, it would
10 be incomplete and I think most of the Committee
11 would not agree with them. So it just seems like
12 a simple question, should I vote 1 or 2? Because
13 I'm hearing 2 because we don't control the
14 output, unless I can better understand the output
15 once we're complete.

16 CO-CHAIR WHITACRE: I think these are
17 great questions and they're certainly going to
18 come up on my list of gaps, because I don't have
19 a complete understanding of this. So, great
20 question, needs to be discussed later, I'm not
21 sure I have the exact answer. Yes, Scott?

22 MEMBER FRIEDMAN: That's a great point.

1 Just to embellish this and get on new also. So,
2 a lot of the Measures are good, they just need
3 tweaking a little bit. And that's Encourage for
4 Continued Development. A lot of the Measures,
5 they bring up a point, but they probably need to
6 go in a different direction, so do we need to add
7 a fourth category? Instead of Encourage for
8 Continued Development or Do Not, we don't want
9 you to stop using it, but it needs to be tweaked
10 significantly. So maybe the NQF should consider
11 a fourth category moving forward for next year.

12 CO-CHAIR WHITACRE: Peter?

13 DR. BRISS: Yes. And what I was going
14 to say was that, I agree that we may need a finer
15 way of feeding back information, because I don't
16 think I've heard anybody say that a well-
17 constructed endoscopy Measure would be a terrible
18 thing, right? And so I don't think the message
19 that we're trying to send is, endoscopy Measures
20 are non-starters, they're public health and
21 clinical care trivial, and we don't want to see
22 anything like that back, right? And we don't

1 have any way to finely say -- we don't really
2 have a clean way of saying, a well-constructed
3 endoscopy Measure would be fine and this isn't
4 it, right?

5 (Laughter.)

6 CO-CHAIR WHITACRE: Yes, Rachel?

7 MEMBER GROB: Yes, I'm just put in mind
8 of the analogy of when you either review or
9 submit for review to a peer reviewed venue that
10 the options that you get are accept with
11 revisions, which would be like Encourage for
12 Continued Development, but then there's the very
13 important revise and resubmit, right? And you
14 will always be told when you revise, that does
15 not mean that we will accept it, but we've given
16 a lot of thought to this and we've given you a
17 lot of feedback and we need to see this back.

18 So, I just offer that as an analogy
19 that may resonate that may resonate with a lot of
20 people in the room because I think what we're
21 saying with these is, revise, like seriously
22 revise, and resubmit. But I agree that it's not

1 clear then how to vote. I will just offer that
2 I've been taking those, as I think has been
3 suggested, as a 2, because I don't think it's
4 clear enough to us what the Developer will do and
5 whether it will come back to the MAP in a way
6 that's satisfactory. But I think we need to
7 revise the categories.

8 CO-CHAIR WHITACRE: These are great
9 comments. There's also an ambiguity in my mind
10 as to whether or not we are really addressing
11 this vote to CMS and whether or not it should be
12 considered for these programs, which is
13 ultimately I thought the purpose of the
14 Committee. We've taken on the task, and I
15 believe rightly so, of providing feedback to the
16 Developers, because we're saying, hey, we'd
17 really like to see better Measures and we think
18 you're going in the right direction or you're
19 not. So there's a dual purpose and that's why I
20 think there's some ambiguity. I'm seeing this as
21 a message to CMS saying, I wouldn't even consider
22 this for any programs the way it is, or, yes, if

1 they did a little better and they got back to you
2 with revisions. So there's ambiguity as to the
3 audience. Peter?

4 DR. BRISS: And I don't want to speak
5 for my CMS colleagues, but I will say, so I'm an
6 old member of the Committee, and so CMS pays very
7 careful attention I think to what the MAP says as
8 a general principle. And so I find it unlikely
9 if you voted 1 and considered that a revise and
10 resubmit, with advice to CMS and advice to the
11 Developer, I think it seems to me to be unlikely
12 that CMS would know that all that conversation
13 happened and just kind of blindly accept a set of
14 unchanged Measures that we'd said might deserve
15 some further development.

16 CO-CHAIR WHITACRE: Yes, Beth?

17 MEMBER AVERBECK: So, listening to the
18 conversation, I'm going to use, I think we're
19 being very Minnesota nice because we really want
20 this to succeed, but I think to Peter's comment,
21 if it's significant revision, the conversation
22 may reflect don't encourage further consideration

1 with this particular Measure and the comments
2 around the revision. So that's just an
3 observation.

4 CO-CHAIR WHITACRE: I want more bad
5 Measures because we have better discussions.

6 (Laughter.)

7 CO-CHAIR WHITACRE: I think it's great.
8 No, that's true. Yes?

9 DR. ALEMU: I have a question. We are
10 spending a lot of time on Measures which are not
11 completed, which are not fully tested. We're
12 discussing here and taking a large amount of
13 time. Would it be, from CMS perspective, better
14 to have Measures which are already completed,
15 which are fully tested, so that we say, okay,
16 this Measure is relevant to our programs? If
17 there is something which needs to be changed on
18 those fully specified and completed Measures,
19 then it would be helpful to have the discussion,
20 I would say, at the same time.

21 Even if Reva may answer my question,
22 Medicaid has proposed to Measure Developers to

1 come in contact with them before they start
2 developing their Measures, I think, if I'm not
3 mistaken, so that they get ideas on how important
4 the Measure is, whether there are other related
5 or similar Measures, and so on. But even if CMS
6 says, this Measure is not applicable to our
7 programs, but the Measure Developers can use the
8 Measure for their specific societies for quality
9 improvement purposes. So I think I just need
10 clarification why we need to discuss a number of
11 Measures which are not fully tested and
12 completed.

13 CO-CHAIR WHITACRE: Sophia, if you
14 could help us out and then, Reva, if you could
15 speak from the NQF standpoint on what the MAP
16 does.

17 MS. AUTREY: Okay. So, from the
18 beginning of when Measure development starts from
19 the Measure Developer side, we actually reach out
20 to Measure Developers, especially the ones that
21 have Measures currently in the program, and let
22 them know that we are here, if you have concepts,

1 please discuss those with us. We're here,
2 available for any feedback. Some Measure
3 Developers take us up on that, some do not. And
4 those that do actually get much valuable feedback
5 from us and then go back and change it, revise
6 the Measure as needed, based on the feedback that
7 we provide. So we do not get that from all of
8 the Measure Developers, but we do offer that.

9 So, in the instance that a Measure
10 Developer submits a Measure through our call for
11 Measures and they've started testing, because
12 we've actually changed that, we used to accept
13 Measure concepts, that was not good, you guys
14 didn't have any idea what was going on when it
15 came to you. So we stopped doing that. We
16 actually moved it towards, it at least had to go
17 through some phase of testing first. It didn't
18 have to be fully developed because what if you
19 get to that fully developed phase and it comes
20 through the MAP, you've wasted a lot of time and
21 money. But if you started alpha testing,
22 realized it needed to be updated and changed, at

1 least you haven't gone fully through development
2 before it is submitted to MAP. So we have the
3 requirement that it at least had to go through
4 alpha testing before you can submit it and we
5 thought that, that was a nice medium.

6 CO-CHAIR WHITACRE: Reva first perhaps
7 and then Steve?

8 DR. WINKLER: Yes. From NQF's
9 perspective, the MAP work is very specified
10 towards supporting CMS, the Measures Under
11 Consideration list, to provide the pre-rulemaking
12 input. From NQF's endorsement side, we only are
13 looking for fully tested Measures to go through
14 the endorsement process. We also offer a lot of
15 up-front technical advice that different
16 Developers take or not depending. And we do a
17 lot of outreach and, frankly, spend a lot of time
18 at it. And so I think there are a lot of
19 resources, but it's highly variable on what's
20 going on out there.

21 So, one of the things that we are
22 spending a lot of effort on is integrating the

1 MAP and the endorsement processes to the degree
2 that we can. But as you see in this particular
3 set of Measures, very few Measures have been
4 through the NQF endorsement process, so we don't
5 have the benefit of the information that would
6 have been generated during that evaluation. So
7 it's a very dynamic, changing environment with
8 lots and lots of needs on the ground.

9 CO-CHAIR WHITACRE: Steve?

10 MEMBER FRIEDHOFF: It's maybe a newbie
11 question and maybe something that's sort of been
12 asked another way, but there's two tracks it
13 feels like. For Measures that are not fully
14 baked yet, we're either encouraging or we're not
15 encouraging for further development. And then
16 there's ones that are fully developed and we're
17 voting to support or not to support. So I guess
18 my question is, it makes sense to have that, you
19 don't want to be wasting a lot of energy and
20 resources if it's not going to pass the initial
21 muster for encourage or do not encourage, but if
22 we are encouraging something or we have a vote

1 like however this vote turns out, is the
2 implication that a not fully baked initiative
3 that we're supporting or encouraging further
4 development will then eventually come back for a
5 support or do not support vote?

6 Because I'm not sure I fully
7 understand then, I mean, I understand why you
8 would want to try to save the resources, but it
9 seems to me in the end, if some of the encourages
10 are not going to come back, then to me, I think
11 I'd only want to see the fully baked ones as
12 support or do not support, unless they come back
13 again.

14 DR. GOODRICH: Yes. We talked a lot
15 about that, whether or not we should only put
16 Measures on the MUC list that are fully baked.
17 We find that we are getting a lot more Measures
18 coming our way, particularly from the specialty
19 societies, and we thought it would be very
20 helpful to get some direction from the MAP, not
21 just for us, but also for the Developers, as to
22 whether -- I mean, these Measures are expensive

1 to develop, so we thought it would be very
2 helpful to get that kind of direction.

3 So, my experience with being a Measure
4 Developer is also that, when you have something
5 this early in the process that they often do
6 change considerably after you go through testing.
7 And so any Measure that comes to the MAP at any
8 point along the way, if it's undergone
9 substantive changes, we do bring it back.
10 Measures that don't undergo substantive changes,
11 we are not legally required to bring it back, but
12 I don't even know if we've been in that situation
13 yet where we've had Measures that have come so
14 early that then we haven't brought back because
15 they haven't undergone other changes. I don't
16 know if we've done that or not.

17 But certainly, I will tell you my
18 personal opinion is that the information we're
19 getting about the direction of these Measures
20 could really help make a lot of these Measures
21 better and we'd like to see that happen and so
22 they would then, I think a lot of these would, if

1 the Developers take the recommendations of the
2 MAP and go back, would then need to come back
3 through because they would be so substantively
4 different I think.

5 MEMBER FRIEDHOFF: And I'm not
6 discouraging --

7 DR. GOODRICH: Yes.

8 MEMBER FRIEDHOFF: -- bringing through
9 the ones early like you're doing, I guess the
10 follow-up question was then some assurance that
11 they would then come back if there --

12 DR. GOODRICH: Yes.

13 MEMBER FRIEDHOFF: -- to your point,
14 there was a significant change.

15 DR. GOODRICH: Yes, they would.

16 CO-CHAIR WHITACRE: Are these questions
17 for Kate?

18 MEMBER PELLEGRINI: Yes.

19 CO-CHAIR WHITACRE: Okay. Please,
20 Cindy?

21 MEMBER PELLEGRINI: So, Kate, would it
22 be possible or practical or helpful in the future

1 then, could we distinguish within some of these
2 Measure sets, would there be a way to say, these
3 are the ones that are fully baked and are really
4 genuine candidates for the next round of MIPS or
5 whatever program we're talking about? So these
6 are the fully baked Measures and these are the
7 half-baked Measures?

8 (Laughter.)

9 DR. GOODRICH: I think we can talk
10 through that with the NQF Staff how to
11 distinguish that. We do have, within the
12 information we send to NQF, at least within our
13 internal spreadsheets, which I think is what you
14 guys get, where they are in development. So
15 maybe we're just making assumptions that
16 everybody can see exactly where they are in
17 development and maybe we need to just have
18 something that makes that crystal clear.

19 CO-CHAIR WHITACRE: Peter, was it a
20 question again? I have two other people, David
21 and Stephanie.

22 DR. BRISS: It was.

1 CO-CHAIR WHITACRE: Yes.

2 DR. BRISS: It was sort of on this
3 point.

4 CO-CHAIR WHITACRE: Go ahead.

5 DR. BRISS: So a comment on this point,
6 as you're thinking about this in the MAP, the
7 other thing that you might think about is, Kate
8 and I and Girma, and several of the other people
9 around the table probably, were involved in
10 developing a cholesterol Measure, I just want to
11 give you sort of the other side of this story.
12 We've been working on a cholesterol Measure since
13 2013, before the last set of guidelines changed.
14 And we couldn't quite get it into this process
15 this year because people didn't feel like it was
16 baked enough.

17 And so what that means is that I've
18 got to keep explaining to my boss that when the
19 guidelines changed in 2013, and we started
20 sprinting pre-guideline change in 2013, the
21 earliest we can get a new Measure into programs
22 for a universally accepted high priority area

1 that everybody's sprinting on is 2017. And so,
2 one of the things that people are trying to
3 balance is this issue about trying to get
4 committees enough information and trying to
5 shorten some of these ridiculously long time
6 lines.

7 MEMBER SEIDENWURM: Yes. Well said.
8 So speaking as a Measure Developer for the moment
9 here, we find the process of these kind of
10 multiple sort of parallel pathways to be
11 extremely helpful because, as was mentioned, the
12 human and financial cost of developing a Measure,
13 even on a topic that might be important to a
14 specialty society that seems kind of trivial to a
15 group like this, it's hard. And to put in all of
16 that effort, and people really kind of have an
17 emotional commitment to these things after
18 they've been working on them for quite a while,
19 and then to find out that the whole concept just
20 isn't interesting to the program, would be bad.

21 So I kind of like the idea that things
22 are able to bundle up in their kind of nascent

1 states and then people can get feedback. Well,
2 yes, we're really interested in endoscopy, but
3 just not this way, is a good piece of feedback to
4 get before a lot of money and time are spent. So
5 I actually like the idea that the endorsement
6 people kind of know what the MAP is thinking, the
7 MAP gets to know what the endorsement people are
8 thinking, that the Measure Developers get to know
9 what CMS is thinking, and they get to know what a
10 community of their peers is thinking, and what
11 the other stakeholders, who they might not always
12 have access to. It's actually very, very hard as
13 a Measure Developer to get patient and payer
14 representatives to participate on these panels,
15 that's a lot of P's. So this is really -- you
16 guys are helping, we're helping I think. So I
17 kind of like it the way it is.

18 CO-CHAIR WHITACRE: Stephanie, did you
19 have something?

20 MEMBER GLIER: I was going to say
21 almost the same thing. Sort of from the other
22 perspective, from the whole program perspective,

1 one of MAP's roles is to flag gaps for CMS and I
2 think having this kind of a conversation about
3 where the Measures aren't exactly fitting what we
4 want is helping inform our conversation that
5 we're going to have, probably not at 2:00 or
6 whatever time is on the agenda, but a little
7 later today about where we really see the gaps
8 and the types of Measures that we'd like to see,
9 that I think can be helpful, both to the Measure
10 Developers who are paying attention to what we
11 say, I don't know who they are, and also to Kate,
12 who's thinking about where the program can go and
13 what is going to be most useful coming from a
14 body like this. So I think it's still a valuable
15 conversation, even if at the individual Measure
16 conversation level it feels a little off.

17 CO-CHAIR WHITACRE: Rachel?

18 MEMBER GROB: It's just to circle
19 around on some of these points that have been
20 made, I also really agree with what you said,
21 David. I think that it's a very valuable role
22 for MAP and for this group to be giving this

1 feedback. But, again, and, Kate, you were out of
2 the room for part of this discussion, although I
3 know your colleagues will relay it, I think the
4 discomfort that I have felt is that I think
5 there's a little -- we're still needing to align
6 how we describe these votes with an evolving
7 understanding of the MAP's kind of role in
8 informing ongoing development.

9 And so, I'm wondering, as a question
10 for you, whether given all of that's been
11 happening over the last two days, you're going to
12 take the feedback, whether the preponderance of
13 us voted 1 or 2 as sort of a little bit of
14 feedback, we have a little bit of feedback here
15 or we have a lot of feedback here if it's 2,
16 right, because we're not really in a position
17 given that these are half baked to kind of --
18 it's not so much a referendum as a discussion.
19 Is that how you're understanding it?

20 DR. GOODRICH: Yes, it is. And this
21 has evolved over the last couple of years really
22 where these kinds of Measures have been coming to

1 this group in particular more and more. I think
2 in the first year or two of the program, this
3 really didn't happen. And so I think we're all
4 learning sort of what's the best kind of input
5 for you all to give us about those. I think, for
6 us, it goes beyond just these three categories,
7 so if you're saying, Encourage for Continued
8 Development, maybe we could think about if that
9 becomes sort of with a condition, kind of like we
10 have conditional support, is there other
11 conditions associated with that? Something to
12 think about for later, for next year.

13 But I think what's underneath, the
14 conversation and the details that are underneath
15 each one of those recommendations, is what we
16 would want to take back in our conversations with
17 the Developers to say -- I mean, I'll just tell
18 you, personally, I've agreed a lot with what,
19 like personally, with what the MAP has said
20 around of these different Measures in terms of
21 combining Measures and making a composite or
22 incorporating shared decision making, very

1 difficult thing to do, all those sorts of things
2 make all kinds of sense. So I think we would
3 take these back to the Developers and say, hey,
4 this is what we heard, we think that this
5 actually really strengthens the Measures, let's
6 work together on this.

7 CO-CHAIR WHITACRE: Well, that's great.
8 Hopefully we're about ready for a vote then on
9 the first four Measures. But I have to let you
10 know and apologize that I made two mistakes in
11 the course of this discussion. One is, I
12 inadvertently characterized a group of Measures
13 as not being good, that was in levity and that
14 was to point from our internal discussions, and
15 that's not the way we communicate a message. I
16 apologize.

17 Second is that I neglected to agree to
18 the consent calendar. We have some Measures that
19 have not been pulled and we did not by consensus
20 agree to accept those. And those are Measures 5,
21 6, 7, and 8 on the printed sheet. So if I can
22 trace back and ask that we agree as a group that

1 those would be accepted as part of the consent
2 calendar, my next move would be then to ask if we
3 could vote on the first four Measures and then
4 come back for a discussion on 9 and 10.

5 So we agree to accept via the consent
6 calendar 5 through 8? If we can move on then to
7 a vote on 1, 2, 3, and 4, I would make the point
8 also that on the printed paperwork, Measure
9 Number 3 is actually MUC ID 15-212, not 221, and
10 you'll see the correct number on the screen. So
11 let's begin with Measure Number 1.

12 MS. CHAVEZ: Okay. Now voting on
13 MUC15-208 for MIPS. For those on the phone,
14 voting options are 1 Encourage for Continued
15 Development, 2 Do Not Encourage Further
16 Consideration, 3 Insufficient Information.
17 Voting is open. Okay. The voting results for
18 MUC15-208 for MIPS are 33 percent Encourage for
19 Continued Development, 62 percent Do Not
20 Encourage Further Consideration, five percent
21 Insufficient Information.

22 CO-CHAIR WHITACRE: The next Measure

1 would be Number 2 on the printed agenda,
2 Surveillance colonoscopy for dysplasia in
3 Ulcerative Colitis, MUC ID MUC15-221.

4 MS. CHAVEZ: Voting is open. Okay.
5 The voting results for MUC15-221 for MIPS are 23
6 percent Encourage for Continued Development, 73
7 percent Do Not Encourage Further Consideration,
8 five percent Insufficient Information.

9 CO-CHAIR WHITACRE: The next Measure,
10 Number 3, is Surveillance colonoscopy for
11 dysplasia in colonic Crohn's Disease, MUC ID
12 MUC15-212.

13 MS. CHAVEZ: Voting is open. And the
14 voting results for MUC15-212 for MIPS are ten
15 percent Encourage for Continued Development, 81
16 percent Do Not Encourage Further Consideration,
17 ten percent Insufficient Information.

18 CO-CHAIR WHITACRE: And, lastly, Number
19 4, Non-selective beta blocker use in patients
20 with esophageal varices, MUC ID MUC15-209.

21 MS. CHAVEZ: Voting is open. The
22 voting results for MUC15-209 for MIPS are 23

1 percent Encourage for Continued Development, 73
2 percent Do Not Encourage Further Consideration,
3 five percent Insufficient Information.

4 CO-CHAIR WHITACRE: Great, thank you.

5 If we could move on then to a discussion of
6 Measures 9 and 10 on the printed agenda. This is
7 Screening endoscopy for varices in patients with
8 cirrhosis and Screening for Hepatoma in patients
9 with Chronic Hepatitis B, which were pulled for
10 discussion. I can't remember exactly who pulled
11 them. David, was it you?

12 MEMBER SEIDENWURM: I pulled the one,
13 Screening for Hepatoma. There's a couple things
14 about this that I think the Committee should
15 consider and maybe CMS should consider along the
16 way. The first is that the way this is
17 specified, it includes screening with CT and MRI
18 along with screening with ultrasound, and the
19 cost difference is high, the radiation,
20 especially since the hepatoma type protocols
21 involve multiple phases and so that's a pretty
22 big exposure to radiation. And presumably this

1 is an ongoing thing that would be a long-term
2 process, multiple procedures, in a sort of low
3 risk, well, it's an elevated risk population, but
4 the absolute risk isn't super high. So that's
5 something to consider.

6 Now, I think I know why they specified
7 it that way, because they didn't want someone to
8 get an ultrasound if they'd already had a CT or
9 an MRI for some other reason, right? So I kind
10 of get that, but there must be a way to thread
11 that needle or there might be a way to thread
12 that needle. And, then -- that's a technical
13 point, but the real big issue is, we don't really
14 know if this does any good or a lot of good in
15 terms of the actual outcome of the patients.

16 We do know, as a fact, that we do get
17 smaller, earlier, lower stage hepatomas when we
18 do this, and I've personally read hundreds of
19 these and I've found one hepatoma and I felt
20 really good about it. But what I don't know --
21 and we do know that finding things at the
22 earlier, well, we do know that when they present

1 at the earlier stage that they have a better
2 outcome, but what we don't know is if the ones we
3 find screening get you to the better outcome, and
4 we also don't know if all of the hemangiomas and
5 other things that we find along the way mitigate
6 that.

7 So it's rather like the discussion
8 that we had before about prostate cancer, that we
9 have this thing that we can point to people who
10 we think we've helped, but we're not really sure.
11 So I think we have to really consider this
12 carefully in the overall context of care and
13 really where the data are. And it seems to me
14 that this is a common enough disorder,
15 particularly in some of the Asian countries where
16 there are advanced medical systems that can study
17 this question in detail, and it sort of surprises
18 me that we don't have proof that this works yet.
19 And I'm wondering if we want to encourage
20 something like this before we really know that.

21 CO-CHAIR WHITACRE: Thank you. Did you
22 have a sense of why there were no public comments

1 on that? I would have thought the radiology
2 societies would have said there's no documented
3 advantage for screening or perhaps maybe they
4 didn't want to throw rocks, I don't know. Okay,
5 sorry, just wasn't sure. Question?

6 MEMBER SEIDENWURM: Maybe because it
7 was over the Thanksgiving weekend.

8 CO-CHAIR WHITACRE: Scott?

9 MEMBER FRIEDMAN: So I'm looking at the
10 public comments, there is consensus that the
11 American Gastroenterologist Association and the
12 American Society of Gastrointestinal Endoscopy
13 don't endorse it. So I don't think it gets any
14 clearer than that, so who likes the measure? If
15 their own docs don't like it, representing the
16 specialists don't like it, who likes it?

17 CO-CHAIR WHITACRE: Peter?

18 DR. BRISS: These two measures
19 essentially look to me like they have all the
20 problems that we had in the first set of measures
21 and even less evidentiary basis.

22 CO-CHAIR WHITACRE: Any other

1 discussion? If not, we'll proceed with the vote.
2 This will be first on Measure Number 9. This is
3 Screening endoscopy for varices in patients with
4 cirrhosis, MUC ID MUC15-251.

5 MS. CHAVEZ: Voting is open, and for
6 those on the phone, voting options are 1
7 Encourage for Continued Development, 2 Do Not
8 Encourage Further Consideration, 3 Insufficient
9 Information. The voting results for MUC15-251
10 for MIPS are zero Encourage for Continued
11 Development, 100 percent Do Not Encourage Further
12 Consideration, zero Insufficient Information.

13 (Laughter.)

14 CO-CHAIR WHITACRE: Okay. Last measure
15 is Number 10, Screening for Hepatoma in patients
16 with Chronic Hepatitis B, MUC ID MUC15-217.

17 MS. CHAVEZ: Voting is open. Okay.
18 The voting results for MUC15-217 for MIPS are
19 zero Encourage for Continued Development, 100
20 percent Do Not Encourage Further Consideration,
21 zero Insufficient Information.

22 CO-CHAIR WHITACRE: Well, that

1 concludes the gastroenterology measures. Perhaps
2 we can track back and see if anyone is on the
3 line for the previously presented measures on
4 urogynecology. Operator, is there anyone on the
5 line waiting to comment on those?

6 OPERATOR: We just have some CMS and
7 NCHPC online.

8 CO-CHAIR WHITACRE: Great, thank you.
9 Let's move on.

10 CO-CHAIR BAGLEY: Okay. For those of
11 you who are following us on the agenda, I hope
12 you enjoyed your lunch.

13 (Laughter.)

14 CO-CHAIR BAGLEY: We'll proceed with
15 the measures under the miscellaneous topics.
16 And, Reva, do you want to set this up and then
17 we'll have some public comment?

18 DR. WINKLER: Yes, this one is the grab
19 bag. There are onesie-tvosie measures of a wide
20 variety of topics, so we kind of put them all
21 together. There's no other relationship among
22 the measures except that, so they pretty much

1 have to be looked at not as a group, but as a
2 collection of individuals. And there is a good
3 mixture of types of things in it. For instance,
4 we have the first measure of the depression
5 utilization, this is an Outcome Measure. This
6 has been in PQRS for a while. It's an NQF-
7 endorsed measure; we know a lot about it.

8 Then, we see again the measures you
9 talked about in the MSSP, the PQI 91 and PQI 92.
10 These are measures which we had talked about
11 previously. As I mentioned, both of them,
12 they're still being developed, the risk model,
13 and when I updated the discussion guide, I
14 updated it in the MSSP, but it looks like I
15 didn't update it here. My bad; I'm sorry about
16 that. But, again, we should be consistent across
17 them, but these are essentially the same kind of
18 measures you've talked about previously.

19 We do have some interesting new
20 measures. One Potential Opioid Overuse, again,
21 there are some existing measures around opioid
22 use in the clinician set. This would be

1 potentially an added measure. There is also a
2 measure of HIV screening for patients with
3 sexually transmitted diseases. So, again, both
4 of these two -- the opioid and the HIV screening
5 -- are still in development. There is another
6 measure still in development for anesthesia,
7 anesthesiologists on corneal injuries that were
8 not diagnosed in the post-anesthesia care
9 recovery unit, so an anesthesia complication
10 measure -- if you will -- for a wide variety of
11 patients undergoing surgery.

12 And then there are two measures for
13 audiologists, which are, of course, clinicians
14 that are involved in the measurement programs,
15 and there are two measures still in development
16 that would apply to audiologists. And then,
17 again, on the list is the same ischemic vascular
18 care composite measure that we talked about in
19 the MSSP being under consideration also for the
20 MIPS program. So it is a bit of a grab bag, so
21 we kind of put them all together at the end.

22 CO-CHAIR BAGLEY: Okay, thank you. I

1 think the next is to have some public comment.

2 Amy, I see you queueing up over there.

3 DR. MULLINS: So I wanted to speak
4 about the paired depression measure.
5 Specifically, in the Core Measures Collaborative,
6 we had a lot of discussion around depression and
7 depression measures. And we chose two different
8 depression measures; we chose NQF Measure Numbers
9 710 and 1885. One of these -- I mean, these are
10 not those measures. I think Depression Remission
11 at Twelve Months is depression measure 710, but
12 the ones it's paired with are not 1885.

13 The other thing I wanted to speak to
14 is we did a lot of weeping and gnashing of teeth
15 and compromise around depression, and it probably
16 took 18 months to get a Core Measure Set because
17 of the depression measure. And the problem with
18 the remission measure is that it is asking for a
19 PHQ-9 score of less than five. And when I was in
20 practice, I had a lot of patients that came in
21 and they would have a PHQ-9 score of over 20, and
22 to get them to a ten was a huge success. Getting

1 them to less than five was going to be virtually
2 impossible, so asking for a depression remission
3 at six months with a PHQ of less than five and
4 then again at 12 months with less than five would
5 be really, really difficult. And to put this as
6 a composite measure is going to be a challenge.
7 And so, I would recommend that this not go in the
8 MIPS program and, instead, use the core measures
9 that the work group decided on after much, much
10 deliberation. Thanks.

11 CO-CHAIR BAGLEY: Okay. Did you have
12 a comment, Eric?

13 CO-CHAIR WHITACRE: No.

14 CO-CHAIR BAGLEY: Okay. I guess we're
15 open now to other comments. Why don't we do an
16 extraction first? Because we're going to -- and
17 would anybody -- as a courtesy -- like to extract
18 Number 1?

19 MEMBER NIELSEN: I would.

20 CO-CHAIR BAGLEY: Okay. All right.
21 Oh, I'm sorry, they should be on your agenda.
22 Number 3 has been pulled -- 7, 8, and 9.

1 MEMBER GLIER: And since I'm the one
2 who pulled 3 and we talked about it yesterday,
3 I'm happy to unpull 3, unless somebody else wants
4 to talk about it.

5 CO-CHAIR BAGLEY: So anybody else can
6 pull it. Would you like to pull 4?

7 MEMBER PELLEGRINI: Yes, 2 and 4.

8 CO-CHAIR BAGLEY: So 2 and 4? Okay.
9 So, remaining on the consent calendar, I have 3,
10 5, and 6.

11 DR. WINKLER: I just wanted to clarify

12 --

13 CO-CHAIR BAGLEY: Please.

14 DR. WINKLER: -- that the preliminary
15 analysis should be changed to match what it was
16 for MSSP. All right. So as part of your consent
17 calendar so that the two are consistent. All
18 right.

19 CO-CHAIR BAGLEY: One of the things I
20 was going to do with the consent calendar this
21 time particularly is to review the
22 recommendations. So would you help me find a

1 discrepancy if there is one?

2 DR. WINKLER: Yes.

3 CO-CHAIR BAGLEY: Okay.

4 MEMBER GLIER: And is 3 still on the
5 list, or is 3 pulled?

6 CO-CHAIR BAGLEY: Three is not
7 currently pulled. Do you want it pulled?

8 MEMBER GLIER: Yes, sorry.

9 CO-CHAIR BAGLEY: Okay. It's now back
10 on the -- so now I have 5 and 6 on the consent
11 calendar. Going once, going twice. Okay, absent
12 any other hands, we're going to leave 5 and 6 on
13 the consent calendar, and unless there's any
14 objection, we'll accept those as recommended by
15 the staff recommendation. Okay. Let's go to
16 Number 1. And you've heard Amy's conversation,
17 other comments?

18 MEMBER ADIRIM: I have a question.
19 This is Terry.

20 CO-CHAIR BAGLEY: Go ahead.

21 MEMBER ADIRIM: So within MIPS, are
22 there any other depression measures? And, if so,

1 what are they?

2 DR. GOODRICH: So, there's the 710 --

3 MEMBER ADIRIM: Okay.

4 DR. GOODRICH: -- is in MIPS. Well,
5 it's in PQRS.

6 DR. WINKLER: Yes. They can pull up
7 the list.

8 DR. GOODRICH: Oh, okay.

9 DR. WINKLER: I was going to say, go
10 ahead and pull it up.

11 DR. GOODRICH: And I think there's
12 0418, which is screening with follow-up plan, has
13 been in there for a while.

14 DR. WINKLER: This is the spreadsheet
15 that you have as the framework that has all the
16 measures listed out that are currently in the
17 programs. So we'll just try and grab that and
18 pull it up.

19 MEMBER GLIER: And can I clarify, Amy,
20 I don't know if you are -- I'm sorry, I should
21 have this list, but I don't. Did you say the
22 Core Measure Set currently has 710 and 1885? And

1 to clarify for those of you who don't have the
2 QPS pulled up in front of you, 1885 is depression
3 response at 12 months progress towards remission.
4 And maybe Beth is well positioned to talk about
5 those measures briefly, since she belongs to that
6 organization.

7 CO-CHAIR BAGLEY: Marci, I think you
8 were next.

9 MEMBER NIELSEN: Thank you. I share
10 the same concerns that Amy has, but I do want to
11 underscore -- as I mentioned yesterday -- how
12 incredibly important these behavioral health
13 measures are. So, understanding that we've got
14 some other measures in place, and we've got this
15 work that is happening and hopefully announced by
16 the end of the year on a Core Measure Set, an
17 additional item that I might flag that we've not
18 talked about before -- and it's very hard
19 structurally to get at -- but we spend lots of
20 time focusing on individual disease measures
21 without recognizing that that's not really how
22 diseases manifest themselves in people in that

1 the comorbidity -- people having multiple things
2 going on at the same time -- is what often is the
3 reason why a patient can't "comply" with what
4 their physician or their nurse practitioner is
5 asking them to do.

6 So, some place in the record, I just
7 want to reflect that some of the complicating
8 factors of doing measurement development well is
9 that we don't have many measures that relate to
10 multiple comorbidities, of which behavioral
11 health -- depression in particular -- would be at
12 the top of that list.

13 CO-CHAIR BAGLEY: Other comments? Go
14 ahead, Beth.

15 MEMBER AVERBECK: Just a question on
16 the way the measure is proposed is that either
17 remission at six months or at 12 months? I just
18 was trying to understand. Yes, I've got the
19 specs pulled up. It looks like it's either at
20 six months or 12; see, we get a credit for either
21 one is the way I'm reading it.

22 And in response to the comment

1 earlier, certainly responses improving by 50
2 percent, remission is an absolute value under
3 five, and obviously remission is harder to
4 achieve than response. I think it depends on, is
5 the goal of the measure to see improvement, or do
6 we really want to push how many patients do we
7 get in complete remission -- understanding that,
8 that's going to be a lower amount? So I think
9 that's just something to take into consideration.

10 CO-CHAIR BAGLEY: David, you're next.

11 MEMBER SEIDENWURM: Sure. So, I just
12 pulled up the survey and to get a score of below
13 five, you have to answer Not at All to -- in the
14 last two weeks -- little interest or pleasure,
15 feeling down, depressed, hopeless, sleep
16 disturbance, feeling tired, appetite, feeling bad
17 about yourself. So I think that given also the
18 fact that you have the choice between Not at All
19 to get your points and maybe if the MUC were two
20 days longer, we might not score. I wonder if
21 that's the -- sorry, MAP.

22 (Laughter.)

1 MEMBER SEIDENWURM: I wonder if that is
2 the right metric. And I don't treat depression
3 in my practice, but it seems a pretty high bar,
4 and I'm not sure how good of a metric that would
5 be.

6 CO-CHAIR BAGLEY: Jim, you were next
7 and then Amy.

8 MEMBER PACALA: Five is the cut-off for
9 the screen. That's why they're using five, I
10 think. So, again, to go from 20 to five -- or to
11 go from eight to five -- is a very different
12 clinical situation.

13 CO-CHAIR BAGLEY: Amy?

14 MEMBER MOYER: I was just going to say,
15 it's my understanding this is an incredibly well
16 validated and accepted tool, and we don't really
17 need to rehash it here. The data that collected
18 for this -- if I'm understanding correctly -- you
19 can calculate all these measures, so the burden
20 is the same whether you're collecting the
21 remission or whether you're collecting the
22 improvement. I'm usually all about fewer

1 measures and measure parsimony, but in this case,
2 I'd hate to see us lose the more ambitious
3 measure at the expense of going for the others if
4 the burden is the same. This is an area where we
5 could display all these things without additional
6 data burden on providers.

7 CO-CHAIR BAGLEY: Winfred?

8 DR. WU: I just have a question on the
9 core measure collaborative and what it's charged
10 with and what the implications of that group's
11 findings are with respect to CMS programming.

12 CO-CHAIR BAGLEY: Kate, do you want to

13 --

14 DR. GOODRICH: Sure. So, the
15 commitment that we and the private payers have
16 made is that we will implement or, for us, we
17 have to propose measures, so we can't, of course,
18 say what we would definitely finalize, but that
19 we would propose the measures that are in the
20 core set. And that does include removing
21 measures under those same topics that may already
22 be in the program, for example. And private

1 payers have made a commitment to doing the same
2 thing through their contracts. So, that's really
3 what it means.

4 CO-CHAIR BAGLEY: Scott?

5 MEMBER FURNEY: Echoing Amy's comments,
6 if the burden is the same for collecting the
7 information and our goal is remission --- which
8 may be unrealistic for a proportion of the
9 patients -- what we really have is a concern
10 about risk adjustment. So, I'd like to think at
11 least briefly about the downside risks of having
12 a measure that is more aggressive. And the more
13 aggressive the measure, the more risk there is
14 that patients who have treatment-resistant
15 depression, unless there's a risk adjustment,
16 would have difficulty accessing care. So that is
17 my only concern about setting a high bar.

18 In other words, if we were all seeing
19 in primary care the average depressed patient, we
20 should all have the same number -- if we work
21 hard enough -- who get into remission. But there
22 will be a selection bias in treatment-resistant

1 patients who are the sickest of the sick, may
2 have difficulty because providers -- once there's
3 a financial incentive -- may avoid those
4 patients. So my only concern about the measure
5 is that unless we have a risk adjustment for
6 treatment-resistant depression -- which is a
7 pretty advanced state to be in as a measure --
8 then we are building in a disincentive for the
9 sickest patients.

10 CO-CHAIR BAGLEY: Mady?

11 DR. CHALK: And there are a lot of
12 patients, I've looked at what the exclusions were
13 here, and the only exclusions -- or the primary
14 ones -- have to do with people in nursing homes
15 or with other major diagnoses. But there are a
16 lot of patients, such as disabled patients, who
17 will be depressed and will continue to suffer
18 from some level of depression and are never going
19 to reach less than five on a PHQ-9. And I would
20 be concerned that those -- I want to make sure
21 that those people can still get treated
22 appropriately if we implement this.

1 CO-CHAIR BAGLEY: I think from my
2 clinical background, I think that people with
3 three or more episodes of depression over their
4 lifetime are, at least in our minds, are
5 considered chronically depressed and may never
6 reach the level. Let me offer something that
7 might be worthwhile considering, I think that
8 there isn't anybody around the table that doesn't
9 think this is important and that remission is
10 important.

11 I think I hear the problems, number
12 one, with harmonization. In other words, they
13 all ought to be the same. And number two, with a
14 concern about setting a specific number as the
15 target. And that probably needs to have some
16 careful scrutiny. So, one of our options is
17 either to support or conditional support, based
18 on those kind of comments. Is that right?

19 DR. WINKLER: Yes, definitely.

20 CO-CHAIR BAGLEY: Go ahead, Steve.

21 MEMBER FRIEDHOFF: Yes. I agree with
22 that, and I think that one potential way that

1 developers can look at it, and I'm sure that
2 there's others, are based on PHQ-9, there's also
3 standard ranges from mild to moderate and
4 moderate to severe and severe. So maybe a
5 measure like mild or moderate getting to a target
6 of five, moderate to severe and severe getting to
7 a target of five, that's sort of inherently risk
8 adjusted. I'm sure there's other approaches like
9 that, that could be used, but to your point.

10 MEMBER FURNEY: I was just going to, I
11 think, Steve just covered that to some degree.
12 I'll just add that if an Improvement Measure,
13 really we should be able to get 80 percent of
14 patients with moderate depression, and the
15 severes will be happy to get them to the mild to
16 moderate range, then some version of an
17 Improvement Measure would, I think, meet the
18 intent. But, I mean, I would agree that this is
19 an incredibly important measure, I don't want to
20 have it lost in the conversation, but the measure
21 probably needs some improvement.

22 CO-CHAIR BAGLEY: Beth, you're next.

1 MEMBER AVERBECK: Being part of the
2 measure development in this area, the
3 conversation was around obviously a goal of
4 remission with a response also as a kind of
5 intermediary goal, recognizing not everyone would
6 get into remission. And that's why it was a 50
7 percent response rate, instead of looking at the
8 category. So that was discussed, but that's why
9 we went with a response rate. I mean, I do like
10 the suggestion, if -- this is a very important
11 topic and is one of our options to say, support
12 and look at the response rate as opposed to
13 remission, at least in the initial stages, as
14 more people are used to using the metrics. And,
15 Amy, you're right, the measurement burden isn't
16 different, I mean, you collect at different data
17 points, it's a PHQ-9, and so there's no added
18 burden for doing that.

19 CO-CHAIR BAGLEY: Jim?

20 MEMBER PACALA: I just wanted to chime
21 in about the concerns about unintended
22 consequences for adverse selection. I take care

1 of a lot of immigrant patients in Minneapolis who
2 have been tortured and have life-long, years long
3 pattern of depression and PTSD, and so I would be
4 judged on this. And we've got team care and
5 we're doing our very best to care for these
6 patients, but it's a big challenge, certainly, to
7 get their PHQ scores below five. And I would
8 hate to see anything that would discourage a team
9 to care for these patients. Do we have any idea
10 whether measures like this are actually creating
11 adverse selection? That they're serving to drive
12 providers away from the patients who most need
13 care? Do we have any sense of that out there?

14 CO-CHAIR BAGLEY: Scott's got his hand
15 up; he's got all the answers.

16 MEMBER FURNEY: So, I can only point to
17 the literature. It's been years since I read it,
18 but in Great Britain, the implementation of their
19 payment for value system, which now has 15 years,
20 that's one of the first things that was commented
21 on. In the system that I represent, 650 primary
22 care physicians -- just in the discussion of

1 putting intent on quality measures -- I'm seeing
2 patients moved around so much that I'm actually
3 developing a retention measure, a percent having
4 to be retained in practice of diabetics because
5 of my grave concern about the balancing measure
6 needed to prevent patients from being moved
7 around.

8 I'll make one other -- sorry, Amy, I
9 think I'm more cynical than you, one other very
10 cynical point. The people in this room are self-
11 selected and selected for good reasons to be
12 leaders in their field. We have to remember
13 these measures are then taken and distributed
14 across a large population of physicians who will
15 have varying degrees of interest in them and
16 varying degrees of motivation. So, I think we
17 have to think about unintended consequences, I
18 see them regularly in my attempt to regulate
19 quality in a large system.

20 CO-CHAIR BAGLEY: Beth, you were next.

21 MEMBER AVERBECK: I think our
22 experience in Minnesota has been that most

1 systems have gone to looking at PHQ-9 as a vital
2 sign for patients and so being more aware of it
3 in collaborative practices with behavioral
4 health, which is a scarce resource in our state.
5 So, I think maybe that some of the local context
6 might be different, but I think we've seen it
7 certainly raise awareness in looking at how we do
8 more system, team-based care to address it.

9 CO-CHAIR BAGLEY: David, you were next.

10 DR. ALEMU: Yes. I have a question.
11 Is the goal stated in this measure -- I mean, to
12 achieve it -- is it really difficult? Is there
13 any literature or number that tells us that the
14 goal is not achievable when it comes specific to
15 this measure? And I don't want to get this
16 measure lost; it's a very important public health
17 issue. And the components are indicating those
18 fully tested and they are being used. So is
19 there any information that tells us that the goal
20 is not achievable by using this measure?

21 CO-CHAIR BAGLEY: Can anybody kind of
22 direct their comments on that specific question?

1 DR. ALEMU: Because at the beginning,
2 the first speaker told us that -- from the
3 practical point of view -- it was difficult to
4 achieve what is really intended here. So, I
5 would like to get information about that. And I
6 don't want this measure to get lost because it's
7 really a very important issue.

8 CO-CHAIR BAGLEY: Beth or Amy, do
9 either one of you have any --

10 MEMBER AVERBECK: Yes. I was actually
11 trying to look it up. I know there is variation,
12 I think, for the remission, it's been anywhere
13 from 8 percent up into some 25, 30 percent for
14 remission. I remember when we did optimal
15 diabetes, we started at 4 percent and we're now
16 nearing 50 percent -- that's taken a number of
17 years -- but certainly there's variation in the
18 results. But so far, I know like 75 percent
19 probably isn't achievable, but there is a range.

20 MEMBER SEIDENWURM: Yes. I wanted to
21 go back to the issue of adverse selection. I
22 think that there are some areas where you want to

1 discourage adverse selection, like this one, and
2 I think that there are some areas where what's
3 called adverse selection is actually proper care.
4 And I think we want to distinguish among the
5 clinical situations in which -- I'm trying to
6 think of a very extreme example -- perhaps some
7 cardiac surgical procedure in some moribund
8 patient who's outcome is unlikely to be altered
9 in a significant way, well then, what's called
10 adverse selection is actually a desirable thing.

11 But I think for a condition like
12 depression, we want to be very, very mindful of
13 that, and I think we would want to err way on the
14 side of getting people into treatment. And if
15 so, if there were a way somehow of collecting the
16 data, but maybe the way to do this would be to
17 mandate the collection of the data, use it for
18 the improvement, and then calculate remission
19 rates as perhaps a quality improvement goal or
20 something like that. Maybe we could get all of
21 the richness of the information without taking
22 the risk.

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

2 MEMBER NIELSEN: Actually, I think

3 Gayle was next.

4 CO-CHAIR BAGLEY: Go for it, Gayle.

5 MEMBER NIELSEN: Sorry.

6 CO-CHAIR BAGLEY: Marci, would you turn

7 --

8 MEMBER NIELSEN: My hand is just

9 outstretched more.

10 CO-CHAIR BAGLEY: Yes, please turn off

11 your microphone when you're not speaking.

12 MEMBER LEE: I just had a couple

13 points. And one is, I think, as I think Scott

14 pointed out, the risk adjustment is really

15 important. In addition to the comorbidities, I

16 just wanted to point out also the

17 sociodemographic factors as being really key,

18 particularly with this population. And the other

19 question I had is we were talking about remission

20 rates, and I guess I'm just wondering -- and

21 there's probably the folks that have the

22 expertise in this area -- is what percentage of

1 patients never come back, I guess, where you
2 don't get that follow-up six month score or 12
3 month score when you're looking at the rates?
4 Because I'm guessing that that probably occurs
5 quite frequently as well.

6 CO-CHAIR BAGLEY: Eric, you were next.

7 CO-CHAIR WHITACRE: I think there was
8 -- did you have a response?

9 MEMBER AVERBECK: Yes. I think what
10 it's led to is development of registries and
11 availability of doing PHQ-9s online or by phone.
12 And so that's one of the things -- because you're
13 right, if they don't come back, and some people
14 won't come back, but it allows itself two more
15 convenient ways of reaching patients, too, so it
16 doesn't all have to be office-based. But I think
17 those are the system changes that we've seen to
18 try and make sure that we follow up with
19 patients.

20 CO-CHAIR BAGLEY: Now Eric.

21 CO-CHAIR WHITACRE: I just had a
22 question, this is really directed to CMS --

1 Sophia, if you could help us out. I've lost
2 track of where in MIPS we will have reporting for
3 basically credit and performance, where outcomes
4 and benchmarks will be important, and where we're
5 going to get credit just for the sake of
6 reporting. It's a little bit of the old PQRS
7 versus performance issue. I just don't see --
8 and it's probably just me, but I've lost track of
9 where that is in MIPS.

10 MS. AUTREY: Okay. So we have a
11 component, the CPIA, which is where the
12 performance is really going to take shape. But
13 reporting would be under the quality component.
14 So if we could separate it out that way, that's
15 probably where it would be, where the reporting
16 would be under the quality component, and then
17 the performance would be under the CPIA.

18 CO-CHAIR WHITACRE: So, are we -- it
19 used to be that we had credit just for reporting.

20 MS. AUTREY: Yes.

21 CO-CHAIR WHITACRE: That's gone?

22 MS. AUTREY: No longer. Yes, that's

1 gone.

2 CO-CHAIR WHITACRE: All of these will
3 then be tied to a performance number?

4 MS. AUTREY: Yes.

5 CO-CHAIR WHITACRE: Wow. Okay. So
6 that number is really important I guess. That's
7 a very critical part of the measure then as you
8 see it. Thank you.

9 CO-CHAIR BAGLEY: Scott, you were next.

10 MEMBER FURNEY: Wanted to make a
11 comment primarily around what the expected
12 outcomes of adverse selection is, and I'll use an
13 analogy in diabetes. So, if you have an average
14 A1C controller composite, then the impetus will
15 be for primary care physicians to refer out those
16 diabetics or to not have them retained in their
17 panel, which is potentially a good thing.
18 Patients that are poorly controlled diabetics
19 potentially should see an endocrinologist,
20 although many of the endocrinologists do not
21 believe they can be controlled because it's for
22 other reasons -- sociodemographic factors.

1 The point of that being, it has to be
2 equal in the comparison. So primary care
3 physicians can be judged on the same composite;
4 endocrinologists need a different composite. So
5 I think part of the measure development and
6 implementation has to be comparing like specialty
7 if there's not a risk stratification. If there
8 is a risk stratification, then it is more of an
9 equal playing field and it needs to be based on
10 comorbidities and socioeconomic status, and that
11 is not an easy thing to do.

12 The implication for the psychiatric
13 measures is very similar. We can all expect in
14 primary care to get a certain percentage of
15 remission. I think the benefit of choosing a
16 more aggressive measure or metric is that we will
17 actually have a much more concerted effort to get
18 the patients back into the office, do more
19 motivational counseling to get them on more
20 aggressive treatment, so I think that is all a
21 good thing. And as we get the treatment-
22 resistant depression, those then will be referred

1 to a scarce resource in psychiatry. So I think
2 there are potential benefits, I think the concern
3 about risk adjustment has to be addressed, or at
4 least that like specialties are judged the same
5 way or that adverse selection will be a major
6 issue.

7 CO-CHAIR BAGLEY: I'd like to get a
8 couple more comments, and then I think it's time
9 for a vote. I think we're kind of all saying the
10 same thing to some degree. So, Marci?

11 MEMBER NIELSEN: Thanks, Bruce. I
12 agree with Scott that there are a couple of
13 different ways to improve this measure, and one
14 is risk stratification. Another is ensuring that
15 we're looking at specialties differently. But I
16 want to come back to something that Kate
17 underscored, and Scott made a point about this,
18 which is when Medicare all by itself has a set of
19 measures that aren't adapted by the private
20 payers, and those measures don't seem to be
21 particularly meaningful or valid to the clinician
22 offering the services, that is when the practices

1 are inundated and frustrated and don't understand
2 the meaning of our work, because we've just given
3 them one more thing to do.

4 So the importance of the Core Measure
5 Set is that we've got a potential alignment
6 between the private sector and Medicare deciding
7 to use the same set of measures, and the extent
8 to which that core set is applicable to multiple
9 different specialties. And on top of the core
10 set, we have specialty driven measures that,
11 again, are meaningful. But that parsimony piece,
12 Helen corrected me yesterday when I said, let's
13 take a deep cleansing breath and what we're
14 trying to do is have measures that mean more and
15 fewer measures.

16 I know she said that's not true, I am
17 going to push back and say: how could it not be
18 that we want fewer measures? How could that be
19 true? We've got a zillion different measures of
20 a zillion different things. We are wanting those
21 measures to be more valuable, but if part of the
22 goal isn't to have fewer measures, then I think

1 we're missing the forest through the trees here.
2 And so a measure like this -- which is well
3 intended -- isn't where we need it to be if it's
4 going to require the PHQ-9 to be at five and we
5 can't track improvement over time and we can't
6 risk-stratify.

7 So, my question gets back to something
8 we were all talking about, which is: what happens
9 if we vote this down? Are we voting this down
10 with agreement that we're sending this on for
11 future development and we'll have all of these
12 comments? Or is the better strategy to vote this
13 up, recognizing that there's an opportunity to
14 change the measure? I am still unclear about --

15 CO-CHAIR BAGLEY: I'll just remind that
16 if you look on the screen, you do have the
17 opportunity to have conditional support, and the
18 conditions would be the discussion we've just
19 had. So --

20 MEMBER NIELSEN: Okay.

21 CO-CHAIR BAGLEY: -- since this is a
22 fully-baked measure --

1 MEMBER NIELSEN: We can --

2 CO-CHAIR BAGLEY: -- we have a little
3 bit different in the option list. Amy?

4 MEMBER NIELSEN: Got it.

5 DR. WINKLER: I'd also like to add,
6 it's an NQF-endorsed measure, which means your
7 feedback can be taken back to NQF in terms of our
8 annual review of the measure to take another look
9 as per specific feedback from the MAP to the
10 endorsement process, please take a look at those
11 issues, we think they're very important about
12 this measure. So, those are some of the issues.
13 But this measure isn't in development, if you
14 will; it's more just feedback about existing --

15 CO-CHAIR BAGLEY: Right. We're not
16 voting anything down here. We don't really --
17 okay. Amy?

18 MEMBER MOYER: And you both just made
19 the point I was going to make -- that this is a
20 fully baked measure, it has been through the NQF
21 endorsement process, where I'm sure they talked
22 risk adjustment ad nauseam about it and it met

1 their criteria and was endorsed. So, I mean,
2 it's been through that really big, robust
3 discussion.

4 CO-CHAIR BAGLEY: I hear you calling
5 the question. Let's vote. You have before you
6 the Measure MUC15-928.

7 MS. CHAVEZ: And voting options are 1
8 Support, 2 Conditional Support, 3 Do Not Support.
9 Voting is open. Work group members on the phone,
10 please submit your votes via. chat. Thank you.
11 Okay. The voting results for MUC15-928 for MIPS
12 are 32 percent Support, 69 percent Conditional
13 Support, zero percent Do Not Support. So the
14 vote is Conditional Support.

15 DR. WINKLER: And I just want to be
16 clear that we do know what those conditions are.
17 I think they've been enumerated a couple of
18 times. All right.

19 CO-CHAIR BAGLEY: Okay. It was my
20 oversight; I didn't give the opportunity for the
21 lead discussants to speak before we started this.
22 Do any of you have anything to say? By the

1 nature of this list, we're going to kind of take
2 them one at a time anyway and vote on each one,
3 so if you have comments, this might be a good
4 time to do that. Winfred, did you have any
5 comments?

6 MEMBER KOPLAN: On this specific
7 measure that we just voted on, or later measures?

8 CO-CHAIR BAGLEY: Well, later measures
9 because it's a little too late on the one we just
10 voted on.

11 (Laughter.)

12 MEMBER KOPLAN: Right. Okay. I just
13 wasn't clear.

14 DR. WU: And, Bruce, should we just go
15 this measure-by-measure then, so I guess we'll
16 comment on PQI 91?

17 CO-CHAIR BAGLEY: I think that actually
18 will work better.

19 DR. WU: Yes.

20 CO-CHAIR BAGLEY: Yes, right. So, you
21 can get in the queue any time you want.

22 DR. WU: Sure. Well, I'll just lead

1 off by, yesterday I believe we voted this for
2 MSSP as Encourage Continued Support. And I think
3 kind of in light of trying to align the different
4 programs, I think that it would make sense to
5 continue with that current recommendation for
6 MIPS.

7 CO-CHAIR BAGLEY: All right. Let's go
8 to Number 2, and, Cindy, you were the one that
9 extracted that?

10 MEMBER PELLEGRINI: I'd like to talk if
11 I could about 2 and 3 together, because all my
12 questions are the same. These are two, we had a
13 little conversation about this yesterday, two
14 population-based measures measured at a rate per
15 100,000. And they seem like very valuable
16 measures from a public health sense, but I just
17 don't understand really how they are applicable
18 in a program like MIPS. How doing population-
19 based measurement and then attempting to apply it
20 to hospitals or practices works from a practical
21 perspective. So if Sophia could help us with
22 that, that would be great.

1 MS. AUTREY: So, one of the
2 requirements in the legislation for MIPS is that
3 we actually have a number of population-based
4 measures included in the program. So in that
5 vein, we are trying to look more broadly at
6 measures that deal with population-based
7 conditions and issues. So, to address your
8 question of why it's important legislatively --

9 MEMBER PELLEGRINI: Okay.

10 MS. AUTREY: -- that's why.

11 MEMBER PELLEGRINI: I agree it's
12 important, I just don't understand from a
13 pragmatic point of view --- if I'm a provider in
14 the MIPS program, and let's say I'm in
15 independent practice, I'm a singleton
16 practitioner -- how does this apply to me? How
17 do I get measured against it?

18 MS. AUTREY: Right. And that's
19 something that we are actually looking at with
20 attribution as well as looking at geographical
21 coordination and comparisons. So, we haven't
22 really vetted all of that out as to how it would

1 be attributable to individual clinicians. But
2 not just for the individual clinicians, but also
3 clinicians that are in facilities and how we
4 would have those measures be utilized in
5 facilities and the attribution to those
6 clinicians as well. So, we are still looking at
7 that, but that is the reason why we started to
8 look at population-based measures.

9 MEMBER PELLEGRINI: Right. I mean, I
10 think the measures make sense from a measure
11 perspective, but without understanding how the
12 attribution's going to work, I have a hard time
13 recommending that it be added to MIPS.

14 DR. WU: My understanding is that
15 actually PQI 91 and PQI 92, some components of
16 those are actually part of the VM program. Is
17 that correct? And, if so, clearly there's some
18 precedence as far as how this is applied -- maybe
19 not at the individual provider level, but across
20 a larger number of group-based providers. So I'm
21 curious as to here, given that, what's kind of
22 CMS's perspective on being able to just drill

1 that down further and how that approach might go?

2 Sure, I mean, do you feel reasonably
3 confident that -- given that this is already in
4 use in the VM program, where we're looking at
5 groups of providers -- that we'll be able to
6 reasonably measure this at the individual
7 clinician level? And also I'm curious to hear if
8 there's been any feedback as far as group-based
9 providers in the VM program as far as concerns
10 one way or the other with respect to PQI 91 and
11 92?

12 MS. AUTREY: Okay, thank you. So one
13 of the things we've been doing is actually
14 working with the staff at VM to see how or the
15 impact of utilizing this measure in the data that
16 they've gotten back from it. So, we are working
17 with them on this to be more clarifying in how we
18 can implement it in MIPS. So, we are utilizing
19 that.

20 CO-CHAIR BAGLEY: Questions, comments?
21 Anybody on the phone with a comment? All right.
22 Are we --

1 MEMBER PACALA: I just wanted to
2 reiterate my concern yesterday about Number 2,
3 PQI 91, about a potential adverse effect of
4 promoting antibiotic overusage for bacterial
5 pneumonia and UTI.

6 CO-CHAIR BAGLEY: Could that be a
7 condition? Okay. Well -- all right. This is
8 not that kind -- okay, great. Oh --

9 MEMBER GLIER: I'm sorry, just to
10 clarify. Can the staff, can you guys remind you
11 us how we voted on these for the Shared Savings
12 Program yesterday? Were they both Encourage for
13 Continued Development?

14 DR. WINKLER: Very strongly encouraged
15 further development.

16 CO-CHAIR BAGLEY: On both --

17 MEMBER GLIER: Yes.

18 CO-CHAIR BAGLEY: -- is that correct?

19 DR. WINKLER: Yes, on both. Both were
20 the same.

21 CO-CHAIR BAGLEY: Without -- go ahead,
22 Amy.

1 MEMBER MOYER: Sorry, just a point of
2 question. So the PQI 91 is currently endorsed,
3 but not specified at the individual clinician
4 level?

5 DR. WINKLER: No, it's not an endorsed
6 measure because this is a composite. Components
7 may be -- and we've got them specified in the
8 description -- but not the composite. We've
9 never seen the composite per se. And the
10 composite itself is undergoing change and further
11 development of a risk-adjusted method.

12 MEMBER MOYER: Okay. So, should it be
13 a Conditional Support?

14 DR. WINKLER: We just said -- my bad,
15 I'm the one who goofed. I changed it for MSSP,
16 but I didn't change it for MIPS.

17 CO-CHAIR BAGLEY: Okay. So you'll see
18 the options that we have on the screen in terms
19 of voting. So, without further comment, I guess
20 we're ready to vote. And this would be for
21 Number 2; it's MUC15-577.

22 MS. CHAVEZ: Okay. We're now voting on

1 MUC15-577 for MIPS. And for those on the phone,
2 the options are 1 Encourage for Continued
3 Development, 2 Do Not Encourage Further
4 Consideration, 3 Insufficient Information.
5 Voting is open. Okay. And the voting results
6 for MUC15-577 for MIPS are 95 percent Encourage
7 for Continued Development, 5 percent Do Not
8 Encourage Further Consideration, zero
9 Insufficient Information.

10 CO-CHAIR BAGLEY: Yes. With your
11 permission, I'd like to ask for a vote on Number
12 3. I think it was unclear whether we had it on
13 or off the consent calendar, so if you don't
14 mind, we'll just go ahead and vote on that. Any
15 further comments on Number 3 on your agenda
16 before we proceed to a vote? A lot of similar
17 comments to Number 2. Okay, let's go ahead and
18 vote on Number 3; that would be MUC15-576.

19 MS. CHAVEZ: Okay. Now voting and the
20 options are 1 Encourage for Continued
21 Development, 2 Do Not Encourage Further
22 Consideration, 3 Insufficient Information. Okay.

1 And the voting results for MUC15-576 for MIPS are
2 90 percent Encourage for Continued Development,
3 10 percent Do Not Encourage Further
4 Consideration, zero Insufficient Information.

5 CO-CHAIR BAGLEY: Okay. Let's go on to
6 Number 4; that would be Potential Opioid Overuse.
7 Who pulled that? Oh, go ahead, Barbara.

8 MEMBER LANDRETH: I agree
9 wholeheartedly with the idea of preventing opioid
10 overuse. I want to make sure -- based on some of
11 the comments that came in here -- that we are
12 consistent, because one of the commenters said
13 that CMS defines high risk of opioid abuse as 120
14 milligrams, and this measure says 90 milligrams.
15 So just so that it cannot confuse, we need to
16 have a consistent milligrams in whatever we use.

17 MS. AUTREY: We did go through a
18 revision once we received internal comments when
19 it got HHS clearance. And I think that there is
20 still some degree of changes with the guidelines
21 as well on the level. So, we are still accepting
22 any comments or any valid reasons for what that

1 level should be, but we did change that while it
2 went through the internal review.

3 MEMBER LANDRETH: On the same point
4 then, I wanted to make sure that whatever is
5 included as the exclusions is a complete list,
6 because I see what you're including right now as
7 conditions that would be really egregious, like
8 sickle cell, that you would have significant
9 pain. And I know that's kind of a fine line to
10 walk, but as primary care physicians or
11 providers, if we're still being asked to provide
12 adequate pain control and being judged on that, I
13 want to make sure that the measures that were
14 excluded are comprehensive.

15 And then, third, the thing that I'm
16 actually seeing in practice is that many of my
17 counterparts are saying, I don't want to deal
18 with this anymore; I don't want to deal with my
19 patients who have opioid problems, and so they're
20 referring them out to pain specialty. And while,
21 like Scott said, that's good -- and his analogy
22 was serious diabetics get referred to

1 endocrinology, which is a good thing, once you
2 get referred out to pain management, it's a whole
3 different ball game.

4 In terms of the monitoring process,
5 you have to go -- a lot of times it's way across
6 town -- there's very few pain management
7 providers, at least in our town, you can't always
8 get in. And, like this little 75 man said to me,
9 I think he had a little bit of low back pain, and
10 he was going to the pain management specialist
11 faithfully, and it was costing him \$35 or \$45
12 every time, every 30 days, to pee in a cup and
13 get his drug screening done. And that was a
14 financial burden for him. So, we brought him
15 back in the practice, we changed him to Tylenol 3
16 versus a Schedule 2, and that enabled him then to
17 stay with us. But I just want people to be
18 mindful of that additional burden that may not
19 necessarily be on your radar.

20 CO-CHAIR BAGLEY: Peter?

21 DR. BRISS: So, we think this is a
22 really important measure addressing an important

1 and emerging public health area. So, as you go
2 forward with presumably developing or evolving a
3 measure, there's probably work that can be done
4 about justifying the dose and duration that you
5 choose. We favor closer to 90 than some of the
6 other alternatives that have been proposed
7 because of the epidemiologic data of the risk of
8 overdose with dose that sort of does this. So we
9 favor closer to 90, but it needs to be well
10 justified.

11 We would -- one of the things that
12 comes out in the TPHA comments in particular that
13 is sort of about how narrowly or how expansively
14 the measure is defined, one of the things that
15 TPHA proposed was sort of limiting the measure to
16 people that are seeing multiple providers. And
17 while it's true that seeing multiple providers is
18 an additional risk factor, at high doses even
19 people that are seeing a single provider are at
20 higher risk. So we don't favor narrowing the
21 measure in that kind of a way.

22 Finally, we would favor a more

1 parsimonious set of exclusions, because remember
2 you're trying to prevent overdoses, right? And
3 so, the truth is once you get -- there are a
4 couple of exclusions on the list that are sort of
5 unarguable and probably -- palliative care and
6 cancer are certainly unarguable exclusions,
7 everything else I think might be open for
8 discussion.

9 CO-CHAIR BAGLEY: Steve?

10 MS. DAHLIN: This is Connie Dahlin. I
11 just also want to speak about that.

12 CO-CHAIR BAGLEY: Connie, Steve is next
13 and then you'll be on.

14 MS. DAHLIN: Okay, thank you.

15 MEMBER FRIEDHOFF: Thank you.

16 Completely agree with the measure and everything
17 you just mentioned as well. And no surprise to
18 anyone in the room as, again, as putting my payer
19 hat on, I can certainly provide lots of data on
20 risk adjustment, specialty adjustment that shows
21 incredible variation out there. So I fully
22 support this. The one caution is that in terms

1 of posting this on Physician Compare, I think for
2 patients who are doctor shopping for opioids, it
3 could be a very effective tool.

4 (Laughter.)

5 MEMBER FRIEDHOFF: So I might not go
6 that way. Thank you.

7 CO-CHAIR BAGLEY: Okay, Connie, you're
8 up.

9 MS. DAHLIN: Thanks. So I just wanted
10 to kind of follow up with some of the statements.
11 So this one is really difficult. I mean, the
12 palliative care and cancer piece is obviously an
13 exclusion, but what's also sort of happening is
14 that to the point -- and I can't remember who
15 just said it, is when people get to certain
16 doses, there's a lot of primary physicians who
17 are saying, I'm not going to prescribe any pain
18 meds and I'm going to try to get anybody else to
19 write them because I don't want to do it.

20 And, so, it might not be palliative
21 care patients that are even being referred out,
22 it's just people who start to need more pain

1 meds, which we know with certain conditions they
2 do and that they've been evaluated. They just
3 start to be either never prescribed because
4 people look at these doses and think, oh my God,
5 they're going to die, but we know that if people
6 are on chronic opioids, they get used to them.
7 And, so, how do we -- this measure really is
8 worrisome because I think we're not thinking
9 about like with the patients who are on opioids.

10 So if it said like patients who are on
11 opioids who've just had surgery, that they get
12 one dose and they need to be closely monitored
13 after 90 milligrams and really that's great, but
14 I think the sense of once somebody gets on
15 opioids, maybe they go to a pain specialist who
16 gets a regimen, but then they have to go back to
17 their primary provider so that we don't develop
18 this culture of opioidphobia. I know that it's a
19 health crisis and I get all that, but we're sort
20 of swinging the pendulum back now that where the
21 people who actually need these meds are not.

22 And I get the point about doctor

1 shopping, I'm very concerned that we ever post
2 who's doing what with this because that's really
3 scary. Because what's happening right now where
4 I work in a practice, is as a palliative care
5 specialist, anybody who's been on methadone
6 maintenance, if they get admitted to the hospital
7 and they're on methadone, I'm getting a consult,
8 which is just not appropriate. It's because the
9 team is like, well, we're not writing pain meds.

10 So I just want to be very sensitive to
11 all the pieces that happen with a measure like
12 this, that it sort of encourages this lack of
13 responsibility to kind of figure out and do a
14 really thorough pain assessment and what are the
15 appropriate drugs, and also thinking about how do
16 we incorporate both pharmacological and non-
17 pharmacological, which I think we all would
18 agree, it's not good just to throw meds at
19 people, we've got to do that, but we've gotten
20 away from that. So, that's my comment. Thank
21 you.

22 CO-CHAIR BAGLEY: Thank you, Connie.

1 Amy, you were next.

2 MEMBER MOYER: Recognizing that we're
3 in an area I know very little about, I was
4 looking at some work the Bree Collaborative had
5 done in Washington State around opioids and they
6 had also looked at 120 milligrams. And what they
7 had included -- and I think I may have just heard
8 this in the previous comment, was if you're going
9 to go above that, there needs to be a consult
10 with a pain management specialist. So I don't
11 know, given that we're way outside my area, if
12 that is something that works in clinical practice
13 where it would be useful for this measure.

14 CO-CHAIR BAGLEY: Peter, you were next.

15 DR. BRISS: I just wanted to make sure
16 that we're clear when we're talking about this
17 measure that this is talking about chronic opioid
18 use. And so it's not about opioids for things
19 like post-op pain. And we should just be -- it's
20 not acute pain, it's greater than 90 days. And
21 so we should just be clear about what we're
22 actually talking about.

1 CO-CHAIR BAGLEY: Good point. Winfred?

2 DR. WU: Yes, just one question or
3 concern just around attribution. And in thinking
4 about if this is a measurement over the course of
5 a year, a provider who may be prescribing opioids
6 on a short-term course and then this individual
7 later seeking care somewhere else and meeting
8 this definition, I'm just curious as far as how
9 we'll be able to control for this. I mean,
10 because based upon just reading the numerator and
11 denominator, I could -- you know, it could, I
12 think, easily be interpreted both ways, where
13 either someone's being allocated to the provider
14 that's writing the prescription versus just
15 globally looking at the individual's claims over
16 the course of a year. And if you had rendered
17 care and you wrote at least one of those scripts,
18 boom, you're dinged for that.

19 CO-CHAIR BAGLEY: Cindy and then Beth.

20 MEMBER PELLEGRINI: Yes. This is -- so
21 I'm coming back in some ways to the comments that
22 I made on the population-based measures, where

1 this is incredibly important data, there's no
2 doubt about that, I'm just not sure if this
3 belongs in MIPS, where the clear message to
4 providers will be, your rates should be very low,
5 right? And that may not be appropriate for
6 certain providers.

7 CO-CHAIR BAGLEY: Beth?

8 MEMBER AVERBECK: So, I'm making a
9 couple of comments on the measure specifications
10 given that the steward is Centers for Medicare
11 and Medicaid. But I wonder when we look at both
12 numerator and denominator, it looks like one says
13 90 days and one says 15 days. So just in kind of
14 the post-op for some of the orthopaedic
15 procedures, you might see some prescribing in
16 TCUs for a while that are going to see 15 days.
17 Another suggestion might be, consider some of the
18 end-stage renal failures in an exclusion. And
19 then, if there was a measure in Washington, is
20 there an opportunity to take a look at what those
21 measure specifications are so we could maybe
22 consider some alignment from the beginning,

1 because it's a very important topic, I agree.

2 CO-CHAIR BAGLEY: Okay. Did you have
3 a response to that?

4 MEMBER MOYER: I was just going to
5 clarify, the Washington is a guideline, I don't
6 know that they have a companion measure.

7 MS. AUTREY: So, based on the number of
8 comments that we've received prior to it coming
9 to the MAP and the discussion here today, we
10 still think that it is a very important measure
11 that we would want to include and we know that
12 there's a lot of work that needs to be done based
13 on the discussion. So, very much important work
14 and we appreciate all of the comments.

15 CO-CHAIR BAGLEY: I guess that would be
16 kind of my summary as well, that everybody thinks
17 this is very important, it certainly needs to be
18 looked at very carefully in regard to the
19 unintended consequences. I think that's probably
20 the most compelling thing that we're asking you
21 to take a look at because there's a lot of
22 potential there. Are we ready for a vote? Okay.

1 Let's go ahead and vote on MUC15-1169, Potential
2 Opioid Overuse.

3 MS. CHAVEZ: And the voting options are
4 1 Encourage for Continued Development, 2 Do Not
5 Encourage Further Consideration, 3 Insufficient
6 Information. The voting is open. And the voting
7 results for MUC15-1169 for MIPS are 95 percent
8 Encourage for Continued Development, five percent
9 Do Not Encourage Further Consideration, zero
10 Insufficient Information.

11 CO-CHAIR BAGLEY: Okay, thank you.
12 Let's move on. Maybe we can do this before
13 lunch, number seven, and I think, Stephanie, I
14 think you pulled that one. You want to talk about
15 it first?

16 MEMBER GLIER: Sure. I pulled both of
17 the audiology measures. As Reva mentioned, it's
18 great to see measures for the audiologists coming
19 in, really happy to see that they're thinking
20 about how to participate more in these programs
21 and I would encourage them to try again. I think
22 these measures are a good starting place, but

1 they really are documentation measures and, at
2 the very least, if you're going to do a
3 standardized test, maybe report the results of
4 the standardized test so we can see -- get some
5 data about what's happening, even if we're not
6 setting a threshold of what the results should
7 be, because obviously you're just trying to
8 figure out how your patients are doing. But the
9 documentation itself is insufficient information
10 to show high quality care.

11 CO-CHAIR BAGLEY: So you're okay if we
12 talk about both of these together?

13 MEMBER GLIER: I am, yes.

14 CO-CHAIR BAGLEY: Okay. Because
15 they're the same issues, right? Yes. Go ahead.

16 MEMBER PELLEGRINI: As a discussant,
17 when I was looking at these, I had that reaction
18 as well. And also the fact that this is a really
19 low bar measure, right? I mean, you're already
20 at the audiologist, there's something wrong. If
21 they're not doing functional assessments, what
22 are they starting with? So, I'd like to

1 encourage them to go back and be a little bit
2 more ambitious.

3 CO-CHAIR BAGLEY: I had a question for
4 CMS, I guess. So, my understanding is that that
5 visit to the audiologist would not be paid for by
6 CMS. Now, is it okay to have a measure in
7 Medicare where it's not reimbursed? Is that a
8 problem for anybody?

9 MEMBER GLIER: It will be later.
10 Audiologists are one of the list of providers who
11 can be eligible professionals starting in 2019.

12 CO-CHAIR BAGLEY: I'm talking about the
13 visit, not the bonus.

14 MEMBER GLIER: Oh, I --

15 CO-CHAIR BAGLEY: The visit -- is that
16 -- it is covered? So this kind of assessment
17 would be --

18 MS. AUTREY: I don't know about
19 coverage.

20 (Laughter.)

21 CO-CHAIR BAGLEY: Anybody happen to
22 know that offhand? Because it was my impression

1 that that was not part of the usual service.

2 MEMBER PACALA: So you're asking if the
3 objective measure of a functional hearing status
4 and functional communication, assessment of that,
5 whether those are already included in a standard
6 audiologic evaluation? Is that your question?

7 CO-CHAIR BAGLEY: No, my question was,
8 if I'm a Medicare patient, which I am --

9 MEMBER PACALA: Yes.

10 CO-CHAIR BAGLEY: -- and I went to the
11 audiologist, would it be covered by Medicare? I
12 know it's covered by Medicare Advantage often,
13 but would it be covered by Medicare? I think
14 there's a question about that. They clearly
15 don't pay for hearing aids, so --

16 MEMBER PACALA: Oh, no, they cover
17 audiology. They cover --

18 CO-CHAIR BAGLEY: So that's not an
19 issue?

20 MEMBER PACALA: That is not an issue.

21 CO-CHAIR BAGLEY: Okay.

22 MEMBER PACALA: That I can tell you for

1 sure.

2 CO-CHAIR BAGLEY: Okay, good.

3 MEMBER PACALA: I think a related
4 question is, can they up-code if they do these
5 things? And is there some kind of -- I don't
6 know. This is my --

7 CO-CHAIR BAGLEY: I'm with you --

8 MEMBER PACALA: -- I'm standing on the
9 grassy knoll here and --

10 CO-CHAIR BAGLEY: Right.

11 (Laughter.)

12 MEMBER PACALA: -- conspiracy theory.
13 So I don't know whether that's the case or not.

14 CO-CHAIR BAGLEY: The comments -- go
15 ahead, Scott, you're next.

16 MEMBER FURNEY: I agree, the
17 documentation standards are relatively weak. And
18 as we had a very involved discussion about
19 improving depression to remission, it would be
20 nice to have a post-evaluation, what is the
21 patient's hearing after the intervention? So I
22 think an initial measure at least of what their

1 results are as they do their assessment, but
2 ultimately we would gauge the quality of their
3 care based on the patient's impact of their
4 interventions.

5 CO-CHAIR BAGLEY: Now you're in the --
6 back to my question, since the intervention's not
7 paid for by Medicare, is it fair to judge them on
8 that? And this isn't a payment discussion.
9 Let's see, Stephanie, you were next.

10 MEMBER GLIER: I just wanted to put a
11 little bit of a finer point on my comments, which
12 is I think we'd love to see more measures from
13 the audiologists, I think something like a
14 functional status assessment over time would be
15 really valuable. I would recommend not supporting
16 continued development of these measures as they
17 stand for the purposes of voting today.

18 CO-CHAIR BAGLEY: Beth, you were next.

19 MEMBER AVERBECK: So, I think, Bruce,
20 to take your comment about even if it's not
21 covered, if patients are having to pay out of
22 pocket for hearing aids, that might be a really

1 important meaningful measure to have a functional
2 improvement of hearing after an intervention.

3 And, so even though it's not covered, it might be
4 of value as the measure would go under further
5 development.

6 CO-CHAIR BAGLEY: Excellent point.

7 Yes, Gayle?

8 MEMBER LEE: I was just going to add
9 too about going back to the even if it's not
10 covered, some measures -- for example, I think
11 maybe the BMI measure talks about referring to
12 other providers and it's possible that their
13 services may be covered, so maybe if the patient
14 ends up with a speech-language pathologist or
15 somebody else, it's possible that it may be a
16 covered service depending on what it is. So
17 maybe some piece of the measure talking about,
18 okay, you did this test and then what's your next
19 steps? Are you referring to another provider for
20 follow-up care? Or something like that.

21 CO-CHAIR BAGLEY: Okay. Are we ready
22 to vote? Or, Jim, you had another comment?

1 MEMBER PACALA: We're not talking about
2 actual therapeutics here, we're talking about
3 assessment, right? When you order a hearing
4 evaluation to an audiologist? Am I right about
5 that?

6 CO-CHAIR BAGLEY: The first one is
7 actually a speech discrimination test, but it is
8 an assessment, yes.

9 MEMBER PACALA: Well, speech
10 discrimination should be part of a standard
11 audiologic evaluation of -- particularly in an
12 older adult, because that's also impaired. It's
13 not just that they can't hear, they also have
14 varying degrees of speech discrimination problems
15 irregardless of the decibel level at which they
16 can hear. So that should be a standard part. So
17 that's a good idea. But this is all about
18 assessment, right? Okay.

19 CO-CHAIR BAGLEY: Go ahead, Rachel.

20 MEMBER GROB: I just wanted to make
21 sure that the discussion captures specifically
22 the point, not only that we encourage the

1 audiologists to continue -- I agree entirely that
2 these kind of measures are not where we want to
3 go, but I want to applaud their attempt to gather
4 information directly from patients and be very
5 clear that the feedback we're giving includes
6 saying, we want a patient-reported outcome
7 measure. They should go in the PROM direction,
8 because those are very valuable to patients.

9 CO-CHAIR BAGLEY: Other comments? If
10 I don't see any hands, we'll go to a vote. Okay.
11 I think we're ready to vote. And let's take them
12 one at a time. The first one is MUC15-307,
13 that's objective measure for functional hearing
14 status.

15 MS. CHAVEZ: And the voting options are
16 1 Encourage for Continued Development, 2 Do Not
17 Encourage Further Consideration, 3 Insufficient
18 Information. Voting is open. And the voting
19 results for MUC15-307 for MIPS are 29 percent
20 Encourage for Continued Development, 71 percent
21 Do Not Encourage Further Consideration, zero
22 Insufficient Information.

1 CO-CHAIR BAGLEY: Okay. Now, I'd like
2 to go on to number eight, which would be MUC15-
3 313.

4 MS. CHAVEZ: Okay. And we have the
5 same voting options, 1 Encourage for Continued
6 Development, 2 Do Not Encourage Further
7 Consideration, 3 Insufficient Information.
8 Voting is open. And the voting results for
9 MUC15-313 for MIPS are 21 percent Encourage for
10 Continued Development, 67 percent Do Not
11 Encourage Further Consideration, five percent
12 Insufficient Information.

13 CO-CHAIR BAGLEY: Okay. Thank you very
14 much. That's so efficient, that's great. Okay.
15 Let's go on to number nine, Ischemic Vascular
16 Disease All or None Outcome Measure. Of course,
17 we had some conversation about this earlier. So
18 let's open up the discussion, maybe, Reva, do you
19 want to just kind of give us the context?

20 DR. WINKLER: Sure. This measure I
21 think we talked about yesterday for the MSSP is
22 an all or none composite measure. I think the

1 context that I want to be sure everyone's aware
2 of is, there has been in PQRS for several years a
3 really very similar measure, the optimal vascular
4 care measure, NQF Number 76, but in this year's
5 PFS rule, it was removed. And the rationale
6 provided in the rule -- and Sophia can perhaps
7 expand upon that, but the rationale provided in
8 the rule was that it was duplicative of the
9 individual measures for Million Hearts. So that
10 was the rationale given in the final rule. So,
11 essentially, there was already a measure like
12 this, if they've removed it, putting another one
13 back in isn't -- I'd wonder whether that really
14 made sense.

15 CO-CHAIR BAGLEY: Sophia, do you want
16 to expand on that at all?

17 MS. AUTREY: So, you are right, we did
18 remove it from the measure list starting 2016
19 because it was duplicative of the individual
20 measures. But I think that this measure actually
21 includes the piece that -- if I'm not mistaken,
22 it does include the statin piece that was not

1 included in the older measure. Is that correct?

2 CO-CHAIR BAGLEY: Beth, go ahead.

3 MEMBER AVERBECK: Yes, so the Measure
4 0076 is going to come back, I think, in April.
5 So the statin use will be part of it. I mean, it
6 was taken off while we revised the measure based
7 on the updated guidelines. I would say -- so it
8 will be back and it is very -- I mean, I don't
9 know the specifications of this one, but it's the
10 same components.

11 MS. AUTREY: And so, because of that,
12 the removal of the measure -- well, the removal
13 of one of the LDL component was one piece of why
14 it wasn't really something that we could continue
15 to have in the program, but then, once that
16 statin piece was added back in, we wanted to
17 include it back into the measure set.

18 CO-CHAIR BAGLEY: Other discussion?
19 All talked out about this the other day,
20 yesterday? Go ahead, Stephanie.

21 MEMBER GLIER: Yes, I can just put the
22 summary of our conversation yesterday, I think as

1 long as there is a measure of optimal care here,
2 it would be great to have a composite. I don't
3 want to be duplicative with the Million Hearts
4 measures, but I think the composite itself has
5 value. So, my recommendation would be, I'm not
6 sure if this is the right way to vote or not
7 given the voting options and the fact that we're
8 talking about a measure that is not actually
9 listed on the screen, but conditional support for
10 a measure that follows the current guidelines
11 that is a composite measure of optimal care.

12 MEMBER MOYER: And, further, given that
13 there is the endorsed measure and the endorsed
14 measure coming back, I would fully support that
15 being used in the program, but it feels really
16 odd to then go with this other measure that
17 hasn't been through the process, but is kind of
18 the same.

19 DR. WINKLER: In terms of this measure
20 through the NQF process, it was submitted to us
21 and its evaluation final disposition is deferred
22 until it can be put head-to-head with the

1 Minnesota measure in the spring, because there
2 are minor differences, but they are essentially
3 very, very similar.

4 CO-CHAIR BAGLEY: Peter?

5 DR. BRISS: I do want to say that HHS
6 has, to its credit, I think has gone through a
7 lot of effort to align cardiovascular measures.
8 And so when we started out five years ago, there
9 were 30-some different measures in active use in
10 HHS programs just on hypertension. And so
11 there's always a reason for more measures of the
12 same stuff and it's always arguable about which
13 one's the best one, but I'm not personally
14 convinced that more measure creep is actually
15 what we need. Actually I think that going from
16 30-some hypertension measures to one is a pretty
17 good achievement and I'm not dying to do that
18 again.

19 CO-CHAIR BAGLEY: Not sure what you're
20 recommending here, Peter.

21 DR. BRISS: So I'm not personally
22 convinced that we need more measures that

1 duplicate the existing Million Hearts measures.

2 CO-CHAIR BAGLEY: Beth?

3 MEMBER AVERBECK: So, is the Million
4 Hearts measure -- I'm just not familiar with it,
5 is it a bundled all or none measure? Separate
6 components?

7 DR. BRISS: There are four separate
8 measures on the four topics. The choice comes
9 down to how strongly you feel about an all or
10 none composite versus how strongly you feel about
11 parsimony probably.

12 CO-CHAIR BAGLEY: Everybody's tired and
13 hungry, is that what the problem is? Amy, go
14 ahead.

15 MEMBER MOYER: So I'll throw out, I
16 think the advantage of this over those individual
17 measures, particularly when you're looking at
18 Physician Compare, is looking at it as a patient,
19 you're not in a position of saying, well, if I go
20 there, they're doing a really good job with blood
21 pressure, but if I go there, they're doing a
22 really good job with statin. You can pick based

1 on who's going to do the best job of getting you
2 all of those components of your care that are
3 important. It's much easier to use.

4 CO-CHAIR BAGLEY: I guess -- oh, go
5 ahead, Beth.

6 MEMBER AVERBECK: Just a question, so
7 on this either support or conditional support,
8 are we supporting an optimal vascular measure yet
9 to be determined which one through NQF or
10 specific to this one?

11 DR. WINKLER: You have to -- the
12 recommendation has to be specific to this one,
13 that's the job.

14 MEMBER GLIER: So, my personal
15 recommendation, which you are welcome to dismiss
16 if you would like, is to conditionally support
17 this measure pending the NQF Committee's side-by-
18 -side review of this measure against 0076 when
19 0076 is done being updated with the guidelines,
20 with the intention of telling CMS that I would
21 like to see an optimal vascular care measure in
22 the MIPS program. I don't have a dog in this

1 fight.

2 CO-CHAIR BAGLEY: Robert?

3 MEMBER KRUGHOFF: So, in general, when
4 we conditionally support, is it still something
5 that CMS can go ahead with this year or does that
6 require another cycle through?

7 CO-CHAIR BAGLEY: Do you want to answer
8 that, Sophia?

9 MS. AUTREY: If it's conditionally
10 supported and once it goes through the process
11 there are significant changes, it would still
12 have to come back.

13 MEMBER KRUGHOFF: It would have -- so
14 it puts it off for a whole year?

15 MS. AUTREY: Yes, if there are
16 significant changes.

17 CO-CHAIR BAGLEY: If there are
18 significant changes, of course, however you want
19 to define that, but, okay.

20 MS. AUTREY: If there are not
21 significant changes, then it wouldn't have to
22 come back.

1 MEMBER GLIER: So for this measure, if
2 we conditionally support it with the condition I
3 just suggested about doing a side-by-side and it
4 goes to a side-by-side and the NQF committee says
5 0076 is the winner of these two, I assume that
6 because you're already using 0076, you could use
7 it again. But if this measure is the winner of
8 the side-by-side, then our conditional support,
9 assuming it doesn't get changed in that review
10 again, would mean that CMS could use it in next
11 year's rules. So, CMS would not have to come
12 back to us if the measure meets the condition
13 that we specify.

14 CO-CHAIR BAGLEY: So that makes that
15 very important. Maybe -- let me try first and
16 then we have to make sure that NQF agrees with
17 this, but I'm hearing you say the conditions are
18 to reevaluate the statin part of it based on the
19 new guidelines and make sure that that's part of
20 it, and also to consider having it be a composite
21 all or none measure. Are those the two things?
22 No? Okay. Please --

1 MEMBER GLIER: So the condition for
2 this measure, which is the Wisconsin -- the WCHQ
3 Ischemic Vascular Disease All or None Outcome
4 Measure, which already has the statin component
5 in it, the condition would be that it meets
6 current guidelines at the time that CMS is
7 considering using it, which CMS would do whether
8 we said that was a condition or not, and that the
9 NQF committee reviewing the vascular care
10 measures has had the opportunity to do a side-by-
11 side comparison of this measure that we're voting
12 on with 0076, that we're not voting on, and has
13 chosen the best of the two measures, since they
14 are very similar.

15 CO-CHAIR BAGLEY: I want to -- I mean,
16 you're the one that has to write this down.

17 DR. WINKLER: Right. Well, essentially,
18 that's already planned and will happen next
19 spring. That's exactly what's -- and we're
20 already ready to be doing that. So if you're
21 saying that it's conditional on the result of
22 that evaluation, then that's fairly

1 straightforward.

2 MR. LYZENGA: Would a condition also --
3 I just want to clarify what I'm hearing, of
4 approving an all or none composite for this
5 program be that the individual Million Hearts
6 measures be removed? No.

7 DR. WINKLER: No.

8 MR. LYZENGA: Okay.

9 CO-CHAIR BAGLEY: Are we ready for a
10 vote? I see heads nodding, so let's give it a
11 try. So we're going to vote on MUC15-275, and
12 since this is an NQF approved measure, it's --

13 DR. WINKLER: This is not an NQF
14 endorsed --

15 CO-CHAIR BAGLEY: -- a fully developed
16 measure.

17 DR. WINKLER: -- it's a fully developed
18 measure.

19 CO-CHAIR BAGLEY: Thank you. Minor
20 slip on my part. Support, conditional support,
21 do not support.

22 MS. CHAVEZ: Thank you. Voting is

1 open, 1 Support, 2 Conditional Support, 3 Do Not
2 Support. And the voting results for MUC15-275
3 for MIPS are five percent Support, 81 percent
4 Conditional Support, 14 percent Do Not Support.
5 So the vote for this measure is conditional
6 support.

7 CO-CHAIR BAGLEY: Winfred?

8 DR. WU: So this is clearly a different
9 vote than yesterday's MSSP vote and so, I mean,
10 can we revisit that original recommendation that
11 we submitted yesterday? Clearly, since we have a
12 different -- I don't see the difference in
13 opinion as far as why we would favor this for
14 MIPS and oppose it for MSSP, but maybe we can
15 first put that up for a conversation?

16 CO-CHAIR BAGLEY: I would entertain a
17 motion to reconsider.

18 MEMBER NIELSEN: I second the motion.

19 CO-CHAIR BAGLEY: Somebody has to say
20 it first. Winfred, let's assume that you made a
21 motion --

22 DR. WU: Yes, motion to move to

1 reconsider.

2 CO-CHAIR BAGLEY: Thank you. Okay.

3 And a second, thank you, Marci. Okay. So, I'm
4 not sure how we're going to do this voting wise,
5 but basically, we have to revote as if we're
6 considering MSSP. Are you okay with that, Reva?

7 DR. WINKLER: I don't have a problem
8 with it because one of the major issues that the
9 Coordinating Committee really wanted you guys to
10 focus on was alignment, and so you just did it.
11 And we now can talk about how good you did it by
12 bringing it up and revisiting. So, yay.

13 CO-CHAIR BAGLEY: Just to review, our
14 recommendation yesterday was --

15 DR. WINKLER: Yesterday, the vote was
16 ten percent Support, 40 percent Conditional
17 Support, so the sum is only 50 percent on the
18 support side, and then 50 percent Do Not Support,
19 which lands it in the do not support category.
20 The question is, are there real differences
21 between the two programs that you want to think
22 about for this measure? It's perfectly fine if

1 there is a difference in your recommendation, as
2 long as we understand what it is, and typically
3 based on program characteristics.

4 CO-CHAIR BAGLEY: Beth, you had your
5 hand up.

6 MEMBER AVERBECK: Well, I think part of
7 the confusion yesterday might be given that
8 there's already an existing measure that's going
9 to be reviewed and then this is a duplication.
10 So I think the conversation today, we had more
11 clarity around what it was we were voting for and
12 so that might be part of the difference.

13 CO-CHAIR BAGLEY: Everybody comfortable
14 with this? If you're not, this is the time to
15 speak out. Please, go ahead.

16 DR. ALEMU: I just want to point out
17 that the statin use measure, it has to be
18 clarified whether it speaks to the 2013
19 guidelines. This was, I think, before that. But
20 if it speaks to that one, that's fine.

21 DR. WINKLER: This measure does. I
22 mean, that's the whole thing that's going on,

1 that's why there is some of this.

2 CO-CHAIR BAGLEY: Scott?

3 MEMBER FRIEDMAN: So, I'm a simplistic
4 person here, again, a newbie. So what I'm
5 hearing is that there's a measure out there that
6 is similar to this measure, maybe the exact same,
7 and we don't want to have -- we don't need to
8 have two measures that do exactly the same thing.
9 So, I mean, maybe it's semantics that we vote one
10 way yesterday and a different way today because
11 we're saying the same thing and the votes are
12 somewhat nebulous at best -- at worst, and who
13 knows. So, what I'm hearing is that we have a
14 measure, this measure is good, we want to have a
15 measure like this, but if we have two measures
16 that are the same, we don't need two measures.
17 And maybe the vote doesn't really mean anything
18 because it's all been discussed anyways.

19 CO-CHAIR BAGLEY: Rachel, I saw your
20 hand first, then Peter.

21 MEMBER GROB: Yes. I mean, I think
22 what we're saying is, we only need one measure.

1 What I hope we're saying is we only need one
2 measure in MIPS, we only need one measure in
3 MSSP, and we trust NQF to do the side-by-side
4 analysis and decide which measure it is and
5 implement with just one measure for both of the
6 programs.

7 CO-CHAIR BAGLEY: Peter?

8 DR. BRISS: And so the last comment I
9 would make is that in this subject matter, I
10 wonder whether there's such a great rationale for
11 an all or none composite in terms of driving
12 improvement or being interpretable. Because the
13 performance on all four of the components is
14 relatively low. So say it was 50 percent on all
15 four components, which is not so far away from
16 real life, that means that where you'd be on an
17 all or none composite is approaching zero, right?
18 And so, it's not so clear to me -- it would be
19 different if performance were higher.

20 CO-CHAIR BAGLEY: It's in the single
21 digits, but not zero. Go ahead. Beth, go ahead.

22 MEMBER AVERBECK: Just to -- an optimal

1 measure before the statin use was around 60ish
2 percent in a number of systems for the all or
3 none for vascular. So, I mean, there's variety
4 and that's where the opportunity was, but yeah.

5 CO-CHAIR BAGLEY: Scott?

6 MEMBER FRIEDMAN: So, again, that was
7 your interesting comment yesterday is that the
8 composite results are going to be very low and
9 docs don't want to be really low, they want to be
10 really high. And I don't necessarily disagree
11 with that. But there's some people in the room
12 that are saying composite measures are really
13 good and then some people in the room are saying
14 composite measures aren't really good. And, so,
15 maybe we should have a little bit more discussion
16 about whether we should have composite measures
17 or just four individual measures for this. I
18 think overall that health is important and these
19 are all measures that trying to save disease and
20 trying to prevent cardiovascular disease, and the
21 question is whether we should be measuring at the
22 same time or individually?

1 CO-CHAIR BAGLEY: David?

2 MEMBER SEIDENWURM: Well, so, the first
3 point I'd like to make, I think is that in a lot
4 of these areas, the components don't sort
5 independently. So you don't get to six percent,
6 you get to 38 percent or something -- making up
7 the number, because there are some sites that are
8 doing all four things or three of the four things
9 really -- you know, they're doing four of the
10 four things, and other sites that are doing none
11 of them. So I think that that's one point to
12 bear in mind that I don't think it comes down to
13 five percent, even though that's what the simple
14 arithmetic would show you.

15 The other thing is, I think that what
16 I'd like to know in terms of the biology of this
17 phenomenon, is there a synergistic effect among
18 the different components? We know that doing
19 each of them independently improves health, but
20 what I'd like to know is, does doing all four of
21 them at once, is that more improvement in health
22 than the sum of the individual components? And

1 then the other question I'd like to ask is, if
2 the participation in the program is voluntary,
3 are people just going to pick one metric and
4 satisfy their obligation, or -- in which case we
5 need a composite. Or if the participation is
6 mandatory and they have to participate in all
7 four and are judged on all four, then the
8 arguments in favor of the separate measures I
9 think have great merit. So, I guess I have those
10 questions that I'd like to ask.

11 CO-CHAIR BAGLEY: Winfred?

12 DR. WU: So, I think those are all
13 great points. And I think the other thing to
14 focus here on is the fact that the composite
15 measure focuses on ischemic vascular disease,
16 which we know is -- comprises a group that's
17 going to be at the highest risk for a repeat
18 event, whereas when we look at the individual
19 component measures, the one focusing on
20 hypertension includes not only those who have
21 potentially IVD, but, again, folks who have just
22 central hypertension, maybe no other major

1 cardiovascular disease factors. The same thing
2 with the statin measure, which is a three
3 component measure. So the IVD component is just
4 one of a larger group of individuals in that
5 population. So I think that speaks to the
6 importance of having a composite measure that
7 focuses on this particularly high risk group.

8 CO-CHAIR BAGLEY: Scott?

9 MEMBER FURNEY: The composite measure
10 I think is the better one to drive improvement in
11 all measures. And that may seem somewhat self-
12 apparent. In this particular measure, it's
13 somewhat unique in that the lagging measure will
14 always be the tobacco-free component. That's the
15 one that's, I think, the least under the
16 influence of physicians, the most recalcitrant of
17 the conditions, but we use composites for the
18 majority of our metrics when we have them
19 developed and they mature from individual into
20 composite, but it makes you think about your
21 quality improvement very, very differently.

22 And I think the risk of having

1 individual measures, as was said, is that the one
2 measure that will be the most difficult to move,
3 the laggard, in tobacco use, will be the least
4 addressed. And we know that that is actually the
5 most important to address and to resolve. So I
6 think that that's one huge benefit of using the
7 composite. And here is the one measure that will
8 really drive that composite is the one that is
9 the hardest to move.

10 CO-CHAIR BAGLEY: Jim?

11 MEMBER PACALA: Scott said it.

12 CO-CHAIR BAGLEY: Yes, okay. Are we
13 ready to vote? Okay. Now, we're going to vote
14 on MUC15-275 in relation to the MSSP program.

15 MS. CHAVEZ: And the voting options are
16 1 Support, 2 Conditional Support, 3 Do Not
17 Support. Voting is open. The slide did not show
18 the results. Okay. Unfortunately, we'd have to
19 revote.

20 CO-CHAIR BAGLEY: We're going to have
21 to revote. So, are you ready to go for the
22 revote?

1 MS. CHAVEZ: Yes, we are. And it's the
2 same voting options, 1 Support, 2 Conditional
3 Support, 3 Do Not Support. Voting is open.
4 Okay. So the results for MUC15-275 for MSSP are
5 five percent Support, 90 percent Conditional
6 Support, five percent Do Not Support. So the
7 recommendation is conditional support.

8 DR. WINKLER: And the condition is as
9 Stephanie specified.

10 CO-CHAIR BAGLEY: Consistent across
11 programs, right?

12 DR. WINKLER: Right, we're being
13 consistent.

14 CO-CHAIR BAGLEY: Well, we're at --

15 DR. WINKLER: Aligned.

16 CO-CHAIR BAGLEY: We're at an important
17 juncture here. I think that we've made great
18 progress and had very good conversation and I
19 don't think anybody's felt that they haven't had
20 a chance to talk. So we're making pretty good
21 progress. We have lunch scheduled and we have a
22 couple of important open discussions after lunch.

1 I would prefer not to predict what time we might
2 be finished, but it looks like we'll clearly be
3 finished before 4:00.

4 So I guess I need to hear some from
5 the group about should we have a relatively short
6 lunch and keep on going and hopefully make some
7 earlier flights and stuff like that? I see a lot
8 of head shaking. So, 15 minutes to get your
9 lunch and we'll start at 12:30. Do you want to
10 try that? Is everybody okay with that? I see
11 general agreement, we don't have to vote on that.

12 (Whereupon, the above-entitled matter
13 went off the record at 12:16 p.m. and resumed at
14 12:40 p.m.)

15 CO-CHAIR WHITACRE: In the interest of
16 time, I thought we could go forward, especially
17 as it's a bit more of an open-ended discussion.

18 We're at the point where we'd like to
19 discuss gaps and this is specifically gaps in the
20 clinician program measures set.

21 When I looked at this, I wanted to
22 tack on some other ideas of perhaps process

1 improvement and so forth that we can get to
2 later.

3 But, if we could spend some time --
4 and I know Reva has a presentation on this,
5 addressing specifically the issue of gaps in the
6 measure set for clinicians.

7 DR. WINKLER: I wanted to spend some
8 time talking about a couple of the topics that
9 the Coordinating Committee focused on in their
10 in-person meeting in September.

11 As you know, the Coordinating
12 Committee has the role of overseeing all the MAP
13 work across the four different committees.

14 And so, the two particular topics I'd
15 like to talk further with you about were gaps and
16 the other one is alignment.

17 So, gaps is one of those traditions
18 that, at the end of every sort of meeting, we sit
19 down and talk about gaps. But, what's happened
20 over the course of time is we've ended up with a
21 very long list of gaps and that's it. It's a
22 very long list of things, everybody's favorite

1 topic sort of tossed onto the pile.

2 And so, I think -- and one thing the
3 Coordinating Committee would like to do is to
4 begin really thinking more strategically and
5 maybe systematically about gaps as opposed to
6 just, you know, make a list and isn't it fun?

7 So, I mean, something to think about
8 for the clinician measures, and I haven't
9 included the MSSP, I'm really looking at the
10 clinician measure set that's currently, you know,
11 used for PQRS. Those measures are the source of
12 many measures that will evolve into MIPS.

13 You know, there are about 300 measures
14 on the list already. We just looked at another
15 58 measures. It's a big group of measures.

16 And so, one thing I would love to hear
17 some suggestions as opposed to just, you know,
18 tossing out the ideas to add to the laundry list,
19 is can you think of a way of potentially -- some
20 way more strategic to think about gaps in the
21 clinician measure set?

22 You know, one of the things I noticed

1 even on the laundry list is there were often
2 topic areas that would be raised. But then,
3 there were also types of measures or types of
4 things to be measured that were offered that,
5 perhaps, might apply more globally or
6 crosscutting that could be useful.

7 So, you know, as we're thinking about
8 gaps, this is an evolving type of idea.

9 One of the things the Coordinating
10 Committee in their January in-person meeting is
11 going to be doing is looking at trying to develop
12 a way -- framework if you will, I don't know,
13 core concepts, if you will, taking all that's
14 going on in all those areas out there.

15 We're not creating a new one, but look
16 at all the various things that are out there and
17 how we might use them to better understand how,
18 you know, where are truly the gaps that need
19 focused, you know, measure development or,
20 perhaps, what Chris Cassel calls measure mining,
21 going out and finding, are people out there
22 somewhere that we're not familiar with at this

1 point in time, you know, doing and using measures
2 in those -- in that way.

3 And so, during the course of your
4 conversation over the last two days, you have
5 talked about some global type gaps, both in types
6 of measures as well as other things.

7 But, before we get started, I just
8 wanted to sort of give you an update.

9 Last year, the -- sorry -- the gaps
10 list was as you see it. It tended to be the more
11 laundry listoid sort of thing. And, I just
12 wanted to show you where the MUC list from this
13 year kind of addressed things.

14 And so, I think there are still some
15 areas that are potentially a gap. But, I would,
16 again, would like to notice that if you go down
17 to -- down the list down to trauma care and
18 geriatrics and fragility, you can kind of draw a
19 line.

20 And then, there are other types of
21 measures that look at the set differently around
22 things, diagnostic accuracy. I know, Bruce, you

1 had mentioned diagnostic efficiency at one point.
2 So, that's something that's not condition-based
3 but may be a type of approach to looking at
4 quality that may be a little bit different.

5 What we saw over the last two days is
6 meeting the gaps in a measures or specialties
7 with few measures. I mean, that's pretty much
8 what we've done.

9 And then, measures for EHRs that
10 promote interoperability.

11 There were really only, I think, three
12 e-measures within the set of measures we saw
13 despite it being an identified need and goal for
14 CMS.

15 So, in terms -- so I'd, you know,
16 really like to hear some thoughts about it. Kate,
17 did you have anything specific in terms of gaps
18 that would be -- how would -- can the MAP
19 particularly assist and provide, you know,
20 meaningful feedback to CMS on this subject?

21 DR. GOODRICH: So, part of the reason
22 you haven't seen a lot of these gaps over the

1 years filled is probably because there's a
2 dispersion across a number of developers
3 developing measures for the clinician setting.

4 We actually have developed very few
5 measures for the clinician setting historically.
6 You know, because that's really been done by
7 others.

8 And so, when you have that many people
9 developing measures, there's not necessarily a
10 unified approach.

11 Now, we have an opportunity here to
12 make some inroads on this or whatever other list
13 or expanded list we come up with in part because
14 we will be starting to develop measures as
15 required under MACRA.

16 So, I think, you know, I feel like
17 when we talk about gaps, we often but not always
18 come up with at least some very similar themes in
19 terms of types of measures and even areas like
20 geriatrics and frailty and diagnostic accuracy,
21 which, by the way, is really tough. But, we
22 think we're working on.

1 I think what would be helpful for us
2 is not only, you know, continuing to think about
3 where there are key areas where there's no
4 measures or very few, but prioritization, because
5 that's going to be I think the big thing that
6 we're going to be challenged with once we start
7 developing measures. It's how do we prioritize?

8 It's actually not a huge amount of
9 money. It may sound like it is, but it's
10 actually not. And, we also feel -- are sort of
11 debating internally with, you know, how much do
12 we put into what I'll sort of call the
13 infrastructure for measures related to
14 standardized and data elements and standards and
15 that sort of thing in addition to developing
16 actual measures. I don't know if folks have
17 thoughts on that, but we'd welcome that.

18 So, for me, I feel like we sort of
19 know the general types of measures that are
20 needed, you know, it's what's in MACRA, it's what
21 everybody's talked about here.

22 If there are additional areas beyond

1 what's on this slide, we want to hear that. But,
2 for us, it would be really helpful to hear about
3 prioritization. What is needed most fastest?

4 CO-CHAIR WHITACRE: I was daydreaming.

5 David?

6 MEMBER SEIDENWURM: To get the ball
7 rolling, I'm going to start with diagnostic
8 accuracy because I can't help myself.

9 And, I think that there are ways that
10 we can get at diagnostic accuracy indirectly.
11 But, directly getting at diagnostic accuracy at
12 this stage of the game I think is, you know,
13 beyond our ability.

14 I mean, there's just been a, you know,
15 an IOM report that -- and they pretty much threw
16 up their hands and said, you know, we need more
17 research and, you know, they said it better than
18 that, but we do need more research.

19 But, in the meantime, we can get at a
20 lot of the intermediate steps, I think, or at
21 least some of the bigger problems in diagnostic
22 accuracy in three or four different ways, you

1 know, if we had the proper encouragement I think.

2 One thing that we could look at, for
3 example, was we could just have a metric of
4 autopsy rate, you know, per whatever unit at the
5 hospital and then, you know, that would
6 ultimately get people thinking about diagnosis
7 and it would encourage that.

8 So, maybe even some kind of hospital
9 measure maybe or other type of population-based
10 metric of autopsy rate, again, to be developed.

11 There are -- appropriate use measures
12 are actually diagnostic accuracy measures.
13 They're appropriate use of diagnostic procedures
14 because, by enriching the prior probability of
15 disease in the population, they make the
16 predictive values of the outcomes of the test
17 more usable, you know, and higher.

18 So, I think if we encourage
19 appropriate use measures in diagnostic tests, and
20 we've heard about endoscopy and, you know, other
21 imaging tests and I'm assuming also laboratory
22 tests, you know, that behave in the same way.

1 So, I think that we could improve
2 diagnostic accuracy, you know, for our whole
3 health care system in that way.

4 The other thing that we can do is by
5 looking at bringing in metrics that exist in
6 other areas of medical practice into these
7 programs to emphasize their importance.

8 And, for example, in the hospital
9 outpatient for perspective payment system,
10 there's a mammography recall measure that's based
11 on administrative data. It's, you know, it's
12 about as well tested as a measure can be. I mean
13 it's been in Hospital Compare now for I'll say
14 five years, but it could be, you know, plus or
15 minus. And so, we could bring that in.

16 And I think, in addition to that, if
17 we could bring in other easily calculable for
18 mammography metrics such as biopsy positive
19 predictive value and invasive cancers per
20 thousand and things like that, that would help
21 us, you know, square the whole circle around the
22 mammography guideline controversy because, you

1 know, the issue is what is the level of harms
2 that we're doing, right?

3 And so, if we could measure those
4 things, we could decrease the level of harms and,
5 therefore, the controversy about the number of
6 women getting mammograms would commence shortly,
7 we would help diminish.

8 And then, another area that we can
9 look at in imaging, and I think this would also
10 have to do with other types of diagnostic
11 procedures -- again, I'm going to use endoscopy
12 as another example, would be the sort of
13 incidental findings problem.

14 And, we've put forward a metrics in
15 imaging incidental wellness, you know, imaging
16 incidental findings that, you know, have not made
17 it through the process for various reasons.

18 And, you know, I think if we encourage
19 those things, then at least we would improve
20 diagnostic accuracy, not necessarily by
21 increasing sensitivity, but by increasing
22 specificity, which is the other side of the

1 diagnostic coin.

2 Another area in which we could
3 increase diagnostic accuracy was if we thought
4 about kind of care families. And, I don't know
5 how to say that exactly, but what I'm trying to
6 say with that is, if we're saying that a certain
7 procedure should be done, you know, be it a
8 surgical procedure or a diagnostic procedure of
9 some sort, then if we had metrics with respect to
10 the quality of that procedure, then we would wind
11 up with diagnostic accuracy in the sense of the
12 procedures would be indicated to begin with and
13 they'd be performed correctly.

14 So, I think if we thought that way --
15 and, let me give a specific example. And, I
16 think it was proposed a couple of years ago in
17 colonoscopy, you know, there were certain, you
18 know, four or five metrics of colonoscopy
19 quality, you know, withdrawal time, you know, how
20 far do you get? You know, what's the interval
21 between them? You know, what did you do with the
22 specimens? And things like that.

1 That there must be analogous
2 opportunities for all kinds of other care with
3 respect to, you know, diabetes or, you know.

4 So, I think if we kind of thought
5 about nests of measures, you know, that might be
6 appropriate to the subspecialists along the way,
7 that would then, you know, contribute to whatever
8 this apex is, we might help in that whole sphere
9 of things.

10 CO-CHAIR WHITACRE: Terrific, thank
11 you.

12 Peter?

13 DR. BRISS: So, part of our problem is
14 that -- so, I should have said in my disclosures
15 yesterday that I'm a lumper not a splitter,
16 right? So, I've now disclosed.

17 I think part of our problem is that
18 that makes some of these gaps so hard to fill is
19 that we're so hyper-specialized in the measures
20 that get developed in part because the people
21 that are developing measures are -- kind of start
22 from a very specialty orientation. Right?

1 You know, so it strikes me that for
2 many of these gaps on things like patient
3 experience, shared decision making, care
4 coordination, there might be -- you might be able
5 to design a few measures that address a whole lot
6 of quite different patients and providers.

7 And, we might be able to meet a lot of
8 our needs sort of for parsimony,
9 understandability, meeting the needs of multiple
10 specialties. You know, there's all kinds of
11 problems -- and I kind of said some of this
12 yesterday, that there are all kinds of problems
13 that could be, in principle, solved by having
14 some -- seeing if there's some areas where we
15 could get some general measures that applied
16 across contexts.

17 And, the let a thousand flowers bloom
18 bottom up structure of getting measures submitted
19 doesn't help us with that very much. Maybe the
20 incubator could help us with some of that stuff.
21 Right?

22 And, to a lesser extent, some of that

1 could also be done in the more topical measures
2 that I would encourage developers and committees
3 to, whenever they see a measure, to think about,
4 so what's the broadest denominator to which this
5 measure could be put?

6 You know, so we had an experience
7 lately with, I can't remember the details, but we
8 saw a measure concept under development, but it
9 was for some sort of -- some specialized subtype
10 of dementia.

11 And, it was sort of how well are they
12 thinking, right? You know, and so, it struck me
13 that this might apply to essentially every
14 dementia, perhaps, and maybe even a broader set
15 of neurologic diseases. And, you might be able
16 to address a whole lot of things at the same
17 time.

18 I think we could do much more at
19 broadening things than we're currently doing.

20 CO-CHAIR WHITACRE: Thank you.

21 Luther, Beth, and then Bruce.

22 DR. CLARK: One area that I think

1 might be a gap but may be included under shared
2 decision making and that is really how do we
3 better include patient values and preferences?
4 And, not necessarily new measures, but which of
5 the measures might either lend themselves to this
6 or be impacted by considering what the patient
7 values and preferences are?

8 And, I was thinking back in terms of
9 some of the discussions around conservative
10 versus invasive approaches, you know, in the life
11 care where a patient preference might influence
12 the decision, but we're measuring, you know, the
13 clinician's performance.

14 So, if we look at the current
15 measures, which of those might lend themselves to
16 taking that into consideration?

17 CO-CHAIR WHITACRE: Thank you.

18 Beth?

19 MEMBER AVERBECK: As I look at the
20 measures around prioritization, you know, as
21 we're starting to see the costs of care go up
22 again, I wonder if we want to put a lens on

1 around, you know, are the quality measures where
2 we are, they're not perfect.

3 Are they good enough that they might
4 be good enough to then say should we switch our
5 efforts to either those -- and I'm a bundler too.
6 So, is it around shared decision making across
7 either existing measures or a shared decision
8 making that could be applied to one?

9 And that I would put under patient
10 experience because I don't know that it
11 necessarily saves costs.

12 But, now we have choosing wisely and
13 more comments around appropriateness. Is there
14 an opportunity to take a look at some of those
15 choosing wisely categories and are there measures
16 that are being developed around those categories?

17 Are we even taking a look at
18 preventative services? We've done a really nice
19 job of measuring underuse, have we measured
20 overuse? Pap intervals? When do you start?
21 When do you stop? Colonoscopy intervals?

22 I mean there might be -- so, that's

1 maybe small dollars individually, but it's large
2 volume and it's -- so, potentially looking at
3 appropriateness might be an area.

4 CO-CHAIR BAGLEY: You know, this is
5 probably going to sound like it's really off the
6 wall, but I'm going to try to make a point in the
7 end, so bear with me for a minute.

8 You know, in other places in our
9 society, let's take publically traded companies,
10 they're measured by some very specific outcome
11 measures that everybody knows what they are.
12 And, nobody tells them which process measures to
13 use to get outcomes like profitability and market
14 cap and, you know, EBITA and all that kind of
15 stuff. That's just stuff that that's how we
16 measure them. They're very clear outcomes for
17 companies.

18 And, we don't go to those companies
19 and say, well, you know, if you use these process
20 measures, you'd do better on the stock market.
21 We don't do that. We let them figure that out
22 themselves.

1 So, my point is that, is there some
2 way that we can foster participation in quality
3 improvement that has some outcomes?

4 Now, here's where I'm going next, and
5 the outcome ought to be health. You know, we're
6 on a path to try to measure every little tiny
7 piece of the medical industrial complex and make
8 sure that we whip them into shape.

9 I think that, to some degree, is a
10 fool's errand as was Peter's point, I think.

11 But, what about if we had a measure of
12 health? So, let's think about an ACO getting a
13 global payment to take care of a population of
14 people. Or, for that matter, a community that's
15 undertaken the health of their population, what
16 measure might be most -- so, here's all or none
17 composite for you. It's BMI, blood pressure under
18 control, smoking, you know, some stuff that
19 really would make a difference, you know, age
20 appropriate screenings and immunizations.

21 And, sort of, you know, these are our
22 at least intermediate outcome measures for

1 health. What a concept. I mean, I don't see
2 that on this list anywhere.

3 So, I'm sorry, that's probably not
4 what you're looking for, but sometimes, it's time
5 to rethink how we're trying to accomplish what
6 we're trying to accomplish. It's the old idea
7 that if we keep pulling people out of the river
8 without going up the river to try to find out why
9 they're falling in. We're just pulling them out
10 of the river, we're not finding out why they're
11 falling in.

12 CO-CHAIR WHITACRE: That's great,
13 thank you.

14 Amy, Jim, and then Robert.

15 MEMBER MOYER: I have a bunch of
16 things to build on here.

17 In terms of priorities off the list,
18 I think definitely, you know, patient-centered
19 measures -- especially as I was looking through
20 the cancer set, you know, we don't have a lot
21 about functional status, symptom management, pain
22 management, those kinds of things.

1 You know, patients are there
2 throughout the whole process of care. It's
3 potentially a really rich source of data that
4 we're just not tapping as much as we could be.

5 I think appropriate use isn't
6 necessarily specifically called out in there.

7 I'll also out myself as a lumpers and
8 part of that is as I think of, you know, we are
9 working at transforming how we pay for health
10 care. We pay providers and we're just on the
11 start of a bundled payment journey.

12 And, to kind of do those things, the
13 measures you need, you need a lumped, broader
14 measure set. Really specific measures don't lend
15 themselves well to that kind of application
16 because you need to have a risk pool and a larger
17 sum of patients.

18 And, I like your health measure. I
19 kind of have a five that I always talk to
20 people about, you know, physical activity,
21 healthy eating, don't drink too much, don't
22 smoke. And, if we could do all those things

1 without stressing people out, that's my fifth,
2 because that would be really good.

3 So, I think that's all of my points.

4 CO-CHAIR WHITACRE: Terrific.

5 Jim?

6 MEMBER PACALA: I know you've thought
7 about this, but I would make a bid for better
8 measures for care of the complex multimorbid
9 patient.

10 And, I see in the MAP the idea of
11 quality-based compensation and improvement going
12 the way of guideline development. And, you know,
13 we've developed all of these guidelines and the
14 guidelines for all these different specialty
15 societies, right, and they came up with very
16 specific recommendations that, when you're taking
17 care of a multimorbid or a frail patient are
18 often inappropriate or often dangerous.

19 And so, you end up making a conscious
20 decision as a team or a clinician to go against
21 what you know is a guideline recommendation and
22 you're doing it for a patient-centered overall

1 functional outcome purpose.

2 And so, I know now guidelines are
3 starting to adjust, the whole idea of guideline
4 development is trying to adjust for that.

5 So, I'd like to see quality do the
6 same thing. And, you know, I think if we could
7 figure out measures in which somehow a care team
8 or a provider demonstrated that they made an
9 appropriate patient-centered decision that was in
10 concert with the patients' goals, so
11 incorporating goal oriented care into it, and
12 then a conscious decision to not follow a
13 guideline.

14 Or establish an outcome that was of
15 meaning or a goal that was of meaning.

16 So, for example, take diabetes, that
17 there is evidence with different patients that
18 the clinical team has settled upon and a glycemic
19 goal for that patient that is consistent with
20 their overall function, life expectancy and so
21 forth.

22 And, you might say, if a patient -- if

1 a team came up with a glycemic goal of 8.5
2 percent for an A1c for a patient, that might be
3 excellent care. That might be very, very good
4 quality care. And, there might be other
5 processes and care measures that go with that.
6 And, that might also be consistent with what the
7 patient wants.

8 Whereas, for another patient of the
9 same age, a goal of 7.5 percent might be
10 appropriate, depending on what their
11 comorbidities are and functional status.

12 And that, I think that reflects higher
13 quality care. So, I know people are working on
14 that, but if you could somehow capture that type
15 of thoughtful patient centered decision making
16 that was looking at the combination of
17 multimorbidities rather than looking
18 independently at each morbidity in a multimorbid
19 patient. Very hard to do but -- and I know
20 people are working on it.

21 CO-CHAIR WHITACRE: Thank you.

22 Robert and then Stephanie and then

1 Cindy?

2 MEMBER KRUGHOFF: I think this is
3 wonderful, everything I'm hearing and quite
4 ambitious, but I think we're talking about the
5 things that need to be done.

6 I'm going to be a little more -- even
7 more remote from reality here, I think, in the
8 sense that MIPS wants to do something or wants
9 help with us to do things they can measure, you
10 know, this year or next year, four years from
11 now.

12 I'd like to think of our role as a map
13 for clinicians to also be thinking how can we
14 create the kinds of databases that are necessary
15 to do a vastly broader range of much more
16 meaningful measures?

17 And, maybe I'm picking up on what you
18 were saying also, Bruce, that, you know, it's the
19 overall system.

20 And so, you know, it's obvious to me
21 that the limitations of the -- of what's coming
22 out of the EHR, the Meaningful Use expansion.

1 Okay? And, I think it's wonderful that we're
2 moving, you know, forward with the EHRs but the -
3 - it's just very slow that we're moving toward
4 having massive pooled databases of real clinical
5 information.

6 And, beyond that, even more
7 frustrating that, you know, getting to the point
8 where that's -- those data are actually
9 analyzable, you know, by the Feds if they want to
10 do it or by anybody else who wants to do it and
11 reportable at the individual doctor level or even
12 the practice level, depending on what the
13 appropriate level is.

14 You know, that kind of, you know,
15 moving down that path. I just think we have to
16 shout out to CMS, yes, it's good that you've gone
17 where you've gone with electronic, Meaningful
18 Use, but this is a massive new change that has to
19 be made if we really want to encourage quality,
20 be able to measure quality and be able to measure
21 it so that we're not even -- we're not picking
22 around the immediate possible measures, we're

1 thinking --

2 I mean, there are thousands of
3 measures that could be used for particular
4 situations if you have those EHR data.

5 And, I just think we should -- we need
6 to shout that out, you know, constantly. I
7 think, you know, there are some sort of in
8 between stages where we could have, you know,
9 where hospitals could be more responsible for
10 picking up on lab and imaging data to go along
11 with their claims data.

12 And, if you had those things, you
13 could do quite a bit of analysis that would be
14 more meaningful in terms of quality both of
15 hospitals and of the doctors who are practicing
16 in those hospitals. So, I think moving forward
17 on that, it is possible.

18 And, as those of you who've been on
19 this -- put up with me on this committee for all
20 these years know, I'm very frustrated on the
21 front of patient experience because I think we
22 know how to do it.

1 And as some of you know, you know, my
2 organization, what, eight years ago or so,
3 demonstrated that it's not that expensive to do.
4 I mean, it's, you know, \$120.00 a doctor or
5 something to have really good patient experience
6 results.

7 And, the fact that CMS has not pushed
8 forward on that so that includes, you know, that
9 could include shared decision making, care and
10 coordination. It can include communication, all
11 those are things that are very important to know
12 about doctors, and have clear relationships to
13 outcomes.

14 And, CMS is just -- just hasn't picked
15 up on this. They could do it, it's very doable.
16 I mean it would cost, you know, millions of
17 dollars, but tiny next to some of these other
18 things that we're talking about. So, that, I
19 think, is very frustrating.

20 And then, I think patient reported
21 outcomes, it's a much more problematic thing to
22 get people to, you know, everybody to respond on

1 what their conditions were and what their
2 outcomes were, et cetera. But, I think that
3 would be a very good thing.

4 You know, I remember years ago I was
5 on some IOM committee and the suggestion was, we
6 should require patients every year when they want
7 to renew their health insurance to fill out, you
8 know, some sort of health status measure and
9 functional status measure, et cetera so we just
10 have this on an ongoing basis.

11 At any rate, all these things have to
12 do with building the information infrastructure
13 that takes us beyond the point of picking up on
14 the particular measures, many of which are
15 process measures or intermediate outcome
16 measures, to actually having measures that really
17 get to the final thing that we want, you know,
18 that those corporations are trying to achieve.

19 CO-CHAIR WHITACRE: Stephanie and then
20 Cindy?

21 MEMBER GLIER: Thanks.

22 I think I'm mostly building on what

1 other folks have said, so bear with me a little
2 bit.

3 I think in terms of prioritizing for
4 a case request for some input on priorities, I
5 agree with Robert wholeheartedly that I think we
6 need to -- I would very much like to see CMS
7 invest some money from the MACRA measure
8 development stream in the data infrastructure.

9 We need to do a better measurement
10 pipeline overall so that there's faster, easier
11 measure development and we're not relying on slow
12 processes to the -- at least as we are now.

13 I, unfortunately, don't have a whole
14 lot of like really brilliant insights about what
15 that looks like, so happy to --

16 CO-CHAIR BAGLEY: It's called
17 Meaningful Use. I'm sorry.

18 MEMBER GLIER: I'm not touching that
19 one.

20 Health related quality of life, I
21 think there is a lot to be said for health
22 related quality of life tools. I think building

1 them into functional status and patient reported
2 outcomes would be really valuable so that we're
3 not only looking at what is your function
4 specific to this individual condition but also
5 how are you doing more generally.

6 So, if there are measures we can build
7 out of PROMISE or other tools that do that sort
8 of general how is your health work, I think that
9 would add a lot to the sort of patient experience
10 tools we have now with CAHPS where it's about
11 your experience intersecting with the health care
12 system.

13 But, we also need to know how you are
14 doing on your own in your life where you exist
15 most of the time as a patient.

16 And, similarly, and I think this
17 actually builds a little bit on what Jim was
18 saying earlier, I certainly empathize with the
19 specialties who don't feel like they have enough
20 measures to report or they have no measures to
21 report.

22 But, I would really encourage CMS not

1 to take that bullet point that's listed on the
2 gaps from last year as a current priority. I'd
3 rather reframe it as thinking about patients who
4 need care and what good care looks like for them.

5 So, I think this reflects back on the
6 conversations we had yesterday when we were
7 looking at the dermatology measure for organ
8 transplant patients. Important thing, we want
9 them to get screened, but there is probably a
10 whole list of good practice care for organ
11 transplant patients who, all of those things
12 should be met regardless of which practitioner
13 you are seeing.

14 And I think there's some work to be
15 done making sure that those providers can work
16 together to come up with the right measure and we
17 can do the right attribution of things.

18 But the patient centeredness of that
19 needs to be focused on what does good care look
20 like for a patient? How can we help people be as
21 healthy as possible? And, how can we use the
22 resources in the system to the best effect?

1 CO-CHAIR WHITACRE: Thank you.

2 Cindy and then Mady?

3 MEMBER PELLEGRINI: So, I'd like to
4 put in a big plug for care coordination. But,
5 not just among providers, really starting to
6 think about care coordination out into the
7 community and out into all different other parts
8 of, not just the health care system, but all the
9 other kinds of supports and services that a lot
10 of people need.

11 And, I won't take too long, but I want
12 to commend to folks two articles or pieces that
13 appeared in the media in the last week that I
14 think crystallize this argument more than
15 anything else I could ever say.

16 The first was The Washington Post on
17 Sunday had a front page article about the 16-
18 year-old who was the youngest survivor of the
19 shooting at the community college in Oregon about
20 six months ago.

21 So, she got state of the art medical
22 care as a victim, weeks in the hospital, et

1 cetera. But then, I pulled it up here, because
2 then she got sent home, it says here, to a flea-
3 infested rental home with reinforced locks,
4 curtains darkening the living room where she
5 sleeps because, you know, she can't sleep in a
6 regular bed due to her injuries right now, on a
7 \$5.00 garage sale recliner that her mother
8 bought.

9 So, you know, this is -- and, as you
10 read the rest of the article, what you'll see is
11 that she's getting, it sounds like, you know,
12 she's going from doctor to doctor getting medical
13 care and her mental health is a disaster. Like,
14 her trauma is completely and utterly unaddressed.

15 And, her family's trauma and her
16 mother's and, you know, sort of the incredible
17 stress of the situation that they're in. So,
18 that was the first one.

19 The second was that Reuters did a
20 series on neonatal abstinence syndrome and this
21 situation of babies that are born exposed to
22 opioids, spend weeks in the hospital. They get

1 better, they get well enough to be sent home and
2 within weeks or maybe a month or two, they end up
3 dead because they've gone home into situations
4 that were not safe, ultimately, and where their
5 mothers and their parents were getting no
6 services, no support, even though they were known
7 to have usually, you know, multiple issues.

8 So, care coordination, but thinking
9 about it very broadly because, we all recognize
10 that only so much can be done in a physician's
11 office or in a hospital or what have you.

12 We really need to broaden our reach.

13 CO-CHAIR WHITACRE: Thank you.

14 Mady and then Scott?

15 DR. CHALK: In that regard, very many
16 of these gaps that have been identified and what
17 we're talking about are the same gaps that were
18 identified in the Duals last meeting. All the
19 ones from multiple chronic conditions, all the
20 patient-centered measures, the trauma care,
21 especially patient reported outcomes and then,
22 optimal function.

1 So, if NQF is interested in
2 crosscutting various committees about what the
3 gaps are, they keep coming up, it seems to me.

4 CO-CHAIR WHITACRE: Scott and then
5 Steve?

6 MEMBER FURNEY: And, adding on what
7 others have said, I think in that list, we now
8 have more than a hundred use measures, overuse
9 measures that have been offered to us by
10 professional societies.

11 So, the choose wisely list, we are
12 adopting many of those internally and creating
13 measures around them. I think that's fairly low
14 hanging fruit that is great to internally
15 benchmark and also use nationally.

16 As I look at this list and I try to
17 think about what would be my highest priority,
18 there's a single measure that has been on my mind
19 for the last six months or so, multiple chronic
20 conditions, trauma care, I know we're supposed to
21 be more general and not more specific, but I will
22 just say I've not seen a measure of polypharmacy

1 unless I missed it in the 350 plus 58.

2 But, it is a problem that affects our
3 geriatric population that generally reflects poor
4 diagnostics and poor treatment. And, if there is
5 the prioritization for a measure that would be a
6 good symptom of the disease, all of that being on
7 that slide, that's one that I see all the time
8 that reflects the failure of the health care
9 system.

10 CO-CHAIR WHITACRE: Steve?

11 MEMBER FRIEDHOFF: Thanks.

12 Two comments, I mean quickly, I'll
13 just kind of pile onto the overuse phenomenon and
14 choosing wisely, in particular, is probably a
15 good place to start there.

16 But, I think the other thing I wanted
17 to bring up is to kind of expand on some of the
18 comments I heard previously.

19 So, and a lot of my work, primarily
20 what I deal with is Medicaid populations, to some
21 extent Duals and Medicare as well. And, I think
22 what we're seeing actually in some of our State

1 partners is that some of the things that we're
2 being judged on as a health plan are real life
3 outcomes.

4 So, employment rates, homelessness
5 rates, re-incarceration rates, now granted, some
6 of those may not be as applicable, hopefully, in,
7 you know, a pure Medicare population, but, I
8 think, again, it speaks to more life outcomes.

9 And, even in Medicare, we're also
10 evaluated using the health outcome survey which,
11 you know, has lots of different questions, some
12 of which are things like, you know, compared to a
13 year ago, is your health better or worse? Is
14 your functional status better or worse? Is your
15 diabetes better or worse?

16 And, I think, while it gets very
17 complicated, it also speaks to how health care is
18 much more complicated than individual measures
19 like this in the social determinants of health
20 care having such a huge influence. I mean, you
21 know, Cindy, your example was a perfect one.

22 So, I think those are tougher ones to

1 tackle, but in the bigger picture, especially
2 with care coordination within the health care
3 system and also other support agencies, it's, you
4 know, something we probably should consider, too.

5 Thanks.

6 CO-CHAIR WHITACRE: Thank you.

7 Next is Rachel, Peter and then Marci.

8 MEMBER GROB: I don't want to compete
9 with the siren.

10 Wonderful discussion. I just have a
11 few thoughts to add in.

12 One is to pick up on a conversation we
13 had yesterday and I already heard Kate refer to
14 it again, but just so it's captured here, the
15 idea with the patient centered measures of sort
16 of taking them out of a silo and creating some
17 composites.

18 I realize that that's a very
19 complicated methodological task, but if we have
20 resources to invest in addressing gaps, part of
21 what we want is efficiency and stronger measures.

22 And, while I'm, you know, of course,

1 all for all of these patient centered measures,
2 I'm also really interested in seeing our
3 measurement evolve to match what I think we're
4 seeing as a growing phenomenon in care which is
5 more activated patients, more engaged patients, a
6 health care system that wants that, understanding
7 that issues of value and cost are most wisely
8 addressed by making the patients partners to the
9 extent that we can and sort of like a power shift
10 in the like sociology of our health care system.

11 Which, I think our measurement would
12 be do well to evolve towards as an innovation.

13 So, I'd like to see us do some of that.

14 I also think, from a patient's
15 perspective, and those of you who have been here
16 in past years have heard me say this before, but
17 I'll say it again, that we know that patients
18 really want that qualitative or narrative data,
19 those comments.

20 I heard some of the presenters
21 yesterday mention that. So, in thinking about
22 measure gaps, I think our measurement doesn't

1 give patients a lot of the narrative data or
2 really any of it yet. And, that's another
3 innovation that I'd like to see us experiment
4 with.

5 And then, finally, I really echo what
6 several people have said about choosing wisely
7 and, I think we have a lot to learn about how, on
8 the public reporting side, I know we're going to
9 get to that discussion, but it's connected to the
10 gaps, you know, what that really means for
11 patients on how we create an ethos that helps
12 patients understand those measures as vitally
13 important to them, not just to sort of saving
14 money for somebody else.

15 So, I think developing measures and a
16 strategy that take what we're learning from
17 choosing wisely and the tremendous work that the
18 professional societies have done and bring it
19 more into the public reporting realm, building on
20 some innovations that some of you have already
21 been experimenting with and then, thinking about
22 that very strategically.

1 CO-CHAIR WHITACRE: Thank you.

2 Peter?

3 DR. BRISS: I would be remiss, I've
4 co-chaired the behavioral health committee and
5 when we were talking about gaps where mental
6 health and behavioral health always get
7 underemphasized relative to physical health and
8 relative to risk, it's a burden. And so, that's
9 something to keep an eye on.

10 The other thing I would say is, I sort
11 of I love choosing wisely, but I don't think it's
12 the thing that's going to move the needle on
13 overuse or cost.

14 So, I don't see how we can ever make
15 much progress in a global sense from trying to
16 push one overuse of one service at a time. There
17 are just too many of them.

18 And so, I would echo, I think what
19 Bruce was saying earlier, I think we need some
20 much more global measures. We probably need some
21 version of a generally accepted total cost of
22 care measure and some way of pairing that with

1 measures of good quality so that people could get
2 some sense of what value am I getting from my
3 investment. I don't see how we can ever get
4 there one service at a time.

5 CO-CHAIR WHITACRE: Thank you.

6 Marci?

7 MEMBER NIELSEN: I'm going to not
8 repeat all the good things that people said, at
9 least try to. But, I do want to repeat something
10 that Janis mentioned yesterday which is that we
11 have as the unit of analysis in many of these
12 measures. And, I know we've got the group level
13 measures, but we don't measure at the team level.

14 And, as we're trying to change care
15 delivery, what's happening with the multiple
16 measures we have is that the physicians or the
17 nurse practitioners, the person being measured,
18 feels the weight of the world on their shoulder
19 and begrudges all of these measures.

20 But, if they felt like we were
21 starting to measure how the team managed some of
22 these episodes of illness, I think that would be

1 very important.

2 The second piece of that links to how
3 providers see the world is they are feeling
4 incredibly burdened in many, many of specialties,
5 certainly in primary care. And, what are we
6 doing about that?

7 We don't measure -- I mean I'm going
8 to say something about patient experience in a
9 minute, but what about provider experience? And
10 what do we know about what correlates between
11 providers and their satisfaction in their job and
12 whether they're burned out and stressed out and
13 the extent to which that impacts patient
14 experiences?

15 And, we know there's some correlation,
16 but we don't have great measures because we don't
17 have a lot of them.

18 Which links to my final measure
19 regarding patient experience and the CAHPS survey
20 and everybody knows that CAHPS is important, but
21 it's not sufficient. The people who read CAHPS
22 are health care providers, they are not

1 consumers, by and large.

2 The measures that we use for patient
3 experience are not driving consumer behavior in
4 any real way and I don't have the magical
5 answers, but we've got to figure that out because
6 patients don't feel engaged.

7 And, importantly for those folks who
8 are -- have behavioral health issues or multiple
9 chronic illnesses, many of them can't and won't
10 ever fill out a CAHPS survey.

11 So, what are we doing to get the
12 proxies involved? And that's a terrible name,
13 the proxy. Well, how about family and care
14 givers? And what are we doing about family and
15 care givers' experience?

16 And, there's -- I can't believe
17 there's not a single person in this room who
18 hasn't had their own experience. But, my 51-
19 year-old brother at the beginning of the summer
20 was diagnosed with what he thought was the flu,
21 quickly found out it was cancer. He was gone
22 four months later.

1 And so, I got like a CLEP test --
2 that's him telling me right now to shut up.

3 And, we have lots of illness in my
4 family, so again, we've all been in these shoes,
5 but I felt like in four months' time, I got to
6 see it all from the family care giver, my brother
7 was brilliant but took terrible, terrible care of
8 himself, didn't have a good primary care
9 provider.

10 To see that range, wow, was I wrong
11 about what patients and families care about and
12 this is what I do for a living.

13 So, back to Rachel's point about
14 collecting the narrative and using the narrative
15 to help us understand the quantitative. We are
16 so stuck on the quantitative and providers are so
17 frustrated by it. We are missing the forest
18 through the trees when it comes to how we
19 actually take care of a patient and their family
20 so that they do something differently.

21 And then, the patient and the family
22 goes away when the person's gone and I haven't

1 circled back to the nurses on that oncology unit
2 who I am so indebted to.

3 So, how do we make those people who
4 work tirelessly feel valued in this process? We
5 just throw more measures at them. Something is
6 wrong.

7 CO-CHAIR WHITACRE: Thank you.

8 Bruce?

9 CO-CHAIR BAGLEY: Yes, when Janis
10 mentioned team-based care yesterday, I wanted to
11 say something, it just didn't seem like the right
12 place to, but now, it's open forum.

13 You know, I think your first two
14 points actually can drive more team-based care.
15 In other words, as a physician, I am beginning to
16 realize that I can't do well on measures without
17 a systematic approach, a team-based care.

18 And, you know, that would provide me,
19 by the way, with better satisfaction about my
20 work because I wouldn't feel it was all on my
21 shoulders.

22 So, it's really kind of, it is in some

1 ways part of the solution. All you have to do is
2 get physicians, clinicians to recognize that the
3 only way they're going to do well at this stuff
4 is with team-based care.

5 CO-CHAIR WHITACRE: Thank you
6 everyone. Great discussion.

7 David?

8 MEMBER SEIDENWURM: To make one point,
9 by the way, thank you so much for that. That
10 was, you know, just a magnificent point to make
11 and thank you.

12 Just maybe to go back a little bit to
13 the mundane, we do need something about data
14 interoperability. The power of even just
15 rudimentary claims data at an all payer statewide
16 level compared to the piecemeal data approaches
17 that are in the hands of any one payer or any one
18 provider is just extraordinary.

19 And, you know, I don't know if, you
20 know, Rob's going to get fired or me because the
21 radiologist is agreeing with the consumer, you
22 know, advocate. You know, so I don't know if

1 something's going to happen bad here.

2 But, we've just got to have -- we've
3 just got to put this data to use, you know, in a
4 humane way that allows us to improve care at the
5 level of the community.

6 And, it's just amazing what is out
7 there, but that we just can't get to because it's
8 so fragmented. And we need, you know, I'm no
9 major fan of, you know, government regulations,
10 blah, blah, blah, blah, blah, but this is one
11 area, if we as a society are paying for this
12 stuff, then we ought to be able to use it and
13 that the commercial enterprises, including my own
14 that are the repositories of these things, you
15 know, have to commit to an architecture of
16 sharing so that we can learn from this data
17 that's been collected.

18 CO-CHAIR WHITACRE: Well, thank you so
19 much. I can't imagine a better discussion. I
20 wonder if I could invite questions or input from
21 CMS or from the MAP staff? Is there something
22 more you would like to know? Can we add to this

1 discussion?

2 MS. AUTREY: No questions from me. I
3 think that was a lot.

4 DR. WINKLER: Kate actually apologized
5 that she had to step out for a phone call. But,
6 I think the one thing is, is we've all had a
7 chance to talk. I heard some common themes, but
8 do you feel like you gave CMS a sense of
9 priorities? Because, their resources are not
10 limit, you know, limitless.

11 And so, do we feel like we, you know,
12 a lot of wonderful things, no doubt about it. It
13 was, you know, I hope Santa's listening. But, do
14 we feel like we've provided priority? Like, do
15 this one, two, or three things first, because
16 they're urgent.

17 CO-CHAIR BAGLEY: The one thing I
18 heard from the conversation, about a number of
19 different measures, and just by the nature of how
20 we gather measures, they tend to be very
21 specific, like, the pathology reporting measure,
22 you know, why shouldn't it be for all reports?

1 So that kind of thing.

2 Anytime that they can make it as
3 broad, as possible, to provide, to give guidance
4 to all providers about all types of things, would
5 be a clear one, in my mind, anyway.

6 CO-CHAIR WHITACRE: Peter.

7 DR. BRISS: I agree with that. And at
8 least, at least three people around this table,
9 sort of, outed themselves as lumpers, which is a
10 new world indoor record for a measurement table,
11 right? Right, Andy?

12 And so, so you could make a case for,
13 you could make a case for, sort of things that
14 apply broadly ought to be of, generally, of
15 higher priority than things that are more narrow.

16 DR. WINKLER: Okay.

17 CO-CHAIR WHITACRE: May I make a
18 proposal? It sounds like we need to be finished
19 by 3:00 p.m., for most people to make flights, is
20 that correct? The agenda goes beyond that, we
21 have time beyond that.

22 So to prioritize, in my mind, I really

1 need a list. And I've got a list of multiple
2 things here, but I have some things missing from
3 the list.

4 Could we take a couple of minutes to
5 create, while this is on the screen, a new list?
6 I missed, I don't see appropriateness of care, or
7 intervention. We've asked about polypharmacy.

8 Is it okay to take the time? It might
9 take us 15 minutes to pull from this list and
10 just start to add things to a new list and that
11 would be our prioritized list.

12 Because, I still think we have many
13 great ideas, but I don't have a sense that we
14 have a consensus on, this is number one, this is
15 number two, or these are the top three, these are
16 the next three, and those are the next three.

17 Can we do that on the screen, just
18 real-time? So would that be all right with
19 everyone? Just as, I mean, they're asking, the
20 question was prioritization.

21 We have great ideas, no one disagrees
22 with that. We have a multitude, however, of

1 ideas and I think there's an opportunity here,
2 because I know, in discussions, and this may come
3 up, we've asked for what's the feedback from, how
4 do we know that our, our concerns are being
5 heard? We'll have a list. Is that okay with
6 everybody? Okay, super, proceed.

7 MEMBER NIELSEN: Might I make one
8 additional process recommendation to Eric, and
9 that is, there was a list that they generated.
10 You could, simply, tell us, pick three. You only
11 get three.

12 Everybody look at that list and we can
13 have a new list, and raise your hands, who thinks
14 that ought to be, like, if you want a
15 quantitative number for what CMS has already
16 prioritized, and then give us an opportunity to
17 do a new list.

18 DR. WINKLER: Yes. Just to make sure,
19 that list was your list from last year.

20 MEMBER NIELSEN: Oh.

21 CO-CHAIR WHITACRE: Know that we have

22 --

1 MEMBER NIELSEN: Damn.

2 CO-CHAIR WHITACRE: -- CMS' list and
3 they're asking us for one, it sounds like
4 indirectly, through the MAP, so this is a real
5 opportunity, in my mind, I just can't think
6 clearly enough to prioritize all these various
7 topics and understand, as well that this has
8 been, you know, I have my prioritization, but I
9 don't have a sense that this is what the group
10 consensus is, so we have an opportunity, with
11 informatics, we can just put one screen, one
12 slide up, put another slide up and we'll make our
13 own list. Is that all -- hands are going back up
14 again. The slides are not up. Is this a comment
15 about process, or prioritization? Robert.

16 MEMBER KRUGHOFF: I guess, I think we
17 should deliver a broad message and a
18 list-by-list, you know, and a list message, and I
19 do think they're quite different. And I think we
20 have to say, there's some real underlying system
21 changes, in terms of availability of data. All
22 right --

1 CO-CHAIR WHITACRE: I think it's up to
2 us what's on the list, is that a -- we can add,
3 we can add broad priorities, as a --

4 MEMBER KRUGHOFF: Okay that's fine.

5 CO-CHAIR WHITACRE: -- as a topic.

6 (Simultaneous speaking.)

7 MEMBER KRUGHOFF: That's fine. But,
8 to me, it's very different from saying we need,
9 you know, now I've lost some of those items on
10 the list, but, you know, some of those are quite
11 specific, as opposed to, you know, things that I
12 think need to be done, which are, you know, just,
13 you know, have a meaningful use system that
14 actually produces data and --

15 CO-CHAIR WHITACRE: The prioritization
16 may be about process, it could be about fixing IT
17 problems.

18 (Simultaneous speaking.)

19 MEMBER KRUGHOFF: Okay.

20 CO-CHAIR WHITACRE: Or, it could be
21 about deliverables from the MAP, which are more
22 specific.

1 DR. WINKLER: Let me, let me, also
2 just say that, I think, the priorities, which was
3 the specific ask, are important, but in the
4 context of the writing that we do with the
5 deliverable, we can certainly mention other
6 things, so I don't think they're mutually
7 exclusive.

8 MEMBER KRUGHOFF: Yes.

9 DR. WINKLER: But I do think we were
10 specifically asked for priorities, and it would
11 be useful to be able to deliver that, that ask,
12 specifically.

13 CO-CHAIR WHITACRE: This could be like
14 our individual measures. We'll have some
15 measures that we think are gaps and we can
16 prioritize them and say, well we have some
17 overriding comments about this, you need to fix
18 informatics, interoperability, you need to fix
19 public health, whatever.

20 Those are comments. They've asked
21 for, they've asked for a list of prioritized gaps
22 in their measure set. We should be able to

1 deliver that.

2 MEMBER KRUGHOFF: Okay, so are we
3 deciding that, that we talk about the, we talk
4 about those more specific things, and then hope
5 that the comments convey the other thing, or can
6 we actually say, a priority has changed the whole
7 damn system?

8 CO-CHAIR WHITACRE: That's a hard one
9 for them to address. I mean, so --

10 MEMBER KRUGHOFF: That's my priority.

11 CO-CHAIR WHITACRE: -- can we show the
12 list and then have a second slide, or bring two
13 lists up, so we can just pull things one to the
14 other?

15 There you go. So if you can just
16 spread, you can either make two columns in
17 PowerPoint, and then we'll bring things -- so
18 this is the existing list from last year, this
19 was our list.

20 I would maintain, there are some
21 things, you'll have to move them all to one side.
22 Hopefully, it won't be too small. They've asked

1 us to prioritize this and additional new topics.

2 For example, I don't see
3 appropriateness on this. There may be some
4 things that are missing from this list. So if we
5 pull that over, you'll have to display it, maybe
6 -- yes, Bruce?

7 CO-CHAIR BAGLEY: So I'm going to
8 continue my theme. I think there ought to be
9 some measures of health, or something that
10 promotes health.

11 And, to be more tangible, there's
12 actually measures under development and use, and
13 in some places, around preventive services, for
14 instance. And, you know, why isn't that on the
15 list tonight?

16 I'm especially thinking about MSSP.
17 You know, if you're actually having something
18 that's supposed to take a global payment around
19 the health of a population that would be an ideal
20 measure to use in the MSSP.

21 CO-CHAIR WHITACRE: So one, one thing
22 on the list would be global health measures?

1 Yes, Barbara.

2 MEMBER LANDRETH: This might address
3 some of the patient-centered aspect, as well as
4 interoperability, but what I would like to see is
5 a global patient portal that's independent of any
6 EHR system that's owned by the patient that is a
7 repository for all of their medical information
8 that goes with them anywhere they go, and
9 contains information that providers can access
10 and can be used for shared decision-making with
11 patients and providers.

12 CO-CHAIR WHITACRE: I think these are
13 great ideas. We're at a very high level. We
14 need deliverables that will work, tell me if I'm
15 wrong, Sophia, that will work within -- this,
16 these are important ideas, so they belong on our
17 comments. We need to prioritize measures, in a
18 way that's actionable, for CMS, for the upcoming
19 MIPS and MSSP Program.

20 MEMBER KOPLAN: Hi, this is --

21 (Simultaneous speaking.)

22 CO-CHAIR WHITACRE: Hello?

1 MEMBER KOPLAN: Hello?

2 CO-CHAIR WHITACRE: Yes?

3 MEMBER KOPLAN: Yes, hi. One area
4 that I don't see on this list that, I think, is
5 important, since over 30 million people access
6 this form of care, would be emergency medicine
7 and urgent care.

8 It's especially growing in the elderly
9 population. So for, I think, emergency
10 department specific measures would be something
11 to think about.

12 CO-CHAIR WHITACRE: Okay that's added
13 to the list, emergency department. Diane.

14 MEMBER PADDEN: Okay, another area
15 might be tele-health. When we think about
16 communities, rural areas, people who may not have
17 access and how they're getting their care,
18 tele-health, or through that means. That's, kind
19 of, out there, as well.

20 And, I guess, I'd like to make a point
21 about the global health measures. As we speak
22 again about, overall, the health of the

1 individual and what that means, particularly, if
2 there are lots of conditions.

3 And to Luther's point, about patients'
4 beliefs or their culture, where they're at. So
5 we may think of global health at, at a particular
6 area and what's important to us, but we really
7 need to also think functionally about where the
8 patient is.

9 Because, as providers, we don't want
10 to impose our views on what health should be for
11 them. So if they're able to walk a few feet that
12 might be great, but we might say, expect that
13 they're going to walk a half a mile. So I think
14 we just need to be really careful about imposing
15 our own beliefs.

16 CO-CHAIR WHITACRE: Great. Thank you.
17 Jim.

18 MEMBER PACALA: Yes, similarly,
19 goal-oriented care. Patients getting the care
20 they want and not getting the care they don't
21 want.

22 CO-CHAIR WHITACRE: Terrific. And so

1 we have expanded the list. I'm sorry, David.

2 MEMBER SEIDENWURM: One way to
3 operationalize -- perhaps in the shorter-term --
4 something that Barbara was talking about, might
5 be, you know, just some metric around specific
6 data elements that need to be shared, you know,
7 beyond what's in the Meaningful Use Program.

8 But, you know, we proposed an image
9 sharing metric a few years ago and, again, that
10 didn't make it for various reasons. But, you
11 know, perhaps, if we could define a specific data
12 sharing metric that would be, that would be used,
13 we could operationalize a lot of what Barbara was
14 saying without going the whole way.

15 CO-CHAIR WHITACRE: So we have --
16 Peter.

17 (Off microphone comment.)

18 CO-CHAIR WHITACRE: Behavioral health.

19 DR. BRISS: I think we heard
20 team-based care; is that fair to put on the list?

21 CO-CHAIR WHITACRE: So we've expanded
22 the list, which is great. So we still have to

1 prioritize. Because, I'm thinking, and help me
2 if I'm wrong here, they've asked for a
3 prioritized list.

4 They've got a, probably, a bigger
5 list, internally, at CMS. They're asking us what
6 we think is important to address; we pick our top
7 three, or top five, from the list. Amy.

8 MEMBER MOYER: I'm going to throw
9 something out about that team-based care. So
10 when I get my goals for the year, there's not
11 necessarily an expectation I'm the one who's
12 accomplishing those goals, but I'm accountable
13 for those goals.

14 So in some ways, having a measure that
15 a physician is accountable for, can be team-based
16 care. We're not saying you, the physician, have
17 to do these things, you have freedom with how to
18 accomplish that.

19 And I think, in some ways, it's
20 partially how we think about it. We're not
21 saying you, personally, have to do that. And,
22 you know, if my team doesn't meet their goals,

1 it's still on me. But, I think, in some ways, I
2 view that similarly, I guess.

3 CO-CHAIR WHITACRE: This is all
4 valuable. Robert.

5 MEMBER KRUGHOFF: David, would you
6 clarify what you were talking about data sharing
7 and other folks that talked about, you know,
8 having access to your own, I guess, your own
9 medical record?

10 That's part of it. But, I guess, is
11 there also a part where, where we evaluate the
12 physician on whether the physician is making sure
13 that that record is available to you, that record
14 is shared with other doctors and that -- and it's
15 shared with a community-wide, you know, a
16 nationwide database.

17 And I'd like to push for all those
18 things. And physicians do have a fair amount of
19 control, as to how far they're going to push down
20 that path.

21 And, you know, I think they should be
22 held accountable for trying to find electronic,

1 you know, medical records system that, if Epic
2 won't do it for them, then get another one or
3 something.

4 CO-CHAIR WHITACRE: So perhaps another
5 way to go about this is the reverse. I'm having
6 trouble prioritizing. So let's do the reverse.
7 Let's take things off the list that we think are
8 the least important.

9 And I would propose measures for
10 specialties with few measures. We already have
11 50 new, new ones, and that's already on the radar
12 screen.

13 So yes we think it's important for
14 those specialties, but to be honest, in all
15 fairness, they probably should have been doing
16 their work behind the scenes, developed a QCDR,
17 be working on their own measures. So let's take
18 that off the list. Can we agree on that?

19 (Off microphone comment.)

20 CO-CHAIR WHITACRE: No, boo, that's
21 bad? You guys need more measures? You're like
22 50 to 51, right? So what else is already being

1 addressed, or is a methodology that we can put
2 aside? Cancer outcomes might be high; it's a big
3 ticket item.

4 MEMBER LANDRETH: I wonder --

5 CO-CHAIR WHITACRE: I'm sorry, go --

6 MEMBER LANDRETH: -- since we have
7 some measures around end of life, I mean, it's
8 not that it's important, but if we have to
9 prioritize, we already have some around advanced
10 care planning and advanced directives. That may
11 be that could, since we see a new measure
12 compared to last year, maybe take that off.

13 CO-CHAIR WHITACRE: Is that
14 reasonable? Okay. Who else? I'm sorry. Steve.
15 I'm watching the list.

16 MEMBER FRIEDHOFF: You know, just
17 comparing last year when I wasn't here, to this
18 year, I'm kind of seeing some overlap between the
19 patient-centered measures, and then -- looking on
20 the new list -- global health measures and
21 goal-oriented care.

22 I don't know that they're identical,

1 but I see enough overlap there that it feels like
2 what the group prioritized last year is similar
3 in that space to what the group's prioritizing
4 this year. So I don't know if there's a way to
5 bundle them up, a little better, but they feel
6 like there's a lot of overlapping circles there.

7 CO-CHAIR WHITACRE: Which might be
8 more actionable for CMS, which would lead -- and
9 I'm thinking not just CMS, but measure
10 developers.

11 Because if we prioritize this list, it
12 seems, to me it ought to be useful to measure
13 developers. They say, hey, if I want my measures
14 to be accepted and put on the list, I'm going to
15 do one that reflects X, Y, or Z -- it could be
16 cancer care, could be trauma, could be team-based
17 care. Which is the more actionable element?
18 Bruce.

19 CO-CHAIR BAGLEY: I want to make a
20 process suggestion. You know, we're sort of
21 trying to do nominal group process without doing
22 it, so the first step is to brainstorm.

1 So I would suggest that you all take a
2 minute, or two, to think about, on your own, what
3 should be on the list is not on the list. We,
4 sort of, did that a little bit. That's the first
5 step.

6 The next step is to give you three
7 votes, or however many votes, as Marcie
8 suggested, and then, we actually do it without
9 dots, by raising hands, if you're -- if
10 everybody's honest, we can do it that way.

11 So you might actually do a regular
12 nominal group process. Once you're satisfied
13 with the list and once you've kind of refined the
14 list to the, you know, the proper categories, if
15 you will.

16 CO-CHAIR WHITACRE: Great input from
17 my Co-Chair. We're refining the list. But,
18 please, Rachel and Stephanie, and then Barb.

19 MEMBER GROB: So I just have a further
20 clarification, and maybe this is from CMS, are
21 you wanting from us measure gaps like substantive
22 areas where we don't have adequate measurement,

1 or are you wanting gaps in measurement capacity,
2 like, that would speak more to what the data
3 sources are, or whether we could develop
4 composites that, you know, that rolled up both
5 shared decision-making and patient experience and
6 other kinds of outcome measures, or are you
7 wanting a little bit of both? Because our list
8 is also a little bit of a mash-up, and those
9 really are two different things.

10 And I know CMS has not a gazillion
11 dollars but some resources to do this, so I'm
12 wondering, are you going to do both, sort of,
13 measurement capacity building, as well as
14 investment and specific measurement areas of
15 substance?

16 MS. AUTREY: Thank you for the
17 question. For this, the content of this
18 discussion, the former was really what we were
19 looking at.

20 Not that -- not that the capacity and
21 the process is not important, because we would
22 like that in the notes and information we get

1 back from the summary, but for this, this
2 discussion and the priorities, the former is,
3 really, what we're looking for.

4 CO-CHAIR WHITACRE: We're looking at
5 topics --

6 MS. AUTREY: Condition.

7 CO-CHAIR WHITACRE: -- really within
8 -- terrific.

9 MEMBER MOYER: I'm trying to help you
10 out, Eric, I'm going to take something off the
11 list. Trauma. United States does trauma better
12 than anything we do, and it's going to cost a lot
13 of money regardless.

14 Are we doing inappropriate trauma
15 care? I don't know that we are. What we don't
16 do is primary care very well, and so I would
17 suggest that we take trauma care off of there.

18 CO-CHAIR WHITACRE: Sounds like we're
19 in agreement. Stephanie.

20 MEMBER GLIER: So I don't want to rain
21 on the parade, here, and I think this input is
22 useful, but I also think it's going to be

1 haphazard, based on the people who happen to be
2 sitting at this table and the things that we
3 happen to have in our heads at this moment.

4 And, short of doing a really
5 comprehensive review of the full MIPS framework
6 spreadsheet, along with all of the measure
7 concepts that everybody knows --- that anybody
8 anywhere knows are under development at this
9 moment.

10 I think it's difficult for us to
11 really give CMS a comprehensive list of where we
12 think the gaps are, based on the measures that
13 are actually available right now.

14 I think -- I think it is difficult to
15 say that, these priorities are universal, in any
16 kind of a way, because they are just, sort of,
17 the scraping off of our brains, at this moment.

18 So I don't want to slow us down here,
19 if people have really good ideas, but I'm, sort
20 of, skeptical about the output of this 15-minute
21 process.

22 CO-CHAIR WHITACRE: Understood.

1 Please, Scott.

2 MEMBER FURNEY: I can't think this
3 quickly. Akin to the point that was just raised
4 by Stephanie, this is an incredibly complex
5 topic.

6 I think the guidance that we need from
7 CMS, are you looking for major content areas --
8 as most of the things listed last year were
9 content areas -- or do you want us to dive into
10 the 350 measures and tell you which ones that are
11 missing that would be higher priority?

12 And, so if we're prioritizing content
13 areas that we think are missing in general,
14 that's a different question altogether than if
15 we're looking at individual items.

16 MS. AUTREY: I think the content areas
17 would be something that we would want to hear
18 from.

19 MEMBER FURNEY: Okay. The follow-up I
20 would have then is I don't think this can be done
21 quickly; in a way, I think we can get some ideas
22 up, but I agree with Stephanie.

1 I think that this is a better process
2 to be done deliberately over a period of time, so
3 I think we have some ideas up there, but I don't
4 know that we can come to a conclusion to give CMS
5 a list of priorities in ten minutes, safely.

6 CO-CHAIR WHITACRE: Couldn't agree
7 more. It's to jumpstart the process.

8 MEMBER FURNEY: Okay.

9 CO-CHAIR WHITACRE: The question is,
10 we can all take it home, as homework, we can turf
11 it to another community, we can review, you know,
12 other spreadsheets, the question is: how to move
13 forward to answer the question? It's a great
14 question, and we should be very, very, you know,
15 honored to be asked that.

16 DR. WINKLER: One of the things I can
17 propose is, given lots of good ideas, but
18 concerns about process is, indeed. This is going
19 to be a topic for the Coordinating Committee, in
20 January, to talk about how MAP -- not just you,
21 but all three MAP groups --- should be addressing
22 this and perhaps taking both.

1 You know, some of the ideas, I think,
2 do help CMS with the caveats that you don't feel
3 like, you know, doing it off the cuff and that,
4 you know, at the end of two days of work is
5 really a particularly, you know, well-thought-out
6 process, and so that feedback -- in terms of how
7 do we go forward -- is maybe not just for this
8 workgroup, but is across the entire MAP and will
9 include the other workgroups which resides at the
10 Coordinating Committee, and it is a major agenda
11 item for them, for January.

12 So I'm going to take the heat off of
13 you, because I think you have raised issues that
14 are particularly important. You know, I heard
15 over and over a couple of things, you know,
16 around the patient-centered measures, around
17 outcomes for function and symptom management, you
18 know, you said that like 100 times yesterday.
19 You said it 100 times today. This one isn't hard
20 to figure.

21 You know, appropriateness has come up
22 many, many, many times. So I mean, I think there

1 are a couple, to me -- two, three, four top
2 themes --- that are big picture that have been
3 reiterated over and over.

4 But, I think, the feedback to needing
5 a process across MAP to have, sort of, a way of
6 thinking about gaps and how things should evolve,
7 is something bigger than any of the individual
8 workgroups, or something that -- and something
9 that needs a little more structure and process to
10 support it. Is that reasonable?

11 CO-CHAIR WHITACRE: Rachel, and then
12 Robert.

13 MEMBER GROB: I think that makes a lot
14 of sense, what you said, Reva. And, just as a
15 matter of historical look back, since I've been
16 here for a few years, I have heard this workgroup
17 over and over -- despite the fact that, all of
18 you are so busy and this is, essentially, a
19 volunteer activity -- voice of strong interest in
20 this kind of proactive activity as a complement
21 to the more reactive.

22 I don't mean that in a derogatory

1 sense. But we, basically, react to the MUC list
2 that's been processed by NQF, and this is sort of
3 another function of the workgroup, and I've just
4 been impressed by all of you, my colleagues here,
5 at how much interest there's been in that.

6 I have that kind of interest, and so I
7 do think that if NQF and CMS asked us to do this,
8 not on a time frame that's so quick, because we
9 have a lot of time before the next MUC list comes
10 out in 2016, right?

11 Like, we could take the time and have
12 a whole day meeting and have some evidence that
13 we consider, so that we're not making a sort of
14 ad hoc decision. I agree, totally, with what you
15 said, Stephanie; it deserves our careful
16 consideration, so that you're not getting,
17 basically, a bunch of, like, anecdotal
18 impressions from people who care passionately
19 about it, but don't -- haven't considered it yet.

20 CO-CHAIR WHITACRE: Robert.

21 MEMBER KRUGHOFF: Yes, I mean, I think
22 we can very usefully give some sense of what we

1 think are, you know, some of the priority areas
2 right off here, and the fact that we have them up
3 here and we've altered them a little bit, I
4 think, is already -- it would already be useful
5 to CMS.

6 I think, I guess, and I may be the
7 only voice here, I'd like to know if I'm the only
8 voice, who says we also have to say that, we have
9 to say, we've sat around, I'd like us to say,
10 we've sat around for, you know, a couple of days
11 and we've thought about this all our lives.

12 And, and we think CMS has to, you
13 know, its highest, in my view, its highest
14 priority is to change the underlying data systems
15 to really improve on the, you know -- and so this
16 meaningful use tool and, you know, to me, is a
17 very big deal.

18 Things like that, that are really
19 possible that can make a change across all kinds
20 of different conditions and all kinds of
21 different patients, et cetera, but getting more
22 data together.

1 And, you know, that's just a -- that's
2 just a shout out, it's not something that is that
3 concrete, but I think it's important. I think it
4 would be desirable for a group like us to say,
5 you know, we've sat around here and we're trying
6 to do this and we're trying to deal with your
7 individual measures one at a time, but you need
8 to change.

9 And you need to make --- or you need
10 to make underlying changes in the entire data
11 system, and we think that's very important. And
12 so, you know, that's -- that's a different kind
13 of job, but we really want you to do it and do it
14 -- and put as much resources as you can in that
15 direction. So it's not just giving them a set of
16 measures.

17 CO-CHAIR WHITACRE: Great. Thank you.
18 I knew I could rely on the wisdom of the
19 Committee. Cindy.

20 MEMBER PELLEGRINI: Just briefly,
21 because -- and this is a little off topic, but
22 Reva, since you've mentioned that there is going

1 to a Coordinating Committee meeting in January --
2 there were some other things that I just wanted
3 to make sure that do get captured, and maybe even
4 considered or transmitted to that group for their
5 meeting, which was the thoughts about changing
6 the MUC process for next year to improve it.

7 So the ideas that we came up -- that
8 we suggested about additional voting options, you
9 know, and around, perhaps, tiering the measures
10 between those that are really ready for prime
11 time and those that aren't.

12 And then, I also wanted to throw out
13 there the idea, you know, I think we're all very
14 sensitive to the fact that, sometimes when we
15 defer action on these things, that's putting it
16 off for a year or possibly more. Should we
17 consider, don't throw things at me -- you know, a
18 mid-year MUC process? Half --

19 DR. WINKLER: It --

20 MEMBER PELLEGRINI: Half the work at
21 two meetings.

22 DR. WINKLER: Yes. The, sort of, last

1 question. I can make a slide of it, or put it as
2 a formal general item and we always ask is
3 process improvement, so you have been offering
4 them and, again, and we are hearing them.

5 Some we can just take and go, yes
6 great, and, and put them into play, you know, and
7 some we can take to Coordinating Committee, if we
8 feel it's something that's going to be across MAP
9 to all the other workgroups. So your
10 recommendations, suggestions are quite welcome,
11 and we're certainly open to them.

12 CO-CHAIR WHITACRE: I did want to add
13 some other things to the process. I went around
14 the room asking people to make some notes.
15 Clearly, in my mind, it's just hard to believe,
16 over the last couple of days, what I've heard
17 from, you know, a group of interested, engaged,
18 insightful people, all the different comments.

19 We've got a direct line to CMS, in
20 terms of -- in terms of our opinions and
21 insights, and we're missing the measure
22 developers. I mean, it's a huge loss.

1 To be honest, ophthalmology, without
2 Scott, I'm not sure what we would have done with
3 those measures, how we would have understood
4 them. I think the votes and recommendations
5 could have been different.

6 And I do understand that an invitation
7 goes out from CMS and/or from the NQF, letting
8 them know that these will be presented.

9 But, I'll have to tell you, that based
10 on my quality experience -- because I represent
11 the ASBS at AMA RUC -- when it comes to money,
12 the people are in the room. They're in the room,
13 with multiple consultants, and I just can't
14 believe that we think money is more important
15 than quality.

16 We would have had a much different
17 understanding of many of the measures had the
18 developers been here -- and been here, ideally,
19 in person.

20 And I understand that represents cost
21 and time, but this is important activity. So the
22 single most important change I would make --

1 speaking as an individual on the Committee -- now
2 would be to have the measure developers here when
3 their measures are developed. Scott.

4 MEMBER FRIEDMAN: So, this is my first
5 year, again, I guess, I've said that seven times.
6 This is, if I've learned one thing is you have to
7 have the measure developer and a clinician that
8 has expertise in the field in the room.

9 And if they don't, and Reva said, well
10 we asked them, but they -- they -- we don't make
11 them come. Well, you can't make them come, but
12 dear God, this is -- this is measure development
13 101.

14 If they want to get their measures
15 developed and put in use, they have to be here,
16 to support them. Otherwise, you can tell them,
17 with no uncertain terms, that the likelihood of
18 your measures getting favorable outcomes goes
19 down significantly.

20 And just -- you got to stress this to
21 them. And cost is not an issue. We're talking
22 about lots of money here, and this is my

1 livelihood.

2 CO-CHAIR WHITACRE: Other issues? I
3 had one other. I'd certainly like to know what
4 happens to our recommendations, whether it's in
5 how the measures were changed, so I'd like the
6 measure developers here.

7 And then, see again, next year, what
8 happens with those measures, or next year, or not
9 at all. Or, perhaps, even come back as a
10 composite, or whatever it is, to see that there's
11 been some change and to know where the
12 opportunities for change are, plus it would
13 enhance our communication with the developers,
14 which in my mind, might improve the development
15 process. Amy.

16 MEMBER MOYER: I realize we can't
17 change this, and don't anyone throw anything at
18 me, but in some ways it concerns that me that,
19 now, you know, I was talking to Kate earlier and
20 she said, well all the measures now have payment
21 tied to them.

22 So it concerns me that we're seeing

1 measures coming through and their first real
2 world, big time experience is going to have money
3 tied to it, you know, which is one of the higher
4 stakes applications.

5 You know, we're not seeing them coming
6 through NQF, get that endorsement, see the
7 experience, how does it work, it's just kind of
8 out there. You know, we, we can't really control
9 that, and I don't necessarily want to delay
10 things by years and years and years. I think
11 we're already behind, but it just -- it makes me
12 a little uncomfortable.

13 DR. WINKLER: Has it been said?

14 MEMBER FURNEY: It could be a serious
15 tangent, but this has been done before and we
16 have a whole group of colleagues in Great Brittan
17 who've run something like this for 15 years.
18 Should we consider whether we can get input from
19 other expert -- experts?

20 I mean, there are a whole set of
21 measures that we could look at, and if we want to
22 identify gaps in our measures, we can compare

1 against other more mature system's evaluation of
2 a comprehensive system. It seems like a sensible
3 place to start.

4 DR. WINKLER: Okay. I think we're --
5 I was going to say, are we done with gaps? Are
6 we gapped out?

7 Another topic that the Coordinating
8 Committee spent a large amount of time on, and
9 continues to be an ongoing thing, you know,
10 within MAP, but outside of MAP, and that's the
11 whole issue of alignment.

12 And I think you all addressed this a
13 couple of times in your discussions, which is
14 what you're asked to do, is really think about
15 how measures could be used, you know, across
16 programs, so that there is a reduction in burden
17 -- reduction in chaos.

18 And so we did see at sort of the last
19 vote went back to say oh, you know, we, we need
20 to be internally consistent to promote the
21 alignment across the two programs, and so that
22 was an example of that.

1 And so I think that, particularly, for
2 instance, like, for the Medicare Shared Savings
3 Program, there might be an opportunity to think
4 about: are the measures within the clinician set
5 -- the PQR MIPS set, whatever -- that, you know,
6 might align well into that program?

7 There are, also, I think, thanks to
8 David, brought up the issue around looking
9 outside the traditional clinician box to measures
10 that are being used, say, in some of the hospital
11 programs, or the outpatient programs that end up,
12 you know, attached to the hospital workgroup, or
13 even the PAC/LTC programs that might be
14 appropriate for, you know, clinicians that work
15 in those settings, such that those folks aren't
16 getting measured by, you know, multiple sets of
17 measures that may be less aligned than desirable.

18 So these are, these are things that we
19 really want to think about. And you have done a
20 certain amount of it and raised a couple of good
21 examples.

22 The question is: how might we further

1 that whole idea of alignment of the clinician
2 measures with all the other measurement activity,
3 both within federal programs, but then you've
4 also heard about the core measure sets that is
5 the public/private, you know, kind of,
6 collaborative effort to align measures.

7 And that's played a role for us, too.
8 So I think you're going to see that this is a
9 bigger and growing issue and concern across,
10 pretty much, all measurement enterprises.

11 And are there ideas that you can help
12 us understand how we might better support that --
13 those alignment efforts -- in terms of how we
14 bring information to you, how -- how do we get
15 our hands around addressing that question for
16 clinician-level managers?

17 CO-CHAIR WHITACRE: Yes.

18 MEMBER FURNEY: I'd be interested to
19 hear, you know, Peter mentioned that he was able
20 to --- HHS was able to consolidate for 30 some
21 odd, you know, cardiovascular disease measures
22 down to one. And so I'm curious, maybe, you

1 know, there's some lessons learned there that,
2 maybe, we can take back and apply to our work
3 going forward.

4 CO-CHAIR WHITACRE: I certainly
5 benefitted from Mady's presence, having somebody
6 from another workgroup to be able to give the
7 insight made me think about the measures a little
8 bit differently. Perhaps, somebody from the
9 hospital workgroup, as well, be part of the
10 committee. David.

11 MEMBER SEIDENWURM: Okay. You know,
12 just one thing, you know, again, from the
13 developer perspective. For example, I worked on
14 a headache workgroup, and we had a
15 migraine-specific quality of life metric that was
16 applied.

17 Well, you know, I bet half the
18 questions on that migraine metric overlapped
19 with, you know, a dozen other metrics. So I
20 wonder if we could, every time something like
21 that comes up -- you know, some disease-specific
22 quality of life metric -- we could at least make

1 sure that the -- there's some kind of preferred
2 common core of questions that are asked, so that
3 way we bridge the gap between what's needed for
4 this specific purpose at hand, and also what's
5 needed for the broader -- you know, you mentioned
6 earlier -- the broader health metric that we
7 think is important.

8 So I wonder if there's some kind of a,
9 a market basket that we could provide people of
10 component tools that could be used and, you know,
11 different types of outcome metrics, different
12 types, types of quality of life metrics that
13 would form the common core of all of these
14 disease-specific metrics that our colleagues and
15 the various disciplines need, you know, whether
16 they be dermatologists, or ophthalmologists, or
17 neurologists, or whatever.

18 CO-CHAIR WHITACRE: Thank you. Oh,
19 Mady and Peter.

20 DR. CHALK: Would there be any
21 advantage to pulling together the leadership of
22 each of the committees -- just the leadership

1 group -- to talk with NQF about, and CMS, for
2 that matter, about what is crosscut?

3 You know, it would be very, you don't
4 need a whole committee to do that, but you do
5 need the leadership of each of the groups to be
6 able to look at, okay, what's the last iteration
7 of our measures that have been put forward,
8 whether it's the hospital group, or the clinician
9 group, and where, and the gaps, and look at them
10 together, rather than in isolation from each
11 other.

12 CO-CHAIR WHITACRE: I was just give a
13 list of dates and potential time to meet with the
14 Coordinating Committee. So I guess, they're
15 expecting us to somehow have that discussion?
16 They didn't tell me the agenda.

17 DR. WINKLER: But I think, I think one
18 of the constraints we have is trying to do so
19 much of this, you know, within this very narrow
20 two-month time frame over the holidays.

21 So some of these ideas are something
22 that, perhaps, we might be able to expand some

1 other time frame when we're not feeling quite so
2 overwhelmed with the task at hand, but I -- you
3 know, something definitely to think about.

4 DR. BRISS: So I think there are some
5 principles that might help you, sort of -- sort
6 of get to better alignment. So you might have
7 heard me say earlier that broader measures are
8 easier to align than narrower ones, right?

9 There are things like, I think, part
10 of the problem is that the quality enterprise,
11 really, at large, is too bottom-up for this
12 purpose, right?

13 And so what, I mean, in some ways --
14 in some ways what you really need is some
15 consensus about a -- if we could generate this
16 sort of consensus about a balanced score card
17 kind of dashboard, right?

18 I could imagine a balanced score card
19 kind of dashboard that said we want to have high
20 quality, we want to have good safety, we want to
21 have patient involvement, engagement,
22 communication, we want to have -- we want to have

1 shared decision-making.

2 And, you know, we could probably get
3 six or eight main buckets of stuff and then, pick
4 some -- pick some leading indicators in those
5 buckets; I think that that would help us a whole
6 lot.

7 CO-CHAIR WHITACRE: Do you mean for
8 every measure in the evaluation process as we go
9 through?

10 DR. BRISS: I mean, start -- I mean, I
11 think you're trying to get it, I think you're
12 trying to be top-down. I think you --

13 CO-CHAIR WHITACRE: Okay.

14 DR. BRISS: I'd like to see a top 20
15 dashboard of -- on which to evaluate American
16 health care. And there is, I mean, see, this
17 sort of gets back to an old Tom Frieden and
18 Farzad Mostashari paper, they write about it,
19 about, this is health care, as if health
20 mattered, right?

21 You know, I think that if we started
22 from the top and said: what are a few things we

1 could change, if we were really trying to drive
2 improvements in -- in population health? We
3 wouldn't -- we wouldn't open with a random
4 collection of 600 NQF-approved measures and
5 others, others that aren't yet NQF-approved,
6 right?

7 And, and so, and so, and so I think --
8 I think we ought to, if you started with the
9 dashboard, some of the alignment stuff would fall
10 out, I think.

11 CO-CHAIR WHITACRE: Cindy.

12 MEMBER PELLEGRINI: So we already,
13 actually, kind of have that. It's the
14 often-maligned Healthy People 2020, right? So
15 it's kind of a Christmas tree. There's no
16 question; there's probably way too many measures
17 in it.

18 But there are the leading health
19 indicators and they're the categories for Healthy
20 People 2020. And it would be very interesting to
21 see how some of the measures and the groupings of
22 measures align -- again, because that is what we

1 have, as a nation, identified as our top health -
2 - public health priorities.

3 And then, there are other areas, like,
4 HRSA's Title 5 health indicators, many of which
5 align, almost, directly, or directly, in some
6 cases, to clinician measures on things like -- or
7 some of the existing measures, low birth weight,
8 early elective deliveries, immunizations, et
9 cetera, they're not all perfect.

10 But, MCHB went through a heck of a
11 process coming up with the Title 5 Paternal and
12 Child Health Block Grant measures, and it would
13 be worth, you know, looking at other places in
14 the government like that.

15 MEMBER PACALA: It's an attractive
16 idea, but it's -- it's all going to be put back
17 on primary care. I mean, I live in Minnesota, so
18 I have a dashboard that my -- my clinic manager
19 shows me every month of how we're doing in our
20 clinic and it's all on best measures.

21 And, and it's, you know, it's a total
22 of a dozen measures, or so, and I get my diabetes

1 composite, my vascular composite, asthma,
2 depression, and so forth. So, you know, and some
3 of those correlate to 2020 things, and some of
4 them don't -- immunization rates and so forth.

5 So I -- while it's attractive, it's
6 really going to -- it's really going to just pile
7 on primary care, again. So there are some
8 limitations there.

9 I'm wondering if there couldn't be a
10 series of measures that would be common to
11 different types of roles in medicine, or
12 different types of providers, that would cut
13 across things?

14 So for example, if a provider performs
15 surgery, are there certain types of quality
16 measures that would be patient-centered that
17 would be able to, that would be important and
18 that everybody getting surgery would want to
19 know, and so that would be, you know, I don't
20 know.

21 But I mean, and could there be a core
22 set of quality measures that everybody, who

1 performs surgery, would have to report? For
2 each, you know, and same for people who do
3 outpatient procedures. The same for people who
4 address mental health in care of their patient.
5 I don't know, but something like that.

6 CO-CHAIR BAGLEY: Just, kind of, to
7 respond. It's sort of where I was going before
8 with participation and quality improvement. So
9 if you're a surgeon, you know, do you use a
10 checklist, do you use a timeout, do you assign
11 site of surgery, do you do patient-oriented
12 outcome measures, did the surgery make you
13 better, you know, stuff like that would be far
14 more useful than, did you close the incision with
15 four or five sutures, you know.

16 CO-CHAIR WHITACRE: Oh, Beth.

17 MEMBER AVERBECK: I wonder if one way
18 of, kind of, taking that would be to say, is
19 there a way that we could have measures that
20 follow a patient regardless of who's taking care
21 of them over a course of time?

22 So you're a young kid, it might be

1 immunizations, it might be mental health, it
2 might be end of life, could be co-managed with an
3 oncologist, a geriatrician and a pulmonologist, I
4 mean, and just for example.

5 But, it would be a set of metrics that
6 read that, whoever is surrounding that patient is
7 then held accountable. I mean, it's a different
8 framework, it would take some work, but if that
9 was an idea down the road?

10 CO-CHAIR BAGLEY: Okay, just to
11 comment on that. I think that those of us who
12 have been in this measurement enterprise for a
13 long time have wanted that right from the start,
14 in terms of patient-oriented measures.

15 But the way we've set up the
16 measurement enterprise, it can't seem to get
17 there. It's all about providers. So I totally
18 agree with that.

19 And, you know, we'd have to, kind of,
20 almost start from scratch, to some degree, about
21 how we come up with the measures. But I think
22 that's worth having on the aspirational list, to

1 have things more about the patient. Did the
2 patient get better?

3 CO-CHAIR WHITACRE: Stephanie, then
4 Scott.

5 MEMBER GLIER: So I think, I think
6 that's true, but I also think there's some
7 opportunities here for us to come, like, 10,000
8 feet down from 40,000; we're still too high
9 level, but it's a starting place.

10 And, I think, at the risk of giving us
11 more homework at the beginning of this, having us
12 do more of an overview of both, where you're
13 trying to go with the clinician programs, but
14 also what you're trying to do with the hospital
15 programs and the PAC/LTC programs.

16 So that before we start our review of
17 the MUC list, we actually are thinking of what
18 the goals are of those programs together and how
19 we can make sure that there's some alignment
20 across the goals of the way the programs are
21 structured.

22 And, if there are places where we can

1 focus on, whether it's the same goal, you know,
2 rolled up from the individual clinician level all
3 the way up to a whole facility level.

4 Or what if there's some overlapping
5 content areas we can focus on that are the
6 highest priorities that we think will result in
7 better patient care, better health outcomes, then
8 maybe we can, sort of, have that already on our
9 radio, as we're starting to review the MUC list,
10 whatever it looks like.

11 MEMBER FURNEY: I just wanted to add a
12 comment about, while following, having a metric
13 that follows the patient that's patient-specific
14 is -- is difficult, I do think one of the
15 priorities needs to be the ability to go from
16 acute episodic checklist, or single documentation
17 requirements, to a continuity-based outcome
18 measures.

19 So again, as difficult as the
20 depression measure was for us to discuss and come
21 to a conclusion on, the advance in that is that
22 it's not just that I did a PHQ9, as I diagnosed

1 depression and then I, actually, was required to
2 document improvement.

3 We can argue about how that should be
4 done, but the more we can do of that, and the
5 more we can correlate that with the long-term
6 outcomes, so when you look at the urinary tract
7 infections per 100,000 admission, that has
8 baffled me as to how I -- as a primary care
9 physician -- can prevent that. For me that's an
10 access measure. Right?

11 So yes. So there really, there's a
12 suite of things that has to be included, to be
13 able to look at, it could impact the facility, it
14 can impact the patient, it can impact the health
15 system; if I have better access and I see
16 patients before it becomes a hospitalization, I
17 can triage, but I need to not over-treat the
18 asymptomatic bacteria.

19 I need to have access to the patient,
20 can I get in and be able to intervene before the
21 patient gets too sick? That's our -- it's a
22 truly comprehensive measure and what we're

1 measuring is the end.

2 What we have to do is figure out how
3 to measure that comprehensively enough that we
4 really understand what we're doing benefits the
5 health of the patient and not just a number.

6 CO-CHAIR BAGLEY: Yes, I wanted to
7 confess that I made a grave tactical error by
8 rescheduling my flight at lunchtime. And I will
9 be leaving you now. And I apologize for that;
10 normally, I wouldn't do that, but I didn't
11 predict quite right. So I apologize for that.
12 There's only one airport.

13 CO-CHAIR WHITACRE: Thank you, Bruce,
14 for all your help. It's been a real privilege.

15 DR. WINKLER: Thanks, Bruce. I mean,
16 I think in all honesty, we've covered our agenda
17 items. I think it is important that we do take
18 the opportunity for public comment. Again, there
19 are -- we've had a few loyal folks hang in there
20 for the whole time, and so --

21 CO-CHAIR WHITACRE: So we would invite
22 people in the room, or later, on the phone?

1 OPERATOR: If you would like to make a
2 comment, please press star then the number 1.

3 There are no public comments from the phone line.

4 CO-CHAIR WHITACRE: Great. Thank you.

5 MS. SAGE: Hi. Good afternoon. My
6 name is Jill Sage; I'm with the American College
7 of Surgeons. I want to start off by just saying
8 that I participated in this process since the
9 inception of the MAP, and the materials that the
10 staff put together this year were really great,
11 so I appreciate that.

12 One thing I wanted to address, which
13 is something really relevant to the gap
14 discussion we just -- the Committee just had, is
15 the fact that the College of Surgeons submitted
16 some measures to CMS this summer, which we are
17 hoping to see on the MUC list.

18 And we've touched base with CMS and
19 we're going to follow-up with them to sort of see
20 how we can better communicate, about what they're
21 looking for and why they're not on the MUC list.

22 But I did want to raise the issue that

1 our performance measures committee put in a lot
2 of time and did a really extensive analysis of
3 all the measures in the PQRS program that are
4 relevant to surgical care.

5 And there was, certainly, a huge lack
6 of relevant measures, and so what they did is
7 they all -- they got together and they made a
8 good effort at what they believe is the best
9 representation in a lot of the gaps in care.

10 And we submitted a PQRS Measures
11 Group, and it included three already existing
12 PQRS measures, but then, I believe, seven
13 additional measures. And this measures group
14 goes across all of the various phases of surgical
15 care, so pre-op, peri-op, inter-op, post-op,
16 discharge, and it's really not just focusing on
17 an instance, or a single point of care; it's
18 really attempting to look at the totality of
19 care.

20 And it was designed in a way so that
21 the measures and the measures group, currently,
22 are very broadly applicable to surgery, so it's

1 very cross-cutting in that -- in that sense.

2 But it was also designed so that more
3 procedure-specific areas across those, they will,
4 I guess, the procedure would be inclusive of all
5 the phases, but -- so that procedure-specific
6 measures could be added to that core set of
7 measures.

8 And it really addresses the key work
9 flows of surgical care, and it's inclusive of
10 coordination of care with anesthesia, PCPs, and
11 other specialists.

12 And it focuses, there's measures that
13 include care coordination, shared
14 decision-making, patient and family engagement
15 and, specifically, a lot of the discussion in
16 terms of some of the gaps identified last year,
17 this measure set also has a functional status
18 measure for frailty.

19 There is also measures that address
20 multiple chronic conditions, complex conditions,
21 and also participating in an outcomes -- a
22 surgical, risk-adjusted outcomes registry.

1 So I had made the Coordinating
2 Committee aware of this by submitting a comment,
3 so I did speak to the NQF staff. And I realized
4 that, you know, because of the really rapid MAP
5 process, it would have been difficult for an
6 analysis, or opportunity for these measures to be
7 looked at, at this point in time, without all the
8 additional information.

9 But, I am hoping that this will be
10 discussed at the Coordinating Committee meeting,
11 and perhaps this Committee can talk with CMS, as
12 well, about this. But, at the very least, we
13 would really hope for these measures to come
14 forward.

15 And I'll also note that some of the
16 measures, when we submitted them to CMS, we were
17 hoping for some feedback, as well, so that we
18 could have then moved forward and still can do
19 this in this upcoming year, assuming we get kind
20 of a green light, or we're hitting the mark, do
21 some more detailed testing on the measures, too,
22 so we would have that information. Thank you.

1 CO-CHAIR WHITACRE: As you all know,
2 I'm a surgeon and a Member of the College of
3 Surgeons, so I'd ask Reva to respond, or let the
4 Committee.

5 DR. WINKLER: I'm not terribly sure
6 exactly what to respond to. Again, I think that
7 the measures that the MAP is -- deals with, as
8 the task, as the work in front of us, or the
9 measures that are given to us, by CMS on the MUC
10 list, so -- and that's, really, our job. And so
11 I would see if CMS had any comments?

12 (Off microphone comment.)

13 DR. WINKLER: Okay. Yes, I mean,
14 again, you know, the only information we have is
15 the information you just provided, so it's a
16 little hard for us to have something to work
17 with.

18 MS. SAGE: Yes, and I absolutely
19 understand that; I just did want to bring it to
20 the attention of the Committee, because --- on
21 behalf of surgery -- we really are trying to
22 address a lot of those gaps.

1 CO-CHAIR WHITACRE: Yes we've got one
2 more comment on the phone. Other public
3 comments, on the --

4 MEMBER GLIER: Could you just hang on
5 for just a second? I ---- hi, sorry, I'm here.
6 While CMS is figuring out if they can respond to
7 you. It sounds like the topic areas are some of
8 the same things we talked about, and I think
9 that's great.

10 You may have heard this in the
11 discussion today, but if you're looking for
12 additional feedback about type of measure
13 development that this Committee would find
14 useful, taking a patient-focused perspective and
15 trying to work with the other specialties, who
16 might touch the patients in their continuum of
17 care might be valuable, so that there's a measure
18 that goes beyond just relevance to the surgeons,
19 themselves, but in fact is about the whole team
20 of care.

21 MS. SAGE: Okay. Thank you.

22 CO-CHAIR WHITACRE: There's another

1 public comment on the phone.

2 OPERATOR: Sir, your comment comes
3 from Koryn Rubin.

4 MS. RUBIN: Hi, this is Koryn Rubin
5 from the American Medical Association. I want to
6 echo, I believe, it's Robert Krughoff's comments,
7 from Consumer Union, in regards to building the
8 necessary infrastructure that supports
9 interoperability.

10 Just having process measures that
11 measure interoperability is not going to get us
12 where we need. The ONC -- through their various
13 workgroups -- has looked at some of this, through
14 their advance health models workgroup, in terms
15 of some of the areas of infrastructure, how to
16 support alternative payment models and outcome
17 measures and patient-reported outcomes measures
18 and functional status.

19 Without the investment in the
20 infrastructure, we are going to be stuck in the
21 current state that we are in, and also, getting
22 at the idea of position burden is, you know,

1 there is a real issue.

2 And, also, in terms of enhancing
3 patient care, is by just doing chart
4 documentation, in terms of collecting patient
5 functional status is not going to, you know, move
6 the needle on quality improvement, because it
7 maintains the silo approach when it can't be
8 captured in the EHR.

9 And, you know, they may, would be
10 happy to provide more detailed feedback, in terms
11 of the various interoperability infrastructure
12 issues that need to occur to enhance quality
13 measurement and the quality, and move the quality
14 needle.

15 CO-CHAIR WHITACRE: Thank you. Are
16 there other comments? Anyone else on the line?

17 OPERATOR: There are no more comments
18 from the phone line.

19 CO-CHAIR WHITACRE: Thank you very
20 much.

21 DR. WINKLER: I think, just since
22 folks are leaving, everyone travel safely. Just

1 next steps, I mean, MAP does move quickly. The
2 recommendations, as well as a narrative that kind
3 of tries to pick up all this stuff, is scheduled
4 to begin a public comment period right before
5 Christmas -- I think it's the 23rd --- that will
6 go through January 12th, I believe.

7 And then the Coordinating Committee
8 will meet in late January -- the 26th is when it
9 is. And then, our final deliverable, with the
10 recommendations, are due to CMS on February 1st.
11 The final version of the narrative for us doesn't
12 -- isn't due until March 15th, but things are
13 moving very, very quickly.

14 So we thank you, very much, for all
15 the work you've done to help us meet these rather
16 challenging time lines. But we've always done
17 it, and this is year number five, so for many of
18 you who've been around for a few years, again,
19 thanks. There was a question? Somebody had a
20 raised hand.

21 CO-CHAIR WHITACRE: Stephanie.

22 MEMBER GLIER: Is the Committee going

1 to have a, is the workgroup going to have a
2 chance to review the narrative -- either before
3 or after the public comment period -- before it
4 goes to the Coordinating Committee?

5 DR. WINKLER: Perhaps. We'll kind of
6 have to see what's going on. It's one of those
7 where it gets kind of tough.

8 CO-CHAIR WHITACRE: Well if there are
9 no other comments, I'd like to thank everybody
10 for their participation. A wonderful group; I
11 thought we had great discussions. Thank you all
12 for taking the time.

13 (Whereupon, the meeting in the above-
14 entitled matter was concluded at 2:30 p.m.)
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Clinicians Workgroup

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