

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

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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.

1 CO-CHAIR BAGLEY: Thanks, John.

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

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

17 Amy, do you have some comments?

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

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

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

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

8 MEMBER HASSETT: Hi.

9 CO-CHAIR BAGLEY: Good. Thanks for
10 joining.

11 And is Leslie Zun here as well?

12 (No response.)

13 CO-CHAIR BAGLEY: Okay, maybe not yet.

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

1 who needs to see it.

2 And let's see. Is Harold Pincus here?

3 Oh, hi, I didn't see you before. Thank you.

4 From Medicaid liaison, MAP Medicaid liaison.

5 And is Leslie Kogan on the phone?

6 She's new. Okay. Well, anyway, we'll look
7 forward to hearing from you.

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

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

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

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

1 and the second is a subject matter expert.

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

5 And just wanted to give you a couple
6 of reminders that you had on your form when you
7 submitted that to us. Organizational members
8 represent the interests of a particular
9 organization. We expect you to come to this
10 table, enter into these discussions representing
11 those interests. Because of your status as an
12 organizational representative we ask you only one
13 question specific to you as an individual. We
14 ask you to disclose if you have any interest of
15 \$10,000 or more in any entity that's related to
16 the work in front of you.

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

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

3 MEMBER WHITACRE: Subject matter.

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

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

12 And I can't see your name tag.

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

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

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

21 MEMBER NGAMWAJASAT: Charlene
22 Ngamwajasat, the Primary Care Information

1 Project. No disclosures.

2 MEMBER JAGUN: You couldn't hear me?

3 Can you hear me?

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

5 MEMBER JAGUN: Sorry about that. Dayo

6 Jagun, Genentech. No financial disclosures.

7 MEMBER BOWMAN: Kevin Bowman, Anthem.

8 No financial disclosures.

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

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

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

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

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

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

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

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

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

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

17 (No response.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MS. MUNTHALI: Thank you very much.

22 And at this time we have a number of

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

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

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

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

17 MS. MUNTHALI: Great. Thank you.

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

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

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

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

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

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

21 (Laughter.)

22 MS. MUNTHALI: Well, thank you.

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

3 I don't have any.

4 MS. MUNTHALI: Thank you so much.

5 MEMBER KRUGHOFF: I guess that wasn't
6 clear.

7 MS. MUNTHALI: Thank you.

8 CO-CHAIR BAGLEY: Any other questions
9 of Elisa?

10 (No response.)

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

13 MS. MUNTHALI: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

22 And so, so I just am curious because

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

4 (Show of hands.)

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

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

14 But if you'd advance the slides.

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

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

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

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

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

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

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

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

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

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

17 So if you move to the next slide.

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

21 But if you can move to the next slide.

22 This, for folks who haven't seen it,

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

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

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

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

9 So if you move to the next slide.

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

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

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

1 the second one.

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

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

21 Move to the next slide.

22 The next grouping is about

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

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

6 And the third is patient experience
7 and functional outcomes.

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

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

18 Next slide, please.

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

1 see so many meaningful measurement areas here:

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

7 Move to the next slide. Thank you.

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

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

1 levers, policy levers available to address equity
2 of care.

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

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

15 If you move to the next slide.

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

21 So if you move to the next slide.

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

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

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

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

1 So that's one piece.

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

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

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

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

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

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

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

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

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

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

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

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

20 Anybody else have any questions?

21 MEMBER YONG: All just sick of hearing
22 me talk.

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

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

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

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

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

1 think, hopefully you'll see this represented.

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

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

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

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

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

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

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

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

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

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

1 that measure.

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

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

21 CO-CHAIR BAGLEY: Thanks, Ted.

22 Go ahead.

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

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

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

16 So one important point is that when we
17 have -- we have many different programs at CMS.
18 And the intention is not that every, all of the
19 18 Meaningful Measure areas should apply to every
20 single program. So you may have programs where
21 there is some Meaningful Measure that apply more,
22 just to use your example, in our Home Health

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

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

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

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

1 I guess three ways:

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

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

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

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

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

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

20 Peter, go ahead.

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

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

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

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

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

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

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

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

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

3 I hope that helps.

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

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

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

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

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

1 know, for thinking.

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

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

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

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

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

11 MEMBER SHALLER: I just have one.

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

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

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

1 capture that?

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

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

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

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

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

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

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

16 (Phone interruption.)

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

22 I hope that helps. Probably could be

1 clearer about that from this. I'm sorry.

2 MEMBER SHALLER: Thank you.

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

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

14 MS. DUDHWALA: Thank you, Bruce.

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

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

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

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

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

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

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

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

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

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

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

22 Your role really is to evaluate

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

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

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

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

22 So you'll see here highlighted the

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

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

9 Number three, the measure addresses a
10 quality challenge.

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

15 Five, the measure can be feasibly
16 reported.

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

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

1 of the measure have been identified.

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

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

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

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

22 And then I'm going to have Erin talk

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

5 MS. O'ROURKE: Sure. Thank you.

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

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

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

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

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

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

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

9 DR. PINCUS: Yes.

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

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

21 So the committee suggested that might
22 help guide that conversation.

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

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

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

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

1 and do not support.

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

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

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

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

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

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

14 DR. PINCUS: Right.

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

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

22 MEMBER FRIEDMAN: Yes. So I brought

1 this up on the conference call.

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

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

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

1 MEMBER BURSTIN: Thanks. Just a quick
2 question.

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

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

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

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

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

5 So it's more of an informational
6 update.

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

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

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

19 Stephanie, you're next.

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

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

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

14 No, we can't?

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

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

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

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

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

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

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

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

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

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

17 Just, do you understand what I'm
18 saying?

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

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

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

14 CO-CHAIR BAGLEY: You decided to pass?

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

17 MEMBER YONG: Sure. Thanks, Bruce.

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

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

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

22 And the final sort of comment I'll

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

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

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

1 conversation all over again around a specific
2 measure probably.

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

11 So, if it's okay --

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

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

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

1 the --

2 Oh, do you want to talk about voting?

3 MS. DUDHWALA: Yes.

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

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

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

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

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

1 denominator.

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

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

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

22 The in-person meeting discussion guide

1 will organize contents as follows:

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

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

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

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

22 Step two, the measures under

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

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

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

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

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

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

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

1 or suggested refinements.

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

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

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

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

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

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

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

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

21 Abstentions are discouraged but will
22 not count in the denominator.

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

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

8 MS. DUDHWALA: Erin, do you agree?

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

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

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

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

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

5 Option 1 is -- we'll just to option 1,
6 2, 3, or 4. The number should show up on your
7 clicker. If it does not, let us know and we'll
8 replace the clicker.

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

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

15 Okay, and how many votes should we
16 have?

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

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

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

1 have to do a count in the room?

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

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

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

15 So, now can we go on?

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

18 Let's see, I'll try mine.

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

22 MS. JUNG: So, we should have one more

1 vote.

2 CO-CHAIR BAGLEY: There's 20.

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

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

9 MS. JUNG: Yeah.

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

13 MS. JUNG: Okay.

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

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

22 And then what, so far I have not heard

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

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

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

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

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

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

13 MS. DUSEJA: Thank you, Bruce.

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

19 Want to introduce yourself?

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

22 MS. DUSEJA: And you guys have met Ted.

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

6 So, next slide, please.

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

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

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

4 Next slide, please.

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

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

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

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

19 And then the risk adjust episode
20 groups.

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

1 with quality.

2 Next.

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

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

21 I'll hand it over to Ted.

22 MR. LONG: Okay. All right. Thank you

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Next slide, please.

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

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

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

1 episodes to build, resulting in what you see
2 today.

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

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

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

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

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

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

1 countless, hundreds of hours into this.

2 Fourth component, risk adjustment.

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

9 Then finally, aligning with quality.

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

22 We gave all of that information, after

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

9 Next slide, please.

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

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

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

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

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

22 So we really wanted to by the time we

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

7 Next slide, please.

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

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

22 We have fully specified the measures.

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

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

21 So, next slide is just a Q&A.

22 So, happy to answer any questions.

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

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

7 Oh, Ann, you're first. Sorry.

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

13 MR. LONG: Thank you.

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

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

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

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

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

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

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

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

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

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

19 So, next up is Helen.

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

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

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

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

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

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

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

1 and explained in a different way.

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

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

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

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

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

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

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

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

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

22 MR. NAGAVARAPU: Yes. No, thanks for

1 the question.

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

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

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

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

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

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

22 There is another change that they made

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

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

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

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

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

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

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

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

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

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

1 Payment System for clinicians in that program.

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

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

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

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

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

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

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

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

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

1 providers.

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

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

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

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

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

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

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

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

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

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

11 MR. NAGAVARAPU: Yeah, thanks for the
12 question.

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

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

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

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

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

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

5 CO-CHAIR BAGLEY: Stephanie.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 further there's two issues.

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

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

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

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

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

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

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

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

18 That would be something we could talk
19 about moving forward.

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

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

5 Do you want to?

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

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

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

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

1 indicators and what's the correlation there?

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

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

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

1 that have come through.

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

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

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

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

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

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

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

8 CO-CHAIR BAGLEY: You're next.

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

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

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

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

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

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

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

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

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

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

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

1 the administrative piece of this.

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

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

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

1 it is the quickest way to get here.

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

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

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

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

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

1 decision making claims on the patient in the
2 initial hospitalization, at least 30 percent of
3 the claims. And you can well imagine 32 percent,
4 28 percent, so you know, we're going to need to
5 see how that plays out. But it was kind of the
6 coin of the realm going in, and there was not
7 great reason to say that that's not a good place
8 to start. But we need to recognize this is a
9 work in progress as to how this happens.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 collaboration as well?

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

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

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

12 MEMBER ZUN: I do not have any left.

13 MEMBER HASSETT: I do not.

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

22 So at this time is there anybody in

1 the room that would like to make a comment?

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

5 There you go.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 CO-CHAIR BAGLEY: Thank you.

12 Anyone else in the room?

13 (No response.)

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

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

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

21 MR. CONWAY: Hi. Can you hear me?

22 CO-CHAIR BAGLEY: We can. Go ahead,

1 please.

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

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

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

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

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

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

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

17 We looked at an alternative side of
18 case minimums for the measures, looking at 10,
19 20, 30, 40, 50. I think the measures sent to the
20 MAP focused on 20, 30, 40, just because those are
21 case minimums that are more in line with some
22 traditional CMS reporting. But, you know, we

1 could, we could provide additional information
2 there.

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

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

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

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

1 would, we expect would further increase that.

2 MR. CONWAY: Thanks.

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

7 To quickly summarize, yeah, the
8 reliability I believe for the calculations we
9 have were every measure at a case minimum of 20
10 for individual clinicians had a reliability of
11 .65 or higher. Most were higher than .7, almost
12 all, so.

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

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

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

21 Thank you.

22 (Whereupon, the above-entitled matter

1 went off the record at 10:49 a.m. and resumed at
2 11:04 a.m.)

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

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

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

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

1 similar.

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

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

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

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

1 technical question about the measure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (Off microphone comments.)

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

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

1 well as the other mechanisms we have for public
2 feedback.

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

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

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

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

22 MEMBER WHITACRE: So potentially, the

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

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

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

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

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

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

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

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

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

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

20 MS. DUSEJA: Yes.

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

1 vote? Yes, Peter, please.

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

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

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

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

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

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

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

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

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

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

1 363, or are you not. So it really is a yes or no
2 vote.

3 (Off microphone comments.)

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

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

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

1 you can vote no.

2 (Laughter.)

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

5 (Off microphone comments.)

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

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

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

15 MS. JUNG: It's 19.

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

18 MS. JUNG: Yes, that's correct.

19 CO-CHAIR BAGLEY: Okay.

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

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

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

8 CO-CHAIR BAGLEY: So that exceeds the
9 60 percent criteria. So those are approved as-
10 is. So we'll now open a conversation on 363,
11 MU17-363. And Scott, I'll have you take the
12 first volley, and then I would like to hear from
13 the lead discussants.

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

22 So in the 47 facilities that we serve

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

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

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

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

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

5 (Simultaneous speaking.)

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

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

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

20 CO-CHAIR BAGLEY: So do not support?

21 MEMBER FRIEDMAN: Do not support, yes.

22 CO-CHAIR BAGLEY: So the motion on the

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

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

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

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

22 And so that's one piece of evidence

1 that makes me feel comfortable about this type of
2 concern. So if you look, for instance, at the
3 90th percentile and the 99th percentile for this
4 particular measure, for urban areas the 90th
5 percentile of risk adjusted cost is \$30,688, for
6 rural areas it's \$30,627. So a difference of
7 about \$60 off a base of \$30,000.

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

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

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

1 actually having any impact on data.

2 And fortunately, we don't see that.

3 In the highest deciles, you see predictive ratios
4 where observed spending is actually slightly less
5 than predictive spending in the highest two
6 deciles of risk orders.

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

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

22 But fortunately, it looks like the

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

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

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

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

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

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

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

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

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

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

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

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

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

1 be potentially fruitful.

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

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

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

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

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

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

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

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

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

1 exact procedures that David just mentioned.

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

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

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

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

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

1 CO-CHAIR BAGLEY: Okay. Stephanie?

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

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

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

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

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

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

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

1 cohort as tightly defined as possible.

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

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

10 MR. NAGAVARAPU: That's right.

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

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

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

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

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

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

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

1 structural causes.

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

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

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

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

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

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

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

15 MS. JUNG: Okay. Voting for MUC17-
16 363, intracranial hemorrhage or a cerebral
17 infarction is now open. Option one, yes. Option
18 two, no.

19 CO-CHAIR BAGLEY: And you have the --

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

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

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

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

11 (Off microphone comments.)

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

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

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

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

1 CO-CHAIR BAGLEY: All those in favor

2 --

3 (Off microphone comments.)

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

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

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

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

1 this consent calendar?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 a minute to give him an open line.

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

6 OPERATOR: Soeren's line is open.

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

9 CO-CHAIR MOYER: We can hear you now.

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

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

1 resubmit as you requested.

2 CO-CHAIR MOYER: Dale?

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

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

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

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

1 does not guarantee that you would see it again.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 MEMBER ZUN: Correct.

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

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

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

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

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

20 CO-CHAIR MOYER: Okay. Harold?

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

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

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

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

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

1 level.

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

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

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

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

22 MEMBER WHITACRE: Okay.

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

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

6 DR. PINCUS: Right.

7 (Simultaneous speaking.)

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

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

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

22 CO-CHAIR MOYER: Leslie, did you have

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

7 And I heard attribution and I heard
8 potentially some considerations about what the
9 level of control or accountability is for the
10 physician with regard to the measure, and that
11 there may be some additional exclusions or other
12 categories that might be needed.

13 Yes, go ahead, Ann.

14 MEMBER GREINER: So, given the kind of
15 urgency in responding to this issue, do we have
16 any sense of how quickly the NQF endorsement
17 committee could take this measure up at the
18 clinician level?

19 DR. PINCUS: We actually are having
20 regular calls. And so there is a process that's
21 in place. I can't remember the exact schedule,
22 but it's sort of every few months where that's

1 going on. I think the regulatory step may not be
2 the meetings of the endorsement group as much as
3 it is putting together the data, or to respond to
4 these issues.

5 CO-CHAIR MOYER: I would expect that
6 as well. All right. We are going to vote, if
7 our handy voting machine is ready. So a yes vote
8 is for conditional support to offer the measure
9 with the full range of issues at the clinician
10 level addressed.

11 MS. JUNG: And just one moment. We're
12 again having issues. Apologies. Let's see.
13 Okay, let's give that another try. So this is
14 for the MUC17-139, continuity pharmacotherapy for
15 opioid use disorder.

16 (Off microphone comments.)

17 MS. JUNG: Let's see if this will
18 reset really quickly. Okay, the total, oh you
19 can't see it on that screen. But the responses
20 for this are zero right now. I think that's just
21 counting historically what has been voted. But
22 it's not clearing at this moment. So if we could

1 give it a try, that would be great.

2 So this is MUC17-139. Option one,
3 yes. Option two, no. And if this doesn't work,
4 we will move to a hand vote.

5 CO-CHAIR MOYER: Okay, we are going to
6 move to a hand vote, although part of me thinks
7 we need to stand up. So if you're voting yes on
8 this measure, stand up and stretch or something.

9 (Off microphone comments.)

10 MS. JUNG: So that's 21 votes for yes
11 with 100 percent.

12 CO-CHAIR MOYER: All right. We are
13 moving on to the next area of the consent
14 calendar. This is another consent calendar of
15 one. This is the HIV screening measure. And
16 John, I'm going to let you queue this one up.

17 DR. BERNOT: Sure. Again, one measure
18 here. This is HIV screening, MUC17-367. The
19 preliminary analysis recommendation was
20 conditional support with the condition of NQF
21 endorsement which will review testing and
22 demonstrate reliability at the clinician level.

1 CO-CHAIR MOYER: All right. This
2 measure has been pulled from the consent
3 calendar, so there will definitely be discussion
4 on it. But first, we will start with any public
5 comment related to it. Is there anyone in the
6 room who would like to make a public comment on
7 this measure?

8 I don't see anyone in the room.
9 Operator, would you announce on the lines that
10 this is open for public comment?

11 OPERATOR: Yes, ma'am. If you would
12 like to make a public comment, please press star
13 and then the number one. There are no public
14 comments at this time.

15 CO-CHAIR MOYER: Okay. To start the
16 discussion, Stephanie, you had pulled this from
17 the consent calendar. Could you give us a brief
18 perspective on why you had pulled it and what
19 we're hoping to accomplish?

20 MEMBER GLIER: Sure. I pulled the
21 measure because it's possible that I was
22 misreading the actual testing data. But it

1 looked to me like the measure is a fairly high
2 performing measure to begin with.

3 And it's quite narrow. And as the
4 public comments on this measure reflected, there
5 seem to be some other good ways to assess HIV
6 screening going on in the population.

7 Perhaps the MIPS program is not the
8 best way to promote HIV screening among the
9 Medicare population, particularly since the
10 measure is specified for a primarily non-Medicare
11 population.

12 So my motion would be to recommend a
13 do not support vote, not because I don't think
14 public health and HIV screening is important.
15 Believe me, I'm trying not to undermine my whole
16 MPH here. But I'm not sure that this is an
17 effective measure for the MIPS program and have
18 some concerns. So if others feel differently,
19 I'm very interested to hear that.

20 CO-CHAIR MOYER: All right. We will
21 go to the lead discussants for response. Helen?

22 MEMBER BURSTIN: So it's an

1 interesting perspective, Stephanie. I think it's
2 a real struggle, as you look at this measure,
3 what's the right level of analysis. It sounds
4 like the developer has in fact addressed some of
5 the concerns raised as part of the standing
6 committee review.

7 It's still not completely clear
8 whether the issue that has been raise multiple
9 times as part of comments as well as the review
10 of what happens with patients who get screening
11 outside of the clinical setting, and how that
12 data is captured I think remains a pretty
13 significant issue.

14 So, I would personally prefer that it
15 maintains its conditional support to allow a
16 committee who's already seen it to have a chance
17 to look at how the measure's been modified and
18 specifically see if there are opportunities,
19 particularly, I think it's an e-measure as well,
20 to see if there might be opportunities to pull in
21 population level data to perhaps have the best of
22 both worlds where you might be able to at least

1 understand the proportion of patients in a
2 community who are screened, and then look at that
3 clinical level measure in that context.

4 I think, you know, obviously it's a
5 grade A recommendation of the task force. I
6 think it's the right thing to do. I don't
7 actually share as much of the concerns these days
8 about patients declining screening. I know that
9 was mentioned in the AAFP comments.

10 I think it has very much in practice,
11 when I see patients that I resident just become a
12 normal routine screening test we do. This is
13 just what's recommended for your age and sex.

14 It doesn't, I think, have quite as
15 much of the stigma. But again, I practice in a
16 big urban center. So perhaps some of that
17 reflects living in places where HIV may not be
18 quite as comfortable a conversation.

19 So I would actually recommend that it
20 maintains its conditional support to allow the
21 standing committee that knows it well to look at
22 the changes and see if those other modifications

1 would work.

2 CO-CHAIR MOYER: I'm going to break in
3 really quickly. We've had some people say
4 they're having trouble hearing all of the
5 speakers. So if you could make sure that you
6 talk directly into your mic and maybe get a
7 little bit closer so that everyone can hear
8 what's going on. That would be great, thank you.
9 Charlene, I'm going to let you give opening
10 comments, and then we'll come up to you.

11 MEMBER NGAMWAJASAT: So I agree with
12 the motion for maintaining conditional support.
13 HIV screening is an important measure given the
14 number of people who are HIV positive but who
15 remain undiagnosed.

16 But I agree that there are issues with
17 the way in which the measure is written in
18 regards to the ever portion of the measure. It's
19 really hard to capture the totality of a
20 patient's history in terms of testing.

21 And I concur with the comments that
22 remain in terms of this is a measure that's

1 related to testing rather than the offer, and the
2 screening associated with that.

3 And then I have a question related to
4 the definition of the HIV test as well. I'm
5 curious if that includes point of care testing
6 such as the rapid testing that's now available.

7 DR. GREEN: Hi.

8 (Off microphone comments.)

9 DR. GREEN: Yes, I was going to. I'm
10 Dan Green, I'm a medical officer. I work in
11 Pierre's division, or group rather. So I can't
12 answer your first question, or your last question
13 rather. But I think there are folks from the CDC
14 on that may be able to answer that.

15 I just wanted to make one comment,
16 Stephanie, to your concern. And it makes perfect
17 sense, the age range 18 to 65. Clearly, we don't
18 have that many folks that are Medicare bennies at
19 that age.

20 But did want to mention that, you
21 know, the program does allow for reporting of all
22 patients, you know, depending on the method that

1 the data's being collected. So from EHR, from
2 registry, from QCDRs, it's going to be all
3 patient data.

4 Claims really is the only one now
5 pretty much that's Medicare and web interface, of
6 course. Thank you. If the CDC folks can answer
7 the last question, that would be great.

8 MEMBER BRISS: Sorry, I can't answer
9 that question.

10 MEMBER YONG: We have CDC colleagues
11 on the phone, on the phone line.

12 MS. JUNG: Operator, do we have, we
13 have a few people on the line. I think it's
14 Ethan Jackobs, Christina Allen, Samuel Simon, or
15 Jenna --

16 OPERATOR: Abigail is open.

17 MS. JUNG: We can hear you.

18 MS. VIAL: Can you hear us?

19 MS. JUNG: Yes.

20 DR. PETERS: This is Dr. Phil Peters.
21 I'm here with Abby. And I think the question was
22 regarding the rapid test. So if a rapid test is

1 done within a healthcare system, that usually is
2 put into the electronic medical record.

3 So from a medical systems standpoint,
4 there wouldn't be a difference between a rapid
5 test done or a traditional lab-based test.

6 I think there was another question
7 about people receiving testing within the
8 community. We don't have data about exactly what
9 percent of all persons are receiving testing
10 within the community. But in general, those are
11 persons who have self-identified as being at high
12 risk for HIV infection.

13 And sort of, that's a very important
14 targeted part of the HIV testing that's done.
15 But this screen is really to kind of get at those
16 people who don't self-identify and don't kind of
17 spontaneously present in the community for HIV
18 testing.

19 And we know at the time that people
20 get HIV diagnosed, about 30 percent of people did
21 not report that they had a risk factor before
22 they got their HIV test. After they get their

1 diagnosis, then usually they report what their
2 risk behavior is.

3 MS. VIAL: And this is Abigail. I do
4 want to just note that HHS has long had a
5 requirement to report on its HIV testing
6 activities to Congress.

7 I would estimate, and I would have to
8 go back and look, but I would estimate about ten
9 percent of tests are actually through publically
10 funded programs through CDC.

11 The vast majority are administered
12 through health, community health centers, or
13 they're billed under Medicare and Medicaid. So
14 very little testing is actually done in the
15 community anymore. Proportionally speaking.

16 CO-CHAIR MOYER: Thank you for that.
17 We'll go to Peter, and then Girma.

18 MEMBER BRISS: So, at a more global
19 level, this is a real important measure. So this
20 is an A recommendation for the task force, 40
21 percent of the new HIV infections sort of happen
22 from people that don't know they're infected.

1 And so in addition to screening, that
2 helps the person being screened. This is also an
3 unusual screening test in the sense that it may
4 protect other people as well.

5 There's a lot of room to move, and a
6 lot of the -- the developer has done a
7 considerable amount of work since the initial
8 committee reviewed a deal with the issues that
9 were raised in the initial committee review.

10 So conditional support might be a
11 reasonable answer.

12 MEMBER ALEMU: I represent the
13 organization or agency that supports HIV patients
14 throughout the country. I think one of the
15 problems, as Charlene and Helen mentioned, is
16 that many people do not know that they are
17 infected, and infections spread.

18 We could have controlled the infection
19 in a much better way if we had such methods. So
20 I think just using the screening, the measure
21 which is recommended, I think with the
22 conditional support for dealing with the

1 requirements which are stated, we are in support
2 of that. So I think it will be a great help.

3 CO-CHAIR MOYER: Stephanie?

4 MEMBER GLIER: So, I'm feeling
5 sufficiently shamed here. I think, I don't know
6 if this is actually an option, but I would like
7 to withdraw my motion.

8 But I would like to state some
9 skepticism here that in a voluntary program where
10 clinicians who are likely treating patients who
11 are not screened frequently for HIV, I'm not sure
12 that I buy the premise that clinicians are likely
13 to choose to report a measure where their rates
14 are going to look low.

15 So I think the measure is actually, in
16 itself is a good measure, and I think this is a
17 really important issue to be measuring, and I
18 hope that HHS will continue to be looking at
19 population level HIV screening so that we can see
20 whether, in fact, if we put this into the MIPS
21 program, are we seeing some sort of concordance
22 between what we're seeing in the performance rate

1 among those clinicians who choose to report this
2 measure and what's happening at the population
3 level because I think if the goal here is to
4 drive screening rates, I'm all for that but I do
5 feel we have to go about the MIPS program being
6 able to effectively do that through this measure.

7 However, motion withdrawn. Going back
8 to the original motion.

9 MS. O'ROURKE: This might be obvious,
10 but just to maybe allay some of Stephanie's
11 concerns. We do capture all of this feedback,
12 and it goes to CMS with the recommendation on the
13 measure.

14 So it's not just the measure. It's
15 all of this conversation. It's also written up
16 in the reports and the spreadsheet that we send.
17 We also pass along MAPS input to the standing
18 committees when they review measures for
19 endorsement. So just to hopefully put your mind
20 at ease that your concerns are noted and do go
21 somewhere.

22 CO-CHAIR MOYER: All right. For those

1 of you on the phone, there are many notes being
2 taken. We are going to go ahead and vote then on
3 the original consent calendar recommendation
4 which was conditional support for the measure, I
5 believe coming back through the NQF endorsement
6 process.

7 MS. JUNG: Great. So we're going to
8 go with a hand vote again. So option one, yes.
9 Sorry. The voting is now open. Please raise
10 your hand for option one. So we have 18 yeses.

11 (Off microphone comments.)

12 MS. JUNG: Okay, 19 yeses. And then
13 option two, no. And two nos. So we have 19
14 votes for yeses and two votes for no.

15 CO-CHAIR MOYER: All right. Since we
16 are on a roll, we're going to keep going for a
17 little bit. We're going to try and get as far as
18 we can by 12:30, and at 12:30 we'll let you eat.
19 But hopefully we'll be more caught up by then for
20 having pushed through.

21 The next consent calendar that we'll
22 be talking about is the functional status

1 measures. And there are several measures on
2 this, two of which have been pulled from the
3 consent calendar, MUC17-170, the average change
4 in functional status following lumbar discectomy
5 laminotomy, and MUC17-177, the average change to
6 leg pain following lumbar spine fusion surgery.
7 And John, I'll let you kick this off.

8 DR. BERNOT: Thank you. So, I will go
9 through these one-by-one here, and we do have
10 four measures under here. The first one is
11 average change in fictional status following
12 lumbar spine fusion surgery. That's MUC17-168.
13 And the initial preliminary analysis for that was
14 support for rulemaking.

15 The next one on the list is MUC17-169
16 which is the average change in functional status
17 following total knee replacement surgery with a
18 preliminary analysis on that one of support for
19 rulemaking.

20 The third one on the list, MUC17-170,
21 that is the average change in functional status
22 following lumbar discectomy laminotomy surgery.

1 The preliminary analysis for this was a
2 conditional support for rulemaking with the
3 condition that the measure should be submitted to
4 NQF for review and endorsement. This measure has
5 been pulled.

6 And the final measure on the calendar
7 is the average change in leg pain following
8 lumbar spine fusion surgery. That's MUC17-177.
9 And the preliminary analysis on this particular
10 one was also conditional support for rulemaking
11 with the condition that it should be submitted to
12 NQF for review and endorsement. And that one has
13 also been pulled.

14 CO-CHAIR MOYER: All right. We will
15 go to public comment, starting with if there's
16 anyone in the room who would like to comment on
17 these measures.

18 Okay, I'm not seeing anyone moving
19 towards the microphone. Operator, would you
20 check to see if there's anyone who would like to
21 comment on the phone?

22 OPERATOR: At this time, if you would

1 like to make a public comment, please press star
2 then the number one. There are no public
3 comments at this time.

4 CO-CHAIR MOYER: Okay, thank you. Are
5 there any other measures that anyone would like
6 to pull from this consent calendar other than the
7 two that have already been identified?

8 Seeing no motion in the room, are
9 there any objections to moving forward to voting
10 on accepting the recommendation on the remaining
11 consent calendar measures?

12 Seeing none, we will open the vote to
13 accept the measures remaining on the consent
14 calendar. Those are all measures that were
15 recommended as support for rulemaking.

16 MS. JUNG: So for this consent
17 calendar, it will be MUC17-168 and MUC17-169. So
18 option one will be yes, option two will be no.
19 Again, we need to see a raise of hands for option
20 one, yes.

21 MS. DUDHWALA: And Michael, if you
22 want to send me or share your vote. Michael

1 Hassett.

2 MS. JUNG: You can put your arms down.

3 Okay, so we have 21 votes for yes.

4 CO-CHAIR MOYER: Okay. Moving to the
5 two measures that have been pulled from the
6 consent calendar, these were pulled by Stephanie,
7 similar to before. I'll just ask you to kind of
8 walk through the reasoning for that.

9 MEMBER GLIER: Surprise, it's me
10 again. Both of these measures are already in use
11 in Minnesota. They're very similar to measures
12 that we have already supported and are already in
13 use in the MIPS program. And I move to recommend
14 support without any conditions.

15 CO-CHAIR MOYER: Okay. We'll go to
16 the lead discussants to respond. Eric?

17 MEMBER WHITACRE: I would tend to
18 agree with that, except for the fact that the
19 last two measures that we're considering are not
20 yet NQF endorsed. So did I understand that you
21 want to go full-tilt without the NQF endorsement?
22 Can we do that?

1 CO-CHAIR MOYER: I believe we have the
2 power to do that. I'm going to let Beth talk
3 about that, though.

4 MEMBER AVERBECK: So, I do some work
5 with Minnesota Community Measurement and had a
6 chance to talk with them prior to this meeting.
7 And there was a plan to submit them for
8 endorsement.

9 Part of the reason they haven't been
10 submitted is the amount of time and effort it
11 takes to go through the process given the staff
12 that we have. So it is being planned to be
13 submitted for endorsement, if that helps.

14 CO-CHAIR MOYER: And, Kevin? You were
15 the other lead discussant on this. Did you --

16 MEMBER BOWMAN: I don't have anything
17 to add.

18 CO-CHAIR MOYER: Okay. David?

19 MEMBER SEIDERWURM: So, I just want to
20 say that I support the content, you know, of all
21 four of these. This is maybe a moment to discuss
22 the requirement for NQF endorsement. Now, I know

1 we're NQF, and I know NQF is a major endorser,
2 the major endorser. But sometimes the process of
3 endorsement does seem burdensome and at times
4 idiosyncratic.

5 And when, sometimes when one comes
6 before the specialty group when fields like the,
7 you know, the restaurant review in Woody Allen,
8 that the food is terrible and the portions are
9 small.

10 And you just don't know quite, you
11 know, what direction you're being pulled in. So
12 I wonder, yet at the same time I also feel that
13 this group isn't really the group that should be
14 bypassing that because just as a group of, you
15 know, very well informed and well briefed
16 specialty experts might seem capricious at times,
17 wouldn't we be even structurally more capricious?

18 So I would respectfully, you know,
19 disagree. And CMS has the flexibility to do what
20 it wants to do. But I think that we ought to
21 maintain the integrity of what I will state is an
22 imperfect process.

1 CO-CHAIR MOYER: I saw Scott first.

2 MEMBER FRIEDMAN: I've been asking
3 this for several more years, I'll ask again.
4 What is CMS' opinion on NQF versus non-NQF
5 endorsed measures for quality reporting?

6 DR. GREEN: So, when there is an NQF
7 endorsed measure, our preference certainly is to
8 adopt the NQF endorsed measure. We are not
9 required to have NQF endorsement. But again, it
10 is preferred, especially when there's a measure
11 with a similar concept that is endorsed.

12 CO-CHAIR MOYER: Peter, is that your
13 card?

14 MEMBER BRISS: Yes. So I think David
15 and I have been around this table as long as
16 anyone perhaps. And we're getting to the, we may
17 have done it enough times that we can finish each
18 other's sentences.

19 I think that over time in the MAP
20 process we've sort of gotten better about what
21 our job is which is sort of making judgements
22 about what measures are appropriate for CMS

1 programs as opposed to what the Committee's jobs
2 are which is getting under the hood on the
3 details of measures.

4 And I would submit that we're better
5 off if we sort of stick to the existing division
6 of labor and not try to short circuit it, for
7 what it's worth.

8 CO-CHAIR MOYER: All right. I'm going
9 to break in briefly in a non-chair capacity. As
10 a user of measures, it's frequently helpful to me
11 to have that NQF endorsement to rely on and to
12 use.

13 In addition, I think it's helpful to,
14 as we look at the kind of sometimes cacophony of
15 measures to have kind of an official measure of
16 something. And I think in many times it's the
17 NQF endorsement that kind of sets that this is
18 the measure standard, and then others should be
19 aligning to that, or at last trying to align to
20 that.

21 So, and I do also have concerns about
22 giving measures a pass on things we might not

1 give other measures on because we like the
2 developer or because -- and not like, but I
3 mean, it's respect that's been earned.

4 But I know that bothers me when I sometimes
5 see it on, or feel like I see it on a standing
6 committee. I saw Stephanie and then I think Amy,
7 and then we'll come back to David.

8 MEMBER GLIER: I think NQF endorsement
9 is a really important process and it has a lot of
10 value. And I'm not trying to undermine the value
11 of NQF at all.

12 I will note, we are not NQF. We are
13 the MAP which is convened by NQF, but we are our
14 own representative organization. So I'm not
15 speaking for NQF, and we do not speak for NQF.

16 I will say personally I totally agree.
17 I think NQF endorsement is really valuable in a
18 lot of ways. I'm glad CMS prefers NQF endorsed
19 measures when available.

20 I think in this case we have two
21 measures that are very similar to measures that
22 have been endorsed. I would expect them to be

1 successful in an endorsement process. I note
2 that they have been used successfully in
3 Minnesota.

4 And therefore, I am led to believe
5 that they are ready for implementation. I would
6 not want that to deter Minnesota Community
7 Measurement from submitting them of endorsement
8 and going through the process in case there are
9 issues that come up.

10 And if during an endorsement issues
11 did come up, if CMS had already adopted them into
12 the program, I'm sure CMS would recognize that
13 and would flag the measures for re-review of
14 income way as they have done with previous
15 measures that have had issues come up during
16 endorsement reviews.

17 So my recommendation, my motion
18 stands, I'm not withdrawing it this time. I
19 really do think these measures are ready for CMS
20 to adopt the into the program, and I would
21 anticipate that that would be going in parallel
22 with Minnesota Community measurement submitting

1 them for endorsement with my expectation that
2 that would likely be successful.

3 MEMBER NGAMWAJASAT: I just had a
4 clarification question. So if MUC17-168 and 169
5 were endorsed by NQF, what is the difference
6 between 170 and 171?

7 (Off microphone comments.)

8 MEMBER NGAMWAJASAT: Right, I know
9 that they're not endorsed. But why would we not
10 follow that same process? I guess that's just --

11 MEMBER AVERBECK: It has to do, and
12 I'm not a surgeon, so I'm a general internist.
13 But my understanding, it has to do with the type
14 of procedure. So it's the same metric, it's just
15 a different type of procedure.

16 And the first two, those procedures
17 were submitted for endorsement. The second two,
18 it's the same specification but under a different
19 procedure code. And so my understanding, for the
20 process, it goes specific to the procedure codes.

21 MEMBER WHITACRE: This is surgery. So
22 I've said two things in support of surgical

1 content since I've been on the Committee. This
2 is a little bit more.

3 They're different procedures, but
4 they're applying the same metric for 170, 177 is
5 a P assessment, but it has comparable measures.

6 So I guess in speaking to Stephanie's
7 concern, I think we have every reason to think
8 that if this goes through with conditional
9 support for rulemaking, the impact will be the
10 same, that these would likely be accepted.

11 MEMBER AVERBECK: But I don't want to
12 make CMS wait to include it in a rule until we
13 finish the endorsement process. That's the
14 distinction here.

15 MEMBER NGUYEN: So the distinction is
16 just the waiting time, the period for that.
17 Okay.

18 MEMBER WHITACRE: Do they, does CMS
19 have to accept our recommendations?

20 PARTICIPANT: I mean, they usually do,
21 right?

22 DR. GREEN: We have to go through the

1 process of putting measures on the MUC list and
2 going through the MAP process. But you know, we
3 obviously highly value you guys' opinions. Hence
4 why we're here.

5 But in the end, I mean, if their
6 secretary deems that there's a sufficient need
7 for a particular measure, we can go against it.
8 And similarly again for a non-NQF-endorsed
9 measure, although we appreciate it when you guys
10 do endorse them.

11 CO-CHAIR MOYER: David?

12 MEMBER SEIDERWURM: Yes. So since
13 we're on the topic of CMS discretion, one of the,
14 and we're on the topic of NQF endorsement and
15 some of the difficulties around that, there are
16 some costly aspects to getting your measures
17 endorsed, and they are the most explicitly
18 defined and scientifically rigorous aspects of
19 the measure testing process.

20 And so what I was wondering, since we
21 have a captive audience of CMS people here, if it
22 would be possible to make the suggestion that we

1 find a way in some aspect of the program, you
2 know, maybe through the practice improvement
3 aspects of the MIPS or somewhere where if people
4 undertake measure testing activities, if they
5 could have some credit or if there could be some
6 other source of funding for this for a group
7 like, you know, Beth's, not to talk about a
8 conflict of interest.

9 But just if there's some way to help
10 out with that because that is a bottleneck for
11 measure developments all over the country.

12 CO-CHAIR MOYER: All right. I fear
13 we're straying a little from the measures. But
14 good discussions, and good points. Is there any
15 other additional discussion around the motion on
16 the floor which is to move these two measures
17 forward with support for rulemaking? Otherwise,
18 I would like to propose that we vote.

19 So I see no burning comments from the
20 floor. So we are going to move forward to vote
21 on these two and the motion on the floor which is
22 to move forward with support for rulemaking.

1 MS. JUNG: So voting for MUC17-170 and
2 MUC17-177 is now open. Option one is yes.
3 Option two, no. Please raise your hands if you
4 would like to vote option one.

5 MEMBER WHITACRE: And this is
6 specifically for rulemaking, not conditional?

7 MS. O'ROURKE: That is the motion on
8 the floor, yes. So, let me make sure I'm
9 tracking. If you vote yes, you are saying fully
10 support the measure, no conditions. If you are
11 voting no, you do not agree with the motion to
12 fully support the measure and we can discuss a
13 new one. I would default that to a conditional
14 support.

15 MS. JUNG: So again, that's option one
16 for yes, please raise your hands. Seven yeses.
17 And for no, please raise your hands. So that's
18 12, that isn't. That doesn't add up correctly,
19 hold on. Can we see yes one more time, please?
20 All right, sorry, that's nine. Okay, so we have
21 our total.

22 So we have nine yeses and 12 nos. I

1 believe with the 12 nos, that is consensus for 60
2 percent.

3 CO-CHAIR MOYER: Okay.

4 PARTICIPANT: No, you failed to make
5 consensus on yes.

6 MS. JUNG: Oh, apologies. Let me
7 quick check.

8 CO-CHAIR MOYER: Okay, so we do not
9 have consensus to move the forward measure, the
10 measure forward with support for rulemaking. So
11 the motion was not supported, and now we would
12 default to -- and now we are going to default
13 back to the consent calendar our recommendation
14 which was conditional support for rulemaking with
15 the measures being submitted to NQF for review
16 and endorsement.

17 Do we need to have any discussion
18 around this, or can we move forward with the
19 vote? It looks like we can move forward with a
20 vote. All right, I'm going to ask people to
21 stand up this time so we make sure we get
22 everyone counted.

1 MS. JUNG: So this is for option one,
2 yes. So that's 21 yeses.

3 CO-CHAIR MOYER: And now we all get
4 lunch.

5 DR. BERNOT: Just yes, one quick
6 message for lunch. So we actually almost caught
7 up. Thank you, Amy. We're only 15 minutes
8 behind. We actually had put a little extra time
9 in lunch. So we will come back at 1 o'clock.

10 That still gives 30 minutes, and then
11 we have a presentation. So there will be a
12 little time to finish up your lunch at that point
13 too while Karen is going over the rural map.

14 So 1 o'clock we'll reconvene to have
15 the rural map presentation. Thank you. Lunch is
16 served in the back.

17 (Whereupon, the above-entitled matter
18 went off the record at 12:31 p.m. and resumed at
19 12:59 p.m.)

20 DR. BERNOT: Okay, we're going to get
21 started this afternoon with a presentation on the
22 rural health MAP.

1 Will you guys quiet down back there?
2 We're starting. Okay, Karen Johnson's with us.

3 Karen, would you just introduce
4 yourself and your position at NQF, and then fill
5 us in on what's going on with the rural MAP?

6 MS. JOHNSON: Sure. So, thank you
7 very much. My name is Karen Johnson, I'm one of
8 the senior directors here at NQF and I have the
9 pleasure of overseeing a new MAP Workgroup that
10 is dealing with rural health.

11 So, I, along with my colleagues,
12 Suzanne, Kate, and Madison, are really excited to
13 work on this project.

14 We wanted to let you guys know that we
15 exist, so that's what this is about.

16 A little bit of background, a couple
17 years ago, we were funded by CMS to do some work
18 on rural health, and that project, really, was to
19 provide guidance on performance measurement
20 issues and challenges for rural providers.

21 So, they wanted us to make
22 recommendations for measures appropriate for the

1 use in CMS payment programs.

2 And one of the interesting things
3 about that is we took care to bring in critical
4 access hospitals, rural health centers, FQHCs in
5 rural areas, folks who traditionally have not
6 actually participated in CMS quality programs, in
7 part because they're not paid through the PPS
8 system.

9 So, there's a lot of challenges.

10 A couple of the issues that we felt
11 that we really needed to understand in terms of
12 rural providers and rural patients are these four
13 here on the list.

14 These are interrelated, right?

15 So, one is geographic isolation.

16 When you're isolated geographically,
17 you may have problems with shortage of staff,
18 transportation issues become a problem, so
19 there's a lot going on with geographic isolation.

20 Small practice size again can be part
21 of that, but it also means that you don't have a
22 lot of people to rely on to report quality

1 measures or to do QI efforts once you know that
2 you have a problem.

3 Heterogeneity, there is no rural
4 provider who looks just like all the other rural
5 providers. They're very different.

6 So, the folks in New England are not
7 the same as the deep South, not the same as the
8 loud West, so a lot of heterogeneity.

9 And that has a lot to do with what
10 measures actually can be used by these rural
11 providers.

12 Not all hospitals in rural areas do
13 surgery, so there's surgery measures that are in
14 the hospital programs they can't report on.

15 Low case volume has to do with having
16 enough patients to be able to have a reliable and
17 valid measures.

18 So, these were all issues that we
19 talked about knowing that they impact the
20 programs and what we can be doing for rural
21 providers by CMS.

22 So, the overall recommendation from

1 that group a couple years ago was surprisingly
2 possibly to us, for sure, make participation in
3 CMS quality measurement and quality improvement
4 programs mandatory for all rural providers.

5 However, allow a phased approach,
6 again, and many have not done this at all, and be
7 sure to address low case volume.

8 There were many recommendations to
9 support that overarching recommendation but
10 several have to do with measure selection.

11 And one of the ones, it's actually the
12 last one on this list here, but one was to create
13 a Measure Applications Partnership Workgroup to
14 buy CMS. And so we're very excited that we now
15 exist.

16 We have this Rural Health Workgroup
17 but we also wanted to -- the recommendations were
18 to use guiding principles for selecting measures
19 that would be used by CMS to use a core set and
20 menu of optional measures for rural providers to
21 not forget about patients-in-home models.

22 So, that takes us to right now.

1 Again, we are a brand-new Workgroup to
2 join you guys and we are going to develop
3 criteria for selecting measures and identify core
4 sets of measures that are rural-relevant.

5 We will also talk about gaps in
6 measurement and talk about alignment, and we'll
7 be doing a measurement topic that's relevant to
8 vulnerable individuals in rural areas.

9 That topic is yet to be determined so
10 I can't tell you what that is for sure yet, but
11 we are very busily working.

12 We will be interacting with other MAP
13 Workgroups, so I'm getting to tell you that we
14 exist in today's discussion with you guys.

15 We're going to be here tomorrow and
16 Thursday as well to talk with the other
17 Workgroups to make sure everybody knows that
18 there are folks who are paying attention to rural
19 issues very specifically.

20 We will be providing input to the
21 Coordinating Committee on the MUC measures, the
22 measures that you guys are looking at, nowhere

1 near in the detail that you guys are looking at,
2 just a holistic approach from the rural
3 perspective.

4 And then finally, the Coordinating
5 Committee at the end of the summer will be
6 reviewing and hopefully approving the
7 recommendations that come out of the Workgroup.

8 So, where are we to date? Well, we've
9 seated our Workgroup, so we have a fantastic
10 group of people.

11 We're very excited about those and we
12 have convened our first meeting just a couple
13 weeks ago and we have another one tomorrow. So,
14 we're moving very quickly.

15 So, the initial guidance, just so you
16 know, that we've gotten from our Workgroup thus
17 far is to pay particular attention and focus in
18 on measures that are NQF-endorsed, that address
19 low case volume, that are cross-cutting, and
20 there is probably going to be a few must-have
21 topic areas or conditions.

22 So, for example, the two conditions

1 that have come up have been diabetes and
2 hypertension.

3 So, what we need to do for identifying
4 the core sets is to really think about what
5 measures will work for most rural providers and
6 their patients.

7 So, that cuts out a lot of the
8 specialty things that would work for other,
9 bigger folks.

10 So, for you today, we have about maybe
11 ten minutes. We wanted to maybe have a little
12 bit of discussion, so a few questions, we can
13 pick one question and talk about it totally or
14 maybe hit a few of these.

15 What are some of the key issues for
16 clinician programs that you want us to think
17 about as we do our work, and particularly around
18 identifying core sets.

19 Does the initial guidance ring true?
20 Cross-cutting, NQF-endorsed, maybe a few specific
21 conditions or topic areas, does that make sense
22 or is there something you think that rural health

1 folks should think about?

2 Going forward, do you have any
3 guidance or input on what we can do to help you
4 going forward?

5 And then finally, what advice can you
6 give our new Workgroup? Many of you have been on
7 MAP Workgroups for a long time, so what should we
8 be thinking about?

9 So, I'm going to open it up and see if
10 anybody has anything they would like to basically
11 provide to the Rural Workgroup?

12 CO-CHAIR BAGLEY: Thank you, Karen.
13 Go ahead, Eric.

14 MEMBER WHITACRE: One thing might be
15 the Medicare designation of an individual
16 clinician's specialty.

17 I know general surgeons who work in
18 some of these locations, and basically, they
19 function as a primary-care physician for many of
20 their patients.

21 And I don't know if that would change
22 how Medicare would look at them in terms of

1 performance, but they're doing a wide spectrum,
2 providing a wide spectrum of care, providing
3 anti-hypertensives, diabetic medications, as well
4 as doing some surgery.

5 CO-CHAIR BAGLEY: Go ahead.

6 MEMBER ALEMU: I'm representing an
7 organization that provides grants and technical
8 assistance to rural providers throughout the
9 country.

10 And what we hear from them
11 consistently is that they don't have measures
12 which are relevant to their specific situations.

13 And what MAP will bring to the table
14 will be those measures that are relevant, at the
15 same time, will be suitable for reporting for
16 reimbursement purposes, and for quality
17 improvement purposes.

18 So, we are excited that CMS has taken
19 action to look into this specific issue.

20 So, in the coming days, the rural MAP
21 will get information from what we are doing today
22 from the clinician group as well as from the

1 hospital Workgroup.

2 I would assume that the measures that
3 they look into will be a subset of what we will
4 be recommending.

5 So, I think to get informed about what
6 will be done in the next few days will be very
7 useful for the MAP, the rural health MAP. Thank
8 you.

9 CO-CHAIR BAGLEY: Peter?

10 MEMBER BRISS: Thank you for that
11 comment. This is a really good direction. In
12 addition to what you said, I'd think about a
13 couple more issues.

14 So, I think that you might want to
15 think about whether the standard NQF endorsement
16 is enough or whether you need an additional lens
17 for rural providers.

18 So, I wouldn't be surprised, for
19 example, that feasibility looked a little
20 different, or expected performance levels looked
21 a little different or risk adjustment.

22 It might need to be different.

1 And so I don't have an agenda about
2 how those should come out but it strikes me that
3 there might be things that you had to do that are
4 on the endorsement process, that you might have
5 to add on to the endorsement fund process to
6 actually make the measures as relevant and useful
7 as they could be.

8 CO-CHAIR BAGLEY: I don't see any
9 other questions or comments. Are there any
10 questions on the phone?

11 I believe none on the phone.
12 Stephanie, go ahead.

13 MEMBER GLIER: I'm sure you were
14 already doing this, and you didn't include who
15 you have on the Workgroup already but I hope you
16 guys are making sure to include the rural patient
17 perspective as well, as you're going through the
18 considerations.

19 So, whether that's actually through a
20 group Member or through getting input directly
21 from what is important to rural patients, what
22 concerns they're facing, as we're thinking about

1 also how to ensure that the measures that CMS is
2 encouraging are valuable.

3 MEMBER SEIDERWURM: Two questions come
4 to my mind.

5 CO-CHAIR BAGLEY: Can I just make a
6 comment about the microphones?

7 The microphones are very directional
8 so make sure you're at least no more than six
9 inches away and talking at the microphone.

10 Because the folks in back can't hear
11 very well and the folks on the phone can't hear
12 very well.

13 Yes, sir?

14 MEMBER SEIDERWURM: Now, most people
15 would pay extra not to hear my voice so it's very
16 rare that I would get that kind of a request.

17 So, are you primarily focused on
18 helping or figuring out how rural practices might
19 be able to report or meet the existing measures?

20 Or are you more focused on creating
21 specific measures for rural practices, or
22 possibly both? That's one question.

1 And then the second is isn't this area
2 a little bit like the socioeconomic status issue
3 that we've wrestled with, that if you're offering
4 a service in a smaller community, unless it's an
5 emergency, completely non-portable service, do we
6 want to have risk adjustment for that variable,
7 or do we want to try to encourage a more uniform
8 style of practice?

9 MS. JOHNSON: So, to your first
10 question, identifying the core set, I think we
11 will probably start with what's available, but
12 some of the discussion that we will have to have,
13 and we've already had it a couple of years ago
14 and we'll talk about it more, it actually gets
15 into the risk adjustment piece.

16 Not everything is going to work as it
17 is probably for rural areas. So, I think some of
18 it might be potentially suggestions for different
19 or additional risk adjustment.

20 It might be a suggestion to, for
21 example, make sure that if care is being
22 delivered via telehealth, that the measure

1 captures that. That might be a simple low-
2 hanging fruit.

3 The other thing that we'll be doing is
4 really talking about gaps in measurement because
5 some of the things that are really important to
6 rural providers, not every one of them of course,
7 but are transitions and care and triaging and
8 hand-offs and things like that.

9 We have very few measures of those
10 kinds of things, so I think it'll be both talking
11 about what we have now that will work now, as
12 well as what we need to go for in the future.

13 MEMBER SHALLER: I just think I'd be
14 remiss if I didn't make a plug for patient
15 experience.

16 I mean, if you're looking for cross-
17 cutting measures, that's probably one of the
18 things you can do for some of these reasons.

19 And we also know that rural providers
20 tend to do pretty well because the small nature
21 of their practices often have relationships with
22 patients that some of the larger organizations

1 don't.

2 MS. JOHNSON: We haven't got to that
3 too much yet. We have several available to us.
4 The balancing thing on that is it can be
5 expensive to do those kinds of things.

6 So, that might become a bit of a
7 problem but we definitely have been talking about
8 that.

9 I think the one thing that has really
10 come up so far in our one meeting is the need for
11 measures of access to care.

12 And I think that's where we'll have to
13 go, as Peter was saying, possibly outside the NQF
14 endorsement.

15 That might be one thing because we
16 don't have a huge number of NQF-endorsed measures
17 that get us there.

18 CO-CHAIR BAGLEY: I'll put myself in
19 the queue.

20 Now, two things that I would say to
21 follow up on Eric's comments, it's kind of going
22 to move towards a primary care set of measures

1 because that's what's happening out there.

2 But the other thing is we have to be
3 very careful not to have two standards of care,
4 just because diabetes is diabetes and it's not
5 okay to have less quality for diabetes because
6 it's rural.

7 And that is going to be difficult to
8 push through. But if there's a right way to do
9 things, then we all ought to be doing them.

10 No matter who's taking care of them or
11 where they're being cared for, they ought to have
12 a similar standard of care.

13 So, other comments or questions before
14 we move on? Okay, Karen, thank you very much.
15 Good luck with that, all right? And keep us
16 posted.

17 All right, are we ready to move on?
18 We're going to move on to the urology measure,
19 the next slide there. And I think there's just
20 one measure on this list as well.

21 Can you bring up the next slide? So,
22 it's not really a consent calendar. We have one

1 measure to consider and that's 239. Thank you.
2 MUC 239, does that sound better when I do it
3 right? Okay, is there any discussion on this?
4 And the recommendation is -- okay.

5 MS. DUDHWALA: Sure, so this is MUC
6 17239 International Prostate Symptom Score for
7 American Urological Association Symptom-Index,
8 changed 6 to 12 months after diagnosis of benign
9 prosthetic hyperplasia.

10 And the decision criteria is
11 conditional support. Oh, sorry, pending NQF
12 submission.

13 CO-CHAIR BAGLEY: The recommendation
14 for preliminary analysis is to have conditional
15 support for and recommend NQF endorsement.

16 Is there further discussion? Oh, my
17 God, Stephanie, what a surprise.

18 MEMBER GLIER: I don't want to pull
19 this measure, I'm happy to stick with the measure
20 that's on the table.

21 I wanted to commend the developers for
22 taking our advice in the previous MAP cycle and

1 revising and resubmitting their measure.

2 Thank you very much for hearing our
3 input, we really appreciate it. Nice job.

4 CO-CHAIR BAGLEY: Okay, obviously, we
5 could have more discussion from the lead
6 discussants but if there's no objection, or did
7 you have anything that you wanted to say about
8 this? Scott, I think Scott --

9 MEMBER FURNEY: Fully supportive.

10 CO-CHAIR BAGLEY: And is there any
11 public comment first in the room? And the
12 operator on the phone, public comment on the
13 urology measure?

14 OPERATOR: At this time, if you'd like
15 to make a public, please press Star then the
16 Number 1. There are no public comments at this
17 time.

18 CO-CHAIR BAGLEY: All right, thank
19 you, and if there's any additional discussion
20 from the group before we vote?

21 And the vote is the vote on the
22 consent calendar which is basically the

1 recommendation of the preliminary analysis which
2 is conditional support, and the condition is
3 pending, not pending but recommended for NQF
4 endorsement.

5 Is everybody clear on that? So, it's
6 a yes or no vote.

7 MS. JUNG: Yes, so voting for MUC
8 17239 is now open.

9 Option 1 is yes; please raise your
10 hands if you would like to indicate yes?

11 Okay, that look like 21 votes for yes.
12 Just to fact-check, any votes for no, Option 2?
13 No.

14 MS. DUDHWALA: Well, we're waiting on
15 the people on the phone.

16 CO-CHAIR BAGLEY: Anybody on the
17 phone?

18 MS. DUDHWALA: If Leslie and Michael
19 can just send in their votes please. Leslie and
20 Michael?

21 MEMBER ZUN: I did, thank you.

22 MEMBER HASSETT: Me as well.

1 MS. DUDHWALA: Sorry, Michael, I
2 didn't get yours?

3 MEMBER HASSETT: It was yes.

4 MS. DUDHWALA: Okay, thank you. So,
5 the total for MUC 17-239 is 21 votes for yes and
6 0 votes for no.

7 CO-CHAIR BAGLEY: Okay, I guess we can
8 move on to the vaccination measure. Hiral, will
9 you talk about that?

10 MS. DUDHWALA: Okay, so this is for
11 MUC 17310, zoster shingles vaccination, and this
12 one also got a conditional support for rule-
13 making, pending NQF endorsement.

14 CO-CHAIR BAGLEY: Okay, are there
15 comments or questions about this measure?
16 There's a post-prandial slumber out there.
17 Peter, wake them up.

18 MEMBER BRISS: So, a number of things
19 have changed about zoster immunization since this
20 measure was developed.

21 So, there's a new vaccine that was
22 recommended about a month ago by the ACIP, the

1 Advisory Committee on Immunization Practices,
2 which is sort of the Preventative Services
3 Taskforce for vaccines, that's going to result in
4 things that are different about what's
5 recommended for a vaccine.

6 So, it's a different vaccine, it's a
7 different number of doses, it's a different age
8 range.

9 And so having a zoster measure is a
10 really important thing and there's going to need
11 to be quite a bit of revision of the measure to
12 get it up to date.

13 So, it might be a revise and resubmit.

14 CO-CHAIR BAGLEY: Okay, and Beth?

15 MEMBER AVERBECK: This isn't a
16 measure-specification question, but one more,
17 there are a lot of comments on whether or not the
18 medication was covered under Medicare.

19 So, that might be a barrier and I
20 don't have the answer for that. It might be
21 covered under Part D.

22 So, it might just be a comment to put

1 with the measure to look into that or at least
2 clarify it, because the practices. A number of
3 them commented on that.

4 CO-CHAIR BAGLEY: Did you guys have
5 any coverage comments or no? No, okay. We
6 forgot to start with public comment. Is there
7 any public comment?

8 OPERATOR: At this time, if you'd like
9 to make a public comment, please press Star then
10 the Number 1.

11 And there are no public comments at
12 this time.

13 CO-CHAIR BAGLEY: Okay, Stephanie, I
14 think you were first?

15 MEMBER GLIER: I think this is
16 important, I think zoster is an important
17 condition to be checking on.

18 My preference, if I had my druthers,
19 would be to have a composite measure looking at
20 all appropriate adult vaccination.

21 So, if there is going to be a revise
22 and resubmit, I would like to encourage CDC and

1 other measure-developers working in this space to
2 put together a composite measure that looks at
3 all appropriate vaccinations being given to a
4 population.

5 So, that's my comment. I'd vote for
6 a revise and resubmit.

7 MEMBER BURSTIN: I agree. I just want
8 to support what Peter said as well.

9 I think the last thing we need are
10 measures that are in conflict as the evidence is
11 changing.

12 We've seen this repeatedly, how
13 difficult it is for clinicians, how difficult it
14 is for patients, and so I think a conditional
15 doesn't work for this.

16 I think it's going to need a pretty
17 significant rewrite and I think that's actually
18 what that category is really intended for.

19 Is there a formal motion or if Peter's
20 going to do that?

21 CO-CHAIR BAGLEY: Since it's on the
22 consent calendar, you'd have to take it off the

1 calendar, and anybody can do that for any reason.

2 And then make an alternative motion,
3 either about the category, one of the four
4 categories, or the conditions, either one.

5 So, somebody think about how they want
6 to do this.

7 MEMBER GLIER: I did already pull it,
8 actually, by email.

9 CO-CHAIR BAGLEY: Oh, you did? I'm
10 sorry. It's not marked on my thing but whatever.
11 Okay. And what's your motion?

12 MEMBER GLIER: And I move to revise
13 and resubmit to update the guidelines.

14 My preference would also be to have
15 this be an entirely different measure that is a
16 composite measure of all vaccinations, but I'm
17 not sure that a revise and resubmit needs to be
18 as specific.

19 So, perhaps other folks can weigh in
20 about whether they're also interested in a
21 composite measure?

22 I think the guidelines update seems to

1 be a minimum bar, and then my higher tier bar
2 would be a composite measure for all vaccinations
3 or more vaccination.

4 CO-CHAIR BAGLEY: Well, I have a
5 question for CMS, I guess. If we select, for
6 instance, do not support but can we give you
7 reasons why?

8 Is that helpful? Or is revise and
9 resubmit really appropriate for this one? Does
10 it make any difference?

11 MEMBER YONG: Well, the specific
12 category we defer to the MAP on, but certainly,
13 it's always helpful to have the reasons
14 documented.

15 CO-CHAIR BAGLEY: Regardless of which
16 four categories? Okay, that's fair. All right,
17 I think I lost track.

18 Beth, why don't you go next?

19 MEMBER AVERBECK: It was just a
20 question.

21 I think it's going to apply to some
22 measures down the road, which is when evidence

1 changes, and the measure will, through its normal
2 review process, get revised based on the new
3 evidence.

4 Does that become conditional support?
5 Does it become revise and submit?

6 Because it's part of the ongoing
7 measure development the stewards need to update
8 anyway.

9 So, I'm just kind of curious how we
10 want to approach those because it won't be unique
11 to this one.

12 CO-CHAIR BAGLEY: David?

13 MEMBER SEIDERWURM: So, I think we've
14 encountered this difficulty before when the
15 evidence changes, yet, we think it's a priority.

16 If a metric is removed from the
17 program, an unintended consequence of that could
18 be that the public or the physician community,
19 provider community, gets the message that this
20 isn't important.

21 And I just want to make sure that we
22 don't have that unintended consequence.

1 So, I wonder if this is withdrawn from
2 the programs, if there's a notation that can be
3 made or some explanatory notes added that we
4 still think this is an important priority.

5 And that CMS also thinks it's an
6 important priority if they do.

7 DR. GREEN: No, we do think it's an
8 important priority. There's not a measure, a
9 zoster measure, in the program currently anyway.

10 So, I don't think that message would
11 be sent. The problem is, albeit, with the
12 evidence changing, it's just a delay in
13 implementation.

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

15 CO-CHAIR MOYER: So, my comment is
16 related to the gentleman's comment.

17 The measures actually currently in the
18 QCDR are the non-MAPs measures, so technically,
19 it's already been collected.

20 And so this is more of a process
21 question.

22 So, if we recommend a revise and

1 resubmit, what happens to, to your point, those
2 providers who are already familiar with this and
3 are potentially collecting this?

4 And they're showing a performance rate
5 of about 47 percent. So, there's a gap there.

6 So, while the current measure is not
7 up to date per the new recommendations, I don't
8 think clinically it's invalid.

9 I think people should still get
10 vaccination, except the age range is different
11 and some of the set of parameters need to be
12 updated.

13 So, it's a bit of a grey area for me.
14 This is my first time on the Conditional
15 Workgroup.

16 So, I agree that we should revise and
17 resubmit, but what happens in the meantime, it's
18 a measure in the QCDR.

19 CO-CHAIR BAGLEY: Peter?

20 MEMBER BRISS: I wanted to make one
21 more -- add one more thing.

22 My wish for potential revisions is

1 that all vaccine measures are getting
2 increasingly complicated, because vaccines are
3 being delivered in an increasing number of
4 places.

5 And so I'd love to have the Committee
6 think carefully about how best to ascertain
7 vaccination, which I think has been really hard.

8 CO-CHAIR BAGLEY: Scott?

9 MEMBER FRIEDMAN: So, this is my third
10 or fourth year and I still don't get it either.

11 So, why can't we do conditional
12 support for rule-making pending updating the
13 measure specifications?

14 Because we know they're going to
15 update them and it's already -- the premise about
16 the measure is still a good one, and all you're
17 doing is changing some specifications.

18 Why can't we just do it that way?

19 CO-CHAIR BAGLEY: Peter, did you have
20 a comment?

21 MEMBER YONG: -- line on the phone so
22 I wanted to make sure if they had any comments,

1 they had a chance to share those.

2 CO-CHAIR BAGLEY: Thank you for that.

3 Are there any comments from the phone?

4 MS. O' ROURKE: Operator, can you
5 unmute their lines?

6 MEMBER YONG: It's Ruth Jenkins.

7 OPERATOR: I'm sorry, unmute whose
8 line?

9 MEMBER YONG: Ruth Jenkins. Is she on
10 the line?

11 OPERATOR: Okay, one moment.

12 MS. JENKINS: This is Ruth.

13 OPERATOR: Hello?

14 MS. JENKINS: This is Ruth.

15 CO-CHAIR BAGLEY: Hi, Ruth, we can
16 hear you. It's Bruce Bagley. Do you have any
17 comments on the vaccination measure?

18 MS. JENKINS: Well, we actually
19 planned to update our recommendation for this to
20 abide by the new criteria that's just come out in
21 the last month.

22 So, we agree with the conditional

1 approval just because we work with our practices
2 and our physicians and we want to have the best
3 one.

4 Although this vaccine is not available
5 yet, we're anticipating it in early 2018.

6 CO-CHAIR BAGLEY: Okay, thank you.
7 Did you have another comment?

8 I was going to say that I think I
9 agree with Scott, that perhaps we can also go
10 with the conditional approval.

11 Because if this is a QCDR measure and
12 they're working with practices, I would assume
13 it's relatively easy to update the parameters of
14 the measure.

15 Unless we want to go down the
16 composite measure route or make those significant
17 changes.

18 But in the meantime, I think if it's
19 age and inclusion criteria for vaccines that
20 qualify for the measure, that should be
21 relatively easy to make.

22 CO-CHAIR MOYER: So, I just wanted to

1 try to address some of the points raised by Scott
2 and Dale, that really I think either category
3 could work in this circumstance.

4 It's up to the Committee and your
5 judgment as to if you think it should be
6 conditionally supported or revised.

7 I think the motion on the floor is
8 Stephanie's to refine and resubmit. We can
9 provide the same feedback about what changes
10 might need to be made with either category.

11 So, it's really you and your judgment
12 of if you want to perhaps give it the extra
13 support that conditional support implies.

14 Or if you think you want it to be more
15 cautious and go with the refine and resubmit.

16 So, the process would be that we'll
17 vote on Stephanie's motion. If that does not
18 pass, someone could put forward another motion to
19 do a conditional support.

20 And to just reiterate that we do
21 collect all this qualitative feedback, if you
22 will. It's not just the votes that go forward.

1 So, in the report, you'll see the
2 points of your conversation.

3 We could share some of the concerns
4 about what's covered and the reimbursement rates
5 as well as what specific changes you would like
6 to see.

7 And reiterate the group support for a
8 sister vaccination and perhaps suggest that we
9 move to a composite of adult vaccines too.

10 So, we can capture all these points
11 and move it forward to CMS. So, I hope that
12 helps but I can try to clarify if it does not.

13 CO-CHAIR BAGLEY: Of course, it helps
14 a lot actually. Stephanie, this is your motion,
15 so your motion on the table is refine and
16 resubmit.

17 And could I ask you to name the -- I
18 think there are three things that you wanted to
19 address. Do you have those on the tip of your
20 tongue or should we --

21 MEMBER GLIER: I think there's only
22 two.

1 CO-CHAIR BAGLEY: Okay.

2 MEMBER GLIER: We can call them three
3 if you want.

4 So, the two are updating to meet the
5 current guidelines, the second is to move to a
6 composite measure if possible, which is really --
7 so, actually, I think maybe this is worth a
8 little bit more discussion.

9 Maybe we can table my motion for a
10 second, because I think if we are actually just
11 saying we should meet the current guidelines and
12 make sure that it's still NQF-endorsed, then I
13 would agree with Dale that we should go with
14 conditional support pending NQF endorsement after
15 updating for current guidelines.

16 And if other folks agree with me about
17 wanting to move to a composite measure instead,
18 then we should be voting refine and resubmit as a
19 composite measure instead.

20 Oh, it's not endorsed, you're right.
21 So, gain endorsement.

22 CO-CHAIR BAGLEY: Right, so there are

1 three. The third would be NQF endorsement,
2 right.

3 So, is everybody clear on where we're
4 at?

5 MEMBER GLIER: Because I left that
6 very unclear. Let's try again.

7 CO-CHAIR BAGLEY: You can't table your
8 motion at this point, but you could withdraw it.
9 You can't table it.

10 MEMBER ALEMU: I would like to make a
11 point before that. We know that measures are
12 dynamic, it's a dynamic process.

13 New guidelines come out, measures
14 change. It may be, in some cases, a year, in
15 other types, six years.

16 So, just recently you know that for
17 hypertension, the new guidelines came out. But we
18 are using the same measure which is out there, so
19 it takes time to change those types of measures.

20 It's not early to develop a measure
21 just within months or a year. The same happened
22 with the cholesterol guideline.

1 In 2013, a new guideline came out and
2 same has tried to cover up with the situation by
3 developing a measure on statin. Maybe we'll
4 discuss it today.

5 So, what I would like to say is we can
6 support conditionally and the measure- developers
7 will update the specifications based on the
8 guideline.

9 Especially when it comes to
10 vaccination, it's really a fast-moving process.
11 So, that's one of the points.

12 The other point is when it comes to
13 composite measures, it's really a painstaking,
14 time-consuming, and difficult process.

15 We cannot have a measure just within
16 a year, as I said earlier, and in this case, if
17 we think this measure is important, it's timely,
18 so we have to see it as a single measure.

19 But moving forward, it has been in
20 earlier MAP meetings recommended that we should
21 focus on composite measures.

22 So, what I would suggest is that let's

1 look at these measures specifically and support
2 it conditionally given that the measure-
3 developers will adjust the specifications.

4 CO-CHAIR BAGLEY: Let me make a
5 suggestion to sort of move us along.

6 Let's vote on the motion on the table,
7 which is to revise and resubmit with the three
8 conditions.

9 And if you think that you would rather
10 give it more support than that, with some sort of
11 the same recommendations, the same conditions, if
12 you will, then you should vote no at this vote.

13 And then we'll be back to the original
14 motion.

15 Go ahead, Diane?

16 MEMBER PADDEN: So, I guess I'm going
17 to just address the composite issue because of
18 the payments, because the shingles is Part D,
19 where if we do a composite, flu and vaccine are
20 Part B.

21 So, will that muddy the waters a bit
22 in terms of a quality measure?

1 CO-CHAIR BAGLEY: Maybe it would make
2 them fix that problem.

3 DR. GREEN: Depending on how the
4 measure's collected, and even claims -- I can't
5 imagine it would, but especially if it's
6 Registry, QCDR, or EHR, it shouldn't affect it.

7 CO-CHAIR BAGLEY: Go ahead.

8 MEMBER GLIER: Sorry, I know you're
9 trying to move us along.

10 I have two points, one is that I think
11 I actually would like to in fact table my motion,
12 or withdraw my motion.

13 Because I think if we're going to go
14 with revise and resubmit, I think we should just
15 say we want a composite measure.

16 I think the sense of this group right
17 now is that's not in fact where we are. So, I
18 think leaving it with the conditional support
19 makes sense.

20 Girma, to your point, I totally hear
21 you, measure-development is hard and expensive
22 and time-consuming.

1 If we are tasked with making
2 recommendations at CMS about what should be in
3 the MIPS program, which is what we're talking
4 about at this moment, I'm not totally convinced
5 that the zoster vaccination is worth one-sixth of
6 a clinician's quality score.

7 I would rather it be a bigger measure
8 that looks at all vaccination, even if that is
9 difficult, even if it does muddy the water with
10 humans.

11 So, my preference would be to have a
12 bigger measure that looks at a bigger portion of
13 patient care to make sure we're getting at the
14 holistic picture.

15 But acknowledging where we are today,
16 again, I withdraw my motion for revise and
17 resubmit. I think we should go back to
18 conditional support.

19 CO-CHAIR BAGLEY: Well, thank you for
20 that. If I might, I have to take a quick aside
21 about composite measures.

22 And when you have individual measures,

1 vaccination's a great example of that, everybody
2 just tries harder to get a better rate at each
3 individual vaccination.

4 When you have flu and pneumonia and
5 zoster, in order to do well on all of those, you
6 actually are pushed to have a systematic
7 approach.

8 So, composite measures really drive
9 quality improvement in a way that individual
10 measures never will.

11 And I think your experience in
12 Minnesota with the diabetes composite measure is
13 a great example of that. It's actually an all-
14 or-nothing composite measure.

15 Unless you're doing all, what is it,
16 six things, you don't get any credit. But you
17 can't do well at that without a systematic
18 approach, a checklist kind of approach.

19 So, I think we should somehow continue
20 the idea that composite's a good idea without
21 kind of dismissing this measure on that
22 particular parameter.

1 Now I'm back to Chair.

2 MEMBER SHALLER: Could I just ask, I'm
3 glad you brought that up because I was wondering,
4 when we use the term composite in this context, I
5 want to make sure I understand, are we talking
6 about a composite of all potential shingles
7 vaccinations?

8 Or are we talking about a much more --
9 all of them? All adult vaccinations? That's
10 what I'm wanting to know, if that's what we're
11 talking about?

12 MEMBER GLIER: Yes, so I'm not
13 recommending a specific set of vaccinations that
14 should be included in an appropriate adult
15 composite measure, but I do think it should be a
16 broader perspective. I don't mean just shingles.

17 MEMBER SHALLER: Okay.

18 MEMBER GLIER: Or just zoster.

19 I mean a wider view of some clinically
20 appropriate set of adult vaccinations,
21 acknowledging that that is a very difficult
22 concept to operationalize.

1 CO-CHAIR BAGLEY: Peter?

2 MEMBER BRISS: Yes, so I like the
3 germane approach about you have the advice be in
4 the short term we want to update a shingles
5 vaccination, and in the longer term we'd like to
6 have people explore an adult vaccination
7 composite.

8 And there's nothing that gets us to
9 what almost everybody is recommending around the
10 table.

11 CO-CHAIR BAGLEY: And the third thing
12 would be NQF, recommending NQF process, right?
13 Is everybody clear?

14 So, unless there's other comments, I
15 think we're ready to vote, and in this case,
16 we're going to vote on the recommendation that
17 this go forward as a conditional support with
18 those three conditions we just said.

19 Is that clear for everybody? And this
20 is a yes or no vote.

21 The conditions are to make sure it's
22 up to date, to consider the usefulness of a

1 composite measure that might include something
2 about zoster vaccination, and that they pursue
3 the NQF endorsement process.

4 Is that where we are at? Okay.

5 MS. JUNG: Okay, voting for MUC 17310
6 is now open.

7 Option 1 is yes; please raise your
8 hands if you would like to indicate yes.

9 And then any nos? Okay, and we're
10 just waiting for the folks remotely to tally in.

11 Okay, so we have 21 yeses and 0 nos.

12 CO-CHAIR MOYER: I get to tell you
13 guys that we're going to take a break and we will
14 -- you know, we're a couple minutes ahead so
15 let's try and reconvene.

16 CO-CHAIR BAGLEY: Let's do one more
17 and then --

18 CO-CHAIR MOYER: Do another one? All
19 right. I guess we're going to do one more set of
20 measures, I apologize.

21 So, the next item on the consent
22 calendar is, oh, the appropriate use measures.

1 Okay, I have one item on the consent calendar.
2 It has not yet been pulled.

3 It is the appropriate use of DXA scans
4 and, Hiral, do you want to introduce this?

5 MS. DUDHWALA: Sure, so this is MUC
6 17173 appropriate use of DXA 6 scans in women
7 under 65 years who do not meet the risk factor
8 profile for osteoporotic fracture.

9 So, this one was given a preliminary
10 recommendation by Staff of conditional support,
11 and this is pending NQF endorsement as well as
12 feasibility issues, addressed across EHRs.

13 CO-CHAIR MOYER: Okay, and we will
14 start with public comment.

15 First, is there anyone in the room who
16 would like to make a public comment on this?
17 Okay, seeing none, Operator, can you check for
18 any public comments on the phone?

19 OPERATOR: Yes, ma'am.

20 At this time, if you would like to
21 make a public comment, please press Star then the
22 number 1.

1 There are no public comments at this
2 time.

3 CO-CHAIR MOYER: Okay, so we will open
4 it up and let the lead discussants speak to the
5 measure, and then if anyone wishes to pull it
6 prior to vote, you can also let us know that.

7 So, we'll start off with David?

8 MEMBER SEIDERWURM: Sure, so this is
9 an overuse measure for DXA scanning for
10 osteoporosis, and basically, you can think of it
11 as the flip-side of the appropriate use measure
12 for DXA scanning, which is have you done DXA on
13 the appropriate population?

14 This is the flip-side of that, have
15 you done it on the inappropriate population?

16 And so the diagnostic exclusions are
17 very complete and very well defined to exclude
18 those patients which would be at high risk.

19 And it's, again, one of those half-
20 full, half-empty kind of problems because one of
21 the comments was, well, it's going to be
22 difficult to implement because the list of

1 exclusions is so long, but if it had not been
2 appropriately complete, the comments would have
3 been to have included them I think.

4 So, I think that especially in the EHR
5 environment, almost all of these would be
6 captured and they should be.

7 So, I would support this as a good
8 quality appropriate use measure for this type of
9 procedure.

10 CO-CHAIR MOYER: And Robert, anything
11 to add?

12 MEMBER KRUGHOFF: In terms of what's
13 going on in real practice and how much
14 information the doctors actually have about this
15 while they're practicing, but it does seem like
16 this is a case where there's probably a lot of
17 these scans that are done that shouldn't be done,
18 and you do want to prevent that.

19 We'd obviously like to have a perfect
20 measure that makes sure everybody who should have
21 it gets it, and everybody who shouldn't have it
22 doesn't get it, and there is a little bit of

1 worry that the safest thing to do is to not do
2 it.

3 In terms of this measure, you're not
4 going to score badly on this measure if you do
5 nothing at all.

6 And so you'd like to have something
7 that counter-balances it, but I'm not aware of
8 any measures where we look at both sides like
9 this.

10 Well, have you done it for exactly the
11 right people? And that would be a very hard
12 measure to have precise enough.

13 So, it seems to me that this is
14 something that's worthwhile to have out there and
15 to say that we want to have people work to
16 improve it, improve the data collection on it,
17 and that it probably will evolve over time.

18 MEMBER SEIDERWURM: Just to clarify
19 one point, there is a metric for the other side
20 of the coin.

21 MEMBER KRUGHOFF: For over 65?

22 MEMBER SEIDERWURM: NQF 0046 I think

1 it was. It's in there. So, the suggestion, if
2 we were going to make one along Bob's suggestion,
3 would be to try to combine them.

4 I think that's technically kind of
5 difficult and sort of hard to specify and report
6 sometimes.

7 So, I think given the present moment
8 in history, we're probably better off with two.

9 MEMBER KRUGHOFF: The over 65 is a
10 much simpler measure.

11 CO-CHAIR MOYER: Eric?

12 MEMBER WHITACRE: I guess to me, and
13 I don't do this, to me this seemed like the ideal
14 opportunity for a composite measure.

15 Are you doing the right thing? I guess
16 it's the problem with EHRs in that it's too hard
17 for them to pull the exclusion criteria, the risk
18 criteria.

19 Is that the problem?

20 MEMBER SEIDERWURM: That and the
21 coding for the claims, but CMS I think can better
22 address the coding issue.

1 MEMBER KRUGHOFF: Isn't there also a
2 grey area, though, where if it's over 65, you say
3 just do it, right?

4 If it's under 65 and there are certain
5 things, then you have to have a real compelling
6 reason to do it.

7 But there must be some kind of grey
8 area in between where it's not such a bad thing
9 not to have done it if you're under 65.

10 Is that the case? I don't know.

11 MEMBER SEIDERWURM: Wouldn't that be
12 by risk factors? Which is I think what's being
13 addressed here.

14 DR. GREEN: Yes, and that's exactly
15 right, David. This is something that I did quite
16 a bit, so it is a little bit complicated.

17 The over 65 is very easy; 65 the
18 recommendation is to get a DXA scan.

19 But particularly in women who are
20 menopausal and have certain number of risk
21 factors, there are scientific ways you can
22 determine if a patient is a candidate for a DXA

1 by entering her risk factors into the FRAX tool
2 and calculating a FRAX score without a T score,
3 which would give you -- then, if the number
4 happens to be 9.3, then that's because that's the
5 risk of a 65-year-old of having a fracture.

6 So, not to give you all a lesson in
7 osteoporosis, I'm sorry, but it is one of my pet
8 things.

9 But to your point, I think it's
10 difficult to have the composite here because
11 you'd have to not just have the 65 but you'd have
12 to have all the opposites, if you will, of this,
13 in terms of should somebody have the DXA?

14 And some of it's also a little bit
15 judgment because the FRAX tool, while very good,
16 doesn't collect every single risk factor.

17 I mean, there's literally pages of
18 risk factors for osteoporosis.

19 MEMBER KRUGHOFF: It'd be interesting
20 to suggest something that tries to cover the
21 entire horizon of the do-it and don't-do-it ones,
22 just as one of our comments on this.

1 But I don't know whether we want to
2 try and recommend a measure that is that
3 demanding.

4 CO-CHAIR BAGLEY: I guess I'm a little
5 confused about the population as we mentioned a
6 couple times.

7 If MIPS is a CMS-Medicare program, how
8 does this particular age group fit into that?
9 Operationally, it's like two different things.

10 DR. GREEN: Great question, Bruce.

11 So, in MIPS we are, except for claims
12 obviously, and web interface because we're
13 populating those folks, except for those two
14 reporting methods, we are collecting all payer
15 data.

16 So, even pediatricians conceivably, if
17 they had a large enough Medicare population,
18 whatever, could report and participate in the
19 program.

20 CO-CHAIR MOYER: Amy?

21 MEMBER NGUYEN: I'm just a little
22 concerned, and I think we already touched upon it

1 briefly, about the feasibility in the reporting
2 aspect.

3 And while we're looking at that
4 burdens and nature of measures in meaningful
5 measures initiatives and everything that we're
6 talking about, these measures are not easily
7 captured in the EHR data, even with ECQM.

8 And that's just my concern, and there
9 are the discrete fields in that electronic
10 record, it might be very burdensome for
11 physicians, physician practices.

12 MEMBER WHITACRE: We have something
13 comparable to this in ordering an MRI for breast-
14 cancer risk. It's a fairly complex calculation
15 to do, not every EHR has it.

16 So, as I see this in that context,
17 this measure pushes people to not do it unless
18 they've taken the extra time to document that it
19 really should be done.

20 And if that's the intent of the
21 measure, and it sounds like it's to reduce
22 overuse, then it will be effective.

1 I'd be more comfortable encouraging
2 people to get the calculation if it's really
3 useful.

4 We use it in breast-cancer risk all
5 the time to order additional studies.

6 So, you don't get a breast MRI, unless
7 they meet a certain calculated lifetime risk.
8 It's an onerous calculation and this is the same.

9 So, the people who don't calculate,
10 it's not going to show up in the claims, don't
11 get the DXA.

12 MEMBER SEIDERWURM: Well, so I think
13 that if you look at the list of diagnoses that
14 are listed here, there are things that are going
15 to be coded, Crohn's Disease, cystic fibrosis,
16 malabsorption, chronic liver disease,
17 malnutrition, history of fracture, gastric
18 bypass, alars, down-lows.

19 I'm just scattering around the list.
20 These aren't things that are going to be sort of
21 hidden in a patient's chart.

22 They're going to be either noted in

1 the problem list or in the request coding or in
2 the bill. They're going to be somewhere.

3 These aren't obscure things, I don't
4 think, whereas, things in the breast cancer risk
5 factor stratification are things like age at
6 menarche and puberty and some of those things
7 which may not show up.

8 And so those, I believe, or family
9 history, those are different types of things,
10 that might not ordinarily show up on a problem
11 list I think.

12 MEMBER WHITACRE: The difference would
13 be you wouldn't be dinged if you didn't get the
14 DXA scan on somebody with Crohn's using this
15 measure.

16 You're not going to sort through the
17 claims and say, oh, this patient has Crohn's,
18 they were 55 years old. You lose a point.

19 MEMBER SEIDERWURM: Yes, pushing to
20 not overuse this.

21 MEMBER WHITACRE: I think that your
22 points would be germane to all overuse measures,

1 so unless we were to reject the concept of
2 overuse measures, we would proceed with something
3 like this, I guess is how I look at it.

4 CO-CHAIR MOYER: So, I guess I do have
5 a question around that for the measure-
6 developers.

7 So, lower is better but frequently
8 with an overused measure, we say, well, we don't
9 know quite what the right rate is.

10 And it almost feels like this is
11 striving for zero. Would that be accurate to
12 say, or no, as a benchmark?

13 MR. SIMON: Can anyone hear me?

14 CO-CHAIR MOYER: Yes, we can hear you.

15 MR. SIMON: Hi, everyone, this is Sam
16 Simon from Mathematica.

17 So, a couple of points I wanted to
18 just raise, I'll take the most recent one first.

19 So, yes, a preferred rate would be
20 zero given that this is an overuse measure.

21 But going back a few points to the
22 feasibility question, there was a fair amount of

1 feasibility testing done for this measure.

2 We spoke with four EHR vendors as a
3 part of testing. Well, we touched on feasibility
4 in two ways.

5 One was talking with four EHR vendors,
6 all of whom supported the feasibility to
7 implement this measure as an ECQM.

8 And then secondarily, we were able to
9 collect data for this measure at three different
10 sites.

11 So, those two factors do sort of speak
12 to the feasibility of implementing this measure.
13 So, I hope that answers some of the questions
14 that just came up recently.

15 CO-CHAIR MOYER: Thank you, that does.

16 One additional thing, question, that
17 I would have then, because I get this a lot from
18 hospitals in our area, we have a lot rural
19 hospitals in Wisconsin, were any of those the
20 smaller EHR vendors, and I think Medicity is one
21 that comes to mind, that we frequently hear from
22 the hospitals, oh, but I have this and it doesn't

1 work.

2 Or we hear from the clinicians.

3 Was it tested in more rural areas as
4 well do you know?

5 MR. SIMON: So, the testing was done
6 at three different sites.

7 So, given that, I don't think we can
8 say anything about rural versus urban, given the
9 small admittedly convenient sample,
10 unfortunately.

11 CO-CHAIR MOYER: I was just curious,
12 thank you. Okay, given that, Robert, do you
13 still have a comment or is your card just
14 remaining up? Okay.

15 I'm not seeing any other comments in
16 the room, so it sounds like we may be ready to
17 move forward and vote on this, if I can get back
18 to the right spot.

19 So, I'm not seeing any other comments.
20 The vote would be conditional support for rule-
21 making and the conditions are NQF endorsement and
22 review.

1 And as part of that, it would undergo
2 a feasibility analysis, so that's contained in
3 it. All right.

4 MS. JUNG: Okay, voting for MUC 17173
5 is now open.

6 Option 1 is yes; please raise your
7 hand to indicate yes? Okay, please raise your
8 hand to indicate no?

9 We're just waiting on the remote
10 voters.

11 MS. DUDHWALA: We have the votes for
12 the remote voters.

13 MS. JUNG: Did someone step out of the
14 room? Are we missing someone? Okay, that make
15 sense.

16 Okay, so the final vote for MUC 17173
17 is 17 yes, 3 no, with a total of 20 votes.

18 CO-CHAIR MOYER: Did you have a
19 general comment, Robert?

20 MEMBER KRUGHOFF: Is it possible in
21 this context just what I was suggesting earlier,
22 the possibility of at least suggesting to the CMS

1 that there is a problem of over not doing, of not
2 doing too much and the problem of we really want
3 to encourage enough to be done.

4 And so we'd like CMS to try to explore
5 ways to create incentives and measures long term
6 that would reward taking all the people who
7 really should have it done, and getting it done
8 when they're under 65.

9 CO-CHAIR MOYER: I see furious rating
10 on the CMS side. I'm going to assume that's been
11 captured in your notes.

12 DR. BERNOT: If I could say for NQF,
13 we have it captured in our notes also as part of
14 the discussion, so, yes, Robert, thank you.

15 CO-CHAIR MOYER: All right, and now we
16 are going to take a 15-minute break. So,
17 reconvene at 2:15 p.m.

18 (Whereupon, the above-entitled matter
19 went off the record at 1:59 p.m. and resumed at
20 2:16 p.m.)

21 CO-CHAIR MOYER: All right. the next
22 item on our consent calendar is the vascular

1 measures under consideration. And I'm going to
2 let John introduce this.

3 DR. BERNOT: All right. Thanks. So
4 I will introduce the next section. The next
5 section is the, as mentioned, the vascular
6 measures. There are three measures on this
7 consent calendar.

8 The first one is MUC17-194. That's
9 the optimal vascular care measure.

10 The second one is the ischemic --
11 excuse me -- let me go give the recommendation.
12 The optimal vascular care MUC17-194, the
13 preliminary analysis was conditional support, the
14 condition that CMS evaluates the program to avoid
15 duplicate and competing measures.

16 The second one was MUC17-234, ischemic
17 vascular disease use of aspirin or anti-platelet
18 medication. The preliminary analysis is the
19 same, conditional support, the condition that CMS
20 evaluates the program to avoid duplicate and
21 competing measures.

22 I need to note on 234, that this

1 measure is being proposed for both MIPS and MSSP.
2 There will be one discussion, but there will be
3 two votes for this. Each program will have its
4 own vote whether it will be included.

5 The third measure is patient-reported
6 and clinical outcomes following ilio-femoral
7 venous stenting. And the preliminary analysis on
8 this is refine and resubmit the measures.

9 It is a composite measure in early
10 development that has not been tested, though the
11 individual measures have had some testing.

12 Before we go to public comment, due to
13 the competing nature, CMS is going to make a
14 statement about these particular measures.

15 So is it to you, Dan?

16 DR. GREEN: Thank you. Yes, it is me.
17 Hi, everybody, again. So I wanted to note about
18 the optimal vascular care, I mean, we're trying
19 to replace a Wisconsin Collaborative measure,
20 which is --- right now it's MIPS quality ID 441,
21 and we're trying to replace it with this measure,
22 the Minnesota measure, which I believe is NQF-

1 endorsed.

2 So, again, as to one of my earlier
3 comments, you know, we prefer to use NQF-endorsed
4 measures when available. We think that's, you
5 know, good for the program and good for our
6 clinicians who are reporting.

7 So PQRS 349 was retired due to blood
8 pressure changes and we had problems aligning the
9 program.

10 So the one thing I do want to mention
11 about 194, is that would also need updating to
12 reflect the new blood pressure that has come out.

13 So the only other thing is, you know,
14 the competing measure. So there is one part of
15 the composite measure, of course, is an
16 individual measure, including ischemic disease
17 use of anti-platelet or aspirin.

18 We do think that this is an important
19 standalone measure and we actually did recommend
20 to Minnesota that they provide this measure in
21 our call for measures. So we asked them to
22 submit it to the MUC MAP list.

1 And we did that because we think that
2 this measure is --- it was approved, first of
3 all, as a QCDR measure. And we do like this
4 measure also because the exclusions are much more
5 appropriate than the measure that we currently
6 have.

7 So, Pierre, did you want to say
8 anything else?

9 MEMBER YONG: No. I think Dan
10 basically covered it. I think there are sort of
11 two issues that we'd love some feedback on, but
12 hopefully there's the -- the duplication issue,
13 which Dan covered in terms of existing measure
14 versus, like, this measure around sort of use of
15 aspirin and anti-platelets and the exclusions are
16 slightly different.

17 And so we think they're more
18 appropriate and have more --- have a more
19 specific age limit as opposed to an open age
20 limit with the other measure, but there's also
21 the duplication --- or the duplication issue
22 between having an individual sort of process

1 measure versus a composite, which includes that
2 process measure.

3 And part of the reason we put both of
4 them on there is because we may have specialists
5 that only do --- may not do or handle all of the
6 issues within the composite. And, therefore, if
7 they don't address all those issues in the
8 composite, they wouldn't be able to report on the
9 composite as opposed to they really just focus on
10 the individual measure.

11 So that's sort of a pro and con there,
12 but we certainly welcome feedback from the MAP
13 about that particular issue.

14 DR. GREEN: One more thing, guys.

15 The anti-platelet aspirin measure, not
16 the current one, but there is one currently in
17 the Million Hearts program, which, as you know,
18 is a big CMS priority program. And, again, this
19 measure just better --- the measure that we're
20 asking to ultimately replace our current measure,
21 as Pierre said, it does take into account certain
22 exclusions, which are much more medically,

1 obviously, appropriate, as well as defines a
2 particular age range of 18 to 75 instead of just
3 18 and older. Thank you.

4 CO-CHAIR MOYER: Thank you. We will
5 now go to public comment starting with people in
6 the room.

7 Is there anyone in the room who would
8 like to publicly comment on this measure? All
9 right. We have a public commenter.

10 MS. BOSLEY: Hi. Heidi Bosley on
11 behalf of the AMA. First of all, Dan, thank you
12 for mentioning the guideline update. We were
13 also going to point that out, but wanted to just
14 make a comment.

15 This will apply to the two diabetes
16 measures as well, the A1c and the composite.
17 There's an increasing concern to have measures
18 that have a somewhat imperfect denominator that's
19 so broadly applicable in a program that is now
20 assigning benchmarks and points with an
21 assumption that you can get a zero to a hundred
22 percent performance.

1 And so what is not clear in measures
2 like this where we know that not all of the
3 patients will achieve a blood pressure as desired
4 in an Alc, how does this then work, and
5 appropriately frame, assign points, and then
6 communicate to patients what is the optimal
7 benchmark.

8 So we would ask that it would be
9 really further looked at either through the NQF
10 endorsement process and/or through the MAP, on
11 how do you begin to risk adjust, how do you begin
12 to look at these clinical and social risk
13 factors, so that we either have a more perfect
14 denominator that encapsulates who should be
15 receiving and achieving these goals, and then see
16 how it would implement into the program.

17 It's an unknown at this moment. So
18 thank you.

19 CO-CHAIR MOYER: Any other public
20 commenters in the room?

21 (Pause.)

22 CO-CHAIR MOYER: Operator, can you

1 check for any public comments on the phone?

2 THE OPERATOR: Thank you. At this
3 time if you would like to make a comment, please
4 press star, then a number one.

5 (Pause.)

6 THE OPERATOR: There are no public
7 comments at this time.

8 CO-CHAIR MOYER: Okay. So as
9 mentioned, the optimal vascular care and then the
10 use of aspirin or anti-platelet medication has
11 been pulled from the consent calendar by
12 Stephanie.

13 Would the workgroup like to pull any
14 --- well, the one remaining measure also for
15 discussion or will we leave that on the consent
16 calendar?

17 As a reminder, the current
18 recommendation for it is refine and resubmit
19 prior to rulemaking because it is a newly-
20 developed measure that has not yet been tested.

21 Dale, do you have a comment on that?

22 MEMBER SHALLER: I have a question

1 related to the duplication issue for the optimal
2 vascular care measure.

3 So if we move forward with proposing
4 conditional support, then CMS would, of course,
5 not have both measures; the WCHQ measure and
6 Minnesota Community Measurement measure. I mean,
7 you would choose one in the end.

8 MEMBER YONG: Right. For the use of
9 aspirin measure?

10 MEMBER SHALLER: No. I'm talking
11 about the composite measure.

12 MEMBER YONG: There is no other
13 competing composite measure.

14 MEMBER SHALLER: I thought the WCHQ
15 was a competing composite measure.

16 (Off microphone comments.)

17 MEMBER SHALLER: So there is another
18 competing composite measure?

19 DR. BERNOT: Sorry. I didn't want to
20 interrupt. Just for the process of this, we
21 actually, unfortunately, have to get through the
22 consent calendar first before we go to the ones

1 that were pulled.

2 So we do have to deal with whether
3 anybody wants to pull MUC17-345 and then we can
4 pick right back up on that discussion after the
5 vote is either that's pulled or we vote on that
6 measure, which is the only one remaining on the
7 consent calendar.

8 CO-CHAIR MOYER: Thanks. So would
9 anyone like to pull the remaining measure or can
10 we vote on the --- to accept the consent
11 calendar?

12 (Pause.)

13 CO-CHAIR MOYER: All right. Seeing no
14 cards go up, we will vote on whether to recommend
15 refine and resubmit prior to rule-making for
16 patient-reported and clinical outcomes following
17 ilio-femoral venous stenting.

18 MS. JUNG: So voting for MUC17-345 is
19 now open. Option 1 is yes. Please raise your
20 hand if you would like to indicate yes.

21 (Show of hands.)

22 MS. JUNG: Okay. Please raise your

1 hand if you would like to indicate no.

2 (Show of hands.)

3 MS. JUNG: Okay. For MUC17-345 we
4 have 21 yes votes and zero no votes.

5 CO-CHAIR BAGLEY: And what was the
6 recommendation? Remember we wanted to --- if
7 we're going to do refine and resubmit, that we
8 were supposed to give some guidance. I guess I
9 wasn't clear on what the guidance --- the two or
10 three things that we want to ---

11 DR. BERNOT: So, yeah, it was --- and
12 maybe I didn't say it very clearly. It was the
13 refine and resubmit with essentially for the
14 testing piece because it is a composite measure
15 in early development. So we'll need to complete
16 testing.

17 CO-CHAIR BAGLEY: So that's the only
18 one?

19 DR. BERNOT: That's the only one that
20 we had on here.

21 MEMBER GLIER: Before we go on, can I
22 offer just additional comments that I don't think

1 need to be captured as a vote, but perhaps will
2 be useful as they're continuing to finish the
3 measure?

4 It's possible that this was actually
5 in the measure specs that we just didn't have
6 enough detail, but it wasn't clear to me what
7 would happen to the patients who were last to
8 follow up for the patient-reported outcome.

9 So I think it would be helpful
10 whenever this actually is when the testing is
11 done, it would be helpful for whoever is
12 ostensibly renewing it for endorsement to have
13 that information.

14 DR. BERNOT: We'll add that to the
15 notes.

16 CO-CHAIR MOYER: All right. So we
17 will move to the two measures that were pulled
18 from the consent calendar. I'm going to start
19 with Stephanie. She can let us know why they
20 were pulled. And then we'll move to the lead
21 discussants.

22 MEMBER GLIER: Thanks. I think my

1 comments go a little bit together although they
2 go in different directions.

3 So I pulled the two vascular care
4 measures. The optimal vascular care measure I
5 would move to vote support.

6 I don't think we need the condition of
7 removing the other measure because CMS has
8 indicated that they already plan to remove the
9 other measure, but since they have also --- it
10 seems a little moot. So I'm happy to move
11 forward either way as people feel appropriate.

12 It's helpful to hear from CMS what
13 your thoughts were behind having a component of
14 that composite also in the program. However, I
15 am concerned about whether people would choose
16 the composite measure if the component measure is
17 available to them.

18 So I know we're not talking about
19 program design today, so we won't talk about
20 program design, but would like to encourage you
21 to make sure that there are appropriate
22 incentives that you have to do the higher-value

1 measures such as composites so that we don't have
2 people choosing easier measures if they are
3 available to them even if we're trying to include
4 measures that allow more clinicians to report.

5 DR. BERNOT: Okay. William, or do you
6 go by "Bill"?

7 MEMBER VAN DECKER: There's mom and
8 apple pie in treating all vascular disease with
9 blood pressure control, blood sugar control,
10 cholesterol control, no cigarettes and an anti-
11 platelet agent for clotting. So, you know,
12 reasonable stuff in the composite.

13 My only two comments on it would be,
14 obviously, new guidelines coming out through
15 multiple societies, through American Heart
16 Association, American College of Cardiology,
17 recently American Hypertension Society, that
18 would weigh on this category of people. If you
19 have peripheral vascular disease, you have more
20 than ten percent risk over ten years.

21 And so the guidelines for blood
22 pressure control would be more 130 over 80 for

1 this specific population which has targeted risk
2 factors and sounds like that could be updated as
3 time goes by or how we deal with changes and
4 consensus guidelines as time goes by.

5 And then the only last comment to this
6 would obviously be, what somebody else alluded
7 to, is obviously this has some patient compliance
8 piece to it as far as, you know, cigarette
9 cessation and cholesterol control and obviously
10 blood pressure control.

11 So some concept of how that goes about
12 being played out down the line, but certainly I
13 think this is a conceptual place we want to get
14 to.

15 DR. BERNOT: Beth.

16 MEMBER AVERBECK: I guess I'll just
17 make a couple of comments. Variations on these
18 measures have been in the public domain and
19 reported for at least over ten years in
20 Minnesota. And we're one of the few states where
21 cardiovascular disease is the number two cause of
22 death and not the first --- not the leading cause

1 of death for a number of reasons, but I do think
2 that this metric has influenced that.

3 The group --- the measure developers
4 do get together when the guidelines change and
5 will update. We did that for the A1c and the
6 optimal diabetes. We'll do it for the blood
7 pressure on this one as well.

8 And then it has been risk adjusted.
9 It's also been reported for patients that are on
10 public programs as part of an equity report.

11 And also for communities of color,
12 it's part of a disparities report. So it has
13 that ability to segment the measure by
14 populations.

15 And since we've been using it over
16 time, we are able to take a look at are we
17 reaching a ceiling affect at some point?

18 And the goal is never a hundred
19 percent on this and so I think those are just
20 some comments around the use of these measures,
21 but I think, Bruce, your comment earlier really
22 does get into the system of care because not one

1 individual can probably do everything for every
2 patient every time. So it does support that idea
3 of team basis and base care.

4 CO-CHAIR MOYER: All right. Any
5 additional discussion on this?

6 (Pause.)

7 CO-CHAIR MOYER: Okay. We can start
8 to move forward with the voting. So I want to
9 clarify that optimal vascular care, did you have
10 a motion to move that to ---

11 MEMBER AVERBECK: To support.

12 CO-CHAIR MOYER: To support. Okay.
13 So that's what we will be voting on first is
14 optimal vascular care, support for rulemaking,
15 full support since CMS has indicated they already
16 plan to address the things that were listed as
17 conditions.

18 DR. GREEN: Just to be sure, that was
19 the blood pressure that we were ---

20 CO-CHAIR MOYER: It was the competing
21 measure.

22 DR. GREEN: Oh, the competing measure

1 and the blood pressure. Gotcha. Sorry. Thank
2 you.

3 MS. JUNG: Okay. Voting for MUC17-194
4 is now open. Option 1 is yes. Please raise your
5 hand if you'd like to indicate yes.

6 (Show of hands.)

7 MS. JUNG: You can lower your hand.
8 Thank you. Any votes for no?

9 (Show of hands.)

10 MS. DUDHWALA: If I can just have the
11 remote people send in their votes? Michael, I
12 just got yours. And, Leslie, I just got yours.
13 Thank you.

14 MS. JUNG: Okay. We have 21 votes for
15 yes and zero votes for no for MUC17-194.

16 CO-CHAIR MOYER: One last chance for
17 any additional discussion on the use of aspirin
18 or anti-platelet medication.

19 DR. GREEN: I feel like you,
20 Stephanie, except I wouldn't have turned down the
21 -- I'm kidding.

22 So, I just want to remind folks again

1 this measure is important to us, meaning CMS, in
2 as much as it is a Million Hearts measure.

3 So it is important for us to be
4 reportable individually, I guess is what I'm
5 trying to say. Thank you.

6 CO-CHAIR MOYER: Okay. And for
7 clarification, it sounded like this was
8 discussion only.

9 MEMBER GLIER: Yes. I had originally
10 planned to move to go to do not support, but I
11 changed my mind.

12 CO-CHAIR MOYER: Okay.

13 MEMBER GLIER: So stick with
14 conditional support.

15 CO-CHAIR MOYER: So first we'll be
16 voting on this for the Medicare Shared Savings
17 program.

18 And the vote that we'll be taking is
19 conditional support for rulemaking. That's what
20 was originally on the consent calendar in the
21 absence of another motion.

22 And that conditional support is that

1 there will not be duplicate or competing measures
2 in the program.

3 MS. JUNG: Okay. Voting for MUC17-234
4 for MSSP is now open. Option 1 is yes. Please
5 raise your hand to indicate a yes.

6 (Show of hands.)

7 MS. JUNG: Please raise your hand to
8 indicate option 2, no.

9 (Show of hands.)

10 MS. JUNG: Okay. For MUC17-234 for
11 MSSP, we have 21 votes for yes and zero votes for
12 no.

13 CO-CHAIR MOYER: All right. We will
14 now consider the same measure, same
15 recommendation, conditional support, with the
16 same condition that there not be competing
17 measures.

18 This time it is for the merit-based
19 incentive payment system.

20 MS. JUNG: Again, MUC17-234 for the
21 MIPS program. Option 1, yes. Please raise your
22 hand if you would like to indicate a yes vote.

1 (Show of hands.)

2 MS. JUNG: Please raise your hand for
3 option 2 if you would like to indicate a no vote.

4 (Show of hands.)

5 MS. JUNG: We have 21 yes votes and
6 zero no votes for MUC17-234 for the MIPS program.

7 CO-CHAIR MOYER: All right. Moving on
8 to the next area of the consent calendar, this is
9 diabetes measure under consideration. I suspect
10 this will be similar discussion. They're
11 somewhat similar measures. And I will send it
12 over to John for introduction.

13 DR. BERNOT: Thanks. So for this
14 section, again, there's two measures. The first
15 one is optimal diabetes care. That is MUC17-181.
16 That will be voted on for both MIPS and MSSP.

17 The preliminary analysis was
18 conditional support with the condition that there
19 are not duplicate or competing measures in the
20 program. That is the same recommendation for
21 both.

22 The second measure is diabetes A1c

1 control. That is MUC17-215. Again, also MIPS
2 and MSSP.

3 The preliminary analysis for that was
4 also conditional support, condition that there
5 are not duplicate or competing measures in the
6 program.

7 I will see, Dan, is there anything
8 further? It sounds like you've addressed a lot,
9 but I'll pass it to you.

10 DR. GREEN: Thank you, John.

11 So just want to take a second real
12 quick about the optimal diabetes care. We have
13 approved it recently as a QCDR measure as an
14 aside and we also did ask Minnesota to self-
15 nominate this one as well for the MUC MAP as we
16 thought it was a very good measure.

17 There was -- optimal diabetes care was
18 MIPS No. 319 that was previously in the web
19 interface and -- well, at the time it wasn't
20 MIPS. Obviously, it was in PQRS in the 2014, but
21 it was removed because the components of that
22 measure were also in the web interface. So

1 obviously it was duplicative reporting.

2 So there is one component in this and
3 that is, of course, MIPS Measure No. 1, which is
4 diabetes poor control, and basically looks at the
5 percentage of patients with a hemoglobin A1c
6 above nine.

7 So it's kind of an inverse measure, if
8 you will, because it's looking at poor control
9 instead of good control.

10 We do think that this NQF-endorsed
11 outcome composite for comprehensive care of
12 diabetes patients, so we do think it provides
13 that.

14 We are -- the other measure that also
15 is, I think, under consideration here is looking
16 to change that diabetes poor control, kind of an
17 inverse measure, into a diabetes good control
18 with using the updated, more evidence-based
19 guidelines of hemoglobin A1c less than eight.

20 So a little bit easier for folks to
21 understand, but also more consistent, I believe,
22 with the guidelines. And, again, of course we

1 would plan to retire any duplicative measure. In
2 this case, it would be PQRS -- or, sorry, MIPS 1.
3 Old habits die hard.

4 So I think that's it. Pierre, did you
5 want to -- one more thing. The blood pressure
6 would need to be updated as well.

7 CO-CHAIR MOYER: Okay. We'll open
8 this for public comment, starting with any public
9 comments in the room.

10 (Pause.)

11 CO-CHAIR MOYER: Okay. There are no
12 public comments in the room. Operator, would you
13 check for any public comments on the phone?

14 THE OPERATOR: Yes, ma'am. At this
15 time if you would like to make a comment, please
16 press star and the number one.

17 (Pause.)

18 THE OPERATOR: Okay. At this time
19 there are no public comments.

20 CO-CHAIR MOYER: Okay. And in a
21 recurring theme, these have both been pulled from
22 the consent calendar from Stephanie. So, I'll

1 give her first comment.

2 MEMBER GLIER: I'd like to withdraw my
3 pulls for both of these.

4 CO-CHAIR MOYER: Okay. So they are
5 back on the consent calendar now unless someone
6 else would like to pull them.

7 Reminder, they are all in the consent
8 calendar for conditional support for rulemaking.
9 And that conditional support has to do with
10 competing measures.

11 Okay. Peter, go ahead.

12 MEMBER BRISS: Yes, I have a question
13 about this one. I understood that for the last
14 set of measures you wanted to keep a standalone
15 measure that was a component of the other one
16 because that was important for Million Hearts,
17 but I don't understand in this one why we want
18 both an Alc control -- a standalone Alc control
19 measure when you're also talking about an optimal
20 control measure.

21 So what's the -- so why aren't these
22 duplicative measures and why do we want to have

1 both of these?

2 DR. GREEN: Great question, Peter.

3 Wish you'd kept it to yourself -- no, I'm
4 kidding.

5 (Laughter.)

6 MEMBER BRISS: That was a federal team
7 foul.

8 DR. GREEN: We'll take care of him
9 afterward. I'm kidding. So, no, seriously, that
10 is a great question.

11 We do think that there may be an
12 opportunity for different types of eligible
13 clinicians to report this measure.

14 For example, while we would argue that
15 endocrinologists would have ultimate
16 responsibility for patient care as it relates to
17 diabetes, you know, this measure does contain,
18 for example, a smoking component, meaning the
19 composite measure contains a smoking component.

20 So failure of one of the elements
21 could cause the clinician to fail the whole
22 measure for that particular patient.

1 And I think it's a reasonable
2 argument. We could say, well, again, if they're
3 taking care of their diabetes, they should
4 absolutely be counseling the patient. And you
5 and I would probably totally agree because some
6 closet-smoking crazy person in terms of
7 counseling, but the reality is some people may
8 not report on the composite because of the --
9 it's a little bit more onerous.

10 And we don't want to -- just because
11 some people may not choose to report the
12 composite, we don't want to have diabetes
13 completely ignored. As you know, it's a major
14 health problem.

15 So if I had to choose between somebody
16 picking, you know, good control for the
17 hemoglobin A1c or not doing anything as it
18 relates to the diabetes, obviously you and I both
19 would agree about that, too. We would prefer the
20 hemoglobin A1c and have them work toward the
21 others.

22 CO-CHAIR MOYER: Okay. I do want to

1 clarify I have had a point of order. Apparently
2 once something is taken off the consent calendar,
3 it's not on the consent calendar, but we can
4 still vote on them. We just need to vote on each
5 thing separately. So we can alternate arms so we
6 don't get lopsided.

7 I do want to give an opportunity for the
8 lead discussants to talk about the measures and
9 I'll kick it over to Amy.

10 MEMBER NGUYEN: So I wanted to -- so
11 I definitely agree about updating regarding the
12 ACC and AHA guidelines. And I wanted to just
13 bring attention in terms of the optimal diabetes
14 care, the 181.

15 Was there a performance calculation
16 done in Minnesota for that one?

17 (Off microphone comment.)

18 MEMBER NGUYEN: Yes. Okay. And then
19 for -- is it -- what is it? 215? I think you
20 had talked -- you brought it up in terms of the
21 poor control and the good control and in the ACO
22 measure.

1 So for the sake of being parsimonious
2 in alignment, we've got these ACO measures that
3 are looking at the poor control, but then now if
4 we have this for the good control, I'm just again
5 looking at the burdensome nature for the
6 provider. So I just wanted to bring those two
7 points up.

8 CO-CHAIR MOYER: Pierre, did you want
9 to address that?

10 MEMBER YONG: Yes. And thanks, Amy,
11 on this last point about what's in SSP versus in
12 MIPS.

13 We have purposely aligned what's been
14 -- what's in SSP, the measure set, with what's in
15 the MIPS web interface.

16 We also have our SSP colleagues on the
17 phone, but I think the intention is to continue
18 with that alignment.

19 So, Rabia or Sarah, is there anything
20 you want to say about this?

21 MS. KHAN: No. This is Rabia. Just
22 to echo what you just said. So the purpose of us

1 including this measure was to maintain alignment
2 with MIPS for web interface reporting.

3 And I do understand we do have, like,
4 a diabetes measure within our current measure
5 set, but this would be considered for possibly
6 replacing the existing measure.

7 MEMBER YONG: And I would note that --
8 and I think folks made this clear -- but both of
9 these measures are on for both MIPS and SSP. So
10 when you vote, you'll have four votes, I think.

11 CO-CHAIR MOYER: Okay. Dale, do you
12 have anything to add?

13 MEMBER GLIER: I think these are
14 excellent measures and should move forward with
15 all of them. Experience in Minnesota has
16 demonstrated that they're very useful.

17 CO-CHAIR MOYER: Girma.

18 MEMBER ALEMU: Yeah. In the optimal
19 diabetes care measure analysis, as I see it,
20 there is exclusion of smokers. Does it apply
21 only to nonsmokers in the composite?

22 If I have read it correctly, that's

1 what it says.

2 MEMBER GLIER: No, it's not an
3 exclusion. It's one of the -- it's one of the
4 component measures of whether --

5 MEMBER ALEMU: Yes. It says it's for
6 -- just applies to nonsmokers.

7 CO-CHAIR MOYER: So potentially better
8 addressed by someone else. But since I'm
9 familiar with the measure because this is in our
10 P4P, you don't have to be a nonsmoker to be
11 included in the denominator. You have to be a
12 nonsmoker to be credited into -- to earn credit
13 for the measure.

14 So a smoking patient would not be
15 considered to meet all of the conditions for the
16 composite.

17 MEMBER ALEMU: Yes. What I want to
18 point out is that there is also smoking cessation
19 measure. I don't know whether it has been
20 clarified earlier.

21 So why don't we include the smoking
22 cessation measure in the composite? Smoking

1 being one of the main factors which we wanted to
2 look into. So I just -- I would like to have
3 clarification about that.

4 MEMBER AVERBECK: I think, going back
5 to the rationale for having smoking in the
6 optimal measures is it's an outcome. Either you
7 smoke or you don't smoke just because it's of
8 significance in cardiovascular disease.

9 So it's a risk factor that if we can
10 influence it -- I think there's studies done
11 that, you know, clinicians can influence smoking
12 rates to some extent for patients quitting that
13 we wanted it to be an outcome measure, not just a
14 if you smoke, we recommended that you quit,
15 because that's more of a process measure. So
16 that was the rationale for that.

17 So the smoking cessation counseling is
18 not a component. It's just a yes or no if you
19 smoke or if you don't smoke.

20 CO-CHAIR MOYER: Any other discussion
21 on the measures?

22 (Pause.)

1 CO-CHAIR MOYER: Okay. So seeing no
2 cards go up, we'll start through -- there will be
3 four votes. There are two votes on each measure.

4 The first one is for the Medicare
5 Shared Savings Program on optimal diabetes care.
6 And this will be a vote for conditional support
7 for rulemaking. And the condition is the removal
8 of competing measures.

9 MS. JUNG: Okay. Voting for MUC17-181
10 for MSSP is now open. Option 1 is yes. Please
11 raise your hands if you would like to indicate a
12 yes.

13 (Show of hands.)

14 MS. JUNG: Okay. Option 2 is no.
15 Please raise your hand if you'd like to indicate
16 a no.

17 (Show of hands.)

18 MS. JUNG: Okay. Our total vote count
19 now is 20. So for this measure, MUC17-181 for
20 MSSP, the final vote count is 20 yeses and zero
21 noes.

22 CO-CHAIR MOYER: All right. The next

1 vote is for the merit-based incentive payment
2 system. And this is also for optimal diabetes
3 care.

4 Again, that's a conditional support
5 for rulemaking with a condition of removal of
6 competing measures.

7 MS. JUNG: Okay. Voting for MUC17-181
8 for the MIPS program is now open. Option 1 is
9 yes. Please raise your hand if you'd like to
10 indicate a yes.

11 (Show of hands.)

12 MS. JUNG: Okay. Please raise your
13 hand if you'd like to indicate a no.

14 (Show of hands.)

15 MS. JUNG: The final vote for MUC 181
16 for the MIPS program is 20 votes yes, zero votes
17 no.

18 CO-CHAIR MOYER: Okay.

19 DR. GREEN: I'll be quick, Amy. One
20 more thing I just want to say real quick to give
21 Peter some comfort regarding this measure as an
22 individual measure.

1 You know, this measure was the first
2 measure actually in PQRS. It was PQRS 1 and
3 carried forward in to MIPS, which it's not a
4 nostalgia thing here, but there are folks -- it
5 is a frequently-reported measure and people have
6 bene using this measure year over year to
7 actually look to see their quality improvement.

8 So that would be another thing I'd ask
9 you to consider. Thank you.

10 CO-CHAIR MOYER: Okay. The next vote
11 will be diabetes A1c control. This is for the
12 Medicare Shared Savings Program.

13 The recommendation is for conditional
14 support for rulemaking and the condition is the
15 removal of competing measures.

16 MS. JUNG: Voting for MUC17-215 is now
17 open. Option 1 is yes. Please raise your hand
18 if you'd like to indicate a yes.

19 (Show of hands.)

20 MS. JUNG: Option 2 is no. Please
21 raise your hand if you'd like to indicate a no.

22 (Show of hands.)

1 MS. JUNG: The final count for MUC 215
2 for MSSP is 20 votes yes, zero votes no.

3 CO-CHAIR MOYER: All right. The last
4 measure, everyone. This is diabetes A1c control
5 for the merit-based incentive payment system.

6 The recommendation is conditional
7 support for rulemaking. And the condition is the
8 removal of competing measures.

9 MS. JUNG: Voting for MUC17-215 for
10 the MIPS program is now open. Option 1 is yes.
11 Please raise your hand if you would like to
12 indicate yes.

13 (Show of hands.)

14 MS. JUNG: Option 2 is no. Please
15 raise your hand if you'd like to indicate no.

16 (Show of hands.)

17 MS. JUNG: The final vote for MUC17-
18 215 for the MIPS program is 20 votes yes, zero
19 votes no.

20 CO-CHAIR MOYER: All right. Next up
21 on the agenda is -- I'll hand it over to Pierre.
22 He's going to present input on measures for

1 removal criteria.

2 MEMBER YONG: So congratulations on
3 making it through the MUC list. So thank you
4 very much.

5 So we thought we would take advantage
6 of the in-person meeting. So this is being done
7 across all the workgroups.

8 We mentioned earlier in our opening
9 comments that we are taking the meaningful
10 measures framework and not only applying it to
11 the MUC list and thinking about that, but also
12 thinking about the current existing measure sets
13 within the programs.

14 So I thought this would be a nice
15 opportunity to solicit your input about the
16 criteria and the factors we should be thinking
17 about when we are going through that process
18 across all of our programs. So it's not just the
19 MIPS program and MSSP, but also all the hospital
20 programs, the ESRD QIP program, you know, the
21 post-acute care programs, all the programs that
22 we work on.

1 So if you go to the next slide, this
2 is the basic question we'd love some feedback on.
3 And so I assume it will be a very robust
4 discussion, but what criteria should CMS consider
5 as it reviews the measure sets for our quality
6 reporting and value-based purchasing programs.

7 And I will say that we'll appreciate
8 any feedback we get about this, and certainly any
9 process in terms of removal of measures and
10 proposal of measures would go through our normal
11 rulemaking process for notice and comment
12 rulemaking.

13 What we did was pull together, if you
14 go to the next slide, some draft criteria. And
15 so certainly, appreciate any reaction to this if
16 anything is missing. If you think there's
17 something that's really important for us to think
18 about, feel free to flag any of that.

19 So the first is the measure should be
20 meaningful to patients and providers. We
21 obviously want to keep patient-centered, high-
22 priority quality measures that are aligned with

1 not just clinical guidelines as we've been
2 talking about today, but also with the meaningful
3 measure areas that we've discussed earlier.

4 Sometimes with particular programs
5 there are specific statutory requirements about
6 measures that we do need to include in programs
7 as such so we want to continue meeting the -- our
8 statutory requirements.

9 In terms of measure type, that's
10 another factor that we really think about. So,
11 have really tried to move towards outcome
12 measures and so have preference for outcome
13 measures.

14 Oftentimes there are not outcome
15 measures available yet. So in those cases,
16 certainly we would use process measures as long
17 as they're closely tied to the outcome of
18 interest.

19 Something we want to see given that
20 these are often programs that are not just
21 quality-reporting programs, but accountability
22 programs where payment is actually determined or

1 influenced by the performance of these programs,
2 do believe that there should be some variation in
3 performance of these measures so that there is
4 some meaningful distinction between providers as
5 they're getting paid based on the performance on
6 the measures.

7 Burden is something we've talked
8 about. So considering the amount of burden
9 associated with the measure.

10 And realize that there's no measure
11 that's really no burden, as somebody pointed out
12 earlier, forget who it was. Even with claims-
13 based measures there's a lot of investment in
14 terms of reviewing the claims, making sure
15 they're accurate and then reviewing feedback
16 reports, but we do want to try to minimize the
17 burden associated with the use of the measures.

18 If you go to the next slide,
19 unintended consequences. This was another topic
20 of discussion on some of the measures today, but
21 certainly we do want to think about any
22 unintended consequences from use of the measure.

1 Operational issues, so sometimes there
2 are operational issues that may impact the
3 measure.

4 We had a discussion about this with
5 some of the measures earlier about sort of EHR
6 feasibility.

7 So those are some of the things that
8 we think about when it comes to keeping measures,
9 as those sometimes arise after we -- after we
10 learn about them after it's implemented into the
11 program.

12 And finally, alignment. So alignment
13 with -- and sort of measures with private pairs
14 across and within CMS programs to minimize
15 duplication of measures.

16 Again, this is again similar to
17 conversation we just had about de-duplication of
18 measures. So we may want to call that out
19 separately, but really appreciate any feedback
20 that you have about any of these criteria.

21 So I'll turn this back over to Amy and
22 Bruce.

1 CO-CHAIR MOYER: All right. Well, it
2 looks like we have -- Peter would -- has some
3 feedback for you.

4 MEMBER BRISS: I'll try not to get
5 another federal family foul. So can you go back
6 one slide, please? Can you guys go back one
7 slide, please? It is that point in the
8 afternoon.

9 And so an important thing that I think
10 isn't reflected here is the -- is sort of the
11 preventable burden of the -- the service or the
12 condition, right?

13 So basically potential public health
14 benefit of the measure is something that I don't
15 think is -- it might be rolled up into
16 meaningfulness, but it's probably important
17 enough to call it out on its own and I'm a little
18 afraid that everybody's preference for outcome
19 measures is getting overdone.

20 And so I actually think that you might
21 want to loosen that one up a little bit, either
22 outcome measures or composite measures or process

1 measures that are closely related to outcome
2 might be better.

3 Some things are -- some things are --
4 a lot of things the outcomes are relatively rare
5 or far in the future and I wouldn't -- and
6 nonetheless some of them are -- some things are
7 important to do. And so, there's two things.

8 And then I do want to call out
9 composite measures. I'd like to see us move in a
10 world where we're trying to be more parsimonious
11 and I'm not sure that the two examples that we
12 just looked at are the right ones.

13 I'm not voting on a particular measure
14 here, but I would like to see us roll up more of
15 our individual, one-thing-at-a-time measures into
16 important composites.

17 And I think that the Minnesota
18 Community Measure composites that we just looked
19 at are really nice examples of picking the four
20 or five most important things for a condition and
21 rolling them into one measure.

22 CO-CHAIR MOYER: Stephanie.

1 MEMBER GLIER: I agree with almost
2 everything Peter just said. Thanks.

3 I think one of the reasons that I --
4 that we -- my organization has had some concerns
5 about process measures, even those that are sort
6 of closely tied to outcomes, is that the closely
7 tied to outcomes gets a little tenuous.

8 And particularly when we're looking at
9 a program like MIPS where it's a minimum number,
10 you choose which measures we're concerned about,
11 process measures that are not as high value as
12 the outcome measures, particularly something like
13 a composite measure or patient-reported outcome
14 displacing --- so we're worried about process
15 measures displacing the higher value measures.

16 So if we had --- I mean, this is never
17 going to happen, but if we had mandatory
18 reporting in the clinician programs or if we had
19 mandatory sets that did have higher value
20 measures, I think we'd be much more open to
21 including more process measures that are tied to
22 outcomes in there.

1 But unless that is true, from our
2 point of view, it's much more important to have
3 truly outcome measures or a composite measure or
4 another measure type that looks at a bigger slice
5 of what a patient's experience of their health
6 is, whether that's their experience of their
7 interactions with the healthcare system, or their
8 functional status, or their quality of life, or
9 the preventable disease that they did not
10 experience because they got the care that they
11 needed upstream.

12 So I think that you guys do have most
13 of those things captured in here, but wanted to
14 sort of put a little texture on it from the
15 purchaser perspective, at least.

16 CO-CHAIR MOYER: And I would add to
17 that, that in an outcome process I think what we
18 really try to look at when we put a program
19 together is how do we make sure they're achieving
20 what it is we want them to achieve, however that
21 is.

22 And sometimes that, you know, is kind

1 of the outcome composite, the optimal care
2 measures are great for that.

3 You don't just achieve that. You have
4 to make a change in how you, you know, take care
5 of patients and how you approach it. It has to
6 be systemic versus, okay, we're checking some
7 things off.

8 And so things like that where, you
9 know, it's really changing care and moving it in
10 the direction we want to see it I think is, you
11 know, high value for a purchaser perspective and
12 patient, but I would also hope at the end a high
13 value for providers.

14 I'm sure it's painful to get there,
15 but I would hope at the end it's a better place
16 than where you left if, you know, if the measure
17 really had the intended consequence.

18 And I think Eric was next.

19 MEMBER WHITACRE: I'd like to speak a
20 little bit to the variation in performance. And
21 this is me speaking as a surgeon, not
22 representing the American College of Surgeons. I

1 don't know their point of view on this.

2 There are certain things we do in
3 surgery that are critical to quality maintenance.
4 And the analogy I would make is people love doing
5 this with pilots.

6 The single-engine land license, if
7 you've ever flown a Cessna 150 at 5,000 feet and
8 the door starts to go thwacka-thwacka-thwacka and
9 you look over at the instructor and he goes, oh,
10 it does that, you feel really good that you've
11 done something called the pre-flight checklist.

12 And it's something that's a religion.
13 And what you do, you go around, you kick the
14 tires, you check the gas, you look at the pitot
15 tube, you check the windshield.

16 That doesn't improve my skill or the
17 flight, but it makes it safe. And we have some
18 things like that in surgery.

19 And I'm concerned that if those are
20 removed from the measures list, it may, because
21 we all have limited time and resources and focus
22 and energy, I'm afraid it may take away from some

1 of the things that are critically important.

2 So I can imagine when I get on my
3 American flight to go back home, I'm going to
4 really be glad if the team, because it's a team
5 sport, did the pre-flight checklist, whatever
6 they all had to do.

7 And while they may have their quality
8 or performance measures of looking at CO2
9 reductions based on headwind and this and that
10 and whatever, I really want them to have done
11 that.

12 And we have some things like that in
13 surgery where the variation of performance,
14 granted, is still very, very small, but even that
15 0.1 percent will mean some inappropriate or
16 wrong-site surgeries and I wouldn't want those
17 numbers ever to increase.

18 So I'd like certain measures to be
19 considered critical for quality maintenance as
20 absolutely fundamental.

21 And we have some of those in surgery
22 and it's pretty simple, you know. It's the time

1 out. It's, you know, the right patient. It's
2 the appropriate surgery and so forth.

3 And, again, given limited time,
4 effort, energy, I think something needs to be
5 said for measures that are essential to quality
6 maintenance. Thank you.

7 CO-CHAIR MOYER: Harold, I think you
8 were next and then Helen.

9 DR. PINCUS: So I completely agree
10 with Peter and also what Stephanie said about not
11 being so overbalanced towards future, sort of,
12 outcome measures.

13 You need to have a balanced portfolio
14 and especially with regard to process measures
15 that are proximal to outcomes because I think
16 that's a key issue.

17 One thing, and I don't have an answer
18 for this, but there are measures out there that
19 have not improved.

20 And to take a hard look at the
21 measures that have not improved, which is not
22 necessarily to say that there's, you know, to get

1 rid of them, but to try to understand why they
2 haven't improved and to try to think about what
3 might be sort of the underlying problem there.

4 Is it something where there's, you
5 know, the measures are simply not capturing the
6 kind of information you want? Is there a way to
7 look at, you know, variation within that measure
8 to try to understand that there may be some
9 things that are going on, on high-performing --
10 on the high-performing sites that are -- where
11 they found some secret sauce or maybe it's, you
12 know, it's a problem of artifact that's embedded
13 in the measures, but I think that those are -- I
14 would say is priority areas for considering
15 whether they should be removed or replaced.

16 CO-CHAIR MOYER: Helen and then
17 Stephanie and then Amy.

18 MEMBER BURSTIN: Great. Thank you.
19 This is really very useful, Pierre. Thanks for
20 sharing.

21 I think the one comment I would make
22 is I think many of these sometimes can kind of be

1 in conflict with one another. And so I think
2 it's important to have a balanced perspective on
3 this.

4 Some of the most meaningful measures,
5 for example, may have a pretty significant burden
6 attached to them. Like patient-reported
7 outcomes, I don't want us to get so absolute in
8 this that high-burden measures that are high
9 value don't, you know, potentially get removed.

10 That being said, I think, you know,
11 there are also opportunities to think about
12 potentially removing measures that are claims-
13 based that are not highly reliable and replacing
14 them with potentially slightly higher burden
15 measures from EHRs or from clinical registries to
16 get at a better measure.

17 So the burden one in particular while
18 I agree with it, I think it's important to think
19 about when there may be unintended consequences
20 for pushing too hard on burden and then not
21 bringing forward the measures that matter with
22 the best possible data source.

1 MEMBER GLIER: Eric, I just wanted to
2 respond to you a little bit. From my point of
3 view as a patient, as a purchaser, clinical
4 guidelines are important and I want our measures
5 to be aligned with clinical guidelines, but I
6 want clinical guidelines to be a floor.

7 I want to be able to go to any
8 clinician, I want to be able to go to any
9 facility and assume that they are following best
10 practices established by their clinical area.

11 I don't think we should be using our
12 payment programs, our reporting programs, to
13 ensure that people are meeting the minimum floor.

14 I think if we see things like wrong-
15 site surgeries, that's a problem where we need to
16 be able to address that. And I think that's a
17 huge burden on patients, right, a wrong-site
18 surgery, major life impact.

19 But whether you did your hand-washing
20 protocol or whether you did your timeout at
21 exactly the right moment has a little less to do
22 with my patient outcome and how your hospital or

1 how your team chooses to approach the outcomes
2 that I do care about, I think I would rather
3 leave that up to you and not have a measure
4 looking at did you do -- did you have a hand-
5 washing protocol, did you have a checklist that
6 you followed.

7 So I think my preference as a patient
8 and purchaser would be to move away from the
9 baseline clinical guidelines and ask about the
10 outcomes that we really care about and the
11 outputs of the healthcare system overall,
12 acknowledging that there are processes that are
13 going to lead up to those, so, you know, do we
14 have an outcome measure with processes that do
15 roll up and we use the process measures as
16 quality improvement, sure, but I want us to be
17 focusing on CMS programs on those bigger things
18 that we care about, which I hope is consistent
19 with the meaningful measures framework.

20 CO-CHAIR MOYER: Amy.

21 MEMBER NGUYEN: I just wanted to add
22 in terms of alignment, I think we've all been

1 talking about it.

2 I just wanted to clarify and reiterate
3 that we should add the parsimonious and
4 harmonization of the measures along with
5 alignment because I think it's -- it goes in
6 everything that we're talking about in terms of
7 balance and being very true to the providers, the
8 patients, the purchasers to have a congruence of
9 measures that really align with all payment and
10 delivery reform.

11 CO-CHAIR MOYER: Bruce.

12 CO-CHAIR BAGLEY: Yes. Just to weigh
13 in on a couple of things, one is the airline
14 analysis.

15 I mean, I don't think that the
16 American Airlines measures the degree of
17 compliance with pre-flight checklists.

18 Now, I suspect that when they go for
19 a check ride and things like that -- but I
20 suspect that's not a number they're keeping.
21 They expect that to happen. That's a standard of
22 care and sort of, to your point, what's the

1 floor.

2 So I think just because we've reached,
3 you know, a high percentage doesn't mean it's no
4 longer important.

5 So you both make a good point, but we
6 should be pushing for higher -- the other thing,
7 and you're probably going to get tired of hearing
8 me say this, but we keep saying we're patient
9 centered and we're in a bind in that all of these
10 measures are designed to allow providers and
11 clinicians to participate in CMS payment and
12 quality programs in the sense that can we have a
13 push -- and I think we're actually making some
14 progress -- towards patient, you know, patient-
15 oriented outcome measures, really is the -- and
16 may not -- who does it and who's got a measure
17 that fits their specialty and all that kind of
18 stuff.

19 We really need to kind of get to
20 someplace where it's really about the best --
21 optimal, I guess, is the best word -- optimal
22 patient care in certain situations.

1 So I don't have an answer for that,
2 but we're still kind of stuck a little bit
3 because everything we've done up to this point is
4 to allow clinicians to participate in CMS
5 programs, really, you know.

6 And I have to go back a little bit.
7 Back when the Physician Consortium for
8 Performance Improvement was first formed, and I
9 can't remember the exact date, but 2010 or '11,
10 anyway, a while back, long time ago, and the
11 people around the table were all the quality
12 people.

13 And then about three years after it
14 started up, PQRS came in and all of a sudden the
15 people around the table were the advocacy people,
16 you know, how do I protect my group from harm or
17 over-measurement or unfair measurement.

18 And I think we kind of got pretty far
19 down that line to the point where we've got a lot
20 of measures that really are not driving quality
21 improvement.

22 I love the discussion about composite

1 measures and systematic care and things that
2 really are going to drive quality improvement.

3 So I know that's a big thing to take
4 on and certainly probably not in the realm of
5 this committee, but have the opportunity to say
6 that to CMS representatives to have things that
7 drive quality improvement, not just allow
8 participation.

9 CO-CHAIR MOYER: Peter.

10 MEMBER BRISS: Yeah. One more thing.
11 So I hate to follow Bruce with this comment, but
12 the one thing from CMS' point of view, you are
13 going to have to continue to have a critical mass
14 of measures that speak to different kinds of
15 provider groups, right, you know?

16 And so there's nothing -- maybe it's
17 implicit under meaningfulness here, but you're
18 going to have to do it and so you might as well
19 make it explicit.

20 And maybe one way to meet that need
21 and be respectful to what Bruce just said is if
22 we characterize that as not having a critical

1 mass of measures that endocrinologists can
2 participate in, but instead you characterize that
3 as what are the -- we want to make sure that we
4 either have a good quality composite or the top
5 five individual measures that meet the needs ---
6 that most meet the needs of a person with
7 diabetes or a person with thyroid disease or
8 something like that.

9 Then the relevant providers for those
10 kind of people would have something useful to do
11 and we could be patient-centered at the same
12 time, perhaps, but you're going to need to allow
13 providers to have something relevant to play.

14 CO-CHAIR MOYER: All right. Any other
15 advice or suggestions for CMS on the measure
16 removal criteria?

17 I think we talked a lot about measure-
18 adding criteria in some ways, but --

19 CO-CHAIR BAGLEY: Thank you. Anything
20 else you need to know?

21 MEMBER YONG: No. I think we've
22 covered it. Thanks.

1 CO-CHAIR MOYER: Go ahead, Ann.

2 MEMBER GREINER: To build on what
3 Peter just said, I mean, we know that not all
4 specialists have a collection of measures that
5 are appropriate for their specialty, but primary
6 care has a lot of measures, maybe not always the
7 optimal measures.

8 So to the degree that CMS can be
9 removing some of the duplicative or lower-value
10 primary care measures and helping to support the
11 development of better measures for primary care,
12 that would be great.

13 CO-CHAIR MOYER: All right. I think
14 that finishes up that topic for today. We will
15 have one last opportunity for public comment on,
16 I guess, anything we've discussed today.

17 If there's anyone in the room who has
18 a public comment, now would be your chance.

19 (Pause.)

20 CO-CHAIR MOYER: And, operator, will
21 you check for any public comment on the lines?

22 THE OPERATOR: Okay. At this time if

1 you would like to make a comment, please press
2 star and the number one.

3 (Pause.)

4 THE OPERATOR: Thank you. We have a
5 comment from Koryn Rubin.

6 MS. RUBIN: Yes. Hi. This is Koryn
7 Rubin from the AMA. Sorry I couldn't be there in
8 person today. I'm suffering from a respiratory
9 infection and getting over a fever.

10 And so I know my colleagues have kind
11 of filled in, in my place today, but I just
12 wanted to add a few more things to the
13 discussion. Some of them have been said.

14 The AMA has put in a lot of thought in
15 terms of what needs to be considered for ---

16 (Telephonic interference.)

17 MS. RUBIN: --- first and foremost it
18 needs to be considered in the context of the
19 specific program.

20 The implications for a hospital
21 program are different than a physician program
22 due to the diversity among clinical practice,

1 specialty and subspecialty.

2 And when you have a congressional
3 mandate that others have said that all physicians
4 must comply with the program and then in the
5 program, CMS requires a certain number of
6 measures and the type of measure that a physician
7 needs to be -- to report in order to be
8 considered successful, you need to have a large
9 suite of measures to meet every specialty and
10 subspecialty.

11 In general, the AMA does support the
12 removal of measures when clinical evidence has
13 changed regardless of the program.

14 We are, however, concerned with the
15 standards CMS has put in place for removal of
16 measures within MIPS to date and the potential
17 future gap that will be created by solely relying
18 on benchmark data without consideration of
19 clinical factors, scientific evidence and the
20 importance of a measure.

21 There also needs to be more research
22 to determine the appropriate sample size for each

1 quality measure before a quality measure can be
2 determined to be topped out and removed from a
3 program.

4 Many measures have a reporting sample
5 size that represents less than one percent of
6 eligible clinicians who are eligible to report on
7 the measure.

8 And we also have the following
9 recommendations to improve the MIPS process when
10 it comes to removal of measures.

11 Process measures that are proximal to
12 an outcome and for which there's strong evidence
13 that fulfillment of the measure intent such as
14 providing or not providing a specific treatment,
15 will improve patient outcomes should be retained,
16 the unintended consequences of removing key
17 topped out measures are unknown.

18 Also, better analysis needs to be
19 performed. Physician performance can vary by
20 practice setting, patient population, geography,
21 years in practice, volume of cases of particular
22 condition, or how long the physician has been

1 reporting.

2 So there's a need to examine the
3 breadth and depth of reporting based on the
4 number of physicians who successfully report on a
5 measure.

6 There's also a need to examine
7 reporting based on the number of physicians who
8 successfully report on the measure and the length
9 of time the measure is reported on within a given
10 performance year.

11 Also with performance results, some
12 evaluation for performance results of a measure
13 that can be considered for removal should be
14 examined for any evidence of variation among
15 subgroups defined by factors mentioned above and
16 other nonclinical factors.

17 Also, with reporting options, CMS will
18 remove a measure when it appears topped out in
19 one category, but not another.

20 Really, it should only be considered
21 topped out and removed once it hits that
22 threshold against all reporting options.

1 Also, one potential way to see if the
2 numbers are reflecting true performance is to
3 compare it to other current data.

4 For example, if a study or clinical
5 registry shows that there's still a gap in care,
6 the performance scores in MIPS may not reflect
7 performance across all physicians. And the
8 results of these subgroups' analyses should also
9 be shared with the relevant stakeholders.

10 We also recommend keeping measures
11 that track performance on major public health
12 issues such as tobacco use and
13 counseling/screening for alcohol use, pre-
14 diabetes, hypertension, opioid use, immunizations
15 and hepatitis C.

16 Also, you also have to consider
17 measures, how they're used in other programs.
18 For example, there are many health plan-level
19 measures that are part of the Medicare Advantage
20 Star Rating System that are reliant on clinical
21 action.

22 To ensure compliance, the private

1 plans incorporate them into physician contracts.
2 So for purposes of alignment, CMS or the MAP
3 should evaluate how physicians' measures may
4 relate to other quality programs.

5 Therefore, CMS should consider
6 alignment across other programs when deciding
7 whether to remove or retain measures in MIPS.

8 Thank you for considering my feedback
9 and hopefully you can incorporate it into the
10 discussion today.

11 CO-CHAIR MOYER: Thank you, Koryn.

12 Is there any other public comment
13 online?

14 THE OPERATOR: No, ma'am. There are
15 no other public comments.

16 CO-CHAIR MOYER: All right. Well,
17 this feels like a very successful day, everyone.
18 We considered, I guess, 22 measures total because
19 they're across both programs. So 22 for MIPS.
20 Two of those were support, 18 were conditional
21 support, and two were refine and resubmit. Then
22 for MSSP there were three measures, all of which

1 were conditional support.

2 And I appreciate everyone for your
3 time and your contributions. And the thought
4 that had gone into your approaching this meeting
5 makes everything go well. Thank you.

6 Bruce.

7 CO-CHAIR BAGLEY: Thanks, Amy. I'd
8 like to add my thanks to everyone, but
9 particularly I'd like to thank the staff and for
10 a couple of reasons.

11 First of all, the discussion guide,
12 that must take a huge amount of work and it makes
13 our work doable.

14 (Applause.)

15 CO-CHAIR BAGLEY: And I just want to
16 add that a lot of this work has been done in a
17 pretty short time line and often over the
18 Thanksgiving holiday week or weekends or time
19 outside of usual work hours. Let's put it that
20 way. So we appreciate that.

21 I think we had a great discussion this
22 morning about a whole new type of measure in

1 terms of the cost of care resource use measures.
2 And to my knowledge, there's been a lot of stuff
3 talked about in the past, but this is a concrete
4 step forward that's being pushed by CMS that
5 really could have some real traction in other
6 than a local market.

7 So I think this is really a monumental
8 day and, you know, a tribute to all the work that
9 you did to get this ready.

10 The fact that it kind of came out the
11 way it went in, in the sense that we didn't
12 really recommend to change much was a testament
13 to the amount of work that you did to get it
14 prepared, Pierre. So to you and your teams,
15 thank you for that.

16 MEMBER YONG: So I just want to take
17 the opportunity, also, from CMS' behalf to thank
18 all of you for the hard work you put in today. I
19 think it was an incredibly successful day.

20 And by my count, you know, I think
21 about 11 measures, which was astounding to me,
22 actually, were completely, universally had a

1 hundred percent agreement across the MAP which is
2 -- I have not seen in the four years I've been
3 doing this. So, that was pretty amazing to me.

4 And I think, hopefully, that reflects
5 a couple of things. I think, you know, looking
6 at this and it started with the conversation
7 about the role of refine and resubmit and, you
8 know, I would note that only one of the measures
9 actually, I think, got refine and resubmit and
10 the others were in the other categories.

11 I think, one, appreciate, I think, the
12 conversation that you had at the beginning and
13 sort of everybody's flexibility in terms of
14 thinking through how to use that in the most
15 appropriate way. I think from our standpoint, we
16 found that very helpful.

17 And, two, hopefully this does reflect
18 how we've sort of really taken a look at how we
19 approach the MUC list and sort of the kinds of
20 measures we put on the MUC list. So hopefully
21 that actually contributed, too, but I do want to
22 thank, in particular, Bruce and Amy for their

1 efforts and sort of co-facilitating today, the
2 NQF staff, Hiral, John as well as others, and
3 Madison as well as other staff on NQF.

4 And I also want to particularly thank
5 all the CMS staff who many of you have seen at
6 the table today, but many of whom you may even be
7 familiar with because you may have talked to on
8 the phone, but weren't at the table. But I just
9 want to name them, but -- so there's Dan Green,
10 Sophia Sugumar, Jennifer Harris, Susan Arday,
11 Reena Duseja, Ted Long and Michelle Jaffe. Thank
12 you to all of them for making today a success.
13 Thank you.

14 (Applause.)

15 MEMBER YONG: Okay. And just thank
16 you all for your time and for showing up here
17 today and spending your day with us and your
18 thoughtful deliberation.

19 I know you have to talk about the next
20 meeting. As you're packing up, Madison is going
21 to talk about the timeline and next meetings.

22 MS. JUNG: Sorry to break up the

1 celebration party. In terms of next steps, I'll
2 be brief.

3 I'm sure a lot of you are familiar
4 with this --- the pre-rulemaking timeline. In
5 terms of immediate next steps in these following
6 days the rest of the week, we have the PAC/LTC
7 group here tomorrow, the Hospital group here the
8 following day, and then following the summary and
9 compilation of our comments and your thoughtful
10 recommendations, the MAP --- we'll bring that to
11 the MAP Coordinating Committee. And they'll have
12 their in-person meeting January 25th and 26th.

13 The immediate next public comment for
14 this will be December 21st to January 11th. For
15 contact information you can please --- you can
16 find that on our project page. In addition too,
17 workgroup members, you can look at the SharePoint
18 page.

19 As always, if you have any questions
20 or lingering thoughts, please reach out. Our
21 email is mapclinician@qualityforum.org.

22 And then finally, just a big thank you

1 from the NQF staff for making all the long
2 travels here. It's very much appreciated
3 especially during this busy season.

4 A big thanks to Bruce and Amy for your
5 leadership. And that's it. Thank you for
6 coming.

7 (Applause.)

8 (Whereupon, the above-entitled matter
9 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

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