NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP

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CLINICIANS WORKGROUP

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TUESDAY
DECEMBER 12, 2017

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Bruce Bagley and Amy Moyer, Workgroup Co-Chairs, presiding.

MEMBERS PRESENT:

TERRY ADIRIM, MD, MPH, FAAP, American Academy of Pediatrics
BETH AVERBECK, MD, Health Partners, Inc.
KEVIN BOWMAN, MD, Anthem
HELEN BURSTIN, MD, MPH, FACP, Council of Medical Specialty Societies
SCOTT FRIEDMAN, MD, American Academy of Ophthalmology
SCOTT FURNEY, MD, FACP, Carolina's HealthCare System
STEPHANIE GLIER, MPH, Pacific Business Group on Health
ANN GREINER, MS, Patient-Centered Primary Care Collaborative
DAYO JAGUN, MBBS, MPH, Genentech
ROBERT KRUGHOFF, JD, Consumer's CHECKBOOK
CHARLENE NGAMWAJASAT, MD, Primary Care Information Project
AMY NGUYEN, MD, MBA, FAAFP, CAPG

DAVID J. SEIDENWURM, MD, American College of Radiology
WILLIAM VAN DECKER, MD, American College of Cardiology (substitute for Paul N. Casale, MD, FACC)
PATTI WAHL, MS, St. Louis Area Business Health Coalition

SUBJECT MATTER EXPERTS (VOTING):
MICHAEL HASSETT, MD, MPH *
DALE SHALLER, MPA
ERIC WHITACRE, MD, FACS
LESLIE ZUN, MD *

FEDERAL GOVERNMENT MEMBERS (NON-VOTING):
GIRMA ALEMU, MD, MPH, Health Resources and Services Administration
PETER BRISS, MD, MPH, Centers for Disease Control and Prevention
PIERRE YONG, MD, MPH, MS, Centers for Medicare & Medicaid Services

MAP MEDICAID TASK FORCE LIAISON:
HAROLD PINCUS, MD, Medicaid Adult Task Force Chair

NQF STAFF:
ELISA MUNTHALI, MPH, Acting Senior Vice President
JOHN BERNOT, MD, Senior Director
KAREN JOHNSON, Senior Director
TAROON AMIN, NQF Contractor
HIRAL DUDHWALA, Project Manager
MADISON JUNG, Project Analyst
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

HEIDI BOSLEY, American Medical Association
BRAD CONWAY, American College of Gastroenterology *
REENA DUSEJA, Centers for Medicare & Medicaid Services
DANIEL GREEN, MD, Centers for Medicare and Medicaid Services
RABIA KHAN, Centers for Medicare and Medicaid Services *
THEODORE LONG, Centers for Medicare & Medicaid Services
SOEREN MATTKE, RAND Corporation
SHARON MCILRATH, American Medical Association
SRI NAGAVARAPU, Acumen
PHIL PETERS, Centers for Disease Control and Prevention *KORYN RUBIN, American Medical Association *
SAMUEL SIMON, Mathematica *

*** present by teleconference**

C-O-N-T-E-N-T-S

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

(9:00 a.m.)

DR. BERNOT: Well thank you, and good morning, everyone. I want to welcome everyone here for the Measure Applications Partnership Clinician Workgroup today. Thank you so much for coming to Washington, D.C., on a cold December day. We really appreciate it.

For those of you who do not know me, my name is John Bernot. I am the NQF senior director for this Clinician Workgroup. I really want to start by just thanking you for coming here. We know this is a lot of work in a very short amount of time to prepare for this, and we truly, truly appreciate you taking the time and everything that you do for this workgroup.

We have, not surprisingly, a packed agenda for a one-day meeting. But I do think it will be a really good day of lively discussion. So without further ado, I will turn it over to our chairs, our co-chairs Bruce Bagley and Amy Moyer.

CO-CHAIR BAGLEY: Thanks, John.

Well, good morning, everyone, and welcome. And thank you for spending your day with us and whatever travel time it took to get here as well. And we have a lot of exciting things to talk about today. Hopefully you are ready to participate and help us get this right and give CMS some advice.

CMS has a large contingent here. I counted about six or seven people here from the CMS team. And I think that they are ready to listen to our comments. And, of course, we will have official comments, but I think they also listen carefully to the discussion about the kinds of things that we're concerned about. So, we are looking forward to a robust discussion.

Amy, do you have some comments?

CO-CHAIR MOYER: I just wanted to echo the welcome. And I am glad to be able to join you all in person this year. I have been looking forward to some really productive discussion. And it's a smaller measure list than perhaps in

the past, but definitely some interesting things to discuss on there.

So, welcome, and let's have a great day.

CO-CHAIR BAGLEY: Do we have -- we have a couple of members on the phone. Is Michael Hassett on the phone?

MEMBER HASSETT: Hi.

CO-CHAIR BAGLEY: Good. Thanks for joining.

And is Leslie Zun here as well?

(No response.)

CO-CHAIR BAGLEY: Okay, maybe not yet.

Just a note, if you are speaking your light needs to be on, otherwise the people on the phone will not hear you. And if any of you have done a phone meeting you know that can be very annoying to hear somebody talking from across the room and you can't really tell what they're saying. So, if I say "microphone" and interrupt you, that's not to be rude, it's just to make sure we're getting the message out to everybody

who needs to see it.

And let's see. Is Harold Pincus here? Oh, hi, I didn't see you before. Thank you. From Medicaid liaison, MAP Medicaid liaison.

And is Leslie Kogan on the phone? She's new. Okay. Well, anyway, we'll look forward to hearing from you.

And then we also have Karen Johnson from the NQF Rural Health Committee.

And is Elisa here yet? Ah, okay. There you go. So can you help us through the conflict of interest?

MS. MUNTHALI: Good morning, everyone. My name is Elisa Munthali, and I am the Acting Senior Vice President for Quality Measurement at NQF. I just wanted to welcome you and thank you so much for being on the workgroup.

I will combine the introductions and disclosures of interest. And we will divide it into two parts because there are two types of members that are sitting on this workgroup. The first type is an organizational representative,

and the second is a subject matter expert.

So we'll start with the organizational representatives. I think that's the bulk of the committee.

And just wanted to give you a couple of reminders that you had on your form when you submitted that to us. Organizational members represent the interests of a particular organization. We expect you to come to this table, enter into these discussions representing those interests. Because of your status as an organizational representative we ask you only one question specific to you as an individual. We ask you to disclose if you have any interest of $10,000 or more in any entity that's related to the work in front of you.

So what we will do is go around this table first. Your co-chairs are subject matter experts, so we'll start with the first committee member that's an organizational representative. And we're going to ask you to orally disclose what you gave us on your form.

So I think we'll start, Eric, subject matter.

MEMBER WHITACRE: Subject matter.

I'm sorry. The, the only disclosure is I'm a member of the American College of Surgeons' Performance Measures Committee, which is involved in creating quality measures for surgery.

MS. MUNTHALI: So we're going to skip Dale because you're a subject matter expert as well.

And I can't see your name tag.

MEMBER VAN DECKER: Bill Van Decker from ACC. No financial disclosures.

MEMBER FRIEDMAN: Scott Friedman from the American Academy of Ophthalmology. No financial disclosures.

MEMBER FURNEY: Scott Furney from Carolina's Healthcare System. No financial disclosures.

MEMBER NGAMWAJASAT: Charlene Ngamwajasat, the Primary Care Information

Project. No disclosures.

MEMBER JAGUN: You couldn't hear me? Can you hear me?

CO-CHAIR BAGLEY: Yes, we can. Yes.

MEMBER JAGUN: Sorry about that. Dayo Jagun, Genentech. No financial disclosures.

MEMBER BOWMAN: Kevin Bowman, Anthem. No financial disclosures.

MEMBER NGUYEN: Amy Nguyen, CAPG. No financial disclosures.

MEMBER PADDEN: Diane Padden, American Association of Nurse Practitioners. No financial disclosures.

MEMBER WAHL: Patti Wahl, the St. Louis Business Health Coalition. No financial disclosures.

MEMBER GLIER: Stephanie Glier, Pacific Business Group on Health. No financial disclosures.

MEMBER SEIDERWURM: David Seiderwurm, American College of Radiology. I'm a shareholder in Southern Medical Group and RNNG Medical Group.

And I do medical legal consulting and I am a measure developer with the American College of Radiology.

MEMBER AVERBECK: Beth Averbeck, Health Partners. No financial disclosures.

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

MEMBER GREINER: Ann Greiner, Patient-Centered Primary Care Collaborative. No disclosures.

MS. MUNTHALI: So that, I think, concludes our organizational representatives. In case there's anyone on the phone that we're not aware of, if you're an organizational representative if you could please disclose any conflicts of interest you may have.

(No response.)

MS. MUNTHALI: Doesn't sound like it. So we'll proceed now to the subject matter experts.

So, I wanted to thank all of the organizational representatives.

And because you sit as a subject matter expert we ask you a lot of questions regarding your professional activities and as they relate to this work. When you disclose we are not asking you to summarize your very impressive resumes but we are particularly interested in the work that's relevant to this committee. So we're interested in grants, and consulting, and speaking arrangements, but not just the paid ones, also those that are not paid where you may have been a volunteer.

I think there are a couple of reminders I wanted to bring up today. You sit on this committee or this workgroup as an individual. You are not representing the employer that you work for or anybody who may have nominated you.

I also wanted to mention that just because you disclose does not mean you have a conflict of interest. We do this in the spirit of transparency and openness. And so we will start with your co-chair, so Amy.

CO-CHAIR MOYER: I am Amy Moyer. I sit on the Measure -- gosh, it's a different MAC. The MAC Committee for the Wisconsin Collaborative for Health Care Quality. They don't have a measure in front of us, but I believe they have a measure that is competing to a measure that's in front of us.

CO-CHAIR BAGLEY: Good morning. I'm Bruce Bagley. And I am on the Committee for Performance Measurement for the NCQA which oversees the HEDIS measurements. And I have no conflicts, just I come with a boatload of biases but no, no conflicts.

MEMBER WHITACRE: I should go again. I'm representative not for the American College of Surgeons but a subject matter expert. And as I said previously, I sit on the Performance Measures Committee of the College of Surgeons which is involved in creating quality measures for surgery. No other conflicts.

MEMBER SHALLER: I'm Dale Shaller. And I'm a subject matter expert in patient

experience. And that ties to my work with the CAHPS Consortium, the Consumer Assessment of Healthcare Providers and Systems, over the past couple of decades through a Yale University grant and a prime contract with Westmont. And I do a fair amount of consulting through individual organizations and regional coalitions on patient experience and patient input.

MS. MUNTHALI: I understand that Leslie Zun is on the phone and Michael Hassett.

MEMBER ZUN: Good morning, this is Les Zun. I have no disclosures, although I am President of the American Association for Emergency Psychiatry.

MS. MUNTHALI: Thank you. Is Michael on the phone?

MEMBER HASSETT: This is Michael Hassett. I have no conflicts of interest. I do work with the American Society of Clinical Oncology on their measure development efforts.

MS. MUNTHALI: Thank you very much.

And at this time we have a number of

federal liaisons that are joining us. They're non-voting but they are here participating in the process. And so I'll start with Ted and perhaps to Pierre, if you'd like to introduce yourselves.

MR. LONG: Thank you. My name is Ted Long. I am a CMS senior medical officer for quality measurements in our Quality Measurement and Value Based Incentives Group. And thank you for having us today.

MEMBER YONG: Hi. This is Pierre Yong. I just also wanted -- I'm from CMS, and I just wanted to say thank you to you all to add to the thanks that everybody else has made.

MEMBER BRISS: And I'm Peter Briss. I'm with Centers for Disease Control and Prevention.

MS. MUNTHALI: Great. Thank you.

Just a couple of other reminders. If at any time during this meeting you remember that you may have a conflict, we want you to speak up. You can do so in real time or you can approach the co-chairs or any one of us on the NQF staff.

If you, likewise, believe that one of your colleagues may have a conflict you may pull any one of us aside. If you feel that they are acting in a biased manner you may also do the same.

So I'm going to ask before I leave if there are any questions you have of each other based on the disclosures of interest that you heard.

CO-CHAIR BAGLEY: Robert, we need to have at least grill you as well. If you want to ask him.

MS. MUNTHALI: So, Robert, welcome. We just wanted to see if you have, based on what you submitted to us on your disclosure of interest form, if you can orally disclose whether you have any conflicts.

MEMBER KRUGHOFF: I had my knee replaced six weeks ago. And I'm wanting to have some answers here.

(Laughter.)

MS. MUNTHALI: Well, thank you.

MEMBER KRUGHOFF: I'd like to do a patient report or anything else you want.

I don't have any.

MS. MUNTHALI: Thank you so much.

MEMBER KRUGHOFF: I guess that wasn't clear.

MS. MUNTHALI: Thank you.

CO-CHAIR BAGLEY: Any other questions of Elisa?

(No response.)

CO-CHAIR BAGLEY: Okay, thank you very much.

MS. MUNTHALI: Thank you very much.

DR. BERNOT: Well, we'll just introduce the NQF staff also. We have certainly tried to set up everything so that it's easy to follow today. But if you have any questions whatsoever at any point in the day, please let us know. Pull any of us aside and we will either answer it or find the answer for you if we can.

But I want to take just a moment to have the NQF staff introduce themselves so you

know who all is on the team. We can start with Madison.

MS. JUNG: Hi. My name is Madison Jung and I will be the project analyst.

MS. DUDHWALA: Hi. My name is Hiral Dudhwala. I am the project manager. And looking forward to today.

MS. O'ROURKE: Hi. I am Erin O'Rourke. I am the senior director supporting the Coordinating Committee. So no official role in the Clinician Workgroup but here in case anyone has MAP process questions or history questions and to take the conversation back to the Coordinating Committee.

MR. AMIN: Taroon Amin. I am a consultant to NQF focused on measurement science issues. I am also supporting the MAP Coordinating Committee as well.

CO-CHAIR BAGLEY: Okay. And thank you very much. And as you know, we have a number of people in the peanut gallery back there keeping an eye on things. So they will have an

opportunity to speak up when we have the public comment period. So make sure that you're ready when your turn comes on the agenda.

I'd like to turn it over now to Pierre to talk about the meaningful measures and some of the programs of CMS. Pierre is the lead of our, of the CMS delegation here today. And we enjoyed having you last year, Pierre, and I'm sure we'll have a great conversation again this year.

MEMBER YONG: Thanks so much, Bruce. And like I said before, I really do want to thank all of you for volunteering and taking your time, not just for all day today and travel to and from D.C., but also, you know, in the pre-meetings and the pre-work as well as after, the follow-up after the meeting. So really do want to thank all of you. Nice to see many familiar faces around the table. And also want to welcome any new members to this effort. So, thank you, guys, really looking forward to spending the day with you all.

And so, so I just am curious because

I have done this presentation a number of times. But raise your hand if you've heard this presentation already.

(Show of hands.)

MEMBER YONG: Okay. If you've heard it more than once keep it up. Yes. Yeah, okay.

So I'm not going to go through, because it seems like most people have, have already heard this presentation. Do want to save times for questions, feedback, and so I won't go through the whole presentation in depth. So you'll excuse me if I sort of go through it fairly quickly.

But if you'd advance the slides.

Okay. So if you go to the next slide, so Meaningful Measures sort of it's a framework that we had worked on at CMS that really drew on a number of different sources but really came out of some of the feedback we've gotten from the MAP in prior years, as well as feedback we've gotten in other setting, in Rules as well as in other discussions with many stakeholders about, you

know, the sort of proliferation, if you will, of measures that we've had in our programs over the past couple of years.

And with that sort of growing number of measures across our quality programs people have told us that it's really hard to really discern what's really important. What are we, are we really focusing on the key quality issues that really will drive and improve patient care, which is I think what we are all here to do. Right? So that's where it's sort of the genesis of this.

And we saw and we had comments about this in the LAN white paper. And I have a graphic about that which many of you have seen already.

But I really wanted to think about not only what are the most meaningful sort of areas for us to focus on but what are the right kinds of measures? And so this slide really is some of the underpinnings, sort of additional considerations that we are thinking of when it

comes to the right kinds of measures. So we want to have measures that really address high impact areas. And those areas are the ones, the 18 that are, initial 18 that are outlined in the following slides that really sort of target and safeguard public health but really are patient-focused and are meaningful to patients as well as providers.

We I think have had many conversations across this room about really preferring and trying to move towards outcome-based measures where possible. You know, key consideration is, you know, burden. We understand that, you know, getting data and reporting that to CMS is a burdensome activity. And so we want to make that worthwhile. So we want to minimize the burden but also make sure that the data that's being reported to CMS is somehow fed back to you all so that you can then take action on it. And it really feeds into quality improvement.

But these measures actually show and demonstrate opportunity for improvement, that

there's variation and a quality gap, and really can help support in this movement towards population-based payment models.

The other consideration in the last bullet is also alignment. So we've certainly heard a lot, but particularly from clinicians and providers that you're reporting many measures to many different payers. Right? CMS is not the only player in town, there are many other players, whether they're other payers or state-based organizations or other initiatives that you are working with that all have quality measures. So how do we then work towards trying to minimize burden by aligning measures, not just within and across CMS programs but also externally with other payers as well.

So if you move to the next slide.

These are some of the sources that we drew on. But I'm going to move on quickly. NQF is one of them, which I'll highlight.

But if you can move to the next slide.

This, for folks who haven't seen it,

is a diagram from the LAN population health measurement white paper that came out last year. If you look on the right side of the slide I think it nicely conceptualizes and sort of puts into graphic form what we're trying to accomplish here.

So, if you look at the bottom of the right side you'll see these level three, or these little dots, what they have termed atomistic performance measures. So if you think of any of the individual measures that we have in our programs we think of those as sort of little dots. And what the LAN white paper was really trying to put forward was this need to move towards these level one and level two dots, which are these higher level summary performance measures which are, which, you know, are termed sort of big dots.

And so what we thought would be a good way forward was in this Meaningful Measures framework was really trying to push us forward to these bigger dots.

I will say, and make a clarification, that, you know, while the particular sort of idea here from the LAN white paper was actually big dot measures, what we have in the framework aren't measures specifically, they're actually measurement areas. So they really help us focus on what we think are the most meaningful measurement areas.

So if you move to the next slide.

These are the 18 initial meaningful measurement areas that we have identified drawing on all those sources that we identified from before, including the NAM work around vital signs, including the NQF work around strategic measures and other sources. They are grouped into six categories.

And if we move to the next slides we'll quickly review them.

The first category is making care safer. And here we have two Meaningful Measure areas. The first is healthcare-associated infections. And preventable healthcare harm is

the second one.

On the right side of the slide you can see that we've already started to think about how does this apply to our current portfolio of measures. And so here we have examples of current measures that really fit and sort of fit in and meets the intent, I think, of the meaningful measurement area in question.

So here, for example, under healthcare-associated infections we have the CAUTI measure and CLAPSI measures. And so those are represented in the C in very, very tiny orange print how they have been represented and implemented in a couple of our different programs. So I think that sort of provides a potentially sort of strong signal that we conclude is an important issue that for across programs and facilities that is somewhere that we should be focusing attention to really help drive improvement in quality.

Move to the next slide.

The next grouping is about

strengthening person and family engagement. Here we have care that's personalized and aligned with patients' goals.

The second is end-of-life care according to patients' preferences.

And the third is patient experience and functional outcomes.

If you move to the next slide. And I'm not going to go through the details of each slide in the interests of time.

But the third slide is promoting effective communication and coordination of care. Here we have three meaningful measurement areas: the first being medication management; the second being admissions and readmissions to hospitals; and the third being seamless transfer of health information.

Next slide, please.

The next domain is promotion of effective prevention and treatment of chronic disease. Here we have it's a pretty broad grouping, as you can see, so that's why you can

see so many meaningful measurement areas here:

The preventive care management of chronic conditions; prevention, treatment and management of mental health; prevention and treatment of opioid and substance abuse disorders; and then risk-adjusted mortality.

Move to the next slide. Thank you.

Working with communities to promote best practices of healthy living is the next domain. And here we have equity of care as well as community engagement.

And I just want to pause for a second on equity of care because I think you might conceptualize this as sort of measures addressing equity of care. We think of it as a little bit broader than that. Certainly there are other tools, again identified through, you know, some of the work that NQF has done and with the SES Trials as well as the Disparities Workgroup but also identified in other sources such as the NAM Report on social risk factors, as well as the ASPE report. But I think there are multiple

levers, policy levers available to address equity of care.

And those familiar with the Hospital Readmission Reduction Program work that we've done, we have moved towards stratification in that program, so comparing hospitals with similar proportions, caring for similar proportions of dual-eligible patients as a way to sort of address the equity of care issue that's been raised in that particular program.

So I think the broader concept here is that it's not just about measurement, but there are other tools available that can potentially help address this particular focus area.

If you move to the next slide.

Making care affordable is the last domain. And here we have appropriate use. We have patient-focused episode of care, and risk-adjusted total cost of care. And that will bring us to our 18.

So if you move to the next slide.

So, I think we've done this, we've

gotten a lot of, had the opportunity to do a lot of presentations and got a lot of questions. That's been really fantastic, I think, in helping us think through sort of how, does this framework make sense to people? Are there ways to improve it? And so certainly welcome your input on this.

I think a couple of the sort of common questions that I think we'll just cover right now just to make sure everybody's on the same page. But Meaningful Measures is a framework. It's not a new program. It's a new quality reporting program. Doesn't impose new requirements, doesn't have measures by itself.

That's a common sort of point of confusion but just wanted to put that out there that it's a framework to help us think through our measurement strategy across all of our CMS quality programs, reporting programs and how we use measures across all of those programs, not just the quality reporting programs, but when I use that term I'm using it broadly so it includes the accountability programs as well.

So that's one piece.

I think the other piece that we've gotten is how will this sort of -- how will this impact me? Will this reduce burden for me as a clinician? We really think and hope it will. We have started to apply this.

I mentioned in those, in one of the first early slides some of the underpinning principles in terms of considerations, and not just whether or not it meets a measure, is within and fits within one of the meaningful measurement areas itself, it's also all these other considerations: whether it's an outcome-based measure; whether it's meaningful to patients; whether there is significant burden placed on that.

So we think this, in conjunction with a lot of the other work that CMS has been engaged in, for example with the Core Quality Measures Collaborative and their line measures across public and private payers. We have started doing some work really trying to map out and address

potential solutions and identify potential solutions when it comes to eCQM development and implementation, for example. So we think a lot of these initiatives together will ultimately, hopefully, reduce the burden that providers have in terms of quality reporting.

And I think the other sort of common sort of question is sort of does this sort of framework actually does it resonate with clinicians in particular, and particularly with specialists. I think we've gotten that question.

We certainly think that and welcome that sort of feedback actually from folks in the room. I think there are different ways certainly to sort of conceptualize quality measures, and different frameworks. There are lots existing.

We think there are lots of ways that, you know, there are concepts here that are important to many specialists that are represented here. For example, if you're a surgeon you would think that, you know, surgical site infections are really important. And we

think that's really well represented and clearly represented here.

If you're a clinician taking care of a patient with, you know, rheumatoid arthritis, then a functional status is really important for that patient. So that's I think represented here. But certainly there are different ways to organize that information. So, but we welcome that input.

So I'm going to stop there. I'll turn to Ted, who's been my partner in crime on this, and see if he has any additional comments. But otherwise we welcome some comments from you and discussion.

MR. LONG: Yeah, yeah. No, just welcome comments and discussion. Thank you.

CO-CHAIR BAGLEY: Well, it's a good time for any questions or clarifications. Anybody have any? I do if nobody else does.

Anybody else have any questions?

MEMBER YONG: All just sick of hearing me talk.

CO-CHAIR BAGLEY: You know, I think this is a great framework. And it's allowed us to sort of categorize some of the measures we already have. I think the real power in this is to look at the highest levels and then try to look back downstream to see what measures might support those things.

As you're aware, we haven't really done that very well in the long path of measurement development. We've kind of said, Who needs to be measured? Or what needs to be measured? You know, back down at the base level as opposed to strategically looking from the big bubbles to little bubbles.

So, is there some plan to try to do that?

MEMBER YONG: So I can start and, Ted, maybe you can fill in.

So, yes, I think that's a great point, Bruce. And thank you for bringing that up. I mean, I think we have started to think about how to apply this in a broad sense. So certainly I

think, hopefully you'll see this represented.

And the MUC list, you'll notice it's a fairly concise and parsimonious MUC list. That's across all programs. So we have three days of MAP meetings this year versus six for the prior years, so we really tried to apply the framework in looking through the MUC list. And we have actually only put forward on the MUC list actually 25 percent of the measures that were actually submitted during the open call for measures.

We are looking closely at our existing measure sets across our programs and really trying to do a critical examination of, you know, the measures in those programs to determine whether or not it makes sense to keep those measures. You know, so we're doing that work right now.

I think it's part of that work, and certainly there's already been a lot of work done around sort of gap analyses, but I think it helps us then, again, do it in a focused way to

identify sort of gaps. And I think this then feeds into sort of a longer term sort of notion that you're talking about in terms of, you know, what are the measures we need? How does that feed into measure development? So, I think for us that certainly is another next step.

I think it also plays into things like the FOA that's going to be forthcoming next year, funding opportunity announcement, excuse me, that we have for measure development for QPP, Quality Payment Program. And so I think that sort of aligns not only this work but also aligns with the work that's happening under the Measure Development Plan, which is a report that we put out every spring in terms of measurement gaps for QPP. So I think that all of that aligns.

So it will take time to sort of get full alignment, but we think that's a worthwhile activity to pursue.

MR. LONG: Yes, and that's actually I think what you're bringing up is a really important point. There's two dimensions that the

framework has. First is it lays out comprehensive cross-cutting criteria that any given measure would go through in order for us to evaluate it. Is it outcome based? What's the impact? Is it stable over time or is there incremental increase each year? What's the incremental sort of effect on burden?

So that's the first case of what it means for an individual measure. But the really important piece, too, and this is something we've been asked a fair amount is what if you have a measure that maybe if you look at it in isolation it makes sense. But what if it doesn't fit into one of the meaningful measurement areas? What does that mean?

Well, it could mean that that's a specific focus and that measure has its own purpose in and of itself. Or it could mean that if the Meaningful Measures are intended to capture the areas of highest priority and the measure doesn't fit in there, maybe that's an opportunity for us to think about the role of

that measure.

And when we've been doing that so far with the MUC list, and then what we want to do is then take this across our measure sets at CMS, we think it's going to happen more and more. And there may be opportunities. For example, if anybody here sees the Meaningful Measures areas and says, we know, CMS, this is really high priority, you don't have a Meaningful Measure area for this. Or, you should really tweak the way that you're conceptualizing one of them. That's the type of feedback we're very open to now.

So what we want to do is get it right to the point where we're confident that the Meaningful Measure areas we have, if you look at any given measure, it should have a home there. And if it doesn't, it's an opportunity to talk about it so we can lend it a more parsimonious place.

CO-CHAIR BAGLEY: Thanks, Ted.

Go ahead.

MEMBER BOWMAN: Quick question. So the work, working with communities from a best practice of healthy living, it looks like, it seems like a lot of this is home health, skilled nursing, and long-term care. I guess I'm just curious, how is, how is that -- I guess it's not what I traditionally think of as healthy living and promoting life, diet, exercise. Seems like transitions of care and stuff like that. So I'm just curious where, what's the end goal of that?

MR. LONG: Yes, I can start there. And if we can maybe go to that slide I think it might be helpful. It's slide, like 9 or 10. Almost.

So I'll get started as we find it here.

So one important point is that when we have -- we have many different programs at CMS. And the intention is not that every, all of the 18 Meaningful Measure areas should apply to every single program. So you may have programs where there is some Meaningful Measure that apply more, just to use your example, in our Home Health

Quality Reporting Program versus SNF versus IRF versus LTACH. What are the Meaningful Measure areas that would be most applicable to those compared to the Quality Payment Program?

That's a conversation to have. But the intention is not that the Quality Payment Program and the Home Health Quality Reporting Program will have all of the same Meaningful Measure areas that matter the exact same amount for each of those programs.

That said, so if you want to get at what healthy living means, we do want to have this get at that. And it's hard, I know, because we, the Meaningful Measure areas are just sort of phrases here. But if the phrases don't resonate with what you think of as the key thing that really characterizes healthy living, that's what we want to know. This is the time.

So we used to have our emails on the slides but I think we have a new email address we can share. But that is the exact type of feedback we would love to have, both in terms of

I guess three ways:

A) does the meaningful, do the Meaningful Measure areas we have here need to be tweaked?

B) if there's a new area we don't have, what would that be? or;

C) if there's ways to describe what it means for healthy living.

I would just give an example here. As it pertains to equity of care, how could we describe that better? Would there be a way to focus on that? Would there be specific measures that would be illustrative for that?

So I think those three areas of feedback would be really helpful for us if you want.

CO-CHAIR BAGLEY: Other comments or questions? Anybody on the phone with a comment or a question?

Peter, go ahead.

MEMBER BRISS: Yeah, it'd like to, I'd like to actually pile on on the last comment. I

think that there's -- it isn't so much a language problem, it's a content problem. So in the healthy living thing, you know, you know the big four American risk behaviors account for 40 percent of American deaths. Right? And so it's everything reduces to smoking, alcohol, inactivity, and diet.

And that's, those are really important healthy living things that the healthcare system can influence, and it's not well reflected in here as it stands I think.

MR. LONG: And this is Ted. A quick comment. Actually, equal disclosure, I'm a practicing primary care physician, so I couldn't agree more. Not a day goes by where those are not issues that I, that are issues for my patients, too.

And I think with one of the challenges here, and this is to your point, too, is when thinking about things like healthy living does that mean that the measures for prevention for opioid use disorder, for alcohol use screening

should they fall under the category of best practice of healthy living? Should they fall under the Meaningful Measure area of prevention, preventive care so we can characterize it as? Or we have the Meaningful Measure area for substance abuse, substance abuse disorder to be distinguished from mental health issues?

So it's a bit of a challenge in terms of things that characterize healthy living. Whether we would put them all as sort of unique Meaningful Measure areas here or the degree to which we would want to include them under sort of the concepts that we have so far.

So I think taking this holistically, I think that's really where we want to get this right is does that mean we should tweak what we currently have because we currently have preventive care as one of the key highest priority areas. We currently have substance use disorder, prevention, and treatment as one of the highest priority areas. But we could create new areas that would better capture what you're

referring to. And that's the exact type of feedback we really need.

I hope that helps.

MEMBER BOWMAN: Yes. So really when I think of healthy living I also think of things like is there access to like cooking classes at, like, supermarkets, like a Whole Foods, or Safeway, Wegman's that's in an inner city or something like that. That's what I kind of think of. So I guess measures that we're not even looking at that.

You know, if you have a patient that doesn't even know what appropriate, you know, diet should be or things like that, access to that in the community.

MR. LONG: Yes. And I think that's great feedback.

And maybe if we could follow up via email, too, I think that would be very helpful for us, if you don't mind.

MEMBER SEIDERWURM: So, I like the framework because it provides a structure, you

know, for thinking.

But to sort of follow up a little bit on the prior comment, there are things that the healthcare system per se can do, and there are things that our civilization as a whole can do, and they are not always the same things. And so just if we can think about the difference between what an ophthalmologist can do to help his patient with, you know, cataract or retinal problem or whatever versus what, you know, a society can do about putting grocery stores in neighborhoods that don't have them.

So it seems as though we're almost denigrating some of the things that are towards the bottom right of the chart when those are perhaps sometimes the very things that the healthcare practitioners, the clinicians whom we're here to talk about today can do. So, you know, it's a balance.

And I love the way those smaller, seemingly smaller actions, though I mean to the patient at that moment perhaps they're quite

large, you know, the knee replacement or whatever, how they roll up together. And I think that framework is really super important. But we shouldn't have any -- I don't think we should allow ourselves to have the thought in our heads that those things are somehow smaller because they are after all what, you know, doctors and patients do.

CO-CHAIR BAGLEY: Thank you. I don't see any other hands, any other questions.

MEMBER SHALLER: I just have one.

CO-CHAIR BAGLEY: Oh, all right. Dale.

MEMBER SHALLER: Is the intent to make sure that every measure that's on the list of measures finds a home in this framework, an exclusive home? In other words, is there a place where a measure, and I'm thinking specifically of CAHPS, you've got it in the category of engagement, but also aligns in coordination with care and communication.

So I'm just wondering if there's overlap and where these belong. Does your model

capture that?

MR. LONG: I'll start and then, Pierre, please jump in.

Yeah, in the real world that's a real problem. And that's a challenge. So taking CAHPS right now, we have it under the Meaningful Measure area of patient experience and functional outcomes.

The categories, again, which are the banners at the top, working with communities to promote best practices of healthy living, I think this is something that we could be a little bit clearer about. The categories themselves are just for organizing the Meaningful Measure areas themselves. The Meaningful Measure areas are the areas where we want to have the targeted high priority identification.

So, on this slide the Meaningful Measure areas are equity of care and community engagement. We've grouped them under the banner or the quality category, if you will, of working with communities to promote best practices of

healthy living. But one of the problems we want to solve with the Meaningful Measure areas is the categories here. The reason we didn't want to have those, for example, be the Meaningful Measure areas is they are so broad that a lot of measures fall under multiple categories.

So our hope is that the Meaningful Measure areas will help to address that at least to some degree. Now, so for example, CAHPS fits pretty nicely in patient experience of care, which we identified as its own Meaningful Measure area because that's a high priority for us at CMS.

But does that mean the CAHPS doesn't have --

(Phone interruption.)

MR. LONG: Sort of a better fit for measures that are high priority areas than if we went with the categories alone because the categories are so much broader than the Meaningful Measure areas are.

I hope that helps. Probably could be

clearer about that from this. I'm sorry.

MEMBER SHALLER: Thank you.

CO-CHAIR BAGLEY: Okay. If anybody's on the phone please mute your phone. Don't put us on hold but mute your phone.

Most of you around the table are pretty familiar with the rulemaking process. We've been at this for a long time. But I would like Hiral to review that quickly just to make sure we're kind of all on the same page about what our task is today, of course, and where it fits in the grand scheme of the rulemaking process.

MS. DUDHWALA: Thank you, Bruce.

A couple of things before we go into that though. I see a lot of you have a lot of questions. So just a reminder, if you have a question just take your tent card and put it up so that we know who has a question and we'll try to go in the right order.

And also, before we get started I just wanted to highlight the agenda for our day. You

know, we have a pretty busy day. So, as you've see, we've already done our disclosure of interests and spoken about the Meaningful Measures framework.

I'm going to shortly go over the overview of the pre-rulemaking approach.

We will then go into an overview of the MIPS cost measures. And then start really just reviewing the measures for both the MIPS program as well as the MSSP program.

In between we will have a short presentation about our MAP Rural Health project. So that will be reviewed later in the afternoon.

And then we do have a few other agenda items, just as you see here highlighted, input on the measure removal criteria will be discussed this afternoon. There will be an opportunity for public comment at the end of the day as well as throughout the day.

So, and also just to review, especially for those of you who may be new to the workgroup some of our meeting objectives for

today is really to review and provide input on the measures under consideration for the federal programs applicable for clinicians and ACO care. And then, you know, throughout the day discussing strategic issues related to clinician and ACO care.

All right. And then we can go ahead and do an overview of the pre-rulemaking. I know some of you have been on this workgroup for a while so it will be a lot of review. But there are a few new members, so.

So the approach that we have is to analyze and select measures. And it's a 3-step process. We provide a program overview reviewing the current measures, evaluating them up for what they would add to the program measures that I know we did have a web meeting with all of you in November, so we really went into detail with the program overview. You know, and again, you know this is a one-day meeting so that was all provided in the November web meeting, so.

Your role really is to evaluate

measures under consideration today, reaching a decision about every measure under consideration. There are decision categories which we will talk about. And it's to have consistency and a standardized method.

Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached.

So, to facilitate this process there is a preliminary analysis of the measures under consideration. So our NQF staff did conduct a preliminary analysis of each measure under consideration. And it uses an algorithm that asks a series of questions about each measure under consideration. This was an algorithm that was developed by the MAP Measure Selection Criteria and approved by the MAP Coordinating Committee to evaluate each measure.

It really is intended to provide MAP members with a succinct profile and to serve as a starting point for MAP discussion.

So you'll see here highlighted the

seven algorithm criteria. Again, this is not new for those of you that have been participating in this. But, you know, it does look at addressing a critical quality objective not adequately addressed by the measures in the program set.

The measure is evidence-based and it's either strongly linked to outcomes or an outcome measure.

Number three, the measure addresses a quality challenge.

Number four, it contributes to efficient use of measurement resources or supports alignment of measurement across programs.

Five, the measure can be feasibly reported.

Six, the measure is reliable and valid for the level of analysis, program and/or setting for which it is being considered.

And seven, if the measure -- if a measure is in current use, no unreasonable implementation issues that outweigh the benefits

of the measure have been identified.

And you'll see on here our decision categories highlighted. The four categories you'll see on the left in blue we have the support for rulemaking, condition support for rulemaking, refine and resubmit for rulemaking, and enough support for rulemaking.

So there have been, I know, at least from the November web meeting there were some questions that arose on the refine and resubmit. There were concerns about this category. So the Coordinating Committee created this category with the thought that measures under consideration receiving this designation would be brought back to MAP before implementation.

A few other highlights is the HHS Secretary has statutory authority to propose measures after considering MAP recommendations.

We have the feedback loop that was implemented to provide MAP members updates on measures on prior MUC lists.

And then I'm going to have Erin talk

about this more, but you know, this was something that's under review with the Coordinating Committee. If you want to bring up more highlights.

MS. O'ROURKE: Sure. Thank you.

So I just wanted to pause here because we heard your concerns in November about this category. To give everyone some of the history who may not have been on that since the beginning. We have struggled with how we -- how MAP expresses support for the concept of a measure but when the information available may be limited, or they have some, some specific concerns about how the measure is specified but the guidelines necessitate moving forward.

So we've gone through many iterations. We originally had a category of support direction. There was a desire to be a little more concrete around what that meant. So we moved to conditional support. And then reviewing measures under development through a separate pathway.

There were also some problems there. So we created this refine and resubmit category to preserve what people liked about the measure under development pathway. That was that a measure wouldn't go down when everyone agreed it was important and we should move forward on continuing to, to develop it or make changes that are necessary but not given that support that we heard from developers can be challenging to get the resources to continue work on it.

However, this year there were some concerns raised that unfortunately MAP doesn't always get to see the changes that they give the measure this designation of refine and resubmit. But as Hiral said, the Secretary does have the authority to move forward with it. And a measure might not always come back to MAP to be re-discussed and re-voted on.

So we brought this issue to the Coordinating Committee during their web meeting on November 30th to reiterate that the intent was to support the concept that they -- to recognize

that there's a potentially significant issue with the measure that should be addressed before it's implemented.

The Coordinating Committee did want to provide some advice to the workgroups. And, Harold, I might put you on the spot to see if you have anything to add. Harold is one of our Coordinating Committee co-chairs.

DR. PINCUS: Yes.

MS. O'ROURKE: The committee suggested that workgroup members may want to use this category judiciously, perhaps giving a measure this designation when it really does need a substantive change that would require it to come back to MAP. Both CMS and NQF have processes that define a substantive change. On the endorsement side there's a set number of criteria that designate a re-review.

And Ted, Pierre, correct me if I'm wrong, but CMS maintains similar process.

So the committee suggested that might help guide that conversation.

The committee also noted to please clarify what the suggested refinements are. This is something we heard from Coordinating Committee members who review and finalize the workgroup decisions, as well as some measure stewards and developers, that the more concrete you can be with your guidance, the more they can actually act on it and make those changes.

So, Harold, not to put you on the spot, but if there is anything you'd want to share from your perspective as co-chair.

DR. PINCUS: So what we identified really was a problem with using refine and resubmit is that there is no process for refining and resubmitting. So that that creates a problem with having that category.

And so but there is this kind of netherworld between so there's supporting and then there's supporting with conditions when there's a very specific condition that can be, you know, readily or reasonably achieved within the time frame versus and then in between that

and do not support.

And that's a frustration that all the workgroups have had in terms of that sort of netherworld between having a specific condition and sort of just saying we don't support it, and trying to express what the concerns are that limit that. But revise and resubmit is just poorly labeled, isn't really what -- you know, doesn't really work as a category.

So a couple of thoughts have been put forward. One is to simply eliminate it as a category and just make a recommendation to not support it. It's really that, that low. Or to perhaps reduce the threshold to support it. That's one idea.

The other is to keep it but use it more judiciously, and when we do use it, to be very explicit about what the problems are so that there's a possibility for CMS to sort of take that information and apply it because it's, you know, potentially within the time frame or potentially around the next round. But the idea

is to have as full a discussion and a feedback to CMS so they can actually use this information going forward. And that's really what we want to do.

The name of the category is less important in some ways. But it's really to focus more specifically on just those measures on the MUC list where we think there's something to salvage there but we need to give them more advice about how to fix it.

CO-CHAIR BAGLEY: Well thank you. It seems to me that the ambiguity is really resubmit to whom?

DR. PINCUS: Right.

CO-CHAIR BAGLEY: And we have no, no ongoing process for the MAP to reconvene and all that sort of thing. So I assume the measure developer is the one that has to resubmit it. But to whom is really what the problem is there.

I have a 3-people stack. Scott Friedman first.

MEMBER FRIEDMAN: Yes. So I brought

this up on the conference call.

So, the conditional support, if there's something that needs to be tweaked and they tweak it, I'm not sure it has to come back to us. But on the call we had refine and resubmit. And then we had a discussion a year ago. And to be honest with you, I didn't remember all the nuances on the discussion. And you're asking us to make a decision on stuff I didn't really remember.

And so what I said was if it's refine and resubmit, you resubmit it and we discuss it here. It doesn't make sense to me to discuss it on this quick phone call and approve them. And if they've been corrected, that's fine, I'm not sure it needs to come back to us to approve it. If it's the initial approval you can, you can approve it without having it -- but, again, it's hard for me to approve something that I don't really have enough information on in a quick phone call.

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

MEMBER BURSTIN: Thanks. Just a quick question.

I think one of the concerns to start with has been the question of what do you then do with measures that are not fully developed and tested. And I think that was at least to start, as Harold just recalled, a lot of those measures float into this category.

So unless the measures coming forward on the MUC list are in fact all fully developed and tested, you're basically left them with a pretty stark choice of do not support. Am I interpreting that correctly, Erin?

MS. O'ROURKE: Yes. And I think that's why we kind of ended up with tough choice for the committee that you have imperfect information. But a do not support has some fairly potentially serious repercussions for continuing development of a measure.

I did want to clarify just on Scott's point about the intent of the feedback loop. We implemented that as a way to update MAP members

about what's happened since you've seen the measure and to show how your input has been acted on. But not necessarily take a new vote or ask for formal approval.

So it's more of an informational update.

But that is something where we want feedback on, whether the feedback loop worked and how we should move forward with that this year.

So I think this is a work in progress and an issue that, as Helen mentioned, we've struggled with since the beginning when MAP is forced to look at measures so early and with imperfect information. But a "do not support" does have consequences.

CO-CHAIR BAGLEY: Just a couple other comments. Then, Pierre, I'm going to give you the final word here.

Stephanie, you're next.

MEMBER GLIER: Thanks. Helen, thanks for raising the testing issue. I wonder actually, though, if we can revisit how we

discussed testing because I think we were -- CMS is not submitting measure concepts to us anymore. A couple years ago we did see straight concepts that were not fully specified or tested or even begun testing. And that's not true anymore. We're seeing measures that are somewhere, they're fully developed, they're somewhere in the testing process. Testing may not be complete.

But I think the way I understand these categories, if we are -- we could totally say conditional support pending testing that demonstrates evidence of reliability, validity, and the other endorsement criteria are met.

No, we can't?

MS. O'ROURKE: Yes. Sure, so this is, unfortunately, where things get a little challenging and where we've tried to perhaps clarify what's the role of MAP and what's the role of endorsement. So MAP doesn't have strict requirements about submitting testing data. And we tried to turf any questions about looking at, you know, the specific results of reliability and

validity testing to the CDP standing committees who are specifically charged with reviewing the scientific acceptability of a measure.

We asked MAP to think more about the fit-for-purpose and for a specific program is this the right way to be going. However, we know it's hard for people to make decisions about a measure that could be used for payment and public reporting with imperfect information about whether it is reliable and valid.

But I did want to clarify that we, we don't ask for testing results. If you look at the refine and resubmit, that is a bit of the line in the sand of whether we consider the completion of testing, whether it's early development or fully developed. And that's some of the language here.

MEMBER GLIER: I don't want to undermine you at all. I totally under -- I have read this a number of times. I understand where you guys are drawing the line. And I think I'm questioning the application of it because I think

actually if you look at the discussion guide you guys put together -- which I love. Thank you for putting it together. I very much appreciate it. -- there are some places where you say conditional support pending NQF endorsement showing that testing matches the updated specification, that's conditional support.

And there's also revise and resubmit to show the testing is done at the individual clinician level.

And I can see the distinctions there. But I think from a MAP point of view those seem very much like something that a CDP committee should be looking at and not something that MAP should be trying to distinguish between. To me -- and I acknowledge that I'm saying something that is different than what the official matrices and categories say, but it seems to me that our conditional support should be for the broader statements about what we expect a measure to achieve or to demonstrate before we think CMS should consider implementing it in a program,

without saying you need to -- I think the problem is revise and resubmit sounds both like we like the direction of this concept. We think you need to incorporate this new information or you need to adjust it in the following way. That really is a change in the way the measure is specified rather than we think this is probably good, just prove it.

So I think my, my personal preference would be to say we think this is good, just prove it, should be conditional support and we should be very clear about what those conditions are. So, for me that is both the measure is, like, somewhere in testing and we think it looks good but we're not going to -- we don't expect that to come back to us, because we think it looks good.

Just, do you understand what I'm saying?

MS. O'ROURKE: Yes. And that's helpful. And I think that's an important clarification. But historically we've used conditional support for when a measure basically

just needs to go to the endorsement process and get that final review and the condition is pending NQF endorsement.

Whereas some of the testing my not necessarily match the specifications. We tried to highlight that I think more as a, a flag for the workgroup members that you may want to discuss and suggest further refinements. But I think that's helpful feedback and something we can consider when we look at these again. Because it's good to know what works for you all and what doesn't and how we can clarify and make them more usable.

CO-CHAIR BAGLEY: You decided to pass?

Okay. Pierre, would you give us kind of your CMS view.

MEMBER YONG: Sure. Thanks, Bruce.

So, a couple things. Certainly appreciate the conversation. And I think, as Erin has highlighted, it's been sort of an evolving category over the years. And so obviously there is a lot of nuance that happens

underneath the actually category, the recommendations and such. And so that's a particular reason why you see, as Bruce mentioned six, but I think there are at least eight of us here, CMS employees who are here all day with you all. So they're listening and sort of taking notes, copious notes as we listen to the conversation that's had about each measure and sort of taking that back as we think about sort of our next steps.

Would actually, I think, as we have this conversation encourage, you know, Erin and the staff to make sure that there's sort of the categories are applied equally throughout the MAP committees, just because that will help us. Because if you readjust how you use these categories, hopefully that will also carry over to the other committees, too, because otherwise it's very hard for us internally to know the different standards if they are applied differently across the workgroups.

And the final sort of comment I'll

make, and it sort of addresses a little bit of what Helen brought up, as well as what Stephanie brought up, but we did try to be very judicious in terms of what we put forward on the MAP this year. So my hope -- I'm crossing my fingers and my toes -- but that there probably will be less, hopefully, measures that may fall into this refine and resubmit for rulemaking category this year.

I know that also there have been some changes in the voting process because there were some measures last year which, you know, didn't quite reach that 60 percent threshold and so then fell to the less, the next lower threshold which tends to be refine and resubmit sometimes. And so, hopefully with these tweaks there will be less measures that fall into that category. But we'll see.

CO-CHAIR BAGLEY: I'd actually like to move on. I think we've heard the conversation. And it will come up later if somebody wants to do refine and submit. We're going to have this

conversation all over again around a specific measure probably.

But, Harold, thanks for the advice in terms of making us more sensitive to the fact that if we're going to say refine and resubmit we better be very specific. Because I think you're right, in the past sometimes we would just use it as a grading system without actually giving some full advice about what's the trouble with the measure.

So, if it's okay --

DR. PINCUS: Hey, I mean a lot of -- just to follow up on what Pierre said -- a lot of what our understanding of what CMS finds helpful is the discussion, and in a qualitative sense, of what the problems are and what are some strategies about how to fix it.

MEMBER YONG: That's right. Thanks, Harold.

CO-CHAIR BAGLEY: Okay. I think it's time to actually dig into the whole project here today. And we're going to start by talking about

the --

Oh, do you want to talk about voting?

MS. DUDHWALA: Yes.

CO-CHAIR BAGLEY: I didn't want to talk about voting. Do you want to talk about voting? Okay. So you all understand how we're going to go about deciding.

MS. DUDHWALA: Okay. Just a few more housekeeping things before we get into the fun stuff, so.

So we just wanted to go over with you the voting instructions very briefly. And just make sure that everyone knows who has voting capacity.

Everyone should have one of these clickers if you are a voting member. If you don't, please let us know.

So the key voting principles is that MAP has established a consensus threshold of greater than 60 percent of participants. So the stakeholder groups would need to agree to reach the threshold. Abstentions do not count in the

denominator.

Every measure under consideration receives a decision, either individually or as a part of the slate of measures. All of the measures are voted on or accepted as part of the consent calendar.

So, the workgroup will be expected to reach a decision on every measure. There will not be a category of split decisions. That would mean the Coordinating -- that would mean that the Coordinating Committee decides on that measure. However, the Coordinating Committee may decide to continue discussion on a particularly important matter of the program policy or strategy.

Okay. The staff will provide an overview of the process for establishing consensus through voting at the start of each meeting. After additional introductory presentations from staff and the chair to give context to each programmatic discussion, voting will begin.

The in-person meeting discussion guide

will organize contents as follows:

Measures under consideration will be divided into a series of related groups for the purpose of discussion and voting. And that is how we have done this for this clinician in-person MAP group.

Each measure under consideration will have been subject to preliminary staff analysis based on the decision algorithm that we just reviewed.

The discussion guide notes the results of the preliminary analysis, i.e., you know, support, do not support, conditional support, or refine and resubmit, and provides the rationale to support how that conclusion was reached.

Okay, so first up will be the staff will review a preliminary analysis consent calendar. The staff will present each group of measures as a consent calendar, reflecting the result of the preliminary analysis using the MAP selection criteria and programmatic objectives.

Step two, the measures under

consideration can be pulled from the consent calendar and become a regular agenda item. We did reach out to all of you for any input. But it can also be done today during the in-person.

The co-chairs will ask the workgroup members to identify any MUCs they would like to pull off the consent calendar. Any workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion. Workgroup members are asked to identify any MUCs to be pulled off for individual discussion prior to the in-person meeting, if possible, or at the in-person.

Workgroup members should clarify if they are pulling a measure for discussion only or if they disagree with the preliminary analysis and would like to vote on a new motion. Measures pulled for discussion will focus on resolving clarifying questions. If during the course of the discussion a workgroup member determines the discussion has shown the need for a new vote, a workgroup member can put forward a motion.

Potential reasons members can pull a measure: disagreement with the preliminary analysis, or new information is available that would change the results of the algorithm.

Once all of the measures that the workgroup would like to discuss are removed from the consent calendar the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar.

If a measure is not removed from the consent calendar, the associated recommendations will be accepted without discussion.

So, step three, discussion and voting on measures identified for a new motion. Workgroup members who identify the need for discussion describe their perspective on the use of the measure and how it differs from preliminary recommendations in the discussion guide. If a motion is for conditional support or refine and resubmit, the member making the -- the member should clarify and announce the conditions

or suggested refinements.

Workgroup members assigned as lead discussants for the relevant group of measures will be asked to respond to the individuals who requested discussion. Lead discussants should state their own point of view, whether or not it is in agreement with the preliminary recommendation or a divergent opinion.

The co-chair will then open for discussion among the workgroup. Other workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interests of time.

After the discussion, the workgroup members who made the motion have the option to withdraw the motion, otherwise the workgroup will be asked to vote on the motion.

If the motion is for conditional support or refine and resubmit, the chair can accept conditions or suggest refinement based on the workgroup discussion.

If the main conditions or refinements directly contradict each other, the chair should ask for a separate motion after the original motion has been subject to a vote.

Step four is tallying the vote. If the motion put forward by the workgroup member receives greater than 60 percent of the vote, the motion will pass and the measure will receive that decision.

If the motion does not receive greater than 60 percent of the vote, the co-chair will resume discussion to develop another motion. To start the discussion, the co-chairs will ask for another motion. If that motion receives greater than 60 percent of the vote, the motion will pass. If not, discussion will resume.

If no motion put forward -- if a motion -- if a no motion put forward by the workgroup achieves greater than 60 percent of the preliminary analysis, decisions will stand.

Abstentions are discouraged but will not count in the denominator.

Okay, and I don't know if there are any questions or, Bruce, if you want to add anything since you've gone through this in the past and used this, but.

CO-CHAIR BAGLEY: No. I think on the third bullet here, we would still have to vote for the preliminary analysis and get 60 percent.

MS. DUDHWALA: Erin, do you agree?

CO-CHAIR BAGLEY: It just doesn't -- you know, we have to vote on every one. And that would just be -- in other words it would just revert back to the original motion which is the PA and the recommendation. You have to vote at some point.

MS. O'ROURKE: Okay. Yes, that makes sense. We can vote the original motion then.

MS. JUNG: I'll make this as fast as possible.

So, everybody who's an organizational member and a subject matter expert should have these clickers here. I'm just going to go to this next slide.

So, the voting slides are those two screens up in the front. There's no question. Please select option -- or for those of you on the phone, please message us your votes.

Option 1 is -- we'll just to option 1, 2, 3, or 4. The number should show up on your clicker. If it does not, let us know and we'll replace the clicker.

Also, you have the option to select or change your answer as many times as you would like, it's just the last answer that you log will be the one that is counted.

CO-CHAIR BAGLEY: And if you push the same answer three times it only counts once.

Okay, and how many votes should we have?

MS. JUNG: We have 21. So, for a 60 percent consensus we need 13 votes on the option.

CO-CHAIR BAGLEY: So I see, does that mean 15 people have voted? We're getting there.

All right, anybody asleep at the switch? Okay. We only have 17. I mean, do we

have to do a count in the room?

Okay, we're getting there. Okay. And we have two on the phone. Do we have a way to get their votes? Okay, great.

MS. O'ROURKE: I did want to just -- Yeah, to jump in, you'll see Madison and Harold clicking clickers. Staff obviously do not get votes. They're voting proxy for people on the phone. This is from their link. So just to clarify.

CO-CHAIR BAGLEY: So this isn't set up as a timed vote. So we'll just watch and see when the popcorn stops popping and then call it. Okay, good.

So, now can we go on?

MS. JUNG: So, did you put your vote in? Okay.

Let's see, I'll try mine.

CO-CHAIR BAGLEY: It looks like we still only have 19. So why don't you guys go or why don't you find out an exact number of people.

MS. JUNG: So, we should have one more

vote.

CO-CHAIR BAGLEY: There's 20.

MS. JUNG: So, if we could all press one more time that would be great. Oh, there we go. Okay, so now we have 21.

CO-CHAIR BAGLEY: That may have happened that somebody pushed it before the timer started.

MS. JUNG: Yeah.

CO-CHAIR BAGLEY: And if you think you may have pushed it before the timer started, just push it again and you're fine, so.

MS. JUNG: Okay.

CO-CHAIR BAGLEY: Okay, now we can move on.

I think on this, on this particular first group of measures, first of all they're all very, very similar. It's a whole new category. And we're going to start with a presentation from Ted and his group. And then we're going to have public comment.

And then what, so far I have not heard

anybody wants to pull a specific measure from the consent calendar. So what I'm going to try to do is have a conversation about the measure category and the characteristics of these measures, preferably without pulling any of them off the calendar.

If somebody wants to pull any one off the calendar, then it will get a separate vote. But I'm going to start with a conversation about kind of a class of measures, the type of measures, rather than the clinical topic. And then if we get through with that and people have a concern about a particular clinical topic, then that's the time to pull it from the consent calendar.

Does anybody have any -- Does that sound right to people, especially those of you who have spent some time looking through all of these? I mean all the recommendations are the same. Pretty much all of the commentary are the same. And all of the public comment is pretty much the same for all the measures. So it just

seems like that is a reasonable way to approach it from our face-to-face discussion.

So if there's no objection to that, why don't you guys start with kind of the overall picture, and how these came about, and why did you choose this methodology. And I'm sure there will be some questions about the methodology. But sort of have a general discussion before we get into worrying about voting for an individual measure.

Ted, please start. Reena, or who's leading? Reena, go to you. Okay.

MS. DUSEJA: Thank you, Bruce.

Good morning. My name is Reena Duseja. I am the Director of the Division of Quality Measurement at CMS as well as an emergency physician, and been working on this work with Ted Long and with our contractors.

Want to introduce yourself?

MR. NAGAVARAPU: Sri Nagavarapu. I am co-project director of project for Acumen.

MS. DUSEJA: And you guys have met Ted.

So, we're going to tag team on this presentation here. So, we'd like to give you an overview of the MIPS cost measures. And I'll take the first few slides and then hand it over to Ted.

So, next slide, please.

So, in order to meet the mandate of MACRA, CMS has been developing cost measures that are episode based for the Merit Based Incentive Payment System. The measures that you're seeing today on the MUC list actually are measures that we selected for our wave one of development. And they were picked basically because we saw these as, like, high volume, high cost for Medicare beneficiaries.

And so the eight measures that are listed here are the ones that we're submitting for the MAP to consider. Of note, that these measures were really developed with extensive stakeholder input. And what we mean by that, and we'll go into more detail, is that we got input, got a lot of gathering input from clinicians,

specialty societies. We've also engaged with patients and family representatives, subject matter experts, and other stakeholders.

Next slide, please.

So there are actually five essential components to the cost measures. So a cost measure really represents the Medicare payments for the Medicare care -- medical care for an insured patient during an episode of care. And there's five components here. So you'll see that on this slide.

One is actually defining the episode groups, for how long the duration of care that a patient is counted into the system.

Then there's this issue of attributing the episode group to clinicians.

The third issue is really assigning cost to the episode group.

And then the risk adjust episode groups.

And finally there is this consideration of how do you align the measure

with quality.

Next.

So this one shows you that we have really engaged a broad bench of stakeholders. And to each component of the cost measures through development. And you'll see here, like, for example, the Technical Expert Panel, the role here in the development of the cost measures was to provide high level guidance to the overall development process.

We've also implemented what we call clinical subcommittees. And the role of the clinical subcommittees is to select the episode groups to develop and provide detailed clinical input to each component. And so that actually you need in selecting the episode windows, the attribution roles, the service assignment roles, their roles in the Risk Adjustment Model, all the components that I talked about in the previous slide.

I'll hand it over to Ted.

MR. LONG: Okay. All right. Thank you

again for the opportunity to come in and talk today. This has been a long time coming for us. We've been excited to bring these new cost measures forward.

One of the reasons we've been particularly excited is if you take one thing away from what our introduction here is, and the key to the methodology we used here is that it is defined by clinician and specialty society input. Every single step of the way -- and I'm going to give you some granular details and examples here -- is defined by the input we receive from practicing clinicians, from the societies, because we really believe that's the only way to get this right.

We have three big buckets of input. I'm going to go over the buckets here and then I'm going to go back to, on the next slide, the five components of cost measures and give you specific examples about how exactly we infused the input we received into building the cost measures themselves.

The three main buckets are, first, our TEP. So, we've had an excellent TEP that has leaders in academia, practicing clinicians, healthcare administration, and patients and family members as well.

The TEPs met four times to discuss each of the five components of episode-based cost measures I'll go over in a little more detail in a moment.

That high-level feedback has been infused across the whole process. But there's still a need for us to have that granular feedback to understand what exactly should be included in these cost measures. What services should be included?

For, let's say -- we didn't use this -- but if you have a hip replacement, what services are part of the hip replacement pre-op, post-op? What complications are part of that? And if you have post-op pneumonia on day 30, well, that may not be related. But what about day one? What is the exact time frame for

including all of these different aspects of what happens to the patient into these cost measures which are tied back to individual clinicians or groups?

It's very complex, but we've been very fortunate to have our Clinical Committee and our Clinical Subcommittee really guide us at every step of the way.

Our Clinical Committee was something that we -- I know the term sounds similar -- the Clinical Committee had a specific task. This is over a year ago now. They laid out the menu of what episode groups we could build into the first episode-based cost measures. And they looked at trigger codes. So, how do you know when an orthopedic surgeon is doing a hip replacement? Well, you look at the CPT code. So they looked at those specific issues.

Next we convened what we're excited about, our Clinical Subcommittees. And this is something new for us. What we did is we basically said if we want to get this right and

really understand what clinicians and societies think, we really need to have everybody at the table talking about these things.

So, for the first wave -- now, when I refer to waves we have three waves. The reason we have three is because if you look at all of the clinical areas that we could build cost measures based on it's too much to tackle at once. So we divided it by three. So, the first wave is the first third of clinical areas, so that we could get that part right and to move on to the second wave.

What you're seeing today is the results of the first set of measures from the first wave, which is why not all clinical areas are included.

Just for the first wave alone we were fortunate to have nearly 150 clinicians affiliated with nearly 100 national specialty societies at the table with us in in-person meetings and over numerous meetings by phone to make all of these decisions with us and for us.

Next slide, please.

I'm going to dig into a little detail in terms of what the decisions they made is. But, again, the point I really want to drive home is that the clinicians and the societies that partnered with us were the ones that made the decisions with us and for us and informed every step of the process.

For defining episode group here's a good example. So defining episode group means deciding what either procedures or acute in-patient medical admissions we want to build first. Those are the episode groups. So we had our Technical Expert Panel give us guidance about how to approach that.

We then had our first Clinical Committee lay out the menu of options. But then when we narrowed it down to a third of the clinical areas we put our Clinical Subcommittees into a room, they met each other, they shook hands, and they decided what they wanted to do. They made the decision every time for which

episodes to build, resulting in what you see today.

It was not a decision we made at CMS and then asked them to do the work for it. They were invested and they made the decision about which episodes to build based on what they felt was most important. And we gave them criteria and things like that from the TEP's guidance, but it was really their ownership over that because they were our partners in the process.

Second step is attribution. So, in some ways this is, in some ways it's simple, in some ways it's very complex. We had our Technical Expert Panel give high-level guidance on how to approach attribution to know which clinicians would be attributed an episode for a surgical procedure or an acute in-patient medical admission. We then vetted and ran all of this by, comprehensively through, the Clinical Committee -- Subcommittee members which are, again, 150 practicing clinicians from, affiliated with 100 national societies. So that's what we

wanted to do to sort of get the attribution piece right.

Next, assigning costs. So pause for a moment on this one. This is probably the most time consuming one of them all. And I am eternally grateful for all of the time that's been put into this by all of the clinicians who have been working with us.

Every single thing that happens to a patient has a cost or a claim associated with it. To know which of those costs or claims to include in the episode group to include an episode-based cost measure you have to go through each one and you have to decide what's included, what's not included, and on what time frame. I don't think I need to belabor the point that that gets almost infinitely complex.

But we had our team at the table and they looked at everything comprehensively and recommended every step for us. And that's what, again, that's what we really wanted to do to get this right. So our Clinical Subcommittees put

countless, hundreds of hours into this.

Fourth component, risk adjustment. So, again we had our TEP weigh in on a high level what this means conceptually, how to approach this, and then we vetted it through the Clinical Subcommittees, including looking at specific variables that could be leveraged for a risk adjustment model.

Then finally, aligning with quality. Now, we're careful. We know cost and resource use is a new, it's a new MIPS category and it's a category here discussing, we're discussing in NQF today. And we were very intentional about ensuring that the cost measures we're building now and how we're thinking about them have a plan or a current alignment with quality measurement, whether that's an individual quality measure or our TEP has actually given us other strategies to ensure that there's alignment with quality, to paint the whole picture of what this really means for patients.

We gave all of that information, after

TEP had shared with us their thoughts, to the Clinical Subcommittees. And that was part of their, how they decided which episodes to choose. And it was part of how they approached building episodes themselves as well. But I wanted to be clear that that was something that was important to us to include as one of the five essential components from day one.

Next slide, please.

What we did is we worked with our clinical subcommittees to really build these episodes. We had seven clinical subcommittees there with us at every step of the process from choosing which episodes to build to weighing in on every decision. Then, and that concluded the end of the summer. We were on a bit of a time frame here because before we came here to you all today -- we've been looking forward to this day for a while -- we wanted to actually test them.

So we did. We've comprehensively completed now a field test where we're proud to say that we had over 10,000 unique clinician

reports were accessed for clinicians across the U.S. And this is just for these eight episode-based cost measures.

The reason we did that is we really wanted to know what clinicians thought. We got a lot of really good feedback from the field test. And when we field tested the episode-based cost measures they, of course, were tested at that point but field testing gave us that information we needed to really perfect or at least, I shouldn't say perfect, but to really refine the measures with what we had.

And the feedback we got was very helpful but the other step that we took was the feedback that we received from the field test, we then took all of that back last week -- Sri has not slept -- to the Clinical Subcommittees, because they're our team, and we gave all of the feedback to them in a condensed manner. We talked about it all. And we've actually gone ahead and made the changes.

So we really wanted to by the time we

got here today, to the extent that we can, get this right with as much feedback as we can from the 150 clinicians we've engaged the whole way along, to a national field test with 10,000 access reports. All of that has been incorporated into what you see today.

Next slide, please.

To make a high, a few high level points and then I'll stop. The cost measures to us have clear linkage to the Merit-Based Incentive Payment System. So it addresses our priority of making care more affordable.

MACRA, which created the Quality Payment Program, created MIPS, specifically calls for episode-based cost measure development. And that's driven our process. We've incorporated detailed clinical input at every component of cost measure development -- and that's what I went over with those five components -- and exactly how clinicians were there with us at every step of the way.

We have fully specified the measures.

They have gone through field testing. And they are currently claims-based only. Meaning it's a priority for us when we talk of Meaningful Measures to think about what this means for practicing clinicians and groups on the ground. These measures have zero burden. There's no additional reporting that clinicians needs to do. It's purely based on their claims. And we can give them the information that the cost measures have based only on that.

Finally, we have, we've done the reliability and validity calculations. We understand that's part of the scientific acceptability for the CDP process not to overlap, but we have those numbers. I believe they're included. We can share them as well. Because we really wanted to give you all the information today to really understand the level of work that's gone into this, all of the decisions and where we are exactly.

So, next slide is just a Q&A.

So, happy to answer any questions.

And, again, thank you for your time. We've been looking forward to this.

CO-CHAIR BAGLEY: At this point questions just on the process, not about the particular measures, okay. Go for it. You're up.

Oh, Ann, you're first. Sorry.

MEMBER GREINER: Thank you for that presentation. And, gosh, a lot of work has been done. And it seems that that will help in buy-in and the adoption of the measures. So congratulations.

MR. LONG: Thank you.

MEMBER GREINER: Can you talk a little bit about the role of patient and family input, and also just have you considered other stakeholders in terms of your input?

MR. LONG: Yeah. Actually that's a fantastic question. If we had more time I'd be excited to tell you even more about this.

But two responses. First is the role of patients and family members. We were

intentional to include two in our Technical Expert Panel. But we felt like that was a good start but wasn't enough.

So one of the things I didn't mention is we actually created a version of the Technical Expert Panel with only patients and family members. We asked them, what do you think about cost measurement? How do you conceptualize this? What's important to you that we could translate to the Clinical Subcommittees? And then we helped to do that translation.

That's ongoing. And we hope to build it up more and more as we develop more of these cost measures. But we were excited about the idea of really creating, giving patients and family members their own space to have their own influence with a very clear path to the Clinical Subcommittees.

The other pieces that you mentioned, other stakeholders. One of the interesting things about the way we approached this is, for example, for our orthopedic or musculoskeletal

clinical subcommittee. We didn't restrict it to just orthopedic surgeons. We included all of the other clinicians that have a role in affecting patient care along the way because they have insight that we want to build into this as well.

So, I'm a primary care physician myself. I don't have an episode here but I certainly play a role in a lot of this. So we, each of the clinical subcommittees has actually a diverse array of different types of clinicians which have different perspectives, which we are excited about too.

CO-CHAIR BAGLEY: I'm getting a long list here. And let's try to keep this to mostly sort of the development process questions. Okay? And we'll get into some of the technical things about the measures later, if that's okay with people.

So, next up is Helen.

MEMBER BURSTIN: Thank you. It's really great to see the process you went through and how much engagement you pulled in from the

medical specialty societies and the clinicians. Although, interestingly, they still had many comments on these measures. So, oftentimes as we've seen, as people look at these cost measures they are incredibly complex. And so I think oftentimes the devil's in the details. So I would hope that these measures really do flow in for a full review for endorsement because these are really complex.

I have two questions though. One is that you mentioned risk adjustment, but there's no specific discussion of whether you've looked at social risk adjustment. We know cost measures is a very significant concern, particularly around issues of stinting. I don't know if you've already tested these measures or have plans to test these measures for social risk.

And just one very small comment. It's hard to say these are without burden. I know they are claims-based, but the opportunity costs of reviewing these measures is really quite substantive even if they're claims-based.

MR. LONG: Yeah. And actually the way that we want to give this information back is -- I know it's beyond the scope of discussion today -- but we're, it's a great opportunity for us to really translate this, which can be a new area to a lot of clinicians, in a clear, simple, and actionable way. Hear you on that, your specific question there.

MR. NAGAVARAPU: Sure. No, thanks a lot for the question. Real quickly on the second question, one of the great things about the field testing process has been the opportunity to hear from people not only about the measures themselves in terms of substance but how they're presented.

And so I think what we've heard in general is that the field testing reports are an improvement over the way reports were done in the past, let's say, with the supplemental QRURs. But people also pointed out a number of places where that information could be clarified further, that particular items could be stressed

and explained in a different way.

And so I think one of the values of that process has been trying to make sure that that's communicated in sort of as clear a way as possible.

Sorry? Yes, so for the social risk factors we have been testing for social risk factors. This came up originally in the risk adjustment TEP that Ted discussed, because people had an interest in this. We started thinking about it there and constructing socioeconomic factors using information at the census block level from the American Community Survey.

What we've done essentially is take the components of our socioeconomic status index, so elements of educational attainment, income, dual eligibility status, and employment rates, unemployment, and then use those in the risk adjustment models. So take the risk adjustment models as vetted by the subcommittees, add those factors to get a sense of the change in predictive power. And you see very little change

in predictive power based on metrics like adjusted R-squared.

So that's something that we were happy to continue looking at with potentially different socioeconomic factors. But we tried to take as broad a range as possible for that validity testing.

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

DR. PINCUS: Two points. One, it would be helpful to, and you guys have done a tremendous amount of work. And really, I admire the work that you're doing in this area.

Could you give an example of sort of what, something that was learned in field testing that you fed back to the Clinical Committee and they sort of -- that would be helpful to get a sense.

And the second thing, just as the representative from the Medicaid group, these are all for Medicare. Have you thought about any kind of cost measures for Medicaid?

MR. NAGAVARAPU: Yes. No, thanks for

the question.

So I think one, basically as Ted said, we had a series of these webinars with the Clinical Subcommittees this past week. What we did was our team went through the field testing comments that we got and summarized them by category, really by the components that Reena discussed, the five components of episode-based cost measures. Tried to summarize that for the Clinical Subcommittee, highlight the most substantive areas of the measures in order to try and prioritize the discussion.

And then we went through those areas to try and make sure that the subcommittee felt comfortable with the decision.

So, as an example of something that changed last week in response to field testing, the GI Subcommittee built a screening and surveillance colonoscopy measure. That's something where we received field testing comments from specialty societies that were involved in the measure because through the field

testing process they realized that the trigger codes that open the patient cohort for a screening surveillance colonoscopy was broader than they expected and than they really intended with the measure.

And so, what happened was through, through that discussion we were able to scale back the trigger codes. And so they sort of worked to ensure that the episode group was limited to colonoscopies that were actually performed for screening surveillance purposes and doesn't include diagnostic colonoscopies, by requiring a particular modifier to appear on HCPC CPT codes.

They also made some other changes to the patient cohort based on those sorts of comments. So I'm looking here. They added an exclusion of surveillance colonoscopies performed in the inpatient setting and done in the same session as an upper GI endoscopy. And they added an exclusion of endoscopic mucosal resection.

There is another change that they made

there, something that came through sort of loud and clear in the field testing comments from those specific specialty societies was the decision on site of service. Originally in the summer when the measures were being built there was discussion of the site of service issue. And originally there was no subgrouping that was done for site of service.

This was different than what some of the other subcommittees did. So the Ophthalmology Subcommittee for instance for the cataract removal did include a site of service distinction in episode subgrouping. And the GI Subcommittee had a chance to think through this and last week decided to actually subgroup by site of service.

So they updated, they added subgroups on place of service. And the subgroups are sort of a hospital outpatient department, and ambulatory surgery center, and an office setting.

And so I think that's just one example from one subcommittee. But for each subcommittee

we tried to walk through the substantive aspects of the measure based on the specific comments we received and implement those changes.

MR. LONG: Yes. And to your first question, Harold, have we thought about this with respect to Medicaid? We should say I think, I would say the preliminary thoughts, we'd love to talk to you more. Let's go through it today.

CO-CHAIR BAGLEY: David, you were next.

MEMBER SEIDERWURM: Oh, I just was wondering since CMS has withdrawn support for some other care bundle programs, is this meant to substitute? Is this just a different pathway, a different statutory framework? How does all that fit together?

MR. LONG: Yeah, that's a good question. So I'll be very specific about this.

So, MACRA as a statute has a specific requirement for building episode-based cost measures for use in the Merit-Based Incentive Payment System. This is specifically a part of that requirement for the Merit-Based Incentive

Payment System for clinicians in that program.

Beyond that there are, you know, are implications to everything that's done. But this is specifically for that. So the consideration today for you all is really for the Merit-Based Incentive Payment System, given that MACRA requires it, given that we are bringing these here today, do these make sense?

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

MEMBER BRISS: Great work. I'd like to encourage CMS to do some of this kind of rapid learning with these sorts of measures as you're implementing them. My guess is that these sort of very specific cost measures aren't -- my hypothesis is that they aren't that, going to be that useful in reducing global costs of care much because they're such a little slice of all the costs. And they may be subject to some gaming.

And so, so my guess is that we're going to need more global measures. And that these kind of things would have to get into the hundreds, and be very burdensome to actually do

what they're supposed to do. So learn rapidly on these about whether they're useful or not.

MR. LONG: We couldn't agree more. And I will say these are just the first set. So as we move forward I think we will begin to -- give us a little more time -- be able to address that with more episodes, too. But also having a global sense of things is definitely on our minds, too. So I just want to agree with you.

CO-CHAIR BAGLEY: Scott, your card's been up and down. But I actually saved your place in the queue, so go for it.

MEMBER FURNEY: Thanks for not putting me in the back of the line. Helen asked my first questions about socioeconomic risk factors.

The second question, as many of these measures are considered potentially tertiary, is in the system I'm in there are 47 facilities. And there's a very clear correlation with almost any other external risk adjustments we see. The larger facilities appear to have a bias, and that tracks along with the tertiary or quaternary

providers.

So one of my concerns, and I'm going to ask how over time we'll learn, perfection being the enemy of progress, how will we learn about any biases built into the risk adjustment that don't disenfranchise those providers that do high risk work?

MR. NAGAVARAPU: Yeah, thanks very much for the question.

So far in our, in our testing of statistical validity the approach we have taken to this is to try and sort of stratify providers by the risk profile of their patients to get a sense of whether the risk adjustment is compensating appropriately for clinicians with sets of patients with higher risk on average.

What we've seen in sort of standard kind of statistical approaches, like analyzing predictive ratios by risk order deciles is that you don't see, fortunately, any sort of pattern that would suggest that the risk adjustment model is having a more difficult time compensating at

high levels of patient risk. So that's been encouraging.

The other way that we've seen this so far is we've put out a national summary data report publicly that examines risk adjusted cost distributions by various provider characteristics to get a sense of, for instance, whether in rural areas the distributions look substantially different than urban areas.

We haven't seen marked differences there. But and we haven't seen marked differences by sort of provider risk profiles like I mentioned on that metric either. But I think what we can continue doing is monitoring those sorts of characteristics, look at, you know, from suggestions like here is like practice size or group size, for instance, and continue kind of keeping an eye on those sorts of metrics to ensure that as practice patterns evolve over time that we don't see any sort of unintended discrepancy.

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

MEMBER AVERBECK: Just a couple of questions. Is the methodology available to the clinicians along with raw patient level data for improvement opportunities?

And then second, and this kind of crosses a little into the specification question, is both price and utilization included in a cost measure so that as a clinician we could, you know, kind of decide which area has the most opportunity?

MR. NAGAVARAPU: Yeah, thanks for the question.

So in the field test reporting what we've tried to do is include varying levels of detail from sort of the highest level, this is your measure score, this is how it's broken down by subgroup of the measure, so maybe by site of service for instance. And then as you move through the report try and provide more and more detail.

So, you know, thinking about the report in terms of sort of tabs of an Excel

workbook let's say, the first tab is a real high level overview; the second one is trying to break things down by different categories of services, so maybe different specific types of complications and so on. There what we tried to do is split up the utilization and the pricing and sort of for the reason that you're saying; right?

So we have some metrics that say what fraction of your episodes included this complication, let's say. And then, then a separate column that says, okay, what is the average cost contribution to your episodes of this complication? For exactly the reason that you have in mind.

And then as you keep going through the tabs of the report you get to more and more detail. The last tab is sort of each row is an individual patient's episode and provides some detail there. And we've gotten feedback through the field testing process about information people would find more or less important there

that I think we could add or remove going forward. But, you know, we think like trying to tailor that to make things as actionable as possible is going to be crucial.

CO-CHAIR BAGLEY: Stephanie.

MEMBER GLIER: Just wanted to echo other folks saying congratulations on this work. It's an incredible amount of work and you guys have done a great job incorporating a lot of feedback into the process.

I wanted to see if you could elaborate a little bit more on component five, the alignment of cost and quality. I'd really love to know whether that's sort of the clinical subgroups are deciding what quality components count? Or are you really looking like, are you going back to the Meaningful Measures framework and saying, you know, here are the little dots that actually we can draw a dotted line over to the cost category with? Or how are you thinking about that going forward?

MR. LONG: Yeah, that's a great

question. I think the answer is in terms of the sort of what the Clinical Subcommittees are currently doing versus the opportunity moving forward a little bit, so the answer is a little bit both.

So what they're currently doing, what they've used is we give them information on the existing quality measures that would be potentially aligned or even harmonized with the episode-based cost measures they were choosing between. And that was very helpful, I think, for them at that point.

But moving forward there are other things we could do, too, on the program side. So how do we think about what the alignment should look like between quality measurement and cost measurements? And that, I think the Clinical Subcommittees can help us think about that. But that does go on to the CMS program side for us to think about as well. And I think the Meaningful Measures framework will inform how to identify the highest priority areas for that.

So I think that will be a little bit of ongoing work.

And the TEP, the second time the TEP talked about it -- I think it's available now -- they had a really interesting discussion about this, too. So you can go, I can share that with you, too.

MR. NAGAVARAPU: And just to add on that. We tried to think about alignment from sort of multi-dimensionally in the sense of thinking about, one, the overlap of patient cohorts let's say; right? At the most fundamental level, like are you designing a measure where for those specific patients there are also quality measures present; right?

And so what we did is when the selection of episode groups was happening by the Clinical Subcommittees trying to present them information on the extent of quality measures that were available in the MIPS program. And in that discussion is a really interesting discussion because sometimes there would be

measures where there wouldn't be that many existing quality measures, but someone would say, but there are these other quality measures that are relevant. Our society has developed this. They're available and could be used. Right?

And so I'm kind of looking at a list here of for each of the eight cost measures there's a number of quality measures that are sort of have an overlap of patient cohorts. So for like knee arthroplasty, for instance, there's quality measures; for a total knee replacement in shared decision making; perioperative care for like the selection of antibiotics and things like this. Right?

So, for each cost measure there are quality measures with that patient cohort overlap. The other dimension of alignment is sort in the details of measure specifications. And, for instance, the Ophthalmology Subcommittee wanted to ensure that this was aligned with PQRS measures in terms of those definitions. And so the exclusions for certain types of patients that

are used in the PQRS measures are also being used here to try and align the patient cohorts as much as possible.

And then there is a discussion, for instance, about episode windows, how long the range of costs are counted and how that aligns with quality measures. So, for instance, the development of the pneumonia measure there is discussion about what quality measures are out there for pneumonia. Do they look at 30 days? Do they not? Like, where do the 30 days start from, and so on.

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

MEMBER WHITACRE: I didn't want to drag this out but I'm still stuck on the risk assessment. I'm just not quite sure -- this is as a practicing surgeon -- how you exactly do it. And if there's not a profound understanding at the clinician level, whether or not there couldn't be unintended consequences. The harder more difficult cases are often sicker patients. Right now in the current system, CPT

reimbursement rules I get paid the same for doing more work and accepting more risk.

How does this all work? Where I know if Mrs. Smith has diabetes or is a smoker how much risk I'm accepting and how that works in clinical practice?

MR. NAGAVARAPU: Thanks very much. So in practice, the way we're doing the risk adjustment, and it's because of the sensitivity of the types of concerns that you have in mind, is by looking back through the patient's claims history in order to look not only in the exact time of service at the time that the surgery happens, but also before that, that inpatient, outpatient, Part B, physician supplier claims to understand diagnoses that have been seen in the patient's history to try and capture different elements of that history.

Now, traditionally what we have used in cost measures before was a shorter look-back of 90 days. The reason for that was that there's a tradeoff between sort of if you look back

further there's two issues.

One is that you may lose certain patients because you don't have that far of a history on them.

The other is that there are certain acute conditions that may resolve, that sort of arise a year ago that resolves.

So, so traditionally we'd use 90 days. We discussed this with the TEP to get their sense of how long we should be looking back into a patient's history. The suggestions there were to go further. And so, so for these measures we've gone to 120 days. That's something that's easy to update but we feel comfortable with the tradeoff that we're at with 120 days.

And I think, you know, in initial testing we haven't seen really big red flags based on sort of the risk profile of a clinician's patient pool, but that's something that we should, you know, continue to track.

MEMBER NGUYEN: Just wanted to reiterate, thanks a lot for all this great work.

And I wanted to ask specifically if you could talk about the process in thinking about critical care and pulmonary care in this work, as it's so important to resource use, and cost, and the Meaningful Measures framework, and aligning quality and cost for patients?

MR. LONG: I can start and see if you want to add anything.

Yeah, the way we've thought about this is I think there's two dimensions to it. The first is which episode-based cost measures to really focus on in that context to build in the critical care contribution to any patient that needs the services in that episode. But then moving forward, too, we can continue to actually build episode-based cost measures that actually attribute to the critical care clinicians.

That would be something we could talk about moving forward.

Right now what we've done is just built all of the things that can happen to a patient, including if they, unfortunately, have

to go to the ICU, into the episodes that we currently have. Because you couldn't do more, and it's a crucial piece of it. So it is definitely built in.

Do you want to?

MR. NAGAVARAPU: Yeah, I won't add much. I think that's a really exciting important area to look into. And I think the sorts of issues with risk adjustment that are being brought up are, you, coming really to forefront there. And so we're looking forward to working in that area.

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

MEMBER SHALLER: I was just curious, with the field testing that you did, did you get enough data to actually look at -- can you comment on the extent of variation that you saw?

And also, sort of related to Stephanie's question, and this is something you probably having gotten to yet, but the actual correlation that you were able to look at sort of the cost issues compared to some of the quality

indicators and what's the correlation there?

MR. NAGAVARAPU: Sure. So, thanks. We put out a -- there were a lot of, there's a lot of interest in this sort of question about sort of the extent of cost variation. And so what we did is we put together a national summary data report based on the measures. And towards the end of field testing put this up publicly.

And so there what we have provided, in addition to other results, is sort of a distribution of the risk-adjusted cost that you see nationally, as well as broken down by various characteristics, so, of clinicians or patient populations. In general you see quite a substantial performance gap in the initial analyses that we've done, as well as sort of the analyses thematically by sort of areas of complications and so on for field testing.

You do see that things like inpatient readmissions tend to drive this variation. Post-acute care is very important in driving variation. And so there are aspects like this

that have come through.

And we've provided results on the performance gap for the MAP, but more details are available on that national summary data report that we could point folks to online.

MR. LONG: Yeah, actually we can share that. I think it does really capture the various questions specifically and has great figures and graphs and tables and everything.

For your other question related to the relationship between what we see the cost measures going, and quality measures going to, I think that once we implement the measures we'll be able to really understand that. But to the -- it's an important point. It's definitely on our minds. We think a lot about that. So thank you.

MEMBER BURSTIN: I'm just curious what efforts or what alignment there is between this and some of the existing payment methodologies, like the DRGs or the ABCs, which is the actual payment that gets made, which could be very different than the episodes you arrived at.

MR. NAGAVARAPU: Thanks very much. So, I think one of the issues that older approaches to episode grouping often ran into is grouping in a way that doesn't necessarily recognize Medicare payment policy. And the reason that can be problematic is that you get variation attributed to clinicians that really is not in their control but is sort of a relic of Medicare payment policy and the way the DRG system is geared.

So to give you a specific example, there are particular procedures that could occur in an inpatient setting that could appear with a range of DRGs, MS-DRGs. And if you're not careful to condition on only the DRGs that are clinically tied to that procedure it would be easy to get a very heterogeneous pool of episodes where you would potentially be penalizing a clinician for performing a procedure in a case where there's something much more extreme that happened to a patient that pushed them into a high payment MS-DRG that really typically isn't associated with, with that procedure.

And so what we've tried to do, both in partnership with the Clinical Subcommittees as well as kind of building on previous work we've done with episode groupers is try and condition as much as possible on Medicare payment policy to try and avoid penalizing a clinician for situations like that.

CO-CHAIR BAGLEY: You're next.

MEMBER FRIEDMAN: Again I'd like to echo all the work that Acumen's done.

In reading over the comments, one of the issues was unintended consequences that with these procedures if commissions are going to be graded some will go to a lesser invasive procedure initially, which may or may not be successful, and then subsequently go to the reported condition, which may in fact increase the cost to this particular disease process.

Have you guys looked at that and addressed that? Do you have any concerns about that?

MR. LONG: Yeah, I'll start with that.

I think this is a really important point. I think it circles around the fifth component there, which we consider a cost measure to really be complete once there is a plan in place for what it means to have quality measurement done concurrent with the cost measurement itself. Because the only way to really, or the best way to really get at your question there is to look at what happens, what actually happens to the patient. Did they get the care they need? What was their outcome?

And the way to do that is quality measurement. So, you know, with the measures here it's been a, we're very intentional to have it be one of the five core components of it because to us we aren't doing the world any good if we don't have a way to really know if there are unintended consequences from happening.

So there's a piece now where we want to make sure these measures have current quality measures that exist to our plan in place. And that's been a very important part of the work so

far. But moving forward, to the points made earlier, that's something we're going to continue to monitor. And that's going to need to be something that we continue to think about the ways to really build together cost and quality. And that has program issues, too. But it's something that is really, really important and we are definitely thinking about that. So I appreciate the point.

MEMBER VAN DECKER: Thanks. Bill Van Decker from Cardiology again. My non-financial disclosure is I was honored to be the co-chair of the Cardiovascular Subcommittee of this project, so I have some familiarity with it.

And then, number two, I'd like to thank the 30 members of the subcommittee who struggled with what I think is a challenging new frontier here, trying to do the best we can recognizing unintended consequences are possible, and try to get this the best we can.

So I'll make a couple of quick comments and then I'd like to ask a question for

the administrative piece of this.

I think that the subcommittee struggled most with what, well, the obvious -- first of all, I think the subcommittee, at least in cardiovascular, which chose two areas to go into, was shrewd in trying to find the cleanest type of homogeneous groups to start with for which there are relatively good quality markers out there. Because you have to start from somewhere where you have some solid base to go.

This is going to get much more complex when you get into a lot of acute medical conditions and the Venn diagram of overlap becomes dramatic, and then we have to recognize that.

You know, the areas that we struggled with the most were risk adjustment, as everyone pointed out. I think that we should all be honest with ourselves that the risk adjustment here is claims-based mostly because that's the coin of the realm. So we're dealing mostly with HCC, we're not dealing with registry data. But

it is the quickest way to get here.

We have argued a lot for socioeconomic conditions. Coming from North Philadelphia I understand those.

And lead to my summary question here, but we did struggle with that.

Now, the second piece of this is attribution to a clinician who may or may not have total control over what's going to happen in this episode. You know, these groupings are basically, at least in this first go-round, cut into either procedural groups which somebody could worry about one procedure choice over another. But there's also some acute medical conditions in here.

The procedural ones are going to be attributed to the procedural physician, plus or minus how they look at that. But at least that's a fairly straightforward marker.

The acute medical stuff, like acute MI or pneumonia, is going to be attributed to the clinician who has the majority of the E&M

decision making claims on the patient in the initial hospitalization, at least 30 percent of the claims. And you can well imagine 32 percent, 28 percent, so you know, we're going to need to see how that plays out. But it was kind of the coin of the realm going in, and there was not great reason to say that that's not a good place to start. But we need to recognize this is a work in progress as to how this happens.

And then, you know, the last piece of this was basically subgrouping to make sure that we were as homogeneous as possible and that we were at least picking things that have quality markers that can get folded in from other realms or be watched, like deaths and readmissions and the complication rates, especially in the cardiovascular world, which are relatively well known from our registry data than CBR.

So that's kind of just my summary things on what obviously was a intense process, including the refinement meeting last week where we talked about stakeholder input.

I guess my question after that long summary to the administration piece is this is obviously a work in progress. How do we see adjustments down the line? What do we see as the feedback focus committee, the subcommittees, so that we try to get this better and better before we even worry about the Venn diagram of the more and mores? How do you see that playing out?

MR. LONG: Yeah, that's a great question.

So I think, well, first-off thank you. And I think one of the points you made, which is really important, is these are hard decisions. None of this is easy. This is all a new area for all of us. And the reason why we're fortunate to have you involved and the other 30 members is, again, what we have now our approach has really been we really want to know what clinicians and what people like yourself think. That's the best way we're going to get to the best place.

But it's not, it's not like it's a yes or no, black/white easy, or right/wrong decision.

A lot of these things are very challenging. And thank you for sticking with us, and including last week.

You know, moving forward, I think it's an issue for us from a program standpoint at CMS about any measure, whether it's a quality measure or one of these cost measures, that may be changed over time. And that's where there's a maintenance process under CBG for the National Quality Forum. And it's something that we actually welcome.

And I think what we have today are the fully specified measures with all of the input that we have to date. But that's not to say that six months from now, a year from now there might be a coding change or there might be new ICD--10 codes, or there might be a new perspective that somebody has that's, you know, your committee then says, well, you know, we should really look at this.

And we're, I just want to be clear, we're very open to having those conversations

ongoing. And, you know, I think that the mechanism NQF affords, especially with, again, the endorsement process, offers an opportunity for us to really continue to think about the measures and to continue to think about them over time longitudinally with key milestones.

So I will end by saying thank you again for all your help because we really would not be here without you, so.

CO-CHAIR BAGLEY: Patti, want to have the last comment before we go to the public comment?

MEMBER WAHL: Sure. So representing the purchaser perspective, I know a lot of our employers work directly with health plans and these similar type measures, as well as directly with providers. And I know in the past CMS has partnered with NQF and with the American Health Insurance Programs, AHIP, for a common set of harmonization of measures across the spectrum. So I was wondering if these type of measures, if you're considering adding them to that

collaboration as well?

MR. LONG: Thank you for your interesting and creative idea. Let's talk. But today we're, right now we're at the point where we're excited that we sort of have them at a critical point and we want to sort of have a stepwise progression.

But the sky's the limit in terms of where we could go. So thank you.

CO-CHAIR BAGLEY: Okay. Michael or Leslie on the phone, any comments or questions?

MEMBER ZUN: I do not have any left.

MEMBER HASSETT: I do not.

CO-CHAIR BAGLEY: All right. I think it's time to move to public comment. And we'll do that in sort of two phases. One, we have public here in the room and we have a microphone for them. And we also have the opportunity of the Operator open up the lines for public comment on this group of measures, sort of a similar discussion to what we've had.

So at this time is there anybody in

the room that would like to make a comment?

Are you heading for the mic? Make sure it's working. Could you make sure the microphone's working.

There you go.

MS. McILRATH: Okay. I'm Sharon McIlrath with the American Medical Association. I want to start by saying that the AMA supports the use of the episode groups in general. We think it's a better way to go than the current cost measures that we have from the VBM.

On the other hand, and we think this process has been really excellent, unfortunately we don't think it's complete. And so we cannot give full support to the measures that are before you today.

Just some things that, that have -- where we would like to have more answers. Well, one question is the representativeness of the sample. Unfortunately the time was truncated for that and it was very difficult to draw the reports out. Even some members of some of the

panels had difficulty doing that. And it's our understanding that primarily the respondents were very large groups.

So we don't know how that would play out when it gets into a smaller group. We know that it was about 7 percent of groups that represented about 20 percent of physicians. We don't know -- I mean we know those people accessed the report. We don't know what they did with it. And we don't know what the individual physicians did.

We don't know what happened at the individual measure level. We don't know how many responded at that level. We don't know what the reliability is at the different minimum case thresholds and how that would stack up with the responses that were received.

There were some of the -- a couple of the measures where almost everyone was in a group, every one of the respondents was in a group where they had 10 to 20 minimum cases. And so we don't know even how many of them would have

met a 20 caseload. So that is a place where we'd like to have some more information.

And we think that that's a place where this group needs some more information.

Noting, as somebody said, that a number of the specialties still have some concerns.

Another issue is that, as was pointed out, the GI group made some major changes. I think -- I don't know about other ones. But a question would be how would it stack up after if you did another field test with those measures and what would you see in terms of the variability after you had switched the site of service, where you treated that.

So there is we also have some concerns about the tie with the quality, as has been discussed here. In particular, one of the TEP discussions there was a lot of -- I mean it appeared that the physicians were not going to be able to choose or there was, there was more control over what the physician had to do, and

less ability for a physician to pick measures that would have actually matched with their practice and had some relevance for them.

Another issue is, which was mentioned by one of the discussants here, was that there was very little discussion of how would it tie in with clinical, the -- I never get these initials straight -- the qualified registries.

And then on the risk adjuster, the issue about the claims and the discussions in the workgroups, there were a number of comments made by the discussants there about if only they had a claim measure that would tell them this. But they couldn't do this risk adjuster because it isn't on the claims. And as you think about that you can think of a lot of examples where that would be the case.

One, and the question about attribution, we would like to have seen some data that showed, particularly when you had a multiple attribution, who did, who did it get assigned to? Were they people that were in the same group?

Were they people that were in different groups? What specialties tended to get sort of attributed together? You know, would that -- what's the face value of that?

So, the bottom line is we just don't think the -- we don't want, we are not saying that they should not have further work but we are also not ready to say, you know, they have our full support. And as noted, a number of the specialties that were involved did not either.

CO-CHAIR BAGLEY: Thank you.

Anyone else in the room?

(No response.)

CO-CHAIR BAGLEY: Okay. Operator, can you make an announcement on the phone, please.

OPERATOR: Those who would like to make a public comment, please press star then the number 1.

Okay, we do have a public comment from Brad Conway.

MR. CONWAY: Hi. Can you hear me?

CO-CHAIR BAGLEY: We can. Go ahead,

please.

MR. CONWAY: Thank you so much for your time. Appreciate it.

Just to echo AMA's comments and a question on process. I know you're not getting into the details of each cost episode at this point, but just a question on process.

And what measure or what version, I guess, of the measure -- I'm sorry. Let me just back up. Brad Conway with the American College of Gastroenterology. And we were part of the technical component and Clinician Panel which, to credit Acumen and CMS, is very inclusive. The meetings, the input, and the process in and of itself was, it was very well appreciated and very well, the feedback we got was pretty good.

But just a question on which version before the NQF is considering right now, is it post the trial, the field testing? Is it post-trial field testing as well as additional input? Or is the episode before NQF right now prior to the field testing?

It's just there seems to be multiple versions, as you mentioned. And I just don't know if the two processes are occurring concurrently or if the measure before the NQF right now includes all the input based on the field testing as well as the input from the Clinical Subcommittees and technical experts.

MR. NAGAVARAPU: Great. No, thanks for both of the comments. And I think they are very closely related in a lot of ways.

So in terms of the material sent to the MAP, so fortunately we were able to, you know, get through reliability and validity testing for these measures. We submitted reliability numbers to the MAP for the measures. And the measures tend to have high reliability.

We looked at an alternative side of case minimums for the measures, looking at 10, 20, 30, 40, 50. I think the measures sent to the MAP focused on 20, 30, 40, just because those are case minimums that are more in line with some traditional CMS reporting. But, you know, we

could, we could provide additional information there.

But we are fortunate to know that the measures as constructed before have high reliability.

Those measures, to answer the second question, those, the measures and the reliability results are based on diversion of the measures before last week's refinements to the measures. And so we anticipate that with the refinements to the clinical validity of the measures that the reliability would improve from this point.

An example of that is the site of service distinction that comes into the colonoscopy measure, as well as the increased homogeneity of the patient cohort for colonoscopy, which will tend to, on both counts, reduce the sort of statistical noise within the measure.

And so I think we're starting from a high starting point in terms of reliability. And there were improvements in this past week that

would, we expect would further increase that.

MR. CONWAY: Thanks.

MR. LONG: Just to add on one thing to that. We did run the reliability numbers. And I think they're in the paperwork that people have in front of them.

To quickly summarize, yeah, the reliability I believe for the calculations we have were every measure at a case minimum of 20 for individual clinicians had a reliability of .65 or higher. Most were higher than .7, almost all, so.

CO-CHAIR BAGLEY: Operator, are there any additional public comments?

OPERATOR: No, sir, there are no other public comments at this time.

CO-CHAIR BAGLEY: So we'll have a 10-minute break. And then we're going to come back and have some additional discussion and, hopefully, a vote.

Thank you.

(Whereupon, the above-entitled matter

went off the record at 10:49 a.m. and resumed at 11:04 a.m.)

CO-CHAIR BAGLEY: For those of you who are at the table, you can see on your screen, there's a list of the measures in this consent calendar. Just to review the consent calendar process quickly, all of these measures are under the cost and resource use measure set.

As you recall, they're all very similar in terms of their construct. Each has a little bit different clinical topic, but they're all very similar in terms of the methodology and the construct.

They all, on this consent calendar, the preliminary evaluations by the staff are all the same, and that is conditional support, conditional support. And the condition on all of them is the same, and that is that they be submitted to NQF at some point in time.

And so there are nuances of course about individual things in terms of the clinical topic, but as a group, they're very, very

similar.

So what I would like to do next is to have the, basically the motion of the staff to accept the consent calendar is really the motion on the table. And that means to accept everything in the consent calendar as-is. So it's kind of a yes or no vote.

Now, before we take that vote, there's an opportunity to talk about some of the, I've said before, we'll have an opportunity to talk about some of the technical things that if you have a question about any of the one.

If you really think that any one of these eight measures should be withdrawn from the consent calendar and voted on its own, and that would be if you thought it should have something else besides conditional support, or if you have another condition you would like to add. So does that make sense to people?

And if you are fine with conditional support, there's no reason to pull it off the consent calendar just to ask, you know, a brief

technical question about the measure.

So I'm going to try to expedite this a little bit. But I don't want anybody to feel that they didn't have a chance to challenge anything that is on the consent calendar.

So if you care to pull something off the consent calendar, primarily because you want to offer a different outcome for that measure, or you have some real problems with how it was constructed or, you know, you really want an in-depth conversation, then now is the time to pull it off the consent calendar.

And I will allow people to pull them off all the way up until the point we vote. Okay? Once we decide to vote, you're done with your opportunity to take them off. Okay?

So I know that's a little confusing, we don't always use the consent calendar. But in a case like this, it makes a lot of sense to do it this way. Eric, go ahead.

MEMBER WHITACRE: I think this is in the spirit of what you're asking. If I have a

general question about the measure specifications, it seems to be the same in each one, can I ask that at this point? It's sort of a generic question.

CO-CHAIR BAGLEY: Sure. And that's sort of what I was hoping would happen. And if we get to the point we're all ready to vote and anybody, any member says, you know, my concern has not been addressed about a specific measure, then that's the time to pull it from the consent calendar.

We'll set it aside, we'll vote on the consent calendar as it is, and then address and vote on that measure separately.

MEMBER WHITACRE: SO this would be a general question, and I think it's true for all the measures. It has to do with the numerator calculation. It says that the numerator is the cost measure, so on and so forth.

This is then multiplied by the national average of observed episode cost to generate a dollar figure. That must be

geographically adjusted, just as in CPT, right, with GPCIs?

MR. NAGAVARAPU: So, the national average observed cost is something that is payment standardized. So it uses CMS payment standardization methodology which includes geographic adjustments.

CO-CHAIR BAGLEY: Are there other questions? Stephanie, go ahead.

MEMBER GLIER: This is more of a program question, not specifically about the measures. Can you walk us through whether CMS has a timeline already in mind for the continued refinement of these measures? Is there a statutory deadline you're working towards from that side from just having episode cost measures?

And perhaps at the risk of getting into an area that you can't talk about yet, are you thinking about how you might be incorporating these into rulemaking in the future, how to build them into the cost category for MIPS to start with?

MS. DUSEJA: That's a great question. So yes, so the goal is obviously bringing these measures to the Committee and getting your input for rulemaking. So that would be the goal.

But in terms of the question that you first started with in terms of refinement, we are committed to continuing the type of getting the feedback from the MAP as well as through the TEPs and our clinical subcommittees to continue to refine the measure.

(Off microphone comments.)

MS. DUSEJA: Well, I think we always have a standard process of doing that. So, you know, we have TEPs usually once a year. We've had the clinical subcommittees, that's more of an open question of how often we can tap into the resources.

They've been so willing at this point to give so much over the summer and the fall, and we'll continue to do it as the need is there. And so there's always that openness to continue involving the clinical subcommittees and TEPs, as

well as the other mechanisms we have for public feedback.

MEMBER WHITACRE: Another question going back to attribution. I noticed in the presentation that there was a formula that was developed. Will this play into the new G-codes, the patient relationship codes? Will that be used, how is that going to be introduced?

CO-CHAIR BAGLEY: I see Ted left you guys in the hot seat. So, is that intentional?

MS. DUSEJA: He had another meeting, unfortunately, for a few minutes. So yes, so we do have patient relationship codes. And the purpose is, we proposed in the rule for, and it was finalized through our PFS for it to be voluntary at this point.

So we really are looking forward to using the patient relationship categories and codes to help us in terms of being able to help with that attribution in getting more information, if that helps.

MEMBER WHITACRE: So potentially, the

clinicians involved could override the formula that you have established. Or would you be looking for that as a part moving forward?

MS. DUSEJA: So no, at this point we're just collecting information. I think it's a little too unknown at this point because the categories have just been developed and proposed. But based on information we get from the reporting, then we'll be able to go back to the TAP and the clinical subcommittees to think about that attribution.

CO-CHAIR BAGLEY: Okay. I have a brief question. A lot of the questions have been about how do we refine and make this better. And as most of you know, an episode has a trigger, an event like Robert's knee surgery, okay, is a trigger.

And then there's a pre-period that you can be expanded or contracted to include, you know, lots of things. If it's too short, you wouldn't find somebody that does an x-ray every month up until the surgery. You know,? If it's

too long, you're picking up too much stuff.

And it was also mentioned earlier that the more complex the patient is, and in terms of all of the other stuff that's going on with them, it's harder to decide what should be in and what should be out.

And can I assume that all of these are -- and also the risk adjustment methodology, those are all things that can be tweaked? I mean, that's sort of you need feedback on all that stuff.

And in my mind, the only way to get that is to put it out there and run it on a larger scale. I mean, isn't that true? I mean, is that your intent?

MS. DUSEJA: Absolutely. I would completely agree with you.

MEMBER WHITACRE: Are the measures being submitted for NQF endorsement?

MS. DUSEJA: Yes.

CO-CHAIR BAGLEY: Okay, all right. Any other general comments before we move to a

vote? Yes, Peter, please.

MEMBER BRISS: Yes, I have one. This is for CMS and NQF. Has your thinking about NQF endorsement for these, I think it would be easier to -- I don't know which committees might opine on which of these measures. But it would be easier if you could do as much bundling as possible.

I think that you're likely to get into trouble if you try to do these eight measures in eight different NQF committees that gave you answers that were all over the place.

MR. AMIN: So, typically these measures would be, well these measures will be evaluated by a cost and resource use standing committee that has, while the criteria are very similar to the quality measures, the specifications obviously for the cost and resource measure is different.

So they will be looking at the importance, the scientific acceptability, usability, and feasibility. But under scientific

acceptability, they'll be looking at what we expect in terms of cost and resource use specifications.

So I think that's a really good point, Peter. I want to make sure to take that consideration.

CO-CHAIR BAGLEY: Okay. Is there any Member who would like to have any of these eight measures extracted from the consent calendar?

MEMBER FURNEY: I would like to have MUC17-363. I have concerns about many of the procedure based codes or hospitalizations for the risk adjustment methodology, creating a bias for tertiary facilities. But that one particularly I think we need to discuss.

CO-CHAIR BAGLEY: 363 will be extracted. Are there any other extractions? If not, we'll move on to approval of the remainder of the consent calendar with the exception of 363 which will be discussed and voted on separately.

So the vote is are you in favor of the remaining consent calendar, with the exception of

363, or are you not. So it really is a yes or no vote.

(Off microphone comments.)

CO-CHAIR BAGLEY: We're voting only on what the consent calendar says. And if it says conditional support, that's what it gets. Now, these all happen to be, but consent calendar could have four different recommendations, in which case a yes vote would be for each one of those individual things.

So this is a consent calendar, we're voting on what you were given ahead of the meeting with that recommendation and the particulars of the condition. So if you want to add a condition, that would be a time, for instance, to pull it off the calendar. Or if you wanted it to be something besides conditional.

But if you agree with the conditional support in this case, they're all that, and the conditions that are in the preliminary analysis, then you should vote yes. If you're not in favor of that, or you're just having a bad day, I mean,

you can vote no.

(Laughter.)

CO-CHAIR BAGLEY: Okay. So the vote is on, do you have the slide?

(Off microphone comments.)

CO-CHAIR BAGLEY: Oh, I'm sorry. Sorry, I apologize.

MS. MUNTHALI: Sorry, that's okay. We just wanted to note that there are two recusals from the workgroup. Diane will be recusing herself, and so will Bill because of their involvement on the technical expert panels.

CO-CHAIR BAGLEY: Thank you for that. So do we know the remaining total count?

MS. JUNG: It's 19.

CO-CHAIR BAGLEY: Nineteen. So we're looking for 19 on the popcorn popper right now?

MS. JUNG: Yes, that's correct.

CO-CHAIR BAGLEY: Okay.

MS. JUNG: So at this time, voting for the consent calendar for cost and resource use is now open. Option 1, yes. Option 2, no. remote

participants, please send in your decisions. Michael Hassett, if you're still with us, please send in your vote.

We still have quorum. So the voting is now closed, we have 18 total responses. Wait for this to pull up. So we have 94 percent yes and six percent no.

CO-CHAIR BAGLEY: So that exceeds the 60 percent criteria. So those are approved as-is. So we'll now open a conversation on 363, MU17-363. And Scott, I'll have you take the first volley, and then I would like to hear from the lead discussants.

MEMBER FRIEDMAN: So, of all of the measures generally supportive of the category and agree that there has been a great deal of work in developing these measures. This is one in particular where I have pretty direct evidence that there will be potential unintended consequences of developing such a measure with what is really a very pleomorphic condition.

So in the 47 facilities that we serve

in our system, we've had to develop a triage system where patients may look identical when you look at coding data, but we keep relatively uncomplicated ones in our smaller rural facilities, the more complex but not disastrous go to our medium level facilities, and then all of the disastrous ones go to one facility.

And so we have enough high volume of these to differentiate into a triage system. And if I understand the measure correctly, from what I've been able to read, this will induce a significant bias against the facilities that accept tertiary patients.

So I would like to have that discussed, and if possible answered so that we know whether that is an unintended consequence. Certainly my fear in looking at many of the procedural measures, I think that echoes what others said earlier.

This one in particular I think is risky because of the pleomorphic nature of the clinical condition.

CO-CHAIR BAGLEY: Can I ask you a question? And that is are you proposing additional conditions, or are you proposing that this be given a different designation?

(Simultaneous speaking.)

MEMBER FRIEDMAN: In its current form, I can't come up with a condition that would allow it to be, at least for me personally to approve it. The coding specificity perhaps could be reviewed. But as we're not supposed to use the revise and resubmit category, I just think the codes covered under this are too diverse of a clinical entity to safety be put into one cost based measure.

CO-CHAIR BAGLEY: And so do you currently have a suggestion for an alternative motion than conditional support?

MEMBER FRIEDMAN: Mine would be not to put this forward to --

CO-CHAIR BAGLEY: So do not support?

MEMBER FRIEDMAN: Do not support, yes.

CO-CHAIR BAGLEY: So the motion on the

table is do not support. That doesn't mean we can't have any kind of discussion, but that's really what the next thing we're going to vote on. Okay. Do you have any response to that, Sri?

MR. NAGAVARAPU: Sure. So, what we've done in order to speak to these sorts of concerns is look at kind of the statistical validity testing that we've done as well as the national summary data report that was put out publically.

Looking at the national summary data report, if you -- and these are, again these are measures for clinicians, but looking at clinicians operating in urban areas let's say versus rural areas.

If you look at the risk adjusted cost distributions from the publically available report, you don't see any discrepancy in sort of the higher levels of episode spending between urban and rural that might be a concern given the type of concern expressed.

And so that's one piece of evidence

that makes me feel comfortable about this type of concern. So if you look, for instance, at the 90th percentile and the 99th percentile for this particular measure, for urban areas the 90th percentile of risk adjusted cost is $30,688, for rural areas it's $30,627. So a difference of about $60 off a base of $30,000.

For the 99th percentile where you might expect the most problems for this type of concern, for urban areas you see $38,689, for rural areas it's $38,750. So that's a difference of about $60 off a base of $38,000.

So that's kind of the first piece of evidence that we have along this front because it's a type of concern that we've been concerned with as well.

The other thing we've done is a more traditional analysis of predictive ratios by deciles of risk scores. What you would expect is that predictive ratios would tend to show larger discrepancies between observed and predicted values for riskier providers if this concern was

actually having any impact on data.

And fortunately, we don't see that. In the highest deciles, you see predictive ratios where observed spending is actually slightly less than predictive spending in the highest two deciles of risk orders.

And so I think this is an important concern that we've thought about in terms of the statistical testing we've done so far. Some of the socioeconomic status testing that we've done before I think also speaks to this concern. And there also we saw very little impact to the predictive power of the models from adding socioeconomic status.

So this is something we're definitely open to adding new risk adjusters, or adjusting risk adjusters, like the sort of the clinical aspects of the risk adjusters were mentioned. And so there's codes that can be adjusted to better represent to get a condition. That's something we can definitely do in refinements.

But fortunately, it looks like the

initial and statistical analysis suggests that the concerns for now aren't showing up in the data. But this is something that we can revisit.

CO-CHAIR BAGLEY: Scott, I would actually like to hear from the lead discussants. And then please save the concern that you have. Scott or Sri --

MEMBER FRIEDMAN: Sure. Sure, sure. I was one of the lead discussants. I'll bring up one of the comments. Again, the comments are, in my opinion are helpful because the sub-specialty organizations comment on them, and the American Academy of Family Practice also suggested there was an issue with this measure and there were two disease processes that were lumped together.

And so, and this is a trend that goes with some of the other measures as well, not so much with the I measure which I have a lot of expertise with.

So the question was, what he brought up, and the question is can we look at the risk adjusting and tweak it to make the measure better

because he's suggesting that, you know, even though you guys look at the data, the data is not real accurate.

MEMBER SEIDERWURM: Oh, sure. I would like to disclose the conflict of interest that I'm a neuroradiologist and that a large source of heterogeneity in cost of care is me in this, you know, in this field. And so I'll just put that out there. You know?

But the first thing is I want to say, you know, that I think that this measure is a really good starting place for looking at the cost of care in stroke, and that in spite of the challenges of lumping, you know, what my livelihood depends on, the heterogeneity of this population, I think that in terms of the clinical consequences and the cost of care patterns, I don't think that that's something that can't be overcome with quality severity adjustment.

So I do think that this has a lot of merit. For example, you know, which was raised and is really completely valid is the difference

between hemorrhagic and non-hemorrhagic strokes, and then some of the underlying clinical factors that the patients might have.

But I think you can get at that with risk adjustment, which is actually fairly good for stroke care. It's not as good as for cardiology, you know, because it just isn't and because the same lesion on one side of the brain behaves very differently than on the other, whereas to a first approximation, you know, the same lesion in a coronary artery behaves similarly. Obviously there's differences.

So I think that we, and I think that the outcomes are also more heterogeneous with respect to specific kinds of function. But again, I think that you can get at all of that with good severity adjustment.

I've already mentioned that the heterogeneity patterns of care are present, but they do not, to a first approximation, correlate very well with outcome. And so I think that again, this is a place where a cost measure would

be potentially fruitful.

One thing that I am concerned about is that there have been in the past, you know, I'll say two or three years several very high quality, randomized trials published in New England Journal, Lancet, you know, places like that that have really revolutionized the interventional care of certain categories of stroke.

And the one, my one principle concern here is that we need to somehow take into account for a costly but extremely effective pattern of care that's, you know, well documented to basically take people out of the disabled outcome groups and put them into the non-disabled outcome groups at a fairly substantial rate.

Now, there's a lot of debate about what the best instrument is and what the best time threshold is and what the best imaging triage is and there's all that stuff.

But that's minimal compared to this change that is quite expensive. And so if there's a way of looking at pattern of care with

respect to clot extraction, I think that is something that might disfavor large centers as was mentioned that are getting specific kinds of referrals.

So as long as that can be taken into account, you know, I say give it a try.

MEMBER BURSTIN: I just want to build on, I think, some of the questions raised about risk adjustment. I think it was less about social risk, and I think the particular issue raised was really whether there might be differences when you look at quaternary hospitals for example.

And my specific question is, and again, what can you do, it's not clear from the limited specifications we have, and of course the endorsement committee should have all of that, what happens to transfers?

Certainly I think a lot of places within your system, Scott, I assume are transferring some of the most complex patients to the most high end facility for some of those

exact procedures that David just mentioned.

CO-CHAIR BAGLEY: Scott, we're back to you.

MEMBER FURNEY: Yes. I think the points have added nicely to what my original concerns were. This is really two different conditions, hemorrhagic and ischemic strokes. And then those are pleomorphic among those conditions.

The analysis that you described, urban versus rural, may not have the specificity of one that is either of tertiary or quaternary compared to primary facilities. That would be very helpful. If we knew that analysis was complete, I would certainly feel better about the measure.

And that can be done either by transfer status, or it can be done by zip code. So if the patient's primary zip code is different than the treatment zip code, and distance are both good correlates of severity of illness.

So those are just other ideas. But I haven't heard much to mitigate my concern so far.

CO-CHAIR BAGLEY: Okay. Stephanie?

MEMBER GLIER: I think maybe I can ask some questions of you guys. So in the clinical subgroup, did you talk about this issue that's been raised about whether these are conditions that should be lumped together or not, and how did the clinical subcommittee comment on those questions?

MR. NAGAVARAPU: Thanks very much. This is exactly the, one of the first issues actually that the subcommittee dealt with because they recognized that that specific family of DRGs is a heterogeneous family. And so they actually did make the distinction that all of you are breaking up and use the principle diagnosis on the inpatient claims to split up patients into these two categories to ensure greater homogeneity.

So this was exactly, like, at the forefront of the subcommittee's mind in terms of the heterogeneity, and there was that division. In fact, in this past week, there was kind of,

people wanted to make sure about the homogeneity of these patients. And so reevaluated the split that was made to make sure that those two groups, these are subgroups that are reported in the field testing reports. You can kind of see the breakdown by subgroups there.

They wanted to make sure that the subgroups were homogeneous, and realize that there's a very small group of patients who receive TPA, thrombolytic agents in the 24 hours prior to admission to a hospital that were captured in MS-DRG 065.

It's a small group, it's around two percent of the original sample. And so what they decided to do, they took a vote on this and decided to exclude those complicated patients that were transferred for exactly the sort of reasons that are being brought up here, that this is a different set of patients.

There was a feeling that the issue with thrombolytic agents is an important one to bring up. But they wanted to keep this patient

cohort as tightly defined as possible.

And so did have these two subgroups, and then within those subgroups added additional exclusions to ensure even the homogeneity of those two specific subgroups.

CO-CHAIR BAGLEY: Sri, am I to understand that the analysis is divided into the two separate clinical categories? Is that what you just said?

MR. NAGAVARAPU: That's right.

CO-CHAIR BAGLEY: Did you hear that? Does that help you at all, Scott?

MEMBER FURNEY: It does. And perhaps that's still leaves the heterogeneity among ICHs. You can have one, an intracerebral hemorrhage that's 4 millimeters and you can have one that's four centimeters. Those are very different, and the transfer in concern.

I would have envisioned these would have been two different items if they're two different conditions. And maybe that's part of my confusion. I think that removes some of my

concern, but the transfer in and severity and heterogeneity of the groups still persists.

MEMBER SEIDERWURM: So since you excluded some of the non-hemorrhagic, I think it is, yes. Since you excluded some of the non-hemorrhagic infarcts to make a pure example, did you also exclude some of the hemorrhagic categories that might be a little different like subarachnoid hemorrhage kind of goes down a pretty different care pathway or was there discussion of that in some way, because I think that is another category that is treated differently that might confound things.

MR. NAGAVARAPU: Yes. Thanks for the question. So it is the case that the subcommittee identified subarachnoid hemorrhages as a specific category that was distinct and excluded them from the patient cohort.

And in terms of other key exclusions from the triggers in order to ensure the homogeneity of the patient population, there was also a series of exclusions based on various

structural causes.

So for instance, the presence of a diagnosis code for malformations of pre-cerebral vessels, there's also a small patient cohort with very distinct conditions such as, like, locked in state.

And so the subcommittee went through and excluded those as well. And I should note that these specifications are in documentation posted on the CMS website. So there's kind of a workbook that walks through the exclusions as well as the risk adjusters that are used.

And if there's risk adjusters that can be captured that can add to this, that's something that we would definitely be happy to.

CO-CHAIR BAGLEY: Okay. The motion before you is to not support this measure. So it's kind of a negative, double negative. Let's be careful about that. So if you vote yes, the recommendation would be not to support this measure. I'm sorry about the confusion that might cause.

But the motion on the floor is for the category of do not support. And you either agree with that and say yes, or you disagree with that. If the motion gets 60 percent or more, then this MUC will get the assignment of do not support.

If you, if it doesn't make 60 percent, we revert to the original motion which is what we have before us in the preliminary analysis. Is that okay with everybody? I want to make sure everybody's clear about what we're doing. Okay.

So we're ready to vote. Is everybody clear on the process? Okay. We're ready to vote. If you vote yes, then the assignment for this particular MUC will be do not support.

MS. JUNG: Okay. Voting for MUC17-363, intracranial hemorrhage or a cerebral infarction is now open. Option one, yes. Option two, no.

CO-CHAIR BAGLEY: And you have the --

MS. JUNG: I'm just going to ask Michael Hassett, can you send me your vote though email? Okay, we have 19 responses, voting is now

closed. So we have 26 percent for yes, and 74 percent for no.

CO-CHAIR BAGLEY: Okay, we revert to the initial motion which would be conditional support with the conditions that you have in your preliminary analysis. And once again, this will be a yes or no vote.

Is there any discussion on the motion? Seeing none, are you ready for the -- I'll let you.

(Off microphone comments.)

CO-CHAIR BAGLEY: We got to wait, get the machine reset. Wait a second.

MS. JUNG: Okay, voting for MUC17-363 is now open. Option one, yes. Option two, no.

CO-CHAIR BAGLEY: So option one, yes is that you agree with the preliminary analysis that it should be conditional support with the conditions stated.

MS. JUNG: Just one moment. It looks like the votes are not being captured, so let me do a quick reset. Okay. So --

CO-CHAIR BAGLEY: All those in favor --

(Off microphone comments.)

MS. JUNG: For those on the phone, that was 16 votes for yes and 13 for no. Three.

CO-CHAIR BAGLEY: I thought this was a great discussion, and the kind of stuff I was hoping we would kind of get out on the table. And the fact that we kind of ended up with approving all those recommending that they go forward is a testament to the amount of work you guys have put into it.

So thank you for that. And like I said before, the only way we're going to tell is to run it out there and see how it works, and see what the trouble spots are. So, thanks for that and thanks for the discussion.

CO-CHAIR MOYER: All right, we are moving on to the next area of the consent calendar which is opioid use measures. This is a consent calendar of one, which is very concise. John, is there anything you want to do to open

this consent calendar?

DR. BERNOT: Sure. Obviously today, the measure up right now is the continuity of pharmacotherapy for opioid use disorder, that is MUC17-139. The preliminary analysis on this was refine and resubmit with testing at the clinician level.

And normally I don't give a commentary, but I did want to make one point to wrap back since we had the discussion about refine and resubmit to Stephanie's point about whereas it could be perceived as an arbitrary line from our perspective, even though that might be the case. We had a very distinct standpoint.

The reason for this being refine and resubmit versus the others is because we did not have testing data at that level of analysis at all, whereas the other one we had it with the condition that it would be then blessed.

So again, that is up for debate with this particular workgroup, but I wanted to clarify why we landed on one versus the other.

It was because we never had the data, that it wasn't even generated, that it was given to us at the clinician level. So just wanted to clarify that. So I'll turn it back to you, Amy.

CO-CHAIR MOYER: All right. We're going to start with public comment. To help us stay on track, we ask that you keep your comments to two minutes or less. And we'll start with, if there's anyone in the room that would wish to make a public comment on this.

I see no one heading to the microphone, so operator, would you announce and open the line for public comment, if necessary?

OPERATOR: If you would like to make a public comment, please press *1 on your telephone keypad. Again, to make a public comment, press *1. We have no comments at this time.

CO-CHAIR MOYER: All right. This measure has not been pulled for discussion, but it is also standing alone on its consent calendar. We will I guess have the lead

discussants present an overview of the measure, and then I believe we could move to vote since it hasn't been pulled.

So if anyone wants to have further discussion after the introduction of the measure, we would need to pull it for discussion, technically. And let's see, Leslie is on the phone. So Leslie, did you have any opening comments you wanted to make on this? All right. Ann, did you have any comments you wanted to make on this?

MEMBER GREINER: Sure, thank you. Obviously this is an important area, a big public health issue, and I believe the only opiate measure that's in the MUC list. I know that it's been endorsed at the plan level, and people see this as a very important measure for promoting the ongoing treatment of individuals that have opiate use disorder. So I think there's no question about its importance.

And I think really the question, which you raised earlier, is whether or not it's

appropriate at the clinician level. And I understand that the endorsement committee was concerned about how clinician attribution worked, and so they raised that concern. And they also suggested that it was not yet ready for P4P.

And so I think we take that concern seriously since our work is to make recommendations for clinician level measurement that relate to payment. And so the fact that we've got some questions about attribution, that we have an endorsement committee that said it's not yet ready for P4P, I think we really should go through the process of getting this measure tested at the clinician level.

And so I guess it would make sense to support this conditionally, you know, if you follow the logic that it would then be tested at the clinician level and make sure that we can address the attribution comments. Thank you. Or attribution concerns I should say, not comments.

CO-CHAIR MOYER: Okay. And just to clarify, as I think Janet stated, this one, they

had actually put as refine and resubmit instead of the conditional support because of the extent of the work and the testing that needed to be done on it. Just to clarify that that is the motion on the consent calendar and on the table.

Are there any additional discussion on this measure, or do we feel that we can move forward with voting on the consent calendar? And I see Harold.

DR. PINCUS: Could you say a little bit of how the clinician, the accountable clinician is defined in this measure as it applies to clinicians?

MEMBER YONG: So the measure steward I believe is on the line, should be Soeren Mattke from RAND. Soeren, do you have a line, and can you address the question?

MS. JUNG: Operator, do you have Soeren Mattke on the line?

MEMBER YONG: I know he's calling in from abroad.

MS. JUNG: Okay, we'll just give her

a minute to give him an open line.

MS. O'ROURKE: Operator? I just want to confirm that you heard here and if you have Soeren on the line, and if you could open his phone.

OPERATOR: Soeren's line is open.

MR. MATTKE: Okay, can you hear me now?

CO-CHAIR MOYER: We can hear you now.

MR. MATTKE: Okay, great. So Soeren Mattke from RAND here for the developer. This is a very new measure that was just submitted and endorsed by NQF this summer. And by the time of the NQF proceedings, we did not have a clinician level analysis ready, partly hampered by the fact that thus far, substance abuse codes have been redacted in Medicare claims, so we couldn't really use the Medicare sample data.

But that's on our to-do list. We have not done commercial, we have done Medicaid. And now that Medicare is releasing substance use codes, we are going to test Medicare and then

resubmit as you requested.

CO-CHAIR MOYER: Dale?

MEMBER SHALLER: This is just a process question because I'm not sure I entirely understood, and I don't want to bog the process down. But by voting in favor of refine and resubmit, the developer goes back and does additional testing at the clinician level. The results, the findings of that study, or analysis, are brought to whom?

Do we ever see it back here again as a resubmitted measure that this group deliberates over, or does it just follow its own sort of course and CMS makes its own decision?

MS. O'ROURKE: So I can answer from what the intent was, and then maybe ask Pierre to weigh in a bit on the CMS perspective. So when the coordinating committee created this, the hope was that measures would come back after testing was completed and MAP could see it again.

However, the way the process is set up, and the authority that the HHS secretary has

does not guarantee that you would see it again. So it's something the coordinating committee members wanted you to bear in mind when you vote, there is not necessarily a guarantee that it would come back on the MUC list and be put back for a formal vote.

You may just be updated on the status through the feedback loop in the fall web meeting.

MEMBER YONG: And so from our standpoint, certainly we will go back internally and have discussions. Certainly, we work with the measure stewards, in this case RAND on this particular measure, and work with them in terms of hopefully addressing some of the concerns raised by the MAP during these discussions.

Internally, there's a discussion over, you know, we seriously consider all of the MAP recommendations. Ultimately, it is, you know, within the secretary's discretion as to whether or not to move forward with proposing after considering the MAP's recommendation.

Sometimes there are other pressing sort of priorities, for example, and noted that we don't have a lot of opioid related measures in the program, and it's one of the priorities that, you know, we are all trying to work towards in terms of addressing the opioid epidemic.

So I'm not saying that we will or will not, but you know, I'm just adding that as a consideration. But sometimes there are other pressing sort of priorities from the agency's perspective that may lead us down the path of proposing a measure after considering the MAP's recommendation.

CO-CHAIR MOYER: I saw Peter first, and then Stephanie, and then I believe we're working on getting Leslie an open phone line so that he can comment as well.

MEMBER BRISS: So, you might consider going forward. You know, it strikes me that this could be a useful distinction that makes the revise and resubmit more useful as opposed to approving, conditional approval.

So if, so it seems to me that sort of logically that conditional approval means we like the measure concept if you deal with some additional details and prove stuff like reliability and feasibility. We're fine with approval.

And a revise and resubmit might be we're kind of positive about the measure concept, but there are more details that would need to be worked out and we would like to see it again after you've worked out those details. That might make those categories clearer, just something for you to consider.

MEMBER GLIER: Thanks, Peter, for teeing me up. I was going to say something really similar which is that I would like to pull this measure. I would like to propose a motion of conditional support pending NQF endorsement, review and endorsement of this measure tested at the clinician level.

I think the reason for that is exactly what Peter said, I think if we say revise and

resubmit, that means that we actually want to talk about some part of the concept here again. I feel like so far it seems like we are all kind of on the same page that this is a good concept.

And if it does in fact work at the clinician level, then CMS should use it. And our job is not to serve as an endorsement committee. We're not reviewing the testing data about whether it works, whether the attribution model works. That's really up to the endorsement committee.

And so if they review it and it works, then I don't think we need to talk about it again, whereas if we do, if there was actually a change to the concept that we were asking for that would require a revision to the measure, that's the kind of thing that I would want to ask for a measure to really come back, if we're asking for it to be a different measure rather than tested at a different level. So my motion is again conditional support pending endorsement at the clinician level testing data.

CO-CHAIR MOYER: Okay, it sounds like Leslie has an open line.

MEMBER ZUN: Yes, hi. Thank you so much. I'm sorry about the difficulty getting into the system. You know, I think conceptually we agree that this is something that needs to be addressed.

I think it needs to be better defined because there are a number of concerns from the clinical perspective such as, you know, why patients are not continuing their therapy, if they're having problems with their therapy or follow up, or ability to obtain the medicine.

So I think it needs to be better defined and looked at to ensure that we're looking at the right criteria.

CO-CHAIR MOYER: Okay. So, Leslie, are you saying that would support the original refine and resubmit?

MEMBER ZUN: Correct.

CO-CHAIR MOYER: Okay. Harold? Sorry, Stephanie, do you have a response to that?

MEMBER GLIER: I have a question in response to that. Leslie, are there specific parts of the, so are you saying that there are different parts of the measure, of the specifications that you think need to be adjusted to either incorporate new exclusion criteria or some other component of the specification per se, that the endorsement committee didn't -- Leslie, are you on mute?

MEMBER ZUN: I'm sorry, I didn't hear that last part of that about the endorsement committee.

MEMBER GLIER: I just trailed off. That's why you didn't hear it. There wasn't much more there. Are there things in the specs that you think need to change that really doesn't need revision at a clinician level?

MEMBER ZUN: Yes, I do think there's things that need to be addressed by a clinician.

CO-CHAIR MOYER: Okay. Harold?

DR. PINCUS: So actually Peter and I co-chair the endorsement committee. But I think

the way Stephanie phrased the recommendation, it's something that seems to me that there is some accountability for response in that it goes back to the endorsement committee for, you know, for consideration as a clinician level measure.

And that's the condition. And so it is specific in terms of a condition and, you know, could fit in that kind of framework. And clearly, there are, like, important issues in terms of applying this at a clinician level.

You know, while there are significant number of individual clinicians that take responsibility and have had the same sort of training and so forth around providing medication systems treatment, that the bulk of the treatment is done in clinic type settings. And the attribution of clinicians is a little bit unclear in terms of how that would apply.

DR. BERNOT: I just want to clarify. So if there's no more discussion, the motion on the table is Stephanie's for the conditional support of NQF endorsement at the clinician

level.

And we will have to vote on that before we can have a different category come forth. We can continue the discussion, but I just wanted to make sure we're clear that is the next vote that will occur.

MEMBER WHITACRE: I just, since the two co-chairs of the NQF committee are here, if it does go back to your committee for review under conditional support, will you be able to address more than just the level of analysis, but will you also get into the --

Would you also be able to get into the specifications, or would they be the same kind of specs that were used at the plan level just applied to a clinician level, or do you get to deconstruct it any further is kind of my question.

DR. PINCUS: My assumption is that what is requested to be addressed is the full range of issues --

MEMBER WHITACRE: Okay.

DR. PINCUS: -- for applying it at a clinician level.

MEMBER WHITACRE: So it's not just, okay. You're not just taking the same measure and trying to do a different sampling. You're --

DR. PINCUS: Right.

(Simultaneous speaking.)

DR. PINCUS: But we wouldn't re-look at the measure for at a plan level.

MEMBER BRISS: Can I comment on that, too? I think that the Committee would, I agree that the Committee would have the opportunity to look at all the issues. I think that as you've heard already, the more specificity you can give us about what you think your issues are.

You know, so there's the level of specification, you guys have been real clear about that. There's less is are, issues are a little greyer to me. So the more specificity you can give us, the better job we'll do in, obviously in dealing with your issues.

CO-CHAIR MOYER: Leslie, did you have

an additional comment? Okay, so not seeing any other comments in the room, or hearing them on the phone, the motion on the floor is to vote for a conditional support. And the condition is to fully address the range of issues for applying this at the clinician level.

And I heard attribution and I heard potentially some considerations about what the level of control or accountability is for the physician with regard to the measure, and that there may be some additional exclusions or other categories that might be needed.

Yes, go ahead, Ann.

MEMBER GREINER: So, given the kind of urgency in responding to this issue, do we have any sense of how quickly the NQF endorsement committee could take this measure up at the clinician level?

DR. PINCUS: We actually are having regular calls. And so there is a process that's in place. I can't remember the exact schedule, but it's sort of every few months where that's

going on. I think the regulatory step may not be the meetings of the endorsement group as much as it is putting together the data, or to respond to these issues.

CO-CHAIR MOYER: I would expect that as well. All right. We are going to vote, if our handy voting machine is ready. So a yes vote is for conditional support to offer the measure with the full range of issues at the clinician level addressed.

MS. JUNG: And just one moment. We're again having issues. Apologies. Let's see. Okay, let's give that another try. So this is for the MUC17-139, continuity pharmacotherapy for opioid use disorder.

(Off microphone comments.)

MS. JUNG: Let's see if this will reset really quickly. Okay, the total, oh you can't see it on that screen. But the responses for this are zero right now. I think that's just counting historically what has been voted. But it's not clearing at this moment. So if we could

give it a try, that would be great.

So this is MUC17-139. Option one, yes. Option two, no. And if this doesn't work, we will move to a hand vote.

CO-CHAIR MOYER: Okay, we are going to move to a hand vote, although part of me thinks we need to stand up. So if you're voting yes on this measure, stand up and stretch or something.

(Off microphone comments.)

MS. JUNG: So that's 21 votes for yes with 100 percent.

CO-CHAIR MOYER: All right. We are moving on to the next area of the consent calendar. This is another consent calendar of one. This is the HIV screening measure. And John, I'm going to let you queue this one up.

DR. BERNOT: Sure. Again, one measure here. This is HIV screening, MUC17-367. The preliminary analysis recommendation was conditional support with the condition of NQF endorsement which will review testing and demonstrate reliability at the clinician level.

CO-CHAIR MOYER: All right. This measure has been pulled from the consent calendar, so there will definitely be discussion on it. But first, we will start with any public comment related to it. Is there anyone in the room who would like to make a public comment on this measure?

I don't see anyone in the room. Operator, would you announce on the lines that this is open for public comment?

OPERATOR: Yes, ma'am. If you would like to make a public comment, please press star and then the number one. There are no public comments at this time.

CO-CHAIR MOYER: Okay. To start the discussion, Stephanie, you had pulled this from the consent calendar. Could you give us a brief perspective on why you had pulled it and what we're hoping to accomplish?

MEMBER GLIER: Sure. I pulled the measure because it's possible that I was misreading the actual testing data. But it

looked to me like the measure is a fairly high performing measure to begin with.

And it's quite narrow. And as the public comments on this measure reflected, there seem to be some other good ways to assess HIV screening going on in the population.

Perhaps the MIPS program is not the best way to promote HIV screening among the Medicare population, particularly since the measure is specified for a primarily non-Medicare population.

So my motion would be to recommend a do not support vote, not because I don't think public health and HIV screening is important. Believe me, I'm trying not to undermine my whole MPH here. But I'm not sure that this is an effective measure for the MIPS program and have some concerns. So if others feel differently, I'm very interested to hear that.

CO-CHAIR MOYER: All right. We will go to the lead discussants for response. Helen?

MEMBER BURSTIN: So it's an

interesting perspective, Stephanie. I think it's a real struggle, as you look at this measure, what's the right level of analysis. It sounds like the developer has in fact addressed some of the concerns raised as part of the standing committee review.

It's still not completely clear whether the issue that has been raise multiple times as part of comments as well as the review of what happens with patients who get screening outside of the clinical setting, and how that data is captured I think remains a pretty significant issue.

So, I would personally prefer that it maintains its conditional support to allow a committee who's already seen it to have a chance to look at how the measure's been modified and specifically see if there are opportunities, particularly, I think it's an e-measure as well, to see if there might be opportunities to pull in population level data to perhaps have the best of both worlds where you might be able to at least

understand the proportion of patients in a community who are screened, and then look at that clinical level measure in that context.

I think, you know, obviously it's a grade A recommendation of the task force. I think it's the right thing to do. I don't actually share as much of the concerns these days about patients declining screening. I know that was mentioned in the AAFP comments.

I think it has very much in practice, when I see patients that I resident just become a normal routine screening test we do. This is just what's recommended for your age and sex.

It doesn't, I think, have quite as much of the stigma. But again, I practice in a big urban center. So perhaps some of that reflects living in places where HIV may not be quite as comfortable a conversation.

So I would actually recommend that it maintains its conditional support to allow the standing committee that knows it well to look at the changes and see if those other modifications

would work.

CO-CHAIR MOYER: I'm going to break in really quickly. We've had some people say they're having trouble hearing all of the speakers. So if you could make sure that you talk directly into your mic and maybe get a little bit closer so that everyone can hear what's going on. That would be great, thank you. Charlene, I'm going to let you give opening comments, and then we'll come up to you.

MEMBER NGAMWAJASAT: So I agree with the motion for maintaining conditional support. HIV screening is an important measure given the number of people who are HIV positive but who remain undiagnosed.

But I agree that there are issues with the way in which the measure is written in regards to the ever portion of the measure. It's really hard to capture the totality of a patient's history in terms of testing.

And I concur with the comments that remain in terms of this is a measure that's

related to testing rather than the offer, and the screening associated with that.

And then I have a question related to the definition of the HIV test as well. I'm curious if that includes point of care testing such as the rapid testing that's now available.

DR. GREEN: Hi.

(Off microphone comments.)

DR. GREEN: Yes, I was going to. I'm Dan Green, I'm a medical officer. I work in Pierre's division, or group rather. So I can't answer your first question, or your last question rather. But I think there are folks from the CDC on that may be able to answer that.

I just wanted to make one comment, Stephanie, to your concern. And it makes perfect sense, the age range 18 to 65. Clearly, we don't have that many folks that are Medicare bennies at that age.

But did want to mention that, you know, the program does allow for reporting of all patients, you know, depending on the method that

the data's being collected. So from EHR, from registry, from QCDRs, it's going to be all patient data.

Claims really is the only one now pretty much that's Medicare and web interface, of course. Thank you. If the CDC folks can answer the last question, that would be great.

MEMBER BRISS: Sorry, I can't answer that question.

MEMBER YONG: We have CDC colleagues on the phone, on the phone line.

MS. JUNG: Operator, do we have, we have a few people on the line. I think it's Ethan Jackobs, Christina Allen, Samuel Simon, or Jenna --

OPERATOR: Abigail is open.

MS. JUNG: We can hear you.

MS. VIALL: Can you hear us?

MS. JUNG: Yes.

DR. PETERS: This is Dr. Phil Peters. I'm here with Abby. And I think the question was regarding the rapid test. So if a rapid test is

done within a healthcare system, that usually is put into the electronic medical record.

So from a medical systems standpoint, there wouldn't be a difference between a rapid test done or a traditional lab-based test.

I think there was another question about people receiving testing within the community. We don't have data about exactly what percent of all persons are receiving testing within the community. But in general, those are persons who have self-identified as being at high risk for HIV infection.

And sort of, that's a very important targeted part of the HIV testing that's done. But this screen is really to kind of get at those people who don't self-identify and don't kind of spontaneously present in the community for HIV testing.

And we know at the time that people get HIV diagnosed, about 30 percent of people did not report that they had a risk factor before they got their HIV test. After they get their

diagnosis, then usually they report what their risk behavior is.

MS. VIALL: And this is Abigail. I do want to just note that HHS has long had a requirement to report on its HIV testing activities to Congress.

I would estimate, and I would have to go back and look, but I would estimate about ten percent of tests are actually through publically funded programs through CDC.

The vast majority are administered through health, community health centers, or they're billed under Medicare and Medicaid. So very little testing is actually done in the community anymore. Proportionally speaking.

CO-CHAIR MOYER: Thank you for that. We'll go to Peter, and then Girma.

MEMBER BRISS: So, at a more global level, this is a real important measure. So this is an A recommendation for the task force, 40 percent of the new HIV infections sort of happen from people that don't know they're infected.

And so in addition to screening, that helps the person being screened. This is also an unusual screening test in the sense that it may protect other people as well.

There's a lot of room to move, and a lot of the -- the developer has done a considerable amount of work since the initial committee reviewed a deal with the issues that were raised in the initial committee review.

So conditional support might be a reasonable answer.

MEMBER ALEMU: I represent the organization or agency that supports HIV patients throughout the country. I think one of the problems, as Charlene and Helen mentioned, is that many people do not know that they are infected, and infections spread.

We could have controlled the infection in a much better way if we had such methods. So I think just using the screening, the measure which is recommended, I think with the conditional support for dealing with the

requirements which are stated, we are in support of that. So I think it will be a great help.

CO-CHAIR MOYER: Stephanie?

MEMBER GLIER: So, I'm feeling sufficiently shamed here. I think, I don't know if this is actually an option, but I would like to withdraw my motion.

But I would like to state some skepticism here that in a voluntary program where clinicians who are likely treating patients who are not screened frequently for HIV, I'm not sure that I buy the premise that clinicians are likely to choose to report a measure where their rates are going to look low.

So I think the measure is actually, in itself is a good measure, and I think this is a really important issue to be measuring, and I hope that HHS will continue to be looking at population level HIV screening so that we can see whether, in fact, if we put this into the MIPS program, are we seeing some sort of concordance between what we're seeing in the performance rate

among those clinicians who choose to report this measure and what's happening at the population level because I think if the goal here is to drive screening rates, I'm all for that but I do feel we have to go about the MIPS program being able to effectively do that through this measure.

However, motion withdrawn. Going back to the original motion.

MS. O'ROURKE: This might be obvious, but just to maybe allay some of Stephanie's concerns. We do capture all of this feedback, and it goes to CMS with the recommendation on the measure.

So it's not just the measure. It's all of this conversation. It's also written up in the reports and the spreadsheet that we send. We also pass along MAPS input to the standing committees when they review measures for endorsement. So just to hopefully put your mind at ease that your concerns are noted and do go somewhere.

CO-CHAIR MOYER: All right. For those

of you on the phone, there are many notes being taken. We are going to go ahead and vote then on the original consent calendar recommendation which was conditional support for the measure, I believe coming back through the NQF endorsement process.

MS. JUNG: Great. So we're going to go with a hand vote again. So option one, yes. Sorry. The voting is now open. Please raise your hand for option one. So we have 18 yeses.

(Off microphone comments.)

MS. JUNG: Okay, 19 yeses. And then option two, no. And two nos. So we have 19 votes for yeses and two votes for no.

CO-CHAIR MOYER: All right. Since we are on a roll, we're going to keep going for a little bit. We're going to try and get as far as we can by 12:30, and at 12:30 we'll let you eat. But hopefully we'll be more caught up by then for having pushed through.

The next consent calendar that we'll be talking about is the functional status

measures. And there are several measures on this, two of which have been pulled from the consent calendar, MUC17-170, the average change in functional status following lumbar discectomy laminotomy, and MUC17-177, the average change to leg pain following lumbar spine fusion surgery. And John, I'll let you kick this off.

DR. BERNOT: Thank you. So, I will go through these one-by-one here, and we do have four measures under here. The first one is average change in fictional status following lumbar spine fusion surgery. That's MUC17-168. And the initial preliminary analysis for that was support for rulemaking.

The next one on the list is MUC17-169 which is the average change in functional status following total knee replacement surgery with a preliminary analysis on that one of support for rulemaking.

The third one on the list, MUC17-170, that is the average change in functional status following lumbar discectomy laminotomy surgery.

The preliminary analysis for this was a conditional support for rulemaking with the condition that the measure should be submitted to NQF for review and endorsement. This measure has been pulled.

And the final measure on the calendar is the average change in leg pain following lumbar spine fusion surgery. That's MUC17-177. And the preliminary analysis on this particular one was also conditional support for rulemaking with the condition that it should be submitted to NQF for review and endorsement. And that one has also been pulled.

CO-CHAIR MOYER: All right. We will go to public comment, starting with if there's anyone in the room who would like to comment on these measures.

Okay, I'm not seeing anyone moving towards the microphone. Operator, would you check to see if there's anyone who would like to comment on the phone?

OPERATOR: At this time, if you would

like to make a public comment, please press star then the number one. There are no public comments at this time.

CO-CHAIR MOYER: Okay, thank you. Are there any other measures that anyone would like to pull from this consent calendar other than the two that have already been identified?

Seeing no motion in the room, are there any objections to moving forward to voting on accepting the recommendation on the remaining consent calendar measures?

Seeing none, we will open the vote to accept the measures remaining on the consent calendar. Those are all measures that were recommended as support for rulemaking.

MS. JUNG: So for this consent calendar, it will be MUC17-168 and MUC17-169. So option one will be yes, option two will be no. Again, we need to see a raise of hands for option one, yes.

MS. DUDHWALA: And Michael, if you want to send me or share your vote. Michael

Hassett.

MS. JUNG: You can put your arms down. Okay, so we have 21 votes for yes.

CO-CHAIR MOYER: Okay. Moving to the two measures that have been pulled from the consent calendar, these were pulled by Stephanie, similar to before. I'll just ask you to kind of walk through the reasoning for that.

MEMBER GLIER: Surprise, it's me again. Both of these measures are already in use in Minnesota. They're very similar to measures that we have already supported and are already in use in the MIPS program. And I move to recommend support without any conditions.

CO-CHAIR MOYER: Okay. We'll go to the lead discussants to respond. Eric?

MEMBER WHITACRE: I would tend to agree with that, except for the fact that the last two measures that we're considering are not yet NQF endorsed. So did I understand that you want to go full-tilt without the NQF endorsement? Can we do that?

CO-CHAIR MOYER: I believe we have the power to do that. I'm going to let Beth talk about that, though.

MEMBER AVERBECK: So, I do some work with Minnesota Community Measurement and had a chance to talk with them prior to this meeting. And there was a plan to submit them for endorsement.

Part of the reason they haven't been submitted is the amount of time and effort it takes to go through the process given the staff that we have. So it is being planned to be submitted for endorsement, if that helps.

CO-CHAIR MOYER: And, Kevin? You were the other lead discussant on this. Did you --

MEMBER BOWMAN: I don't have anything to add.

CO-CHAIR MOYER: Okay. David?

MEMBER SEIDERWURM: So, I just want to say that I support the content, you know, of all four of these. This is maybe a moment to discuss the requirement for NQF endorsement. Now, I know

we're NQF, and I know NQF is a major endorser, the major endorser. But sometimes the process of endorsement does seem burdensome and at times idiosyncratic.

And when, sometimes when one comes before the specialty group when fields like the, you know, the restaurant review in Woody Allen, that the food is terrible and the portions are small.

And you just don't know quite, you know, what direction you're being pulled in. So I wonder, yet at the same time I also feel that this group isn't really the group that should be bypassing that because just as a group of, you know, very well informed and well briefed specialty experts might seem capricious at times, wouldn't we be even structurally more capricious?

So I would respectfully, you know, disagree. And CMS has the flexibility to do what it wants to do. But I think that we ought to maintain the integrity of what I will state is an imperfect process.

CO-CHAIR MOYER: I saw Scott first.

MEMBER FRIEDMAN: I've been asking this for several more years, I'll ask again. What is CMS' opinion on NQF versus non-NQF endorsed measures for quality reporting?

DR. GREEN: So, when there is an NQF endorsed measure, our preference certainly is to adopt the NQF endorsed measure. We are not required to have NQF endorsement. But again, it is preferred, especially when there's a measure with a similar concept that is endorsed.

CO-CHAIR MOYER: Peter, is that your card?

MEMBER BRISS: Yes. So I think David and I have been around this table as long as anyone perhaps. And we're getting to the, we may have done it enough times that we can finish each other's sentences.

I think that over time in the MAP process we've sort of gotten better about what our job is which is sort of making judgements about what measures are appropriate for CMS

programs as opposed to what the Committee's jobs are which is getting under the hood on the details of measures.

And I would submit that we're better off if we sort of stick to the existing division of labor and not try to short circuit it, for what it's worth.

CO-CHAIR MOYER: All right. I'm going to break in briefly in a non-chair capacity. As a user of measures, it's frequently helpful to me to have that NQF endorsement to rely on and to use.

In addition, I think it's helpful to, as we look at the kind of sometimes cacophony of measures to have kind of an official measure of something. And I think in many times it's the NQF endorsement that kind of sets that this is the measure standard, and then others should be aligning to that, or at last trying to align to that.

So, and I do also have concerns about giving measures a pass on things we might not

give other measures on because we like the developer or because -- and not like, but I mean, it's respect that's been earned.

But I know that bothers me when I sometimes see it on, or feel like I see it on a standing committee. I saw Stephanie and then I think Amy, and then we'll come back to David.

MEMBER GLIER: I think NQF endorsement is a really important process and it has a lot of value. And I'm not trying to undermine the value of NQF at all.

I will note, we are not NQF. We are the MAP which is convened by NQF, but we are our own representative organization. So I'm not speaking for NQF, and we do not speak for NQF.

I will say personally I totally agree. I think NQF endorsement is really valuable in a lot of ways. I'm glad CMS prefers NQF endorsed measures when available.

I think in this case we have two measures that are very similar to measures that have been endorsed. I would expect them to be

successful in an endorsement process. I note that they have been used successfully in Minnesota.

And therefore, I am led to believe that they are ready for implementation. I would not want that to deter Minnesota Community Measurement from submitting them of endorsement and going through the process in case there are issues that come up.

And if during an endorsement issues did come up, if CMS had already adopted them into the program, I'm sure CMS would recognize that and would flag the measures for re-review of income way as they have done with previous measures that have had issues come up during endorsement reviews.

So my recommendation, my motion stands, I'm not withdrawing it this time. I really do think these measures are ready for CMS to adopt the into the program, and I would anticipate that that would be going in parallel with Minnesota Community measurement submitting

them for endorsement with my expectation that that would likely be successful.

MEMBER NGAMWAJASAT: I just had a clarification question. So if MUC17-168 and 169 were endorsed by NQF, what is the difference between 170 and 171?

(Off microphone comments.)

MEMBER NGAMWAJASAT: Right, I know that they're not endorsed. But why would we not follow that same process? I guess that's just --

MEMBER AVERBECK: It has to do, and I'm not a surgeon, so I'm a general internist. But my understanding, it has to do with the type of procedure. So it's the same metric, it's just a different type of procedure.

And the first two, those procedures were submitted for endorsement. The second two, it's the same specification but under a different procedure code. And so my understanding, for the process, it goes specific to the procedure codes.

MEMBER WHITACRE: This is surgery. So I've said two things in support of surgical

content since I've been on the Committee. This is a little bit more.

They're different procedures, but they're applying the same metric for 170, 177 is a P assessment, but it has comparable measures.

So I guess in speaking to Stephanie's concern, I think we have every reason to think that if this goes through with conditional support for rulemaking, the impact will be the same, that these would likely be accepted.

MEMBER AVERBECK: But I don't want to make CMS wait to include it in a rule until we finish the endorsement process. That's the distinction here.

MEMBER NGUYEN: So the distinction is just the waiting time, the period for that. Okay.

MEMBER WHITACRE: Do they, does CMS have to accept our recommendations?

PARTICIPANT: I mean, they usually do, right?

DR. GREEN: We have to go through the

process of putting measures on the MUC list and going through the MAP process. But you know, we obviously highly value you guys' opinions. Hence why we're here.

But in the end, I mean, if their secretary deems that there's a sufficient need for a particular measure, we can go against it. And similarly again for a non-NQF-endorsed measure, although we appreciate it when you guys do endorse them.

CO-CHAIR MOYER: David?

MEMBER SEIDERWURM: Yes. So since we're on the topic of CMS discretion, one of the, and we're on the topic of NQF endorsement and some of the difficulties around that, there are some costly aspects to getting your measures endorsed, and they are the most explicitly defined and scientifically rigorous aspects of the measure testing process.

And so what I was wondering, since we have a captive audience of CMS people here, if it would be possible to make the suggestion that we

find a way in some aspect of the program, you know, maybe through the practice improvement aspects of the MIPS or somewhere where if people undertake measure testing activities, if they could have some credit or if there could be some other source of funding for this for a group like, you know, Beth's, not to talk about a conflict of interest.

But just if there's some way to help out with that because that is a bottleneck for measure developments all over the country.

CO-CHAIR MOYER: All right. I fear we're straying a little from the measures. But good discussions, and good points. Is there any other additional discussion around the motion on the floor which is to move these two measures forward with support for rulemaking? Otherwise, I would like to propose that we vote.

So I see no burning comments from the floor. So we are going to move forward to vote on these two and the motion on the floor which is to move forward with support for rulemaking.

MS. JUNG: So voting for MUC17-170 and MUC17-177 is now open. Option one is yes. Option two, no. Please raise your hands if you would like to vote option one.

MEMBER WHITACRE: And this is specifically for rulemaking, not conditional?

MS. O'ROURKE: That is the motion on the floor, yes. So, let me make sure I'm tracking. If you vote yes, you are saying fully support the measure, no conditions. If you are voting no, you do not agree with the motion to fully support the measure and we can discuss a new one. I would default that to a conditional support.

MS. JUNG: So again, that's option one for yes, please raise your hands. Seven yeses. And for no, please raise your hands. So that's 12, that isn't. That doesn't add up correctly, hold on. Can we see yes one more time, please? All right, sorry, that's nine. Okay, so we have our total.

So we have nine yeses and 12 nos. I

believe with the 12 nos, that is consensus for 60 percent.

CO-CHAIR MOYER: Okay.

PARTICIPANT: No, you failed to make consensus on yes.

MS. JUNG: Oh, apologies. Let me quick check.

CO-CHAIR MOYER: Okay, so we do not have consensus to move the forward measure, the measure forward with support for rulemaking. So the motion was not supported, and now we would default to -- and now we are going to default back to the consent calendar our recommendation which was conditional support for rulemaking with the measures being submitted to NQF for review and endorsement.

Do we need to have any discussion around this, or can we move forward with the vote? It looks like we can move forward with a vote. All right, I'm going to ask people to stand up this time so we make sure we get everyone counted.

MS. JUNG: So this is for option one, yes. So that's 21 yeses.

CO-CHAIR MOYER: And now we all get lunch.

DR. BERNOT: Just yes, one quick message for lunch. So we actually almost caught up. Thank you, Amy. We're only 15 minutes behind. We actually had put a little extra time in lunch. So we will come back at 1 o'clock.

That still gives 30 minutes, and then we have a presentation. So there will be a little time to finish up your lunch at that point too while Karen is going over the rural map.

So 1 o'clock we'll reconvene to have the rural map presentation. Thank you. Lunch is served in the back.

(Whereupon, the above-entitled matter went off the record at 12:31 p.m. and resumed at 12:59 p.m.)

DR. BERNOT: Okay, we're going to get started this afternoon with a presentation on the rural health MAP.

Will you guys quiet down back there? We're starting. Okay, Karen Johnson's with us.

Karen, would you just introduce yourself and your position at NQF, and then fill us in on what's going on with the rural MAP?

MS. JOHNSON: Sure. So, thank you very much. My name is Karen Johnson, I'm one of the senior directors here at NQF and I have the pleasure of overseeing a new MAP Workgroup that is dealing with rural health.

So, I, along with my colleagues, Suzanne, Kate, and Madison, are really excited to work on this project.

We wanted to let you guys know that we exist, so that's what this is about.

A little bit of background, a couple years ago, we were funded by CMS to do some work on rural health, and that project, really, was to provide guidance on performance measurement issues and challenges for rural providers.

So, they wanted us to make recommendations for measures appropriate for the

use in CMS payment programs.

And one of the interesting things about that is we took care to bring in critical access hospitals, rural health centers, FQHCs in rural areas, folks who traditionally have not actually participated in CMS quality programs, in part because they're not paid through the PPS system.

So, there's a lot of challenges.

A couple of the issues that we felt that we really needed to understand in terms of rural providers and rural patients are these four here on the list.

These are interrelated, right?

So, one is geographic isolation.

When you're isolated geographically, you may have problems with shortage of staff, transportation issues become a problem, so there's a lot going on with geographic isolation.

Small practice size again can be part of that, but it also means that you don't have a lot of people to rely on to report quality

measures or to do QI efforts once you know that you have a problem.

Heterogeneity, there is no rural provider who looks just like all the other rural providers. They're very different.

So, the folks in New England are not the same as the deep South, not the same as the loud West, so a lot of heterogeneity.

And that has a lot to do with what measures actually can be used by these rural providers.

Not all hospitals in rural areas do surgery, so there's surgery measures that are in the hospital programs they can't report on.

Low case volume has to do with having enough patients to be able to have a reliable and valid measures.

So, these were all issues that we talked about knowing that they impact the programs and what we can be doing for rural providers by CMS.

So, the overall recommendation from

that group a couple years ago was surprisingly possibly to us, for sure, make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers.

However, allow a phased approach, again, and many have not done this at all, and be sure to address low case volume.

There were many recommendations to support that overarching recommendation but several have to do with measure selection.

And one of the ones, it's actually the last one on this list here, but one was to create a Measure Applications Partnership Workgroup to buy CMS. And so we're very excited that we now exist.

We have this Rural Health Workgroup but we also wanted to -- the recommendations were to use guiding principles for selecting measures that would be used by CMS to use a core set and menu of optional measures for rural providers to not forget about patients-in-home models.

So, that takes us to right now.

Again, we are a brand-new Workgroup to join you guys and we are going to develop criteria for selecting measures and identify core sets of measures that are rural-relevant.

We will also talk about gaps in measurement and talk about alignment, and we'll be doing a measurement topic that's relevant to vulnerable individuals in rural areas.

That topic is yet to be determined so I can't tell you what that is for sure yet, but we are very busily working.

We will be interacting with other MAP Workgroups, so I'm getting to tell you that we exist in today's discussion with you guys.

We're going to be here tomorrow and Thursday as well to talk with the other Workgroups to make sure everybody knows that there are folks who are paying attention to rural issues very specifically.

We will be providing input to the Coordinating Committee on the MUC measures, the measures that you guys are looking at, nowhere

near in the detail that you guys are looking at, just a holistic approach from the rural perspective.

And then finally, the Coordinating Committee at the end of the summer will be reviewing and hopefully approving the recommendations that come out of the Workgroup.

So, where are we to date? Well, we've seated our Workgroup, so we have a fantastic group of people.

We're very excited about those and we have convened our first meeting just a couple weeks ago and we have another one tomorrow. So, we're moving very quickly.

So, the initial guidance, just so you know, that we've gotten from our Workgroup thus far is to pay particular attention and focus in on measures that are NQF-endorsed, that address low case volume, that are cross-cutting, and there is probably going to be a few must-have topic areas or conditions.

So, for example, the two conditions

that have come up have been diabetes and hypertension.

So, what we need to do for identifying the core sets is to really think about what measures will work for most rural providers and their patients.

So, that cuts out a lot of the specialty things that would work for other, bigger folks.

So, for you today, we have about maybe ten minutes. We wanted to maybe have a little bit of discussion, so a few questions, we can pick one question and talk about it totally or maybe hit a few of these.

What are some of the key issues for clinician programs that you want us to think about as we do our work, and particularly around identifying core sets.

Does the initial guidance ring true? Cross-cutting, NQF-endorsed, maybe a few specific conditions or topic areas, does that make sense or is there something you think that rural health

folks should think about?

Going forward, do you have any guidance or input on what we can do to help you going forward?

And then finally, what advice can you give our new Workgroup? Many of you have been on MAP Workgroups for a long time, so what should we be thinking about?

So, I'm going to open it up and see if anybody has anything they would like to basically provide to the Rural Workgroup?

CO-CHAIR BAGLEY: Thank you, Karen. Go ahead, Eric.

MEMBER WHITACRE: One thing might be the Medicare designation of an individual clinician's specialty.

I know general surgeons who work in some of these locations, and basically, they function as a primary-care physician for many of their patients.

And I don't know if that would change how Medicare would look at them in terms of

performance, but they're doing a wide spectrum, providing a wide spectrum of care, providing anti-hypertensives, diabetic medications, as well as doing some surgery.

CO-CHAIR BAGLEY: Go ahead.

MEMBER ALEMU: I'm representing an organization that provides grants and technical assistance to rural providers throughout the country.

And what we hear from them consistently is that they don't have measures which are relevant to their specific situations.

And what MAP will bring to the table will be those measures that are relevant, at the same time, will be suitable for reporting for reimbursement purposes, and for quality improvement purposes.

So, we are excited that CMS has taken action to look into this specific issue.

So, in the coming days, the rural MAP will get information from what we are doing today from the clinician group as well as from the

hospital Workgroup.

I would assume that the measures that they look into will be a subset of what we will be recommending.

So, I think to get informed about what will be done in the next few days will be very useful for the MAP, the rural health MAP. Thank you.

CO-CHAIR BAGLEY: Peter?

MEMBER BRISS: Thank you for that comment. This is a really good direction. In addition to what you said, I'd think about a couple more issues.

So, I think that you might want to think about whether the standard NQF endorsement is enough or whether you need an additional lens for rural providers.

So, I wouldn't be surprised, for example, that feasibility looked a little different, or expected performance levels looked a little different or risk adjustment.

It might need to be different.

And so I don't have an agenda about how those should come out but it strikes me that there might be things that you had to do that are on the endorsement process, that you might have to add on to the endorsement fund process to actually make the measures as relevant and useful as they could be.

CO-CHAIR BAGLEY: I don't see any other questions or comments. Are there any questions on the phone?

I believe none on the phone. Stephanie, go ahead.

MEMBER GLIER: I'm sure you were already doing this, and you didn't include who you have on the Workgroup already but I hope you guys are making sure to include the rural patient perspective as well, as you're going through the considerations.

So, whether that's actually through a group Member or through getting input directly from what is important to rural patients, what concerns they're facing, as we're thinking about

also how to ensure that the measures that CMS is encouraging are valuable.

MEMBER SEIDERWURM: Two questions come to my mind.

CO-CHAIR BAGLEY: Can I just make a comment about the microphones?

The microphones are very directional so make sure you're at least no more than six inches away and talking at the microphone.

Because the folks in back can't hear very well and the folks on the phone can't hear very well.

Yes, sir?

MEMBER SEIDERWURM: Now, most people would pay extra not to hear my voice so it's very rare that I would get that kind of a request.

So, are you primarily focused on helping or figuring out how rural practices might be able to report or meet the existing measures?

Or are you more focused on creating specific measures for rural practices, or possibly both? That's one question.

And then the second is isn't this area a little bit like the socioeconomic status issue that we've wrestled with, that if you're offering a service in a smaller community, unless it's an emergency, completely non-portable service, do we want to have risk adjustment for that variable, or do we want to try to encourage a more uniform style of practice?

MS. JOHNSON: So, to your first question, identifying the core set, I think we will probably start with what's available, but some of the discussion that we will have to have, and we've already had it a couple of years ago and we'll talk about it more, it actually gets into the risk adjustment piece.

Not everything is going to work as it is probably for rural areas. So, I think some of it might be potentially suggestions for different or additional risk adjustment.

It might be a suggestion to, for example, make sure that if care is being delivered via telehealth, that the measure

captures that. That might be a simple low-hanging fruit.

The other thing that we'll be doing is really talking about gaps in measurement because some of the things that are really important to rural providers, not every one of them of course, but are transitions and care and triaging and hand-offs and things like that.

We have very few measures of those kinds of things, so I think it'll be both talking about what we have now that will work now, as well as what we need to go for in the future.

MEMBER SHALLER: I just think I'd be remiss if I didn't make a plug for patient experience.

I mean, if you're looking for cross-cutting measures, that's probably one of the things you can do for some of these reasons.

And we also know that rural providers tend to do pretty well because the small nature of their practices often have relationships with patients that some of the larger organizations

don't.

MS. JOHNSON: We haven't got to that too much yet. We have several available to us. The balancing thing on that is it can be expensive to do those kinds of things.

So, that might become a bit of a problem but we definitely have been talking about that.

I think the one thing that has really come up so far in our one meeting is the need for measures of access to care.

And I think that's where we'll have to go, as Peter was saying, possibly outside the NQF endorsement.

That might be one thing because we don't have a huge number of NQF-endorsed measures that get us there.

CO-CHAIR BAGLEY: I'll put myself in the queue.

Now, two things that I would say to follow up on Eric's comments, it's kind of going to move towards a primary care set of measures

because that's what's happening out there.

But the other thing is we have to be very careful not to have two standards of care, just because diabetes is diabetes and it's not okay to have less quality for diabetes because it's rural.

And that is going to be difficult to push through. But if there's a right way to do things, then we all ought to be doing them.

No matter who's taking care of them or where they're being cared for, they ought to have a similar standard of care.

So, other comments or questions before we move on? Okay, Karen, thank you very much. Good luck with that, all right? And keep us posted.

All right, are we ready to move on? We're going to move on to the urology measure, the next slide there. And I think there's just one measure on this list as well.

Can you bring up the next slide? So, it's not really a consent calendar. We have one

measure to consider and that's 239. Thank you. MUC 239, does that sound better when I do it right? Okay, is there any discussion on this? And the recommendation is -- okay.

MS. DUDHWALA: Sure, so this is MUC 17239 International Prostate Symptom Score for American Urological Association Symptom-Index, changed 6 to 12 months after diagnosis of benign prosthetic hyperplasia.

And the decision criteria is conditional support. Oh, sorry, pending NQF submission.

CO-CHAIR BAGLEY: The recommendation for preliminary analysis is to have conditional support for and recommend NQF endorsement.

Is there further discussion? Oh, my God, Stephanie, what a surprise.

MEMBER GLIER: I don't want to pull this measure, I'm happy to stick with the measure that's on the table.

I wanted to commend the developers for taking our advice in the previous MAP cycle and

revising and resubmitting their measure.

Thank you very much for hearing our input, we really appreciate it. Nice job.

CO-CHAIR BAGLEY: Okay, obviously, we could have more discussion from the lead discussants but if there's no objection, or did you have anything that you wanted to say about this? Scott, I think Scott --

MEMBER FURNEY: Fully supportive.

CO-CHAIR BAGLEY: And is there any public comment first in the room? And the operator on the phone, public comment on the urology measure?

OPERATOR: At this time, if you'd like to make a public, please press Star then the Number 1. There are no public comments at this time.

CO-CHAIR BAGLEY: All right, thank you, and if there's any additional discussion from the group before we vote?

And the vote is the vote on the consent calendar which is basically the

recommendation of the preliminary analysis which is conditional support, and the condition is pending, not pending but recommended for NQF endorsement.

Is everybody clear on that? So, it's a yes or no vote.

MS. JUNG: Yes, so voting for MUC 17239 is now open.

Option 1 is yes; please raise your hands if you would like to indicate yes?

Okay, that look like 21 votes for yes. Just to fact-check, any votes for no, Option 2? No.

MS. DUDHWALA: Well, we're waiting on the people on the phone.

CO-CHAIR BAGLEY: Anybody on the phone?

MS. DUDHWALA: If Leslie and Michael can just send in their votes please. Leslie and Michael?

MEMBER ZUN: I did, thank you.

MEMBER HASSETT: Me as well.

MS. DUDHWALA: Sorry, Michael, I didn't get yours?

MEMBER HASSETT: It was yes.

MS. DUDHWALA: Okay, thank you. So, the total for MUC 17-239 is 21 votes for yes and 0 votes for no.

CO-CHAIR BAGLEY: Okay, I guess we can move on to the vaccination measure. Hiral, will you talk about that?

MS. DUDHWALA: Okay, so this is for MUC 17310, zoster shingles vaccination, and this one also got a conditional support for rule-making, pending NQF endorsement.

CO-CHAIR BAGLEY: Okay, are there comments or questions about this measure? There's a post-prandial slumber out there. Peter, wake them up.

MEMBER BRISS: So, a number of things have changed about zoster immunization since this measure was developed.

So, there's a new vaccine that was recommended about a month ago by the ACIP, the

Advisory Committee on Immunization Practices, which is sort of the Preventative Services Taskforce for vaccines, that's going to result in things that are different about what's recommended for a vaccine.

So, it's a different vaccine, it's a different number of doses, it's a different age range.

And so having a zoster measure is a really important thing and there's going to need to be quite a bit of revision of the measure to get it up to date.

So, it might be a revise and resubmit.

CO-CHAIR BAGLEY: Okay, and Beth?

MEMBER AVERBECK: This isn't a measure-specification question, but one more, there are a lot of comments on whether or not the medication was covered under Medicare.

So, that might be a barrier and I don't have the answer for that. It might be covered under Part D.

So, it might just be a comment to put

with the measure to look into that or at least clarify it, because the practices. A number of them commented on that.

CO-CHAIR BAGLEY: Did you guys have any coverage comments or no? No, okay. We forgot to start with public comment. Is there any public comment?

OPERATOR: At this time, if you'd like to make a public comment, please press Star then the Number 1.

And there are no public comments at this time.

CO-CHAIR BAGLEY: Okay, Stephanie, I think you were first?

MEMBER GLIER: I think this is important, I think zoster is an important condition to be checking on.

My preference, if I had my druthers, would be to have a composite measure looking at all appropriate adult vaccination.

So, if there is going to be a revise and resubmit, I would like to encourage CDC and

other measure-developers working in this space to put together a composite measure that looks at all appropriate vaccinations being given to a population.

So, that's my comment. I'd vote for a revise and resubmit.

MEMBER BURSTIN: I agree. I just want to support what Peter said as well.

I think the last thing we need are measures that are in conflict as the evidence is changing.

We've seen this repeatedly, how difficult it is for clinicians, how difficult it is for patients, and so I think a conditional doesn't work for this.

I think it's going to need a pretty significant rewrite and I think that's actually what that category is really intended for.

Is there a formal motion or if Peter's going to do that?

CO-CHAIR BAGLEY: Since it's on the consent calendar, you'd have to take it off the

calendar, and anybody can do that for any reason.

And then make an alternative motion, either about the category, one of the four categories, or the conditions, either one.

So, somebody think about how they want to do this.

MEMBER GLIER: I did already pull it, actually, by email.

CO-CHAIR BAGLEY: Oh, you did? I'm sorry. It's not marked on my thing but whatever. Okay. And what's your motion?

MEMBER GLIER: And I move to revise and resubmit to update the guidelines.

My preference would also be to have this be an entirely different measure that is a composite measure of all vaccinations, but I'm not sure that a revise and resubmit needs to be as specific.

So, perhaps other folks can weigh in about whether they're also interested in a composite measure?

I think the guidelines update seems to

be a minimum bar, and then my higher tier bar would be a composite measure for all vaccinations or more vaccination.

CO-CHAIR BAGLEY: Well, I have a question for CMS, I guess. If we select, for instance, do not support but can we give you reasons why?

Is that helpful? Or is revise and resubmit really appropriate for this one? Does it make any difference?

MEMBER YONG: Well, the specific category we defer to the MAP on, but certainly, it's always helpful to have the reasons documented.

CO-CHAIR BAGLEY: Regardless of which four categories? Okay, that's fair. All right, I think I lost track.

Beth, why don't you go next?

MEMBER AVERBECK: It was just a question.

I think it's going to apply to some measures down the road, which is when evidence

changes, and the measure will, through its normal review process, get revised based on the new evidence.

Does that become conditional support? Does it become revise and submit?

Because it's part of the ongoing measure development the stewards need to update anyway.

So, I'm just kind of curious how we want to approach those because it won't be unique to this one.

CO-CHAIR BAGLEY: David?

MEMBER SEIDERWURM: So, I think we've encountered this difficulty before when the evidence changes, yet, we think it's a priority.

If a metric is removed from the program, an unintended consequence of that could be that the public or the physician community, provider community, gets the message that this isn't important.

And I just want to make sure that we don't have that unintended consequence.

So, I wonder if this is withdrawn from the programs, if there's a notation that can be made or some explanatory notes added that we still think this is an important priority.

And that CMS also thinks it's an important priority if they do.

DR. GREEN: No, we do think it's an important priority. There's not a measure, a zoster measure, in the program currently anyway.

So, I don't think that message would be sent. The problem is, albeit, with the evidence changing, it's just a delay in implementation.

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

CO-CHAIR MOYER: So, my comment is related to the gentleman's comment.

The measures actually currently in the QCDR are the non-MAPs measures, so technically, it's already been collected.

And so this is more of a process question.

So, if we recommend a revise and

resubmit, what happens to, to your point, those providers who are already familiar with this and are potentially collecting this?

And they're showing a performance rate of about 47 percent. So, there's a gap there.

So, while the current measure is not up to date per the new recommendations, I don't think clinically it's invalid.

I think people should still get vaccination, except the age range is different and some of the set of parameters need to be updated.

So, it's a bit of a grey area for me. This is my first time on the Conditional Workgroup.

So, I agree that we should revise and resubmit, but what happens in the meantime, it's a measure in the QCDR.

CO-CHAIR BAGLEY: Peter?

MEMBER BRISS: I wanted to make one more -- add one more thing.

My wish for potential revisions is

that all vaccine measures are getting increasingly complicated, because vaccines are being delivered in an increasing number of places.

And so I'd love to have the Committee think carefully about how best to ascertain vaccination, which I think has been really hard.

CO-CHAIR BAGLEY: Scott?

MEMBER FRIEDMAN: So, this is my third or fourth year and I still don't get it either.

So, why can't we do conditional support for rule-making pending updating the measure specifications?

Because we know they're going to update them and it's already -- the premise about the measure is still a good one, and all you're doing is changing some specifications.

Why can't we just do it that way?

CO-CHAIR BAGLEY: Peter, did you have a comment?

MEMBER YONG: -- line on the phone so I wanted to make sure if they had any comments,

they had a chance to share those.

CO-CHAIR BAGLEY: Thank you for that. Are there any comments from the phone?

MS. O' ROURKE: Operator, can you unmute their lines?

MEMBER YONG: It's Ruth Jenkins.

OPERATOR: I'm sorry, unmute whose line?

MEMBER YONG: Ruth Jenkins. Is she on the line?

OPERATOR: Okay, one moment.

MS. JENKINS: This is Ruth.

OPERATOR: Hello?

MS. JENKINS: This is Ruth.

CO-CHAIR BAGLEY: Hi, Ruth, we can hear you. It's Bruce Bagley. Do you have any comments on the vaccination measure?

MS. JENKINS: Well, we actually planned to update our recommendation for this to abide by the new criteria that's just come out in the last month.

So, we agree with the conditional

approval just because we work with our practices and our physicians and we want to have the best one.

Although this vaccine is not available yet, we're anticipating it in early 2018.

CO-CHAIR BAGLEY: Okay, thank you. Did you have another comment?

I was going to say that I think I agree with Scott, that perhaps we can also go with the conditional approval.

Because if this is a QCDR measure and they're working with practices, I would assume it's relatively easy to update the parameters of the measure.

Unless we want to go down the composite measure route or make those significant changes.

But in the meantime, I think if it's age and inclusion criteria for vaccines that qualify for the measure, that should be relatively easy to make.

CO-CHAIR MOYER: So, I just wanted to

try to address some of the points raised by Scott and Dale, that really I think either category could work in this circumstance.

It's up to the Committee and your judgment as to if you think it should be conditionally supported or revised.

I think the motion on the floor is Stephanie's to refine and resubmit. We can provide the same feedback about what changes might need to be made with either category.

So, it's really you and your judgment of if you want to perhaps give it the extra support that conditional support implies.

Or if you think you want it to be more cautious and go with the refine and resubmit.

So, the process would be that we'll vote on Stephanie's motion. If that does not pass, someone could put forward another motion to do a conditional support.

And to just reiterate that we do collect all this qualitative feedback, if you will. It's not just the votes that go forward.

So, in the report, you'll see the points of your conversation.

We could share some of the concerns about what's covered and the reimbursement rates as well as what specific changes you would like to see.

And reiterate the group support for a sister vaccination and perhaps suggest that we move to a composite of adult vaccines too.

So, we can capture all these points and move it forward to CMS. So, I hope that helps but I can try to clarify if it does not.

CO-CHAIR BAGLEY: Of course, it helps a lot actually. Stephanie, this is your motion, so your motion on the table is refine and resubmit.

And could I ask you to name the -- I think there are three things that you wanted to address. Do you have those on the tip of your tongue or should we --

MEMBER GLIER: I think there's only two.

CO-CHAIR BAGLEY: Okay.

MEMBER GLIER: We can call them three if you want.

So, the two are updating to meet the current guidelines, the second is to move to a composite measure if possible, which is really -- so, actually, I think maybe this is worth a little bit more discussion.

Maybe we can table my motion for a second, because I think if we are actually just saying we should meet the current guidelines and make sure that it's still NQF-endorsed, then I would agree with Dale that we should go with conditional support pending NQF endorsement after updating for current guidelines.

And if other folks agree with me about wanting to move to a composite measure instead, then we should be voting refine and resubmit as a composite measure instead.

Oh, it's not endorsed, you're right. So, gain endorsement.

CO-CHAIR BAGLEY: Right, so there are

three. The third would be NQF endorsement, right.

So, is everybody clear on where we're at?

MEMBER GLIER: Because I left that very unclear. Let's try again.

CO-CHAIR BAGLEY: You can't table your motion at this point, but you could withdraw it. You can't table it.

MEMBER ALEMU: I would like to make a point before that. We know that measures are dynamic, it's a dynamic process.

New guidelines come out, measures change. It may be, in some cases, a year, in other types, six years.

So, just recently you know that for hypertension, the new guidelines came out. But we are using the same measure which is out there, so it takes time to change those types of measures.

It's not early to develop a measure just within months or a year. The same happened with the cholesterol guideline.

In 2013, a new guideline came out and same has tried to cover up with the situation by developing a measure on statin. Maybe we'll discuss it today.

So, what I would like to say is we can support conditionally and the measure- developers will update the specifications based on the guideline.

Especially when it comes to vaccination, it's really a fast-moving process. So, that's one of the points.

The other point is when it comes to composite measures, it's really a painstaking, time-consuming, and difficult process.

We cannot have a measure just within a year, as I said earlier, and in this case, if we think this measure is important, it's timely, so we have to see it as a single measure.

But moving forward, it has been in earlier MAP meetings recommended that we should focus on composite measures.

So, what I would suggest is that let's

look at these measures specifically and support it conditionally given that the measure-developers will adjust the specifications.

CO-CHAIR BAGLEY: Let me make a suggestion to sort of move us along.

Let's vote on the motion on the table, which is to revise and resubmit with the three conditions.

And if you think that you would rather give it more support than that, with some sort of the same recommendations, the same conditions, if you will, then you should vote no at this vote.

And then we'll be back to the original motion.

Go ahead, Diane?

MEMBER PADDEN: So, I guess I'm going to just address the composite issue because of the payments, because the shingles is Part D, where if we do a composite, flu and vaccine are Part B.

So, will that muddy the waters a bit in terms of a quality measure?

CO-CHAIR BAGLEY: Maybe it would make them fix that problem.

DR. GREEN: Depending on how the measure's collected, and even claims -- I can't imagine it would, but especially if it's Registry, QCDR, or EHR, it shouldn't affect it.

CO-CHAIR BAGLEY: Go ahead.

MEMBER GLIER: Sorry, I know you're trying to move us along.

I have two points, one is that I think I actually would like to in fact table my motion, or withdraw my motion.

Because I think if we're going to go with revise and resubmit, I think we should just say we want a composite measure.

I think the sense of this group right now is that's not in fact where we are. So, I think leaving it with the conditional support makes sense.

Girma, to your point, I totally hear you, measure-development is hard and expensive and time-consuming.

If we are tasked with making recommendations at CMS about what should be in the MIPS program, which is what we're talking about at this moment, I'm not totally convinced that the zoster vaccination is worth one-sixth of a clinician's quality score.

I would rather it be a bigger measure that looks at all vaccination, even if that is difficult, even if it does muddy the water with humans.

So, my preference would be to have a bigger measure that looks at a bigger portion of patient care to make sure we're getting at the holistic picture.

But acknowledging where we are today, again, I withdraw my motion for revise and resubmit. I think we should go back to conditional support.

CO-CHAIR BAGLEY: Well, thank you for that. If I might, I have to take a quick aside about composite measures.

And when you have individual measures,

vaccination's a great example of that, everybody just tries harder to get a better rate at each individual vaccination.

When you have flu and pneumonia and zoster, in order to do well on all of those, you actually are pushed to have a systematic approach.

So, composite measures really drive quality improvement in a way that individual measures never will.

And I think your experience in Minnesota with the diabetes composite measure is a great example of that. It's actually an all-or-nothing composite measure.

Unless you're doing all, what is it, six things, you don't get any credit. But you can't do well at that without a systematic approach, a checklist kind of approach.

So, I think we should somehow continue the idea that composite's a good idea without kind of dismissing this measure on that particular parameter.

Now I'm back to Chair.

MEMBER SHALLER: Could I just ask, I'm glad you brought that up because I was wondering, when we use the term composite in this context, I want to make sure I understand, are we talking about a composite of all potential shingles vaccinations?

Or are we talking about a much more -- all of them? All adult vaccinations? That's what I'm wanting to know, if that's what we're talking about?

MEMBER GLIER: Yes, so I'm not recommending a specific set of vaccinations that should be included in an appropriate adult composite measure, but I do think it should be a broader perspective. I don't mean just shingles.

MEMBER SHALLER: Okay.

MEMBER GLIER: Or just zoster.

I mean a wider view of some clinically appropriate set of adult vaccinations, acknowledging that that is a very difficult concept to operationalize.

CO-CHAIR BAGLEY: Peter?

MEMBER BRISS: Yes, so I like the germane approach about you have the advice be in the short term we want to update a shingles vaccination, and in the longer term we'd like to have people explore an adult vaccination composite.

And there's nothing that gets us to what almost everybody is recommending around the table.

CO-CHAIR BAGLEY: And the third thing would be NQF, recommending NQF process, right? Is everybody clear?

So, unless there's other comments, I think we're ready to vote, and in this case, we're going to vote on the recommendation that this go forward as a conditional support with those three conditions we just said.

Is that clear for everybody? And this is a yes or no vote.

The conditions are to make sure it's up to date, to consider the usefulness of a

composite measure that might include something about zoster vaccination, and that they pursue the NQF endorsement process.

Is that where we are at? Okay.

MS. JUNG: Okay, voting for MUC 17310 is now open.

Option 1 is yes; please raise your hands if you would like to indicate yes.

And then any nos? Okay, and we're just waiting for the folks remotely to tally in.

Okay, so we have 21 yeses and 0 nos.

CO-CHAIR MOYER: I get to tell you guys that we're going to take a break and we will -- you know, we're a couple minutes ahead so let's try and reconvene.

CO-CHAIR BAGLEY: Let's do one more and then --

CO-CHAIR MOYER: Do another one? All right. I guess we're going to do one more set of measures, I apologize.

So, the next item on the consent calendar is, oh, the appropriate use measures.

Okay, I have one item on the consent calendar. It has not yet been pulled.

It is the appropriate use of DXA scans and, Hiral, do you want to introduce this?

MS. DUDHWALA: Sure, so this is MUC 17173 appropriate use of DXA 6 scans in women under 65 years who do not meet the risk factor profile for osteoporotic fracture.

So, this one was given a preliminary recommendation by Staff of conditional support, and this is pending NQF endorsement as well as feasibility issues, addressed across EHRs.

CO-CHAIR MOYER: Okay, and we will start with public comment.

First, is there anyone in the room who would like to make a public comment on this? Okay, seeing none, Operator, can you check for any public comments on the phone?

OPERATOR: Yes, ma'am.

At this time, if you would like to make a public comment, please press Star then the number 1.

There are no public comments at this time.

CO-CHAIR MOYER: Okay, so we will open it up and let the lead discussants speak to the measure, and then if anyone wishes to pull it prior to vote, you can also let us know that.

So, we'll start off with David?

MEMBER SEIDERWURM: Sure, so this is an overuse measure for DXA scanning for osteoporosis, and basically, you can think of it as the flip-side of the appropriate use measure for DXA scanning, which is have you done DXA on the appropriate population?

This is the flip-side of that, have you done it on the inappropriate population?

And so the diagnostic exclusions are very complete and very well defined to exclude those patients which would be at high risk.

And it's, again, one of those half-full, half-empty kind of problems because one of the comments was, well, it's going to be difficult to implement because the list of

exclusions is so long, but if it had not been appropriately complete, the comments would have been to have included them I think.

So, I think that especially in the EHR environment, almost all of these would be captured and they should be.

So, I would support this as a good quality appropriate use measure for this type of procedure.

CO-CHAIR MOYER: And Robert, anything to add?

MEMBER KRUGHOFF: In terms of what's going on in real practice and how much information the doctors actually have about this while they're practicing, but it does seem like this is a case where there's probably a lot of these scans that are done that shouldn't be done, and you do want to prevent that.

We'd obviously like to have a perfect measure that makes sure everybody who should have it gets it, and everybody who shouldn't have it doesn't get it, and there is a little bit of

worry that the safest thing to do is to not do it.

In terms of this measure, you're not going to score badly on this measure if you do nothing at all.

And so you'd like to have something that counter-balances it, but I'm not aware of any measures where we look at both sides like this.

Well, have you done it for exactly the right people? And that would be a very hard measure to have precise enough.

So, it seems to me that this is something that's worthwhile to have out there and to say that we want to have people work to improve it, improve the data collection on it, and that it probably will evolve over time.

MEMBER SEIDERWURM: Just to clarify one point, there is a metric for the other side of the coin.

MEMBER KRUGHOFF: For over 65?

MEMBER SEIDERWURM: NQF 0046 I think

it was. It's in there. So, the suggestion, if we were going to make one along Bob's suggestion, would be to try to combine them.

I think that's technically kind of difficult and sort of hard to specify and report sometimes.

So, I think given the present moment in history, we're probably better off with two.

MEMBER KRUGHOFF: The over 65 is a much simpler measure.

CO-CHAIR MOYER: Eric?

MEMBER WHITACRE: I guess to me, and I don't do this, to me this seemed like the ideal opportunity for a composite measure.

Are you doing the right thing? I guess it's the problem with EHRs in that it's too hard for them to pull the exclusion criteria, the risk criteria.

Is that the problem?

MEMBER SEIDERWURM: That and the coding for the claims, but CMS I think can better address the coding issue.

MEMBER KRUGHOFF: Isn't there also a grey area, though, where if it's over 65, you say just do it, right?

If it's under 65 and there are certain things, then you have to have a real compelling reason to do it.

But there must be some kind of grey area in between where it's not such a bad thing not to have done it if you're under 65.

Is that the case? I don't know.

MEMBER SEIDERWURM: Wouldn't that be by risk factors? Which is I think what's being addressed here.

DR. GREEN: Yes, and that's exactly right, David. This is something that I did quite a bit, so it is a little bit complicated.

The over 65 is very easy; 65 the recommendation is to get a DXA scan.

But particularly in women who are menopausal and have certain number of risk factors, there are scientific ways you can determine if a patient is a candidate for a DXA

by entering her risk factors into the FRAX tool and calculating a FRAX score without a T score, which would give you -- then, if the number happens to be 9.3, then that's because that's the risk of a 65-year-old of having a fracture.

So, not to give you all a lesson in osteoporosis, I'm sorry, but it is one of my pet things.

But to your point, I think it's difficult to have the composite here because you'd have to not just have the 65 but you'd have to have all the opposites, if you will, of this, in terms of should somebody have the DXA?

And some of it's also a little bit judgment because the FRAX tool, while very good, doesn't collect every single risk factor.

I mean, there's literally pages of risk factors for osteoporosis.

MEMBER KRUGHOFF: It'd be interesting to suggest something that tries to cover the entire horizon of the do-it and don't-do-it ones, just as one of our comments on this.

But I don't know whether we want to try and recommend a measure that is that demanding.

CO-CHAIR BAGLEY: I guess I'm a little confused about the population as we mentioned a couple times.

If MIPS is a CMS-Medicare program, how does this particular age group fit into that? Operationally, it's like two different things.

DR. GREEN: Great question, Bruce.

So, in MIPS we are, except for claims obviously, and web interface because we're populating those folks, except for those two reporting methods, we are collecting all payer data.

So, even pediatricians conceivably, if they had a large enough Medicare population, whatever, could report and participate in the program.

CO-CHAIR MOYER: Amy?

MEMBER NGUYEN: I'm just a little concerned, and I think we already touched upon it

briefly, about the feasibility in the reporting aspect.

And while we're looking at that burdens and nature of measures in meaningful measures initiatives and everything that we're talking about, these measures are not easily captured in the EHR data, even with ECQM.

And that's just my concern, and there are the discrete fields in that electronic record, it might be very burdensome for physicians, physician practices.

MEMBER WHITACRE: We have something comparable to this in ordering an MRI for breast-cancer risk. It's a fairly complex calculation to do, not every EHR has it.

So, as I see this in that context, this measure pushes people to not do it unless they've taken the extra time to document that it really should be done.

And if that's the intent of the measure, and it sounds like it's to reduce overuse, then it will be effective.

I'd be more comfortable encouraging people to get the calculation if it's really useful.

We use it in breast-cancer risk all the time to order additional studies.

So, you don't get a breast MRI, unless they meet a certain calculated lifetime risk. It's an onerous calculation and this is the same.

So, the people who don't calculate, it's not going to show up in the claims, don't get the DXA.

MEMBER SEIDERWURM: Well, so I think that if you look at the list of diagnoses that are listed here, there are things that are going to be coded, Crohn's Disease, cystic fibrosis, malabsorption, chronic liver disease, malnutrition, history of fracture, gastric bypass, alars, down-lows.

I'm just scattering around the list. These aren't things that are going to be sort of hidden in a patient's chart.

They're going to be either noted in

the problem list or in the request coding or in the bill. They're going to be somewhere.

These aren't obscure things, I don't think, whereas, things in the breast cancer risk factor stratification are things like age at menarche and puberty and some of those things which may not show up.

And so those, I believe, or family history, those are different types of things, that might not ordinarily show up on a problem list I think.

MEMBER WHITACRE: The difference would be you wouldn't be dinged if you didn't get the DXA scan on somebody with Crohn's using this measure.

You're not going to sort through the claims and say, oh, this patient has Crohn's, they were 55 years old. You lose a point.

MEMBER SEIDERWURM: Yes, pushing to not overuse this.

MEMBER WHITACRE: I think that your points would be germane to all overuse measures,

so unless we were to reject the concept of overuse measures, we would proceed with something like this, I guess is how I look at it.

CO-CHAIR MOYER: So, I guess I do have a question around that for the measure-developers.

So, lower is better but frequently with an overused measure, we say, well, we don't know quite what the right rate is.

And it almost feels like this is striving for zero. Would that be accurate to say, or no, as a benchmark?

MR. SIMON: Can anyone hear me?

CO-CHAIR MOYER: Yes, we can hear you.

MR. SIMON: Hi, everyone, this is Sam Simon from Mathematica.

So, a couple of points I wanted to just raise, I'll take the most recent one first.

So, yes, a preferred rate would be zero given that this is an overuse measure.

But going back a few points to the feasibility question, there was a fair amount of

feasibility testing done for this measure.

We spoke with four EHR vendors as a part of testing. Well, we touched on feasibility in two ways.

One was talking with four EHR vendors, all of whom supported the feasibility to implement this measure as an ECQM.

And then secondarily, we were able to collect data for this measure at three different sites.

So, those two factors do sort of speak to the feasibility of implementing this measure. So, I hope that answers some of the questions that just came up recently.

CO-CHAIR MOYER: Thank you, that does.

One additional thing, question, that I would have then, because I get this a lot from hospitals in our area, we have a lot rural hospitals in Wisconsin, were any of those the smaller EHR vendors, and I think Medicity is one that comes to mind, that we frequently hear from the hospitals, oh, but I have this and it doesn't

work.

Or we hear from the clinicians.

Was it tested in more rural areas as well do you know?

MR. SIMON: So, the testing was done at three different sites.

So, given that, I don't think we can say anything about rural versus urban, given the small admittedly convenient sample, unfortunately.

CO-CHAIR MOYER: I was just curious, thank you. Okay, given that, Robert, do you still have a comment or is your card just remaining up? Okay.

I'm not seeing any other comments in the room, so it sounds like we may be ready to move forward and vote on this, if I can get back to the right spot.

So, I'm not seeing any other comments. The vote would be conditional support for rule-making and the conditions are NQF endorsement and review.

And as part of that, it would undergo a feasibility analysis, so that's contained in it. All right.

MS. JUNG: Okay, voting for MUC 17173 is now open.

Option 1 is yes; please raise your hand to indicate yes? Okay, please raise your hand to indicate no?

We're just waiting on the remote voters.

MS. DUDHWALA: We have the votes for the remote voters.

MS. JUNG: Did someone step out of the room? Are we missing someone? Okay, that make sense.

Okay, so the final vote for MUC 17173 is 17 yes, 3 no, with a total of 20 votes.

CO-CHAIR MOYER: Did you have a general comment, Robert?

MEMBER KRUGHOFF: Is it possible in this context just what I was suggesting earlier, the possibility of at least suggesting to the CMS

that there is a problem of over not doing, of not doing too much and the problem of we really want to encourage enough to be done.

And so we'd like CMS to try to explore ways to create incentives and measures long term that would reward taking all the people who really should have it done, and getting it done when they're under 65.

CO-CHAIR MOYER: I see furious rating on the CMS side. I'm going to assume that's been captured in your notes.

DR. BERNOT: If I could say for NQF, we have it captured in our notes also as part of the discussion, so, yes, Robert, thank you.

CO-CHAIR MOYER: All right, and now we are going to take a 15-minute break. So, reconvene at 2:15 p.m.

(Whereupon, the above-entitled matter went off the record at 1:59 p.m. and resumed at 2:16 p.m.)

CO-CHAIR MOYER: All right. the next item on our consent calendar is the vascular

measures under consideration. And I'm going to let John introduce this.

DR. BERNOT: All right. Thanks. So I will introduce the next section. The next section is the, as mentioned, the vascular measures. There are three measures on this consent calendar.

The first one is MUC17-194. That's the optimal vascular care measure.

The second one is the ischemic -- excuse me -- let me go give the recommendation. The optimal vascular care MUC17-194, the preliminary analysis was conditional support, the condition that CMS evaluates the program to avoid duplicate and competing measures.

The second one was MUC17-234, ischemic vascular disease use of aspirin or anti-platelet medication. The preliminary analysis is the same, conditional support, the condition that CMS evaluates the program to avoid duplicate and competing measures.

I need to note on 234, that this

measure is being proposed for both MIPS and MSSP. There will be one discussion, but there will be two votes for this. Each program will have its own vote whether it will be included.

The third measure is patient-reported and clinical outcomes following ilio-femoral venous stenting. And the preliminary analysis on this is refine and resubmit the measures.

It is a composite measure in early development that has not been tested, though the individual measures have had some testing.

Before we go to public comment, due to the competing nature, CMS is going to make a statement about these particular measures.

So is it to you, Dan?

DR. GREEN: Thank you. Yes, it is me. Hi, everybody, again. So I wanted to note about the optimal vascular care, I mean, we're trying to replace a Wisconsin Collaborative measure, which is --- right now it's MIPS quality ID 441, and we're trying to replace it with this measure, the Minnesota measure, which I believe is NQF-

endorsed.

So, again, as to one of my earlier comments, you know, we prefer to use NQF-endorsed measures when available. We think that's, you know, good for the program and good for our clinicians who are reporting.

So PQRS 349 was retired due to blood pressure changes and we had problems aligning the program.

So the one thing I do want to mention about 194, is that would also need updating to reflect the new blood pressure that has come out.

So the only other thing is, you know, the competing measure. So there is one part of the composite measure, of course, is an individual measure, including ischemic disease use of anti-platelet or aspirin.

We do think that this is an important standalone measure and we actually did recommend to Minnesota that they provide this measure in our call for measures. So we asked them to submit it to the MUC MAP list.

And we did that because we think that this measure is --- it was approved, first of all, as a QCDR measure. And we do like this measure also because the exclusions are much more appropriate than the measure that we currently have.

So, Pierre, did you want to say anything else?

MEMBER YONG: No. I think Dan basically covered it. I think there are sort of two issues that we'd love some feedback on, but hopefully there's the -- the duplication issue, which Dan covered in terms of existing measure versus, like, this measure around sort of use of aspirin and anti-platelets and the exclusions are slightly different.

And so we think they're more appropriate and have more --- have a more specific age limit as opposed to an open age limit with the other measure, but there's also the duplication --- or the duplication issue between having an individual sort of process

measure versus a composite, which includes that process measure.

And part of the reason we put both of them on there is because we may have specialists that only do --- may not do or handle all of the issues within the composite. And, therefore, if they don't address all those issues in the composite, they wouldn't be able to report on the composite as opposed to they really just focus on the individual measure.

So that's sort of a pro and con there, but we certainly welcome feedback from the MAP about that particular issue.

DR. GREEN: One more thing, guys.

The anti-platelet aspirin measure, not the current one, but there is one currently in the Million Hearts program, which, as you know, is a big CMS priority program. And, again, this measure just better --- the measure that we're asking to ultimately replace our current measure, as Pierre said, it does take into account certain exclusions, which are much more medically,

obviously, appropriate, as well as defines a particular age range of 18 to 75 instead of just 18 and older. Thank you.

CO-CHAIR MOYER: Thank you. We will now go to public comment starting with people in the room.

Is there anyone in the room who would like to publicly comment on this measure? All right. We have a public commenter.

MS. BOSLEY: Hi. Heidi Bosley on behalf of the AMA. First of all, Dan, thank you for mentioning the guideline update. We were also going to point that out, but wanted to just make a comment.

This will apply to the two diabetes measures as well, the A1c and the composite. There's an increasing concern to have measures that have a somewhat imperfect denominator that's so broadly applicable in a program that is now assigning benchmarks and points with an assumption that you can get a zero to a hundred percent performance.

And so what is not clear in measures like this where we know that not all of the patients will achieve a blood pressure as desired in an A1c, how does this then work, and appropriately frame, assign points, and then communicate to patients what is the optimal benchmark.

So we would ask that it would be really further looked at either through the NQF endorsement process and/or through the MAP, on how do you begin to risk adjust, how do you begin to look at these clinical and social risk factors, so that we either have a more perfect denominator that encapsulates who should be receiving and achieving these goals, and then see how it would implement into the program.

It's an unknown at this moment. So thank you.

CO-CHAIR MOYER: Any other public commenters in the room?

(Pause.)

CO-CHAIR MOYER: Operator, can you

check for any public comments on the phone?

THE OPERATOR: Thank you. At this time if you would like to make a comment, please press star, then a number one.

(Pause.)

THE OPERATOR: There are no public comments at this time.

CO-CHAIR MOYER: Okay. So as mentioned, the optimal vascular care and then the use of aspirin or anti-platelet medication has been pulled from the consent calendar by Stephanie.

Would the workgroup like to pull any --- well, the one remaining measure also for discussion or will we leave that on the consent calendar?

As a reminder, the current recommendation for it is refine and resubmit prior to rulemaking because it is a newly-developed measure that has not yet been tested.

Dale, do you have a comment on that?

MEMBER SHALLER: I have a question

related to the duplication issue for the optimal vascular care measure.

So if we move forward with proposing conditional support, then CMS would, of course, not have both measures; the WCHQ measure and Minnesota Community Measurement measure. I mean, you would choose one in the end.

MEMBER YONG: Right. For the use of aspirin measure?

MEMBER SHALLER: No. I'm talking about the composite measure.

MEMBER YONG: There is no other competing composite measure.

MEMBER SHALLER: I thought the WCHQ was a competing composite measure.

(Off microphone comments.)

MEMBER SHALLER: So there is another competing composite measure?

DR. BERNOT: Sorry. I didn't want to interrupt. Just for the process of this, we actually, unfortunately, have to get through the consent calendar first before we go to the ones

that were pulled.

So we do have to deal with whether anybody wants to pull MUC17-345 and then we can pick right back up on that discussion after the vote is either that's pulled or we vote on that measure, which is the only one remaining on the consent calendar.

CO-CHAIR MOYER: Thanks. So would anyone like to pull the remaining measure or can we vote on the --- to accept the consent calendar?

(Pause.)

CO-CHAIR MOYER: All right. Seeing no cards go up, we will vote on whether to recommend refine and resubmit prior to rule-making for patient-reported and clinical outcomes following ilio-femoral venous stenting.

MS. JUNG: So voting for MUC17-345 is now open. Option 1 is yes. Please raise your hand if you would like to indicate yes.

(Show of hands.)

MS. JUNG: Okay. Please raise your

hand if you would like to indicate no.

(Show of hands.)

MS. JUNG: Okay. For MUC17-345 we have 21 yes votes and zero no votes.

CO-CHAIR BAGLEY: And what was the recommendation? Remember we wanted to --- if we're going to do refine and resubmit, that we were supposed to give some guidance. I guess I wasn't clear on what the guidance --- the two or three things that we want to ---

DR. BERNOT: So, yeah, it was --- and maybe I didn't say it very clearly. It was the refine and resubmit with essentially for the testing piece because it is a composite measure in early development. So we'll need to complete testing.

CO-CHAIR BAGLEY: So that's the only one?

DR. BERNOT: That's the only one that we had on here.

MEMBER GLIER: Before we go on, can I offer just additional comments that I don't think

need to be captured as a vote, but perhaps will be useful as they're continuing to finish the measure?

It's possible that this was actually in the measure specs that we just didn't have enough detail, but it wasn't clear to me what would happen to the patients who were last to follow up for the patient-reported outcome.

So I think it would be helpful whenever this actually is when the testing is done, it would be helpful for whoever is ostensibly renewing it for endorsement to have that information.

DR. BERNOT: We'll add that to the notes.

CO-CHAIR MOYER: All right. So we will move to the two measures that were pulled from the consent calendar. I'm going to start with Stephanie. She can let us know why they were pulled. And then we'll move to the lead discussants.

MEMBER GLIER: Thanks. I think my

comments go a little bit together although they go in different directions.

So I pulled the two vascular care measures. The optimal vascular care measure I would move to vote support.

I don't think we need the condition of removing the other measure because CMS has indicated that they already plan to remove the other measure, but since they have also --- it seems a little moot. So I'm happy to move forward either way as people feel appropriate.

It's helpful to hear from CMS what your thoughts were behind having a component of that composite also in the program. However, I am concerned about whether people would choose the composite measure if the component measure is available to them.

So I know we're not talking about program design today, so we won't talk about program design, but would like to encourage you to make sure that there are appropriate incentives that you have to do the higher-value

measures such as composites so that we don't have people choosing easier measures if they are available to them even if we're trying to include measures that allow more clinicians to report.

DR. BERNOT: Okay. William, or do you go by "Bill"?

MEMBER VAN DECKER: There's mom and apple pie in treating all vascular disease with blood pressure control, blood sugar control, cholesterol control, no cigarettes and an anti-platelet agent for clotting. So, you know, reasonable stuff in the composite.

My only two comments on it would be, obviously, new guidelines coming out through multiple societies, through American Heart Association, American College of Cardiology, recently American Hypertension Society, that would weigh on this category of people. If you have peripheral vascular disease, you have more than ten percent risk over ten years.

And so the guidelines for blood pressure control would be more 130 over 80 for

this specific population which has targeted risk factors and sounds like that could be updated as time goes by or how we deal with changes and consensus guidelines as time goes by.

And then the only last comment to this would obviously be, what somebody else alluded to, is obviously this has some patient compliance piece to it as far as, you know, cigarette cessation and cholesterol control and obviously blood pressure control.

So some concept of how that goes about being played out down the line, but certainly I think this is a conceptual place we want to get to.

DR. BERNOT: Beth.

MEMBER AVERBECK: I guess I'll just make a couple of comments. Variations on these measures have been in the public domain and reported for at least over ten years in Minnesota. And we're one of the few states where cardiovascular disease is the number two cause of death and not the first --- not the leading cause

of death for a number of reasons, but I do think that this metric has influenced that.

The group --- the measure developers do get together when the guidelines change and will update. We did that for the A1c and the optimal diabetes. We'll do it for the blood pressure on this one as well.

And then it has been risk adjusted. It's also been reported for patients that are on public programs as part of an equity report.

And also for communities of color, it's part of a disparities report. So it has that ability to segment the measure by populations.

And since we've been using it over time, we are able to take a look at are we reaching a ceiling affect at some point?

And the goal is never a hundred percent on this and so I think those are just some comments around the use of these measures, but I think, Bruce, your comment earlier really does get into the system of care because not one

individual can probably do everything for every patient every time. So it does support that idea of team basis and base care.

CO-CHAIR MOYER: All right. Any additional discussion on this?

(Pause.)

CO-CHAIR MOYER: Okay. We can start to move forward with the voting. So I want to clarify that optimal vascular care, did you have a motion to move that to ---

MEMBER AVERBECK: To support.

CO-CHAIR MOYER: To support. Okay. So that's what we will be voting on first is optimal vascular care, support for rulemaking, full support since CMS has indicated they already plan to address the things that were listed as conditions.

DR. GREEN: Just to be sure, that was the blood pressure that we were ---

CO-CHAIR MOYER: It was the competing measure.

DR. GREEN: Oh, the competing measure

and the blood pressure. Gotcha. Sorry. Thank you.

MS. JUNG: Okay. Voting for MUC17-194 is now open. Option 1 is yes. Please raise your hand if you'd like to indicate yes.

(Show of hands.)

MS. JUNG: You can lower your hand. Thank you. Any votes for no?

(Show of hands.)

MS. DUDHWALA: If I can just have the remote people send in their votes? Michael, I just got yours. And, Leslie, I just got yours. Thank you.

MS. JUNG: Okay. We have 21 votes for yes and zero votes for no for MUC17-194.

CO-CHAIR MOYER: One last chance for any additional discussion on the use of aspirin or anti-platelet medication.

DR. GREEN: I feel like you, Stephanie, except I wouldn't have turned down the -- I'm kidding.

So, I just want to remind folks again

this measure is important to us, meaning CMS, in as much as it is a Million Hearts measure.

So it is important for us to be reportable individually, I guess is what I'm trying to say. Thank you.

CO-CHAIR MOYER: Okay. And for clarification, it sounded like this was discussion only.

MEMBER GLIER: Yes. I had originally planned to move to go to do not support, but I changed my mind.

CO-CHAIR MOYER: Okay.

MEMBER GLIER: So stick with conditional support.

CO-CHAIR MOYER: So first we'll be voting on this for the Medicare Shared Savings program.

And the vote that we'll be taking is conditional support for rulemaking. That's what was originally on the consent calendar in the absence of another motion.

And that conditional support is that

there will not be duplicate or competing measures in the program.

MS. JUNG: Okay. Voting for MUC17-234 for MSSP is now open. Option 1 is yes. Please raise your hand to indicate a yes.

(Show of hands.)

MS. JUNG: Please raise your hand to indicate option 2, no.

(Show of hands.)

MS. JUNG: Okay. For MUC17-234 for MSSP, we have 21 votes for yes and zero votes for no.

CO-CHAIR MOYER: All right. We will now consider the same measure, same recommendation, conditional support, with the same condition that there not be competing measures.

This time it is for the merit-based incentive payment system.

MS. JUNG: Again, MUC17-234 for the MIPS program. Option 1, yes. Please raise your hand if you would like to indicate a yes vote.

(Show of hands.)

MS. JUNG: Please raise your hand for option 2 if you would like to indicate a no vote.

(Show of hands.)

MS. JUNG: We have 21 yes votes and zero no votes for MUC17-234 for the MIPS program.

CO-CHAIR MOYER: All right. Moving on to the next area of the consent calendar, this is diabetes measure under consideration. I suspect this will be similar discussion. They're somewhat similar measures. And I will send it over to John for introduction.

DR. BERNOT: Thanks. So for this section, again, there's two measures. The first one is optimal diabetes care. That is MUC17-181. That will be voted on for both MIPS and MSSP.

The preliminary analysis was conditional support with the condition that there are not duplicate or competing measures in the program. That is the same recommendation for both.

The second measure is diabetes A1c

control. That is MUC17-215. Again, also MIPS and MSSP.

The preliminary analysis for that was also conditional support, condition that there are not duplicate or competing measures in the program.

I will see, Dan, is there anything further? It sounds like you've addressed a lot, but I'll pass it to you.

DR. GREEN: Thank you, John.

So just want to take a second real quick about the optimal diabetes care. We have approved it recently as a QCDR measure as an aside and we also did ask Minnesota to self-nominate this one as well for the MUC MAP as we thought it was a very good measure.

There was -- optimal diabetes care was MIPS No. 319 that was previously in the web interface and -- well, at the time it wasn't MIPS. Obviously, it was in PQRS in the 2014, but it was removed because the components of that measure were also in the web interface. So

obviously it was duplicative reporting.

So there is one component in this and that is, of course, MIPS Measure No. 1, which is diabetes poor control, and basically looks at the percentage of patients with a hemoglobin A1c above nine.

So it's kind of an inverse measure, if you will, because it's looking at poor control instead of good control.

We do think that this NQF-endorsed outcome composite for comprehensive care of diabetes patients, so we do think it provides that.

We are -- the other measure that also is, I think, under consideration here is looking to change that diabetes poor control, kind of an inverse measure, into a diabetes good control with using the updated, more evidence-based guidelines of hemoglobin A1c less than eight.

So a little bit easier for folks to understand, but also more consistent, I believe, with the guidelines. And, again, of course we

would plan to retire any duplicative measure. In this case, it would be PQRS -- or, sorry, MIPS 1. Old habits die hard.

So I think that's it. Pierre, did you want to -- one more thing. The blood pressure would need to be updated as well.

CO-CHAIR MOYER: Okay. We'll open this for public comment, starting with any public comments in the room.

(Pause.)

CO-CHAIR MOYER: Okay. There are no public comments in the room. Operator, would you check for any public comments on the phone?

THE OPERATOR: Yes, ma'am. At this time if you would like to make a comment, please press star and the number one.

(Pause.)

THE OPERATOR: Okay. At this time there are no public comments.

CO-CHAIR MOYER: Okay. And in a recurring theme, these have both been pulled from the consent calendar from Stephanie. So, I'll

give her first comment.

MEMBER GLIER: I'd like to withdraw my pulls for both of these.

CO-CHAIR MOYER: Okay. So they are back on the consent calendar now unless someone else would like to pull them.

Reminder, they are all in the consent calendar for conditional support for rulemaking. And that conditional support has to do with competing measures.

Okay. Peter, go ahead.

MEMBER BRISS: Yes, I have a question about this one. I understood that for the last set of measures you wanted to keep a standalone measure that was a component of the other one because that was important for Million Hearts, but I don't understand in this one why we want both an A1c control -- a standalone A1c control measure when you're also talking about an optimal control measure.

So what's the -- so why aren't these duplicative measures and why do we want to have

both of these?

DR. GREEN: Great question, Peter. Wish you'd kept it to yourself -- no, I'm kidding.

(Laughter.)

MEMBER BRISS: That was a federal team foul.

DR. GREEN: We'll take care of him afterward. I'm kidding. So, no, seriously, that is a great question.

We do think that there may be an opportunity for different types of eligible clinicians to report this measure.

For example, while we would argue that endocrinologists would have ultimate responsibility for patient care as it relates to diabetes, you know, this measure does contain, for example, a smoking component, meaning the composite measure contains a smoking component.

So failure of one of the elements could cause the clinician to fail the whole measure for that particular patient.

And I think it's a reasonable argument. We could say, well, again, if they're taking care of their diabetes, they should absolutely be counseling the patient. And you and I would probably totally agree because some closet-smoking crazy person in terms of counseling, but the reality is some people may not report on the composite because of the -- it's a little bit more onerous.

And we don't want to -- just because some people may not choose to report the composite, we don't want to have diabetes completely ignored. As you know, it's a major health problem.

So if I had to choose between somebody picking, you know, good control for the hemoglobin A1c or not doing anything as it relates to the diabetes, obviously you and I both would agree about that, too. We would prefer the hemoglobin A1c and have them work toward the others.

CO-CHAIR MOYER: Okay. I do want to

clarify I have had a point of order. Apparently once something is taken off the consent calendar, it's not on the consent calendar, but we can still vote on them. We just need to vote on each thing separately. So we can alternate arms so we don't get lopsided.

I do want to give an opportunity for the lead discussants to talk about the measures and I'll kick it over to Amy.

MEMBER NGUYEN: So I wanted to -- so I definitely agree about updating regarding the ACC and AHA guidelines. And I wanted to just bring attention in terms of the optimal diabetes care, the 181.

Was there a performance calculation done in Minnesota for that one?

(Off microphone comment.)

MEMBER NGUYEN: Yes. Okay. And then for -- is it -- what is it? 215? I think you had talked -- you brought it up in terms of the poor control and the good control and in the ACO measure.

So for the sake of being parsimonious in alignment, we've got these ACO measures that are looking at the poor control, but then now if we have this for the good control, I'm just again looking at the burdensome nature for the provider. So I just wanted to bring those two points up.

CO-CHAIR MOYER: Pierre, did you want to address that?

MEMBER YONG: Yes. And thanks, Amy, on this last point about what's in SSP versus in MIPS.

We have purposely aligned what's been -- what's in SSP, the measure set, with what's in the MIPS web interface.

We also have our SSP colleagues on the phone, but I think the intention is to continue with that alignment.

So, Rabia or Sarah, is there anything you want to say about this?

MS. KHAN: No. This is Rabia. Just to echo what you just said. So the purpose of us

including this measure was to maintain alignment with MIPS for web interface reporting.

And I do understand we do have, like, a diabetes measure within our current measure set, but this would be considered for possibly replacing the existing measure.

MEMBER YONG: And I would note that -- and I think folks made this clear -- but both of these measures are on for both MIPS and SSP. So when you vote, you'll have four votes, I think.

CO-CHAIR MOYER: Okay. Dale, do you have anything to add?

MEMBER GLIER: I think these are excellent measures and should move forward with all of them. Experience in Minnesota has demonstrated that they're very useful.

CO-CHAIR MOYER: Girma.

MEMBER ALEMU: Yeah. In the optimal diabetes care measure analysis, as I see it, there is exclusion of smokers. Does it apply only to nonsmokers in the composite?

If I have read it correctly, that's

what it says.

MEMBER GLIER: No, it's not an exclusion. It's one of the -- it's one of the component measures of whether --

MEMBER ALEMU: Yes. It says it's for -- just applies to nonsmokers.

CO-CHAIR MOYER: So potentially better addressed by someone else. But since I'm familiar with the measure because this is in our P4P, you don't have to be a nonsmoker to be included in the denominator. You have to be a nonsmoker to be credited into -- to earn credit for the measure.

So a smoking patient would not be considered to meet all of the conditions for the composite.

MEMBER ALEMU: Yes. What I want to point out is that there is also smoking cessation measure. I don't know whether it has been clarified earlier.

So why don't we include the smoking cessation measure in the composite? Smoking

being one of the main factors which we wanted to look into. So I just -- I would like to have clarification about that.

MEMBER AVERBECK: I think, going back to the rationale for having smoking in the optimal measures is it's an outcome. Either you smoke or you don't smoke just because it's of significance in cardiovascular disease.

So it's a risk factor that if we can influence it -- I think there's studies done that, you know, clinicians can influence smoking rates to some extent for patients quitting that we wanted it to be an outcome measure, not just a if you smoke, we recommended that you quit, because that's more of a process measure. So that was the rationale for that.

So the smoking cessation counseling is not a component. It's just a yes or no if you smoke or if you don't smoke.

CO-CHAIR MOYER: Any other discussion on the measures?

(Pause.)

CO-CHAIR MOYER: Okay. So seeing no cards go up, we'll start through -- there will be four votes. There are two votes on each measure.

The first one is for the Medicare Shared Savings Program on optimal diabetes care. And this will be a vote for conditional support for rulemaking. And the condition is the removal of competing measures.

MS. JUNG: Okay. Voting for MUC17-181 for MSSP is now open. Option 1 is yes. Please raise your hands if you would like to indicate a yes.

(Show of hands.)

MS. JUNG: Okay. Option 2 is no. Please raise your hand if you'd like to indicate a no.

(Show of hands.)

MS. JUNG: Okay. Our total vote count now is 20. So for this measure, MUC17-181 for MSSP, the final vote count is 20 yeses and zero noes.

CO-CHAIR MOYER: All right. The next

vote is for the merit-based incentive payment system. And this is also for optimal diabetes care.

Again, that's a conditional support for rulemaking with a condition of removal of competing measures.

MS. JUNG: Okay. Voting for MUC17-181 for the MIPS program is now open. Option 1 is yes. Please raise your hand if you'd like to indicate a yes.

(Show of hands.)

MS. JUNG: Okay. Please raise your hand if you'd like to indicate a no.

(Show of hands.)

MS. JUNG: The final vote for MUC 181 for the MIPS program is 20 votes yes, zero votes no.

CO-CHAIR MOYER: Okay.

DR. GREEN: I'll be quick, Amy. One more thing I just want to say real quick to give Peter some comfort regarding this measure as an individual measure.

You know, this measure was the first measure actually in PQRS. It was PQRS 1 and carried forward in to MIPS, which it's not a nostalgia thing here, but there are folks -- it is a frequently-reported measure and people have bene using this measure year over year to actually look to see their quality improvement.

So that would be another thing I'd ask you to consider. Thank you.

CO-CHAIR MOYER: Okay. The next vote will be diabetes A1c control. This is for the Medicare Shared Savings Program.

The recommendation is for conditional support for rulemaking and the condition is the removal of competing measures.

MS. JUNG: Voting for MUC17-215 is now open. Option 1 is yes. Please raise your hand if you'd like to indicate a yes.

(Show of hands.)

MS. JUNG: Option 2 is no. Please raise your hand if you'd like to indicate a no.

(Show of hands.)

MS. JUNG: The final count for MUC 215 for MSSP is 20 votes yes, zero votes no.

CO-CHAIR MOYER: All right. The last measure, everyone. This is diabetes A1c control for the merit-based incentive payment system.

The recommendation is conditional support for rulemaking. And the condition is the removal of competing measures.

MS. JUNG: Voting for MUC17-215 for the MIPS program is now open. Option 1 is yes. Please raise your hand if you would like to indicate yes.

(Show of hands.)

MS. JUNG: Option 2 is no. Please raise your hand if you'd like to indicate no.

(Show of hands.)

MS. JUNG: The final vote for MUC17-215 for the MIPS program is 20 votes yes, zero votes no.

CO-CHAIR MOYER: All right. Next up on the agenda is -- I'll hand it over to Pierre. He's going to present input on measures for

removal criteria.

MEMBER YONG: So congratulations on making it through the MUC list. So thank you very much.

So we thought we would take advantage of the in-person meeting. So this is being done across all the workgroups.

We mentioned earlier in our opening comments that we are taking the meaningful measures framework and not only applying it to the MUC list and thinking about that, but also thinking about the current existing measure sets within the programs.

So I thought this would be a nice opportunity to solicit your input about the criteria and the factors we should be thinking about when we are going through that process across all of our programs. So it's not just the MIPS program and MSSP, but also all the hospital programs, the ESRD QIP program, you know, the post-acute care programs, all the programs that we work on.

So if you go to the next slide, this is the basic question we'd love some feedback on. And so I assume it will be a very robust discussion, but what criteria should CMS consider as it reviews the measure sets for our quality reporting and value-based purchasing programs.

And I will say that we'll appreciate any feedback we get about this, and certainly any process in terms of removal of measures and proposal of measures would go through our normal rulemaking process for notice and comment rulemaking.

What we did was pull together, if you go to the next slide, some draft criteria. And so certainly, appreciate any reaction to this if anything is missing. If you think there's something that's really important for us to think about, feel free to flag any of that.

So the first is the measure should be meaningful to patients and providers. We obviously want to keep patient-centered, high-priority quality measures that are aligned with

not just clinical guidelines as we've been talking about today, but also with the meaningful measure areas that we've discussed earlier.

Sometimes with particular programs there are specific statutory requirements about measures that we do need to include in programs as such so we want to continue meeting the -- our statutory requirements.

In terms of measure type, that's another factor that we really think about. So, have really tried to move towards outcome measures and so have preference for outcome measures.

Oftentimes there are not outcome measures available yet. So in those cases, certainly we would use process measures as long as they're closely tied to the outcome of interest.

Something we want to see given that these are often programs that are not just quality-reporting programs, but accountability programs where payment is actually determined or

influenced by the performance of these programs, do believe that there should be some variation in performance of these measures so that there is some meaningful distinction between providers as they're getting paid based on the performance on the measures.

Burden is something we've talked about. So considering the amount of burden associated with the measure.

And realize that there's no measure that's really no burden, as somebody pointed out earlier, forget who it was. Even with claims-based measures there's a lot of investment in terms of reviewing the claims, making sure they're accurate and then reviewing feedback reports, but we do want to try to minimize the burden associated with the use of the measures.

If you go to the next slide, unintended consequences. This was another topic of discussion on some of the measures today, but certainly we do want to think about any unintended consequences from use of the measure.

Operational issues, so sometimes there are operational issues that may impact the measure.

We had a discussion about this with some of the measures earlier about sort of EHR feasibility.

So those are some of the things that we think about when it comes to keeping measures, as those sometimes arise after we -- after we learn about them after it's implemented into the program.

And finally, alignment. So alignment with -- and sort of measures with private pairs across and within CMS programs to minimize duplication of measures.

Again, this is again similar to conversation we just had about de-duplication of measures. So we may want to call that out separately, but really appreciate any feedback that you have about any of these criteria.

So I'll turn this back over to Amy and Bruce.

CO-CHAIR MOYER: All right. Well, it looks like we have -- Peter would -- has some feedback for you.

MEMBER BRISS: I'll try not to get another federal family foul. So can you go back one slide, please? Can you guys go back one slide, please? It is that point in the afternoon.

And so an important thing that I think isn't reflected here is the -- is sort of the preventable burden of the -- the service or the condition, right?

So basically potential public health benefit of the measure is something that I don't think is -- it might be rolled up into meaningfulness, but it's probably important enough to call it out on its own and I'm a little afraid that everybody's preference for outcome measures is getting overdone.

And so I actually think that you might want to loosen that one up a little bit, either outcome measures or composite measures or process

measures that are closely related to outcome might be better.

Some things are -- some things are -- a lot of things the outcomes are relatively rare or far in the future and I wouldn't -- and nonetheless some of them are -- some things are important to do. And so, there's two things.

And then I do want to call out composite measures. I'd like to see us move in a world where we're trying to be more parsimonious and I'm not sure that the two examples that we just looked at are the right ones.

I'm not voting on a particular measure here, but I would like to see us roll up more of our individual, one-thing-at-a-time measures into important composites.

And I think that the Minnesota Community Measure composites that we just looked at are really nice examples of picking the four or five most important things for a condition and rolling them into one measure.

CO-CHAIR MOYER: Stephanie.

MEMBER GLIER: I agree with almost everything Peter just said. Thanks.

I think one of the reasons that I -- that we -- my organization has had some concerns about process measures, even those that are sort of closely tied to outcomes, is that the closely tied to outcomes gets a little tenuous.

And particularly when we're looking at a program like MIPS where it's a minimum number, you choose which measures we're concerned about, process measures that are not as high value as the outcome measures, particularly something like a composite measure or patient-reported outcome displacing --- so we're worried about process measures displacing the higher value measures.

So if we had --- I mean, this is never going to happen, but if we had mandatory reporting in the clinician programs or if we had mandatory sets that did have higher value measures, I think we'd be much more open to including more process measures that are tied to outcomes in there.

But unless that is true, from our point of view, it's much more important to have truly outcome measures or a composite measure or another measure type that looks at a bigger slice of what a patient's experience of their health is, whether that's their experience of their interactions with the healthcare system, or their functional status, or their quality of life, or the preventable disease that they did not experience because they got the care that they needed upstream.

So I think that you guys do have most of those things captured in here, but wanted to sort of put a little texture on it from the purchaser perspective, at least.

CO-CHAIR MOYER: And I would add to that, that in an outcome process I think what we really try to look at when we put a program together is how do we make sure they're achieving what it is we want them to achieve, however that is.

And sometimes that, you know, is kind

of the outcome composite, the optimal care measures are great for that.

You don't just achieve that. You have to make a change in how you, you know, take care of patients and how you approach it. It has to be systemic versus, okay, we're checking some things off.

And so things like that where, you know, it's really changing care and moving it in the direction we want to see it I think is, you know, high value for a purchaser perspective and patient, but I would also hope at the end a high value for providers.

I'm sure it's painful to get there, but I would hope at the end it's a better place than where you left if, you know, if the measure really had the intended consequence.

And I think Eric was next.

MEMBER WHITACRE: I'd like to speak a little bit to the variation in performance. And this is me speaking as a surgeon, not representing the American College of Surgeons. I

don't know their point of view on this.

There are certain things we do in surgery that are critical to quality maintenance. And the analogy I would make is people love doing this with pilots.

The single-engine land license, if you've ever flown a Cessna 150 at 5,000 feet and the door starts to go thwacka-thwacka-thwacka and you look over at the instructor and he goes, oh, it does that, you feel really good that you've done something called the pre-flight checklist.

And it's something that's a religion. And what you do, you go around, you kick the tires, you check the gas, you look at the pitot tube, you check the windshield.

That doesn't improve my skill or the flight, but it makes it safe. And we have some things like that in surgery.

And I'm concerned that if those are removed from the measures list, it may, because we all have limited time and resources and focus and energy, I'm afraid it may take away from some

of the things that are critically important.

So I can imagine when I get on my American flight to go back home, I'm going to really be glad if the team, because it's a team sport, did the pre-flight checklist, whatever they all had to do.

And while they may have their quality or performance measures of looking at CO2 reductions based on headwind and this and that and whatever, I really want them to have done that.

And we have some things like that in surgery where the variation of performance, granted, is still very, very small, but even that 0.1 percent will mean some inappropriate or wrong-site surgeries and I wouldn't want those numbers ever to increase.

So I'd like certain measures to be considered critical for quality maintenance as absolutely fundamental.

And we have some of those in surgery and it's pretty simple, you know. It's the time

out. It's, you know, the right patient. It's the appropriate surgery and so forth.

And, again, given limited time, effort, energy, I think something needs to be said for measures that are essential to quality maintenance. Thank you.

CO-CHAIR MOYER: Harold, I think you were next and then Helen.

DR. PINCUS: So I completely agree with Peter and also what Stephanie said about not being so overbalanced towards future, sort of, outcome measures.

You need to have a balanced portfolio and especially with regard to process measures that are proximal to outcomes because I think that's a key issue.

One thing, and I don't have an answer for this, but there are measures out there that have not improved.

And to take a hard look at the measures that have not improved, which is not necessarily to say that there's, you know, to get

rid of them, but to try to understand why they haven't improved and to try to think about what might be sort of the underlying problem there.

Is it something where there's, you know, the measures are simply not capturing the kind of information you want? Is there a way to look at, you know, variation within that measure to try to understand that there may be some things that are going on, on high-performing -- on the high-performing sites that are -- where they found some secret sauce or maybe it's, you know, it's a problem of artifact that's embedded in the measures, but I think that those are -- I would say is priority areas for considering whether they should be removed or replaced.

CO-CHAIR MOYER: Helen and then Stephanie and then Amy.

MEMBER BURSTIN: Great. Thank you. This is really very useful, Pierre. Thanks for sharing.

I think the one comment I would make is I think many of these sometimes can kind of be

in conflict with one another. And so I think it's important to have a balanced perspective on this.

Some of the most meaningful measures, for example, may have a pretty significant burden attached to them. Like patient-reported outcomes, I don't want us to get so absolute in this that high-burden measures that are high value don't, you know, potentially get removed.

That being said, I think, you know, there are also opportunities to think about potentially removing measures that are claims-based that are not highly reliable and replacing them with potentially slightly higher burden measures from EHRs or from clinical registries to get at a better measure.

So the burden one in particular while I agree with it, I think it's important to think about when there may be unintended consequences for pushing too hard on burden and then not bringing forward the measures that matter with the best possible data source.

MEMBER GLIER: Eric, I just wanted to respond to you a little bit. From my point of view as a patient, as a purchaser, clinical guidelines are important and I want our measures to be aligned with clinical guidelines, but I want clinical guidelines to be a floor.

I want to be able to go to any clinician, I want to be able to go to any facility and assume that they are following best practices established by their clinical area.

I don't think we should be using our payment programs, our reporting programs, to ensure that people are meeting the minimum floor.

I think if we see things like wrong-site surgeries, that's a problem where we need to be able to address that. And I think that's a huge burden on patients, right, a wrong-site surgery, major life impact.

But whether you did your hand-washing protocol or whether you did your timeout at exactly the right moment has a little less to do with my patient outcome and how your hospital or

how your team chooses to approach the outcomes that I do care about, I think I would rather leave that up to you and not have a measure looking at did you do -- did you have a hand-washing protocol, did you have a checklist that you followed.

So I think my preference as a patient and purchaser would be to move away from the baseline clinical guidelines and ask about the outcomes that we really care about and the outputs of the healthcare system overall, acknowledging that there are processes that are going to lead up to those, so, you know, do we have an outcome measure with processes that do roll up and we use the process measures as quality improvement, sure, but I want us to be focusing on CMS programs on those bigger things that we care about, which I hope is consistent with the meaningful measures framework.

CO-CHAIR MOYER: Amy.

MEMBER NGUYEN: I just wanted to add in terms of alignment, I think we've all been

talking about it.

I just wanted to clarify and reiterate that we should add the parsimonious and harmonization of the measures along with alignment because I think it's -- it goes in everything that we're talking about in terms of balance and being very true to the providers, the patients, the purchasers to have a congruence of measures that really align with all payment and delivery reform.

CO-CHAIR MOYER: Bruce.

CO-CHAIR BAGLEY: Yes. Just to weigh in on a couple of things, one is the airline analysis.

I mean, I don't think that the American Airlines measures the degree of compliance with pre-flight checklists.

Now, I suspect that when they go for a check ride and things like that -- but I suspect that's not a number they're keeping. They expect that to happen. That's a standard of care and sort of, to your point, what's the

floor.

So I think just because we've reached, you know, a high percentage doesn't mean it's no longer important.

So you both make a good point, but we should be pushing for higher -- the other thing, and you're probably going to get tired of hearing me say this, but we keep saying we're patient centered and we're in a bind in that all of these measures are designed to allow providers and clinicians to participate in CMS payment and quality programs in the sense that can we have a push -- and I think we're actually making some progress -- towards patient, you know, patient-oriented outcome measures, really is the -- and may not -- who does it and who's got a measure that fits their specialty and all that kind of stuff.

We really need to kind of get to someplace where it's really about the best -- optimal, I guess, is the best word -- optimal patient care in certain situations.

So I don't have an answer for that, but we're still kind of stuck a little bit because everything we've done up to this point is to allow clinicians to participate in CMS programs, really, you know.

And I have to go back a little bit. Back when the Physician Consortium for Performance Improvement was first formed, and I can't remember the exact date, but 2010 or '11, anyway, a while back, long time ago, and the people around the table were all the quality people.

And then about three years after it started up, PQRS came in and all of a sudden the people around the table were the advocacy people, you know, how do I protect my group from harm or over-measurement or unfair measurement.

And I think we kind of got pretty far down that line to the point where we've got a lot of measures that really are not driving quality improvement.

I love the discussion about composite

measures and systematic care and things that really are going to drive quality improvement.

So I know that's a big thing to take on and certainly probably not in the realm of this committee, but have the opportunity to say that to CMS representatives to have things that drive quality improvement, not just allow participation.

CO-CHAIR MOYER: Peter.

MEMBER BRISS: Yeah. One more thing. So I hate to follow Bruce with this comment, but the one thing from CMS' point of view, you are going to have to continue to have a critical mass of measures that speak to different kinds of provider groups, right, you know?

And so there's nothing -- maybe it's implicit under meaningfulness here, but you're going to have to do it and so you might as well make it explicit.

And maybe one way to meet that need and be respectful to what Bruce just said is if we characterize that as not having a critical

mass of measures that endocrinologists can participate in, but instead you characterize that as what are the -- we want to make sure that we either have a good quality composite or the top five individual measures that meet the needs --- that most meet the needs of a person with diabetes or a person with thyroid disease or something like that.

Then the relevant providers for those kind of people would have something useful to do and we could be patient-centered at the same time, perhaps, but you're going to need to allow providers to have something relevant to play.

CO-CHAIR MOYER: All right. Any other advice or suggestions for CMS on the measure removal criteria?

I think we talked a lot about measure-adding criteria in some ways, but --

CO-CHAIR BAGLEY: Thank you. Anything else you need to know?

MEMBER YONG: No. I think we've covered it. Thanks.

CO-CHAIR MOYER: Go ahead, Ann.

MEMBER GREINER: To build on what Peter just said, I mean, we know that not all specialists have a collection of measures that are appropriate for their specialty, but primary care has a lot of measures, maybe not always the optimal measures.

So to the degree that CMS can be removing some of the duplicative or lower-value primary care measures and helping to support the development of better measures for primary care, that would be great.

CO-CHAIR MOYER: All right. I think that finishes up that topic for today. We will have one last opportunity for public comment on, I guess, anything we've discussed today.

If there's anyone in the room who has a public comment, now would be your chance.

(Pause.)

CO-CHAIR MOYER: And, operator, will you check for any public comment on the lines?

THE OPERATOR: Okay. At this time if

you would like to make a comment, please press star and the number one.

(Pause.)

THE OPERATOR: Thank you. We have a comment from Koryn Rubin.

MS. RUBIN: Yes. Hi. This is Koryn Rubin from the AMA. Sorry I couldn't be there in person today. I'm suffering from a respiratory infection and getting over a fever.

And so I know my colleagues have kind of filled in, in my place today, but I just wanted to add a few more things to the discussion. Some of them have been said.

The AMA has put in a lot of thought in terms of what needs to be considered for ---

(Telephonic interference.)

MS. RUBIN: --- first and foremost it needs to be considered in the context of the specific program.

The implications for a hospital program are different than a physician program due to the diversity among clinical practice,

specialty and subspecialty.

And when you have a congressional mandate that others have said that all physicians must comply with the program and then in the program, CMS requires a certain number of measures and the type of measure that a physician needs to be -- to report in order to be considered successful, you need to have a large suite of measures to meet every specialty and subspecialty.

In general, the AMA does support the removal of measures when clinical evidence has changed regardless of the program.

We are, however, concerned with the standards CMS has put in place for removal of measures within MIPS to date and the potential future gap that will be created by solely relying on benchmark data without consideration of clinical factors, scientific evidence and the importance of a measure.

There also needs to be more research to determine the appropriate sample size for each

quality measure before a quality measure can be determined to be topped out and removed from a program.

Many measures have a reporting sample size that represents less than one percent of eligible clinicians who are eligible to report on the measure.

And we also have the following recommendations to improve the MIPS process when it comes to removal of measures.

Process measures that are proximal to an outcome and for which there's strong evidence that fulfillment of the measure intent such as providing or not providing a specific treatment, will improve patient outcomes should be retained, the unintended consequences of removing key topped out measures are unknown.

Also, better analysis needs to be performed. Physician performance can vary by practice setting, patient population, geography, years in practice, volume of cases of particular condition, or how long the physician has been

reporting.

So there's a need to examine the breadth and depth of reporting based on the number of physicians who successfully report on a measure.

There's also a need to examine reporting based on the number of physicians who successfully report on the measure and the length of time the measure is reported on within a given performance year.

Also with performance results, some evaluation for performance results of a measure that can be considered for removal should be examined for any evidence of variation among subgroups defined by factors mentioned above and other nonclinical factors.

Also, with reporting options, CMS will remove a measure when it appears topped out in one category, but not another.

Really, it should only be considered topped out and removed once it hits that threshold against all reporting options.

Also, one potential way to see if the numbers are reflecting true performance is to compare it to other current data.

For example, if a study or clinical registry shows that there's still a gap in care, the performance scores in MIPS may not reflect performance across all physicians. And the results of these subgroups' analyses should also be shared with the relevant stakeholders.

We also recommend keeping measures that track performance on major public health issues such as tobacco use and counseling/screening for alcohol use, pre-diabetes, hypertension, opioid use, immunizations and hepatitis C.

Also, you also have to consider measures, how they're used in other programs. For example, there are many health plan-level measures that are part of the Medicare Advantage Star Rating System that are reliant on clinical action.

To ensure compliance, the private

plans incorporate them into physician contracts. So for purposes of alignment, CMS or the MAP should evaluate how physicians' measures may relate to other quality programs.

Therefore, CMS should consider alignment across other programs when deciding whether to remove or retain measures in MIPS.

Thank you for considering my feedback and hopefully you can incorporate it into the discussion today.

CO-CHAIR MOYER: Thank you, Koryn.

Is there any other public comment online?

THE OPERATOR: No, ma'am. There are no other public comments.

CO-CHAIR MOYER: All right. Well, this feels like a very successful day, everyone. We considered, I guess, 22 measures total because they're across both programs. So 22 for MIPS. Two of those were support, 18 were conditional support, and two were refine and resubmit. Then for MSSP there were three measures, all of which

were conditional support.

And I appreciate everyone for your time and your contributions. And the thought that had gone into your approaching this meeting makes everything go well. Thank you.

Bruce.

CO-CHAIR BAGLEY: Thanks, Amy. I'd like to add my thanks to everyone, but particularly I'd like to thank the staff and for a couple of reasons.

First of all, the discussion guide, that must take a huge amount of work and it makes our work doable.

(Applause.)

CO-CHAIR BAGLEY: And I just want to add that a lot of this work has been done in a pretty short time line and often over the Thanksgiving holiday week or weekends or time outside of usual work hours. Let's put it that way. So we appreciate that.

I think we had a great discussion this morning about a whole new type of measure in

terms of the cost of care resource use measures. And to my knowledge, there's been a lot of stuff talked about in the past, but this is a concrete step forward that's being pushed by CMS that really could have some real traction in other than a local market.

So I think this is really a monumental day and, you know, a tribute to all the work that you did to get this ready.

The fact that it kind of came out the way it went in, in the sense that we didn't really recommend to change much was a testament to the amount of work that you did to get it prepared, Pierre. So to you and your teams, thank you for that.

MEMBER YONG: So I just want to take the opportunity, also, from CMS' behalf to thank all of you for the hard work you put in today. I think it was an incredibly successful day.

And by my count, you know, I think about 11 measures, which was astounding to me, actually, were completely, universally had a

hundred percent agreement across the MAP which is -- I have not seen in the four years I've been doing this. So, that was pretty amazing to me.

And I think, hopefully, that reflects a couple of things. I think, you know, looking at this and it started with the conversation about the role of refine and resubmit and, you know, I would note that only one of the measures actually, I think, got refine and resubmit and the others were in the other categories.

I think, one, appreciate, I think, the conversation that you had at the beginning and sort of everybody's flexibility in terms of thinking through how to use that in the most appropriate way. I think from our standpoint, we found that very helpful.

And, two, hopefully this does reflect how we've sort of really taken a look at how we approach the MUC list and sort of the kinds of measures we put on the MUC list. So hopefully that actually contributed, too, but I do want to thank, in particular, Bruce and Amy for their

efforts and sort of co-facilitating today, the NQF staff, Hiral, John as well as others, and Madison as well as other staff on NQF.

And I also want to particularly thank all the CMS staff who many of you have seen at the table today, but many of whom you may even be familiar with because you may have talked to on the phone, but weren't at the table. But I just want to name them, but -- so there's Dan Green, Sophia Sugumar, Jennifer Harris, Susan Arday, Reena Duseja, Ted Long and Michelle Jaffe. Thank you to all of them for making today a success. Thank you.

(Applause.)

MEMBER YONG: Okay. And just thank you all for your time and for showing up here today and spending your day with us and your thoughtful deliberation.

I know you have to talk about the next meeting. As you're packing up, Madison is going to talk about the timeline and next meetings.

MS. JUNG: Sorry to break up the

celebration party. In terms of next steps, I'll be brief.

I'm sure a lot of you are familiar with this --- the pre-rulemaking timeline. In terms of immediate next steps in these following days the rest of the week, we have the PAC/LTC group here tomorrow, the Hospital group here the following day, and then following the summary and compilation of our comments and your thoughtful recommendations, the MAP --- we'll bring that to the MAP Coordinating Committee. And they'll have their in-person meeting January 25th and 26th.

The immediate next public comment for this will be December 21st to January 11th. For contact information you can please --- you can find that on our project page. In addition too, workgroup members, you can look at the SharePoint page.

As always, if you have any questions or lingering thoughts, please reach out. Our email is mapclinician@qualityforum.org.

And then finally, just a big thank you

from the NQF staff for making all the long travels here. It's very much appreciated especially during this busy season.

A big thanks to Bruce and Amy for your leadership. And that's it. Thank you for coming.

(Applause.)

(Whereupon, the above-entitled matter went off the record at 3:25 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership Clinicians Workgroup Meeting

Before: NQF

Date: 12-12-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter