

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
CLINICIAN WORKGROUP

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WEDNESDAY
DECEMBER 12, 2018

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

WORKGROUP CO-CHAIRS

BRUCE BAGLEY, MD, National Quality Forum

AMY MOYER, The Alliance

ORGANIZATIONAL REPRESENTATIVES

KEVIN BOWMAN, MD, Anthem

HELEN BURSTIN, MD, MPH, FACP, Council of Medical
Specialty Societies

DAE CHOI, MBA, MPH, Genetech

ROBERT FIELDS, MD, Mount Sinai Health System

SCOTT FURNEY, MD, FACP, Atrium Health

ANN GREINER, MS, Patient-Centered Primary Care
Collaborative

ROBERT KRUGHOFF, JD, Consumers' CHECKBOOK

TRUDY MALLINSON, PhD, OTR/L, FAOTA, The George
Washington University*

IRA MOSCOVICE, PhD, MAP Rural Health Workgroup
Co-Chair

AMY NGUYEN HOWELL, MD, MBA, FAAFP, America's
Physician Groups

DIANE PADDEN, PhD, CRNP, FAANP, American
Association of Nurse Practitioners

KIM RITTEN, HealthPartners*

DAVID SEIDENWURM, MD, Sutter Health/American
College of Radiology
J. CHAD TEETERS, MD, RPVI, FACC, American
College of Cardiology
PATTI WAHL, MS, St. Louis Area Business Health
Coalition

SUBJECT MATTER EXPERTS
MICHAEL HASSETT, MD, MPH
DALE SHALLER, MPA
ERIC WHITACRE, MD, FACS

FEDERAL GOVERNMENT LIAISONS
GIRMA ALEMU, MD, MPH, Health Resources and
Services Administration (HRSA)
PETER BRISS, MD, MPH, Centers for Disease
Control and Prevention (CDC)
REENA DUSEJA, MD, Centers for Medicare &
Medicaid Services (CMS)

NQF STAFF:

TAROON AMIN, Senior Director
JOHN BERNOT, MD, Vice President, Quality
Initiatives
AMEERA CHAUDHRY, Project Analyst

KAREN JOHNSON, MS, Senior Director, Performance
Measures

VAISHNAVI KOSURI, MPH, Project Analyst
MIRANDA KUWAHARA, MPH, Project Manager
ELISA MUNTHALI, MPH, Senior Vice President
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

JOEL ANDRESS, PhD, CMS

SUSAN ARDAY, CMS

JAYANTI BANDYOPADHYAY, MPH, Mathematica*

CHRIS BEADLES, MD, PhD, RTI International*

HEIDI BOSSLEY, MSN, MBA, Bossley Consulting, LLC

RICHARD DOANE, Premier, Inc.*

STEPHAN DUNNING, OptumLabs

DAN GREEN, MD, CMS

DEANNA HAYES, PT, DPT, MS, Focus on Therapeutic
Outcomes, Inc. (FOTO)*

STEPHEN MCCOLLAM, MD, American Academy of
Orthopaedic Surgeons*

JENNIFER McLAUGHLIN, American Medical
Association

SRINIKETH NAGAVARAPU, PhD, Acumen, LLC

COLLEEN PARKER, RN, BSN, CEN, LUGPA and Oregon
Urology Institute*

RYAN PEZOLD, American Academy of Orthopaedic
Surgeons*

LYNN PEZZULLO, RPh, CPEHR, Pharmacy Quality
Alliance (PQA)*

SANDRA POGONES, MPA, CPHQ, American Academy of
Family Physicians*

LINDSEY ROTH, MPP, National Committee for
Quality Assurance (NCQA)*

DARSHAK SANGHAVI, MD, OptumLabs

MICHELLE SCHREIBER, MD, QMVG Group Director,
CMS

HEATHER SMITH, PT, MPH, American Physical
Therapy Association*

KIM SPALDING BUSH, BS, CMS*

JENNA WILLIAMS-BADER, MPH, NCQA*

*Present via telephone

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

2 (8:31 a.m.)

3 CO-CHAIR BAGLEY: Well, welcome to
4 sunny Washington. Those of you who live here,
5 that's fine but for those of you who have
6 traveled, I'm glad you made the trip and I hope
7 you have a good time today.

8 My name is Bruce Bagley and I'm the
9 co-chair with Amy this morning and I think we'll
10 have some introductory remarks and then we'll
11 talk a little bit more about meeting conduct.

12 So, John, do you want to start off?

13 DR. BERNOT: Yes, good morning,
14 everyone. Again, thank you so much for coming
15 out to Washington, D.C. on this early Wednesday
16 morning with holiday season and weather across
17 the country. So we really appreciate that you
18 made the effort to get here.

19 We have a busy day today. This is Day
20 3 of MAP. The PAC/LTC group had gone Monday, the
21 hospital group went yesterday, and this is the
22 final, the clinician group today. So we have a

1 lot on the agenda but we're really happy that you
2 were able to make it.

3 There's a few minor points I'm going
4 to go over more of the logistics of the meeting.

5 The first one is we have a new voting
6 software. I think you'll happy to know, fingers
7 crossed, the last few days, it went very well.

8 It's been a big improvement. I think the
9 committees really were pleased with the change.

10 But we do have instructions on everyone's seat
11 about getting onto the Poll Everywhere software.

12 If at some point over the last 10 or 15 you
13 realize you've not been able to get on or you're
14 having a problem, just let one of the staff
15 members know and we will come around and make
16 sure because we will need everyone to be on that
17 for the voting.

18 The way it works, as you'll be able to
19 see, we're going to do a test, but you will be
20 able to see the votes. We will know who voted
21 but we will not know how you voted. So that's
22 just we have an integrity check that the correct

1 people are voting but we do not know what the
2 vote will look like.

3 All of the meeting materials, if
4 you're following on your computer, are on the
5 public.qualityforum.org website. The discussion
6 guide we'll actually be using which has the
7 hyperlinks to move through it.

8 I think also most of you have been
9 here in the past but if you have not, when you
10 wish to speak, we use the tent cards -- oh sorry,
11 Bruce is going to talk about the tent cards so
12 we're on that one.

13 The other logistics, restrooms are
14 down the hallways this way and then you make a
15 right.

16 So other than that, I'd just like to
17 say thanks again for coming. A busy day today,
18 so I will keep the remarks short from the NQF
19 side but a lot of work has gone into it both from
20 the NQF staff and from comments from the chairs.
21 So I think we'll have a good meeting today.

22 So with that, I will turn it back over

1 to Bruce.

2 CO-CHAIR MOYER: I just wanted to
3 welcome everyone today.

4 And one additional thing I wanted to
5 add very timely, we worked on this with Michelle,
6 if everyone could mute their cell phones.

7 I'm looking forward to some really
8 robust discussion and thank you all for being
9 here.

10 CO-CHAIR BAGLEY: And about the tent
11 cards, the tent cards are so we know who you are.
12 So make sure that we can see them. There's a lot
13 of people in this room and it's a long way to the
14 other end of the table.

15 If you want to speak, all you have to
16 do is catch our eye and we'll put you on a list.
17 So if you will look at -- if I give you the high
18 sign, that means I've seen you and you're on the
19 list. And if at any time you want to know what's
20 going on with the list, we'll read it off to you.
21 But usually that worked pretty well for us and
22 that way, people don't have to worry about

1 putting their tent cards back down and all of
2 that kind of stuff because that gets confusing
3 after a while for the chair, at least. So I
4 would prefer that you use the other method.

5 We're going to dive right in here. Do
6 you want to take the first part, Elisa?

7 MS. MUNTHALI: Yes. Good morning,
8 everyone. My name is Elisa Munthali and I'm the
9 Senior Vice President for Quality Measurements at
10 the National Quality Forum. I welcome and thank
11 you all for being on this workgroup.

12 So what we're going to do today is to
13 combine introductions of the workgroup with
14 disclosures of interest. We're going to do it in
15 two parts because there are two types of
16 workgroup members. There are organizational reps
17 and there are subject matter experts.

18 We'll start with our organizational
19 reps. We'll start with the organizational
20 representatives and the room and then go to those
21 that are on the phone. And then we'll go to the
22 subject matter experts; go to those in the room

1 first and those on the phone.

2 For the organizational reps, we sent
3 you a questionnaire. It was a short
4 questionnaire. We essentially wanted to know the
5 financial interest and work that you've done
6 where you've been paid \$10,000 or in excess of
7 \$10,000.

8 So we will start to the left of me.
9 I think we're starting with I think it's Scott.
10 And if you can introduce yourself, let us know
11 which organization you are with, and let us know
12 if you have any disclosures.

13 MEMBER FURNEY: So my name is Scott
14 Furney. I am a representative of Atrium Health.
15 That's a new name that used to be Carolinas
16 HealthCare System. So we've expanded to Georgia.
17 The name no longer fit so it's now Atrium Health.

18 I have no disclosures of any type.

19 MS. MUNTHALI: Thank you very much.
20 And what I should have done is tell you who is
21 the subject matter experts. There are more
22 organizational representatives on the workgroup

1 than subject matter experts. So for this first
2 round, everyone with the exception of Michael
3 Hassett, Dale, your co-chairs of course, Eric,
4 and I think that's it.

5 So we'll continue on.

6 MEMBER FIELDS: Rob Fields, Senior
7 Vice President, CMO for Pop Health at Sinai. I'm
8 here representing the National Association of
9 ACOs. No disclosures.

10 MS. MUNTHALI: Thank you.

11 MEMBER TEETERS: Hi, I'm Chad Teeters.
12 I'm from the American College of Cardiology and I
13 have no disclosures as well.

14 MEMBER MOSCOVICE: Ira Moscovice,
15 professor at the School of Public Health,
16 University of Minnesota representing the MAP
17 Rural Health Workgroup.

18 MS. MUNTHALI: And, Girma, we'll wait
19 until we introduce our federal liaisons and then
20 we'll have you introduce yourself then. The same
21 with you, Peter.

22 MEMBER PADDEN: Good morning. I'm

1 Diane Padden. I'm representing the American
2 Association of Nurse Practitioners.

3 In terms of disclosure, I do sit on
4 one of the MAP MACRA episode-based cost measures
5 development, as well as the MIPS outpatient
6 measures as well.

7 MEMBER SEIDENWURM: Hi, I'm David
8 Seidenwurm, American College of Radiology and I
9 was a co-chair of one of the episodes, the spine
10 fusion episode.

11 MEMBER WAHL: Good morning. I'm Patti
12 Wahl with the St. Louis Area Business Health
13 Coalition. We represent large self-funded
14 employers. And I have no disclosures.

15 MEMBER BURSTIN: Good morning. Helen
16 Burstin, CEO of the Council of Medical Specialty
17 Societies. No financial disclosures.

18 MEMBER CHOI: Hi, Dae Choi with
19 Genetech. Just a general disclosure that I am
20 employed by Genetech. We have portfolios in
21 oncology, ophthalmology, and neuroscience.

22 MEMBER GREINER: Hi, Ann Greiner,

1 President and CEO of the Patient-Centered Primary
2 Care Collaborative and no disclosures.

3 MS. MUNTHALI: Great. Thank you very
4 much.

5 So Kim Ritten, are you on the phone?

6 MEMBER RITTEN: Yes, I'm on the phone.
7 This is Kim Ritten from HealthPartners in
8 Minnesota and I have no disclosures. I'm sitting
9 in for Sue Bugel.

10 MS. MUNTHALI: Thank you very much.

11 Terry, are you on the phone? Okay,
12 Terry may not have joined us yet.

13 So thank you to all of our
14 organizational representatives. And so now we'll
15 go through disclosures for the subject matter
16 experts.

17 For the subject matter experts, you
18 received a lengthier form that asked you to
19 disclose any activities that were relevant to the
20 work in front of you.

21 Just a couple of reminders. We're
22 interested not just in the paid activities but

1 also those that are not paid. In addition to
2 that, we wanted you to know that even though you
3 disclosed does not mean that you have a conflict
4 of interest. We do this in the spirit of
5 openness and transparency.

6 And so in the room, we'll start with
7 Dale.

8 MEMBER SHALLER: Good morning. Dale
9 Shaller. I am a patient experience subject
10 matter expert. I have no disclosures related to
11 the measures under consideration but do if there
12 were patient experience measures. But since
13 there aren't, I think I'm okay.

14 MS. MUNTHALI: Thank you.

15 Eric.

16 MEMBER WHITACRE: Good morning. My
17 name is Eric Whitacre. I have several
18 disclosures, none financial.

19 I'm a member of the Performance
20 Measures Committee of the American College of
21 Surgeons that's involved in measure development,
22 none of which are directly related to these.

1 But I do for the breast measure, the
2 lumpectomy/mastectomy measure. I have been
3 involved with peripheral emails, not in terms of
4 the measure creation but responding to member
5 frustration over the process.

6 In terms of reimbursements, because I
7 guess that's now part of this committee, I am the
8 ASBS representative to the AMA RUC Committee,
9 alternate to the CPT, and a member of the
10 American College of Surgeons Coding and
11 Reimbursement Committee.

12 MS. MUNTHALI: Thank you. And I think
13 Michael is the next subject matter expert.

14 MEMBER HASSETT: My name is Michael
15 Hassett. Thank you. I'm a medical oncologist.
16 I work at Dana-Farber Cancer Institute in Boston,
17 Massachusetts and I sit on ASCO -- a committee
18 that is responsible for developing measures for
19 ASCO, which is the American Society of Clinical
20 Oncology.

21 MS. MUNTHALI: Thank you, Michael.

22 And your co-chairs, of course, are

1 subject matter experts. I'll turn it over to Amy
2 first.

3 CO-CHAIR MOYER: Hi, I am Amy Moyer
4 and I work for The Alliance. We are a
5 cooperative of self-funded employers. So I am a
6 purchaser.

7 And I have no disclosures relevant to
8 measures that are before the committee today.

9 MS. MUNTHALI: Okay, thank you.

10 CO-CHAIR BAGLEY: Hi, I'm Bruce
11 Bagley. I'm a family physician and at this point
12 in my life, I am independent consultant working
13 less and enjoying it more. And I have no
14 conflicts that are relevant to this.

15 Like all of you, I come with a
16 boatload of biases but I have no conflicts of
17 interest.

18 MS. MUNTHALI: Thank you very much.

19 And we understand that we have another
20 organizational representative on the phone, Trudy
21 from the George Washington University. Trudy,
22 are you on mute by any chance?

1 Okay, we may come back later in the
2 meeting.

3 In addition to having our subject
4 matter experts and our organizational reps on the
5 committee, we also have federal liaisons who are
6 part of the committee but they are nonvoting
7 workgroup members. And so I'll start with
8 Michelle Schreiber, who is from CMS, to introduce
9 herself.

10 DR. SCHREIBER: Thank you. Good
11 morning. I am Michelle Schreiber. I am one
12 month into my job as the new Director of QMVIG,
13 which is the Quality Measures Value-based
14 Incentives Group. It is the group within CMS
15 that owns most of these programs that you love
16 dearly. So, thank you.

17 MS. MUNTHALI: Thank you.

18 DR. SCHREIBER: And I have no
19 disclosures.

20 MS. MUNTHALI: Thank you. Girma?

21 MEMBER ALEMU: Yes, I am Girma Alemu
22 with the Health Resources and Services

1 Administration. I have no disclosures to report.

2 MS. MUNTHALI: Thank you very much,

3 Girma.

4 Peter?

5 MEMBER BRISS: Good morning. I'm

6 Peter Briss. I'm with the Centers for Disease

7 Control and Prevention and I have nothing to

8 disclose.

9 MS. MUNTHALI: Thank you. And Trudy
10 did communicate with us via email and she has no
11 disclosures.

12 So we've heard all of the disclosures
13 and I thank you all for participating. I just
14 wanted to remind you if at any time during the
15 meeting you remember that you have something to
16 disclose, we want you to do so. You can speak up
17 in real time or you can contact any of us on the
18 NQF staff or your co-chairs.

19 Likewise, if you feel that one of your
20 workgroup members is acting in a biased way, we
21 want you to speak up or contact us and let us
22 know.

1 So with that, I thank you again.

2 CO-CHAIR BAGLEY: John, would you like
3 to introduce your staff?

4 DR. BERNOT: Sure. One thing we'll do
5 is just introduce the staff. I want to also
6 point this out, not just so who we are but if you
7 have any questions as Elisa mentioned throughout
8 the day, please grab any one of us and just ask
9 the question. We'll do our best to answer it.

10 But for those of you who I do not
11 know, I'm John Bernot. I'm Vice President of
12 Quality Measure Initiatives with NQF and a member
13 of the Clinician Workgroup.

14 MS. O'ROURKE: I'm Erin O'Rourke. I'm
15 a Senior Director with NQF and I support the
16 Coordinating Committee.

17 MS. KUWAHARA: Good morning, everyone.
18 My name is Miranda Kuwahara and I serve as the
19 Project Manager for this work.

20 MS. KOSURI: I'm Vaishnavi Kosuri and
21 I serve as the Project Analyst on this team.

22 MR. AMIN: Good morning, everyone.

1 I'm Taroon Amin. I'm a consultant supporting the
2 MAP Coordinating Committee.

3 DR. BERNOT: Well, I think that's it.
4 Back to you, Bruce and Amy.

5 CO-CHAIR BAGLEY: Michelle, we're
6 going to ask you to set this whole thing up.

7 Before we do that, Amy, do you want to
8 just say who you are and your conflicts?

9 MEMBER NGUYEN HOWELL: Sure. Hi, good
10 morning, everyone. Amy Nguyen Howell and no
11 conflicts.

12 CO-CHAIR BAGLEY: Okay, thank you.

13 DR. SCHREIBER: Thank you to the co-
14 chairs. As you heard, I'm Dr. Michelle Schreiber
15 and, on behalf of CMS, I'd really like to welcome
16 you all to the MAP. This is a wonderful
17 committee with a lot of diverse opinions, which
18 we look forward to hearing. Sincerely, thank you
19 for your participation.

20 You know your input today is really
21 extremely valuable. As I've been part of this
22 for the last couple of days, the feedback is very

1 important. We take copious notes but truly CMS
2 does listen to the comments that are here and it
3 does influence and change the way that some of
4 these measures are developed, go forward, and
5 become part of rulemaking. So we want you to
6 know that your opinions really do matter.

7 We'd like to thank NQF also for
8 convening this work and for your expertise.

9 I'm joined today by some of my
10 colleagues at CMS, Dr. Reena Duseja, who is the
11 Chief Medical Officer for QMVIG, will be here
12 shortly.

13 We have a number of people in the
14 audience, including some of our experts and the
15 contractors who actually are measure developers.
16 Please take a moment to interact with them if you
17 have questions. They really are the experts in
18 some of these areas.

19 The Measure Application Partnership is
20 an important annual process that, frankly, many
21 of you know better than I do but it's where NQF
22 convenes multiple stakeholders to provide input

1 on measures for use in federal programs, which
2 will become part of rulemaking really almost as
3 soon as these meetings finish.

4 The committee also helps to provide
5 guidance on future direction and helps identify
6 gaps in measures. And of course, there is the
7 opportunity for important public comment that we
8 appreciate very much.

9 So you've heard I'm new to CMS, one
10 month into this. This is the group that is
11 responsible for quality measures, for their
12 development, for their stewarding in the programs
13 that many of you are familiar with, the Hospital,
14 Stars, MIPS, meaningful use, a/k/a Promoting
15 Interoperability, post-acute care, inpatient
16 psych. So it's a host of programs and these MAP
17 Committee meetings are very important in
18 providing input to all of them.

19 So, by way of background, I know a few
20 of you. I don't know many of you. I am a
21 primary care general internal medicine physician
22 and until about a month ago, I was still seeing

1 patients. So this is something that's near and
2 dear to my heart.

3 I'm also a caregiver for an elderly
4 mother and hence, the phone calls this morning.

5 I've worked in healthcare for really
6 many years, always within the healthcare space.
7 This is a new transition to the policy side.
8 It's really very humbling and very exciting to
9 see it from the development of the things that we
10 work with on a daily basis.

11 I was most recently the Chief Quality
12 Officer of the Henry Ford Health System and was
13 also its lead in their Epic implementation. My
14 particular interest, actually, is the
15 intersection of quality quality measures in the
16 electronic medical record and so it's very
17 exciting to, again, be in this spot of
18 development.

19 I know that you've heard presentations
20 before on CMS' important initiative of Meaningful
21 Measures. So let me just touch on a couple of
22 things today to keep in mind as you consider your

1 votes on the measures that are before you.

2 Meaningful Measures was launched
3 really just last year to improve outcomes for
4 patients and caregivers by empowering them with
5 information that is helpful for them to make
6 decisions. But Meaningful Measures is also about
7 making things better for healthcare systems and
8 certainly more importantly for providers. It is
9 about reducing the reporting burden to clinicians
10 and promoting patients over paperwork.

11 With this in mind, we actually
12 narrowed down the initial 184 measures submitted
13 to the MUC list down to a very parsimonious list,
14 most of which have fallen on this committee. The
15 prior two MAPs actually had fewer measures to
16 consider, while you have a larger agenda.

17 You know we do recognize that quality
18 measurement and quality reporting is not a
19 perfect science and that all of the programs that
20 we work with have opportunities for continued
21 refinement.

22 This past month I've really come to

1 appreciate how CMS does take these comments
2 seriously and is working all the time on
3 improving both the measures and the process of
4 developing them and again, delighted to hear your
5 feedback.

6 As part of the effort to reduce
7 burden, last year through Meaningful Measures we
8 removed 79 measures and saved an estimated over
9 \$125 million in expense, while continuing to
10 align measures across multiple programs.
11 Meaningful Measures is a commitment to infusing
12 the principles of value, innovation, and
13 flexibility and follows the CMS quality strategy
14 goals, which include making care safer,
15 strengthening the person and family engagement,
16 promoting effective communication and care
17 coordination, promoting the effective prevention
18 and treatment of chronic disease, working with
19 communities to promote best practices of healthy
20 living and, of course, making care affordable.

21 Meaningful measures is not just about
22 burden reduction, however. The work also calls

1 for identifying and filling in gaps where there's
2 a lack of important measures, some of which
3 you'll see today, and focusing more on outcome
4 and patient-reported measures, although I want to
5 be clear that process measures have a role as
6 well.

7 We'll continue to align measures
8 across all programs and payers. I'm really
9 particularly excited about the work that has
10 reinstituted with the partnership of National
11 Quality Forum, AHIP, America's Health Insurance
12 Providers, and CMS called the Core Quality
13 Measures Collaborative, which is a set of
14 committees that is looking to align CMS measures
15 with the major payers in the United States. So
16 if we can have sort of a seamless view of quality
17 measures and programs, I think that would also
18 help reduce burden.

19 Finally, we recognize that we have to
20 reduce the burden of the measurement systems,
21 including making quality measures more real-time
22 so that they are actionable. There is a great

1 deal of work and thought going on around multiple
2 registries, as well as significant thought to the
3 future and what it means to have electronic
4 quality measures.

5 So please, and a couple of final
6 comments, think about these areas as you make
7 your recommendations today:

8 1) Are we addressing a high impact
9 area?

10 2) Are the measures meaningful to
11 patients and caregivers and include the patient
12 voice?

13 3) Is this an outcome or a process
14 measure? They are different and both have a
15 role.

16 4) What is the burden of the measure,
17 or the burden, or unintended consequence of
18 including the measure in a value-based program?

19 5) Is there a significant opportunity
20 for improvement in the metric area, or is it
21 really just topped out?

22 6) And finally, does the measure fit

1 a population-based payment or alternative payment
2 model and does it align with other programs or
3 payers?

4 I'd also like to close by saying
5 please always, as we do, think about equity and
6 about advancing interoperability in electronic
7 health records.

8 I thank you, and, on behalf of CMS, we
9 all thank you for your time, your dedication, and
10 we look forward to your participation, and look
11 forward to working really with each and one of
12 every one of you. Please feel free to come and
13 talk to us or reach out to us anytime.

14 I turn this back to the chairs. Thank
15 you.

16 CO-CHAIR BAGLEY: Great. Thank you,
17 Michelle. Any questions for Michelle before we
18 go on? She's going to be here all day. She's
19 chained to the chair and taking notes, copious
20 notes. So she's going to try to take in
21 everything that goes on. But you're going to be
22 here all day to answer questions. So, we're

1 good.

2 All right, Miranda, do you want to
3 talk a little bit about the process?

4 MS. KUWAHARA: Yes, absolutely. So,
5 just to provide an overview of how our low today
6 will work, I will start off by describing our
7 approach.

8 So, MAP follows a three-step process,
9 which consists of a program overview, followed by
10 a review of the current measures, and an
11 evaluation of the measures under consideration
12 for the next iteration of the program measure
13 set.

14 Due to the large number of measures
15 under MAP Clinicians purview and in the interest
16 of time, we will not revisit the overview of the
17 MIPS and SSP programs or the current measures,
18 which were reviewed during the orientation web
19 meeting. We did provide you with the measure
20 frameworks, which houses the 2018 and 2019
21 measure sets for both programs. Those were
22 delivered to you in an email sent out on December

1 5th.

2 If you are following along as a member
3 of the public, you can also locate them on the
4 left-hand navigation pane of the web platform.

5 MAP workgroups must reach a decision
6 about every measure under consideration.

7 Decision categories are standardized for
8 consistency across the measures and programs.

9 And one or more statements of rationale should
10 accompany each decision. Next slide, please.

11 NQF staff have conducted preliminary
12 analysis of each measure under consideration,
13 which are presented in the discussion guide also
14 sent out in that package of materials. This
15 discussion guide is also linked on the left-hand
16 navigation pane, if you are following along as a
17 member of the public.

18 Preliminary analyses are intended to
19 provide MAP members with a succinct profile of
20 each measure and serve as a starting point for
21 MAP discussions.

22 Staff use an algorithm developed from

1 the MAP Measure Selection Criteria to evaluate
2 each measure.

3 The preliminary analysis algorithm
4 uses a series of criteria to determine if a
5 measure receives a recommendation of support for
6 rulemaking, conditional support for rulemaking,
7 do not support for rulemaking -- I'm sorry -- do
8 not support with rulemaking for a potential with
9 mitigation, or do not support. And we'll cover
10 those decision categories a little bit later in
11 the presentation.

12 Reflected on this slide is MAP's
13 measure selection criteria, which serves as a
14 tool used to assess the measure sets used in
15 quality initiative programs. The criteria are
16 not absolute rules, rather they are meant to
17 provide general guidance on measure selection and
18 decisions and to complement program-specific
19 statutory and regulatory requirements. Next
20 slide, please.

21 Reflected on this slide are those
22 decision categories I mentioned previously.

1 Please note that do not support for rulemaking
2 with potential for mitigation has newly replaced
3 refine and resubmit. This new category captures
4 measures which are conceptually promising but not
5 yet ready for rulemaking.

6 And a pause here to see if there are
7 any questions from the workgroup about this new
8 decision category.

9 Okay, seeing none in the room and none
10 in the chat, I'll continue on.

11 Sure.

12 MR. AMIN: Yes, if we can go back one
13 slide.

14 So I just want to emphasize to the
15 workgroup in the conversations we've had over the
16 last two days with the prior -- with the Hospital
17 and the Post-acute Workgroups, I just want to
18 note the distinction. Really there's a lot of
19 conversations between the difference between
20 conditional support and do not support with
21 mitigation.

22 I just want to point out the

1 distinction that seemed to resonate the most with
2 the other workgroups, given that this is new as
3 part of the 2018-19 launch of this cycle. So the
4 first is to say that both represent that there
5 are some changes that are required. The real
6 question is the extent of the changes that are
7 required in the measure. So really conditional
8 support for rulemaking is intended to be that
9 these are conditions that we would want the
10 developer and the program implementers to
11 consider but it is good enough to go ahead.

12 For do not support with potential for
13 mitigation, these are items that you believe
14 really need to be addressed before the measure is
15 able to be used in the rule. That is obviously a
16 matter of judgment and we would yield to you all
17 as experts as we are going through these measures
18 to weigh the degree that you feel that these
19 changes need to be considered before going to
20 rulemaking.

21 So that distinction was a topic of
22 conversation among the other two -- the past two

1 days. And before we get into it -- before we get
2 into any specific examples, risk adjustment,
3 attribution, these are going to come up,
4 obviously, as questions and you'll have to judge
5 how much of a concern you have where it falls in
6 terms of the decision category.

7 So just to preempt that before we get
8 into any specific examples, that will be a
9 struggle I am sure but part of it is using your
10 own judgment to weigh how big of an issue it is.

11 CO-CHAIR BAGLEY: Thank you, Taroon,
12 for that.

13 And just to maybe put a fine point on
14 that, the third category last year was refine and
15 resubmit but, as you all know, there was no
16 mechanism for resubmission for this committee to
17 ever see it again for any kind of decisionmaking.
18 So that's the biggest change.

19 CMS, I suppose, can do whatever they
20 want with it after it gets through this committee
21 but it's not coming back to this committee.

22 MEMBER BURSTIN: That's helpful for

1 both counts. It was, the revise and resubmit,
2 for those of us who have been around the block
3 for a while, that was confusing. And so the word
4 ideally in conditional support is helpful.
5 Because it says that identified conditions or
6 modifications that ideally would be addressed
7 prior to implementation. So there's really no
8 clear expectation those changes will be made. So
9 essentially it is you could live with this, is my
10 sense of how I would handle that, versus do not
11 support for rulemaking with potential for
12 mitigation, a very long term, is really we would
13 really expect some of these changes to be made
14 before the measure is implemented. Okay, thanks.

15 DR. SCHREIBER: It did. So for the
16 last couple of days, really the groups have kind
17 of struggled with these categories. And I think
18 the way that we are sort of interpreting is if
19 you're willing to consider it, if you are willing
20 to consider it more or less as is, maybe with a
21 few minor modifications but you really support
22 it, vote that way. If you really don't want to

1 see this move forward, vote on the do not support
2 side of it, the you know not consider the last
3 category.

4 Obviously, you can say don't support
5 at all with the category before it with major
6 modifications. We would take that as you really
7 don't want it to go forward.

8 That being said, as the committee
9 chairs pointed out, CMS does have the right to
10 take any of them forward but we really do take
11 these comments under advisement and if you really
12 don't support it, please make it clear.

13 CO-CHAIR BAGLEY: I think this will
14 become much more clear as we have our discussions
15 as well. So when you start to see what types of
16 things people are concerned about, it will work
17 out.

18 Any questions or clarification?

19 Okay, Miranda.

20 MS. KUWAHARA: All right. So this
21 year we have updated our voting procedures.
22 We've highlighted the new principles in red over

1 the next several slides to draw your attention to
2 those updates.

3 We define quorum as 66 percent of the
4 voting members of the workgroup, both in-person
5 and remote. We've defined consensus as greater
6 than or equal to 60 percent of voting
7 participants and a minimum of 60 percent of the
8 quorum figure voting positively.

9 Next slide, please.

10 We will begin with a staff
11 introduction of each measure under consideration
12 and lead discussants will present on their
13 findings.

14 Our co-chairs will ask for any
15 clarifying questions, to which developers may
16 respond to questions about the measure
17 specifications. They have all received invites
18 to join this meeting remotely so they can address
19 any questions you might have for them.

20 Staff may respond to questions on the
21 preliminary analysis or lead discussants may
22 respond to questions about their analysis.

1 We will then open for a vote on the
2 acceptance of the preliminary analysis decision.
3 If greater than or equal to 60 percent of the
4 workgroup members vote to accept the preliminary
5 analysis assessment, then the preliminary
6 analysis assessment will move forward as the
7 workgroup's recommendation. If we do not achieve
8 that 60 percent threshold, then we will reopen
9 for discussion.

10 Next slide, please.

11 After the discussion concludes, chairs
12 will reopen the measure under consideration for a
13 vote. If the chairs feel that a consensus
14 decision has emerged, then we can vote on that
15 decision category but if the consensus decision
16 has not emerged, we will vote on each potential
17 decision category one at a time, beginning with
18 support, followed by conditional support, then do
19 not support with potential for mitigation,
20 followed by do not support.

21 Next slide, please.

22 The decision category that captures

1 greater than or equal to 60 percent will move
2 forward as the recommendation for that particular
3 measure.

4 If not decision category achieves
5 greater than or equal to 60 percent, then the
6 preliminary analysis decision will stand and the
7 Coordinating Committee will consider that measure
8 informed by the discussions that come out of this
9 workgroup meeting.

10 So are there any questions about the
11 voting procedures?

12 All right, the last and final slide in
13 this section is just an overview of the time line
14 for the cycle. Following this meeting, we will
15 open for a public commenting period between
16 December 21st and January 10th. Then, the
17 Coordinating Committee will finalize the
18 workgroup's input in January and the final report
19 summarizing the measure deliberations will be
20 submitted prior to March 15th.

21 Before we open for public comment, I
22 just wanted to see if there were any questions on

1 any of the material I've covered thus far.

2 Okay.

3 MS. KOSURI: And before we want to do
4 a test run of voting.

5 MS. KUWAHARA: We wanted to do a test
6 run of voting. So I can open it up and just make
7 sure that we have all of our members.

8 So I'm going to unlock it right now
9 and if you could, input yes to submit your vote.
10 And even if you input no, we would know that you
11 have voted.

12 We've got ten votes so far. So if
13 people can continue to vote, we're looking for 17
14 votes -- or 18 votes.

15 MS. O'ROURKE: And if you're having
16 Wi-Fi challenges, we're going to get IT to get
17 you back connected. So apologies and just bear
18 with us one minute while we get IT.

19 DR. BERNOT: And if anyone's having
20 trouble getting onto Poll Everywhere, just raise
21 your hand and one of us will come around and help
22 out.

1 MS. KOSURI: So for those of you who
2 have successfully casted your votes, feel free to
3 go up, get a refreshment, a cup of coffee, while
4 we iron out this new voting platform.

5 (Whereupon, the above-entitled matter
6 went off the record at 9:08 a.m. and resumed at
7 9:22 a.m.)

8 CO-CHAIR MOYER: All right, everyone,
9 if you could take your seats, we're going to keep
10 on track and keep on time. We have a lot of
11 measures to get through today.

12 MS. KOSURI: Hi, everyone. We want to
13 redo the vote again, just to make sure that
14 everyone is able to vote. So could we get
15 everyone back to their seats so we can try that
16 again?

17 So I'm going to clear the poll again
18 and then hopefully you'll be able to -- yes.
19 We're at 13. We're still at 14 votes. So if
20 people can vote again -- 15. We're at 16.

21 DR. BERNOT: So we're looking for two
22 more votes -- one more vote now.

1 MS. KOSURI: One more vote now.

2 MS. KUWAHARA: All right, thank you
3 all for your patience. We are going to move
4 forward.

5 We did take an ad hoc break so we're
6 going to skip over the break we had scheduled in
7 our agenda but we will take this opportunity to
8 hear from any members of the public who would
9 like to offer comments. So, we can begin with
10 those in the room.

11 Seeing no comments in the room,
12 Operator, could you please open the lines for
13 those participating remotely?

14 OPERATOR: Yes, ma'am. At this time,
15 if you would like to make a comment, please press
16 star and then the number 1 on your telephone
17 keypad.

18 Okay, and we do have a comment from
19 Richard Doane with Premier, Inc.

20 MR. DOANE: Yes, good morning,
21 everyone. Thank you so much. It's great to
22 speak with you this morning and I appreciate the

1 opportunity to make comments.

2 So the MAP is considering four opioid-
3 related measures for inclusion in the Medicare
4 Shared Savings Program, also known as MSSP, and
5 we ask the committee do not support these
6 measures for inclusion and I'm going to outline
7 some reasons why. Premier is incredibly
8 supportive of measures across -- setting
9 appropriate opioid use, however, these specific
10 measures are not well-suited for MSSP.

11 As part of MSSP, ACOs receive monthly,
12 unblinded Parts A and B claims data.
13 Unfortunately, ACOs have limited access to Part D
14 information and are unable to monitor this
15 information on an ongoing basis.

16 Additionally, the ACO model
17 beneficiaries are permitted to see any provider
18 and may see providers that are not affiliated
19 with the ACO. The ACO is, therefore, unaware of
20 prescribing practices for these providers and has
21 less of an opportunity to proactively intervene
22 and help modify their prescribing patterns.

1 Premier member ACOs are also working
2 to better manage medications for ACO
3 beneficiaries and is encouraged that CMS has
4 sought comments on how to more rapidly provide
5 Part D data and if the Part D data benefit could
6 be incorporated into ACOs.

7 Additionally, Premier supports and
8 collects three of these measures for PBMs. We
9 just do not support them for ACOs, due to the
10 model constraints that were outlined previously.

11 So in conclusion, since these are
12 claims-based measures, it would be useful if CMS
13 could provide confidential measure results along
14 with national benchmarks to ACOs, however, the
15 measures should not be formally included in the
16 program because ACOs have limited ability to
17 impact measures and the measures have not been
18 tested for this ACO model.

19 Thank you so much.

20 CO-CHAIR MOYER: Thank you.

21 A couple brief housekeeping items.

22 Kevin has joined us. Kevin, would you introduce

1 yourself and give us any disclosures that are
2 relevant?

3 MEMBER BOWMAN: Hi, Kevin Bowman.
4 Nice to meet everyone.

5 I'm with Anthem and I do not have any
6 disclosures.

7 CO-CHAIR MOYER: And Reena, I'd like
8 to introduce you as well.

9 MEMBER DUSEJA: Good morning. Hi, I'm
10 Reena Duseja. I'm the Chief Medical Officer for
11 the Quality Measurement and Value-based
12 Incentives Group so I work with Dr. Schreiber and
13 I have no disclosures.

14 MS. KUWAHARA: Great, thank you all
15 very much.

16 So, John, I will pass it to you to
17 introduce our first SSP measure group.

18 DR. BERNOT: Great, thank you.

19 So the first group of measures we will
20 all relate to the use of opioids. So I will
21 introduce all four of the preliminary analyses,
22 and then we'll have the lead discussants talk,

1 and then it will be open for a discussion, a
2 larger discussion.

3 I want to give a couple of caveats.
4 The preliminary analyses by staff are done
5 through an algorithm that we apply to the best of
6 our ability. that's the one that is used across
7 all of MAP. We work very hard with the other
8 groups to try to strive for consistency. But the
9 take home message: this is the starting point for
10 discussion.

11 The committee here of experts makes
12 the final ruling. So this is to get us started.
13 Hopefully, you see our logic. We will try to
14 highlight the through process that we went that
15 put it into the category. But again, this is the
16 starting point for discussion and, again, the
17 ultimate vote can go wherever you would like it
18 to, as an expert committee.

19 So I'm going to go through this first
20 group of measures, starting with MUC2018-077. So
21 I will introduce the number, I will read the
22 title and I will go over the staff preliminary

1 analysis and give a small snippet of information,
2 if it's relevant.

3 So this measure, again MUC2018-077 is
4 the Use of Opioids from Multiple Providers in
5 Persons With Cancer. The description of this
6 measure is the rate of individuals without cancer
7 -- excuse me. Sorry, I will go back for the
8 record -- Use of Opioids from Multiple Providers
9 in Persons Without Cancer. And the rate of
10 individuals without cancer receiving
11 prescriptions for opioids from four or more
12 prescribers and four or more pharmacies.

13 The preliminary analysis for this --
14 this is an NQF-endorsed process measure. The
15 preliminary analysis was a conditional support
16 for rulemaking with the condition that the
17 duplication/harmonization is considered between
18 this measure and MUC2018-079, which I will get to
19 momentarily. So that's the first measure.

20 The next measure is MUC2018-078. This
21 is the Use of Opioids at High Dosage in Persons
22 Without Cancer. Similarly, it is the rate of

1 individuals without cancer receiving
2 prescriptions for opioids with a daily dosage
3 greater than 120 milligram morphine-equivalent
4 dose for 90 consecutive days or longer. Also a
5 process measure that is NQF-endorsed. The
6 preliminary analysis for this was similarly,
7 conditional support for rulemaking with the
8 condition that that duplication is considered
9 between this measure and also the next one that
10 I'll talk about, which is MUC2018-079 and I will
11 do that one right now.

12 I am moving quickly intentionally
13 because I would like the discussion to be from
14 the committee but feel free to stop me if there's
15 any questions or clarifying points on the PA
16 itself.

17 So the third measure in this group is
18 the Use of Opioids from Multiple Providers and at
19 High Dosage in Persons Without Cancer. This is,
20 essentially, a combination. It is the rate of
21 individuals without cancer receiving
22 prescriptions for opioids with a daily dosage

1 greater than 120 morphine-equivalent dose for 90
2 consecutive days or longer and who received
3 opioid prescriptions from four or more
4 prescribers and four or more pharmacies.

5 The preliminary analysis -- again,
6 also a process measure that is NQF-endorsed. The
7 preliminary analysis is the reciprocal of the
8 first two. This is a conditional support for
9 rulemaking with the condition of considering this
10 potential duplication now between this and 077
11 and 078.

12 So essentially, 077, 078 are two
13 components that make up 079. As the staff
14 preliminary analysis, we're trying to make the
15 committee aware of that and give any guidance to
16 CMS whether this should be individually, the
17 combination, or all put into the Shared Savings
18 Program.

19 And then one last measure that is not
20 related directly to those measures but also
21 around the opioid topic is MUC2018-106. This is
22 the Initial Opioid Prescription Compliant with

1 CDC Recommendations. The description of this is
2 a composite score indicating compliance with five
3 measurable CDC opioid prescribing guidelines.

4 The denominator includes new opioid prescriptions
5 in the measurement year and the numerator
6 includes new opioid prescriptions that are
7 compliant on all five CDC indicators. This is a
8 higher is better measure. It's a composite
9 measure.

10 The preliminary analysis for this was
11 do not support for rulemaking with potential for
12 mitigation. And the mitigation would include
13 specifying the measure at the health plan level.

14 I'll give just one or two brief
15 sentences on this. If looking at the PA, the
16 preliminary analysis and the specifications there
17 is a lot of information about health plan-level
18 data; however, the only data available to us as
19 staff was a county-to-county comparison, which is
20 why it went into the do not support with
21 mitigation, again, through our algorithmic view
22 of this.

1 Are there any questions on any of the
2 four?

3 MEMBER SHALLER: Just a quick question
4 just on the last point. Why would you want to
5 make this contingent on specification at the plan
6 level and not the ACO level, since this is an
7 MSSP measure?

8 DR. BERNOT: That's really probably
9 more appropriate would be ACO level. The
10 language we used is what NQF-endorsement
11 categories are. NQF does not have an ACO-
12 specific endorsement level.

13 But you are correct, actually for the
14 record, it would probably go down better saying
15 at the ACO level.

16 CO-CHAIR MOYER: All right, the lead
17 discussants for these measures, Terry was not
18 able to join us today. So we have a mix of
19 individuals, Ann Greiner, Helen, and Robert. So,
20 is anyone dying to start?

21 I think, given, you know we used to
22 have the consent calendar approach and we're kind

1 of viewing these as all relevant to opioids and
2 that the discussion may better lend itself to
3 looking at them together. Are there any
4 objections from the committee for kind of
5 considering and talking about these as a group?
6 I just want to make sure everyone is okay with
7 that.

8 Not seeing any, Bob, I'm going to
9 start with you.

10 MEMBER FIELDS: Sure. So at this
11 point, NAACOS is not supportive -- do not support
12 with mitigation for all of the measures, with the
13 exception of 078, which we would support with
14 mitigation as stated in the preliminary analysis
15 result.

16 The main reasons is, as stated by the
17 gentlemen from Premier, primarily has to do with
18 data and the ones with multiple providers, the
19 two measures that discuss multiple providers.
20 The way we normally assess this at the clinician
21 level is using state controlled substance
22 databases, for instance, and none of those as far

1 as I am aware, at least none of the ones that
2 I've worked with in North Carolina and New York
3 cross state lines. And so many of our patients
4 in our markets see various providers in multiple
5 states and the data is, essentially invisible to
6 us, at least in anything that would resemble
7 timely and actionable.

8 And so as a result just operationally,
9 it would be really difficult to measure at the
10 clinician level and take action, most
11 importantly, on behalf of the patient. So just
12 fundamentally, it is flawed operationally.

13 And then you know certainly in terms
14 of the support, as stated conditional support on
15 078, we agree with that. I don't have any
16 additional comment on that.

17 And then I agree with the
18 recommendation of do not support for rulemaking,
19 although the reasons why we don't support the
20 last measure, 106, also includes just the large
21 number of variables in the measure, actually
22 trying to compare the five CDC recommendations

1 versus prescribing how it's just, again,
2 operational, is pretty challenging for what
3 providers actually do. The EMRs don't support it
4 that way. It would be pretty challenging to
5 report at that level. So and additional reasons
6 for possible mitigation, besides the one that was
7 stated.

8 CO-CHAIR MOYER: All right, thank you.

9 Additional comments from other lead
10 discussants?

11 MEMBER BURSTIN: I'm happy to go.

12 So echoing some of the other comments
13 as well, I think certainly -- I'll do the PQA
14 ones as a group because I think they are probably
15 more likely linked as to the separate one.

16 I think just the idea that if they're
17 built off of Part D PBM plans, I think it's a
18 real question how adaptable that is to the MSSP
19 program. We just don't know what that looks
20 like, as you try to move it out of a Part D-
21 specific program, which is what PQA developed
22 them for.

1 It's also -- it was pointed out by one
2 of the commenters, there's no exclusion for
3 palliative care although there is for hospice and
4 I think that's an important consideration if it
5 does get conditional support.

6 One of the other commenters also noted
7 the buprenorphine is included as a narcotic and,
8 again in this case, it really doesn't kind of fit
9 if the intent of this is to get at opioid misuse.
10 So one issue there.

11 And I think you know for some, the
12 high dosage one in particular, again it was
13 pointed out for certain patients chronic illness,
14 serious illness care, there may be needs for
15 higher doses and probably many of you have seen
16 some of the concerns raised about potential
17 unintended consequences in the way some of the --
18 not so much the CDC guidelines as written but how
19 the CDC guidelines have actually been implemented
20 in regs and by pharmacies have potentially led to
21 unintended consequences for patients.

22 So I think it's certainly something,

1 if CDC adopts these, I hope they will continue to
2 look for where there are unintended consequences.

3 Actually as an aside, I am co-chair
4 with the CDC at the National Academy of Medicine
5 on standardizing the evidence and standards for
6 opioid use. So one of the big issues we're going
7 to take on is this issue of harmonization of
8 guidelines but particularly this issue of
9 unintended consequences, which I think is real.
10 The issue of what level it's been tested at I
11 think is important.

12 And for the other one, on the initial
13 opioid prescription, I think this is a really
14 interesting measure. I'm glad that Dae Choi is
15 at the table. It's a little hard to understand
16 how that all can be assessed from claims data I
17 think is one of my biggest concerns. Just a lot
18 of those nuances are probably more likely to be
19 in a chart than in a claims data only and I wish
20 we could move beyond. Trying to look at really
21 important measures using only claims, it's time
22 to move beyond that and I think this one screams

1 for being an e-measure, as opposed to just doing
2 that.

3 And again, I think similarly, I think
4 the fact that this one has only ever really been,
5 and correct me if I'm wrong, specified and tested
6 at the health plan level using claims data I
7 think is also another question of how easy is
8 that going to be to be adapted to this.

9 And I would also personally love to
10 get a read from Peter, just a comment just in
11 terms of CDC's read on how well the measure
12 actually is concordant with the CDC guidelines
13 and updates of that are coming out continuously.
14 So it also I think will be somewhat difficult for
15 the measure to keep up with what is a rapidly
16 evolving guideline space.

17 Thanks.

18 CO-CHAIR MOYER: Ann, did you have
19 anything that you wanted to add?

20 MEMBER GREINER: So if those of you
21 sitting around the table don't know, my
22 organization is multi-stakeholder. So we've got

1 everybody under the tent, clinicians, and
2 patients, and employers. And so you know the
3 views that are represented here are very broad.

4 I think you know first off we applaud
5 CMS for trying to get to some measures that
6 address what is obviously a huge public health
7 issue. Maybe there are some states that appear
8 to be making progress but I think we all
9 acknowledge that this is a really major public
10 health issue in this country. And so we do want
11 to try to get to some kind of measure.

12 A number of the comments from
13 respondents was concern about multiple measures
14 and given your desire and I think it's shared by
15 not just clinicians but patients as well that we
16 want to try to reduce the burden of measurement.
17 It would seem that, ideally, we would want to get
18 one of those three measures; 2018-079 because
19 it's broader and encompasses multiple kinds of
20 issues seems to be the one that, if we can
21 address the data issues, would be most attractive
22 to move forward.

1 The data issues, apparently, are quite
2 considerable but we would encourage continued
3 work to try to address this.

4 And at the ACO level, given the
5 ability to go across settings of care and the
6 accountability there, it seems very appropriate
7 to really continue to work on this and move it
8 forward.

9 The exceptions that are in the last
10 measure we thought should be applied to 079 so
11 that you take into account, again if this is
12 possible from a data perspective, you know folks
13 that are in long-term care, or nursing homes, or
14 SNFs, and the like because we know that they are
15 often, frankly, overmedicated and it's
16 problematic. So that is probably something that
17 we would suggest be looked at.

18 Given the multiple range of
19 stakeholders that are a part of our organization,
20 we don't have a stand at this point. I'm very
21 interested in the conversation and encourage CMS
22 to do the continued work to move this forward.

1 Thanks.

2 DR. PEZZULLO: Hi, this is Lynn
3 Pezzullo from PQA, the measure developer for the
4 first three opioid measures.

5 I just wanted to make a point of
6 clarification. I believe one of the comments was
7 that buprenorphine was included in the measures.
8 And to clarify, the measures do exclude
9 buprenorphine.

10 CO-CHAIR MOYER: Thank you for that.

11 Ira, I see you have your card up.

12 MEMBER MOSCOVICE: I just wanted to
13 put a rural perspective on this. The MAP Rural
14 Health Group looked through these measures and
15 felt that 077 was -- all of these measures -- the
16 whole issue of opioid prescribing obviously is a
17 huge issue in the rural environment but that they
18 supported 077.

19 And the reason they didn't support 078
20 and 079 was really the high dosage issue and the
21 fact that there aren't pain management
22 specialists in rural areas and so this would fall

1 on the shoulders, generally, in terms of primary
2 care providers and it's a real challenge for
3 them. And they felt the much more reasonable
4 comparison across all providers would be through
5 using 077.

6 CO-CHAIR MOYER: Okay, I'm going to
7 take a brief pause for Rob Krughoff to introduce
8 himself and let us know if he has any
9 disclosures, since he's joined us.

10 MEMBER KRUGHOFF: Hello. I'm with
11 Consumers' CHECKBOOK Center for the Study of
12 Services. And I'm sorry I had things that messed
13 up my schedule this morning but I'm really glad
14 to be with this group on very important work.
15 Thank you.

16 MS. MUNTHALI: Do you have any
17 disclosures? Any disclosures of interest
18 financial?

19 MEMBER KRUGHOFF: Oh, no, I have
20 nothing to disclose.

21 MS. MUNTHALI: Thank you.

22 MEMBER KRUGHOFF: I keep doing that

1 again, and again every year. So, yes.

2 CO-CHAIR MOYER: All right. So I
3 believe our next step in the process would be to
4 vote on accepting or rejecting the preliminary
5 analysis of NQF. I feel like I'm hearing a
6 desire to change -- oh -- to change that -- the
7 measure developer comments.

8 DR. SANGHAVI: Hopefully you can hear
9 me. Hi, I'm Darshak Sanghavi. I'm Chief Medical
10 Officer at OptumLabs, which is the collaborative
11 research and development organization that sits
12 within Optum as part of United Health Group.

13 I am formerly the Director of
14 Prevention and Population Health at CMS. I
15 developed the Accountable Health Communities
16 model diabetes program certification, a Million
17 Hearts model, and other projects as well.

18 I'm here just because I wanted to
19 briefly talk about the initial opioid prescribing
20 measure for CDC compliance, which is the measure
21 that our organization has put forth for
22 endorsement here and just to address some of the

1 comments that were made both in the written
2 comments, as well as some of the ones we spoke
3 about here.

4 We, as an organization, feel very
5 strongly about this measure and believe it has
6 the potential to markedly improve the health of
7 America. Just by way of baseline, today the
8 opioid crisis kills more individuals than almost
9 any other cause in young people. We have no
10 measures that have yet addressed the crisis on a
11 federal level in the SSP program. So I think
12 that there is some need to actually take action
13 here.

14 In the absence of that, there have
15 been guidelines before. As many of you are
16 aware, CDC 2016 put out guidelines relating to
17 daily -- the reasons this is a composite measure
18 is because opioid prescribing is complex. There
19 are many components, MME, total duration, co-
20 prescriptions with benzodiazepines. And if any
21 of you had a chance to look at the slides that we
22 distributed ahead of time, looking at the

1 national variations measures -- by the way, these
2 are claims-based -- our enterprise, the largest
3 payer in the country right now, runs these on a
4 quarterly basis across all lines of business.
5 These are the measures we used to track our plan
6 performance at both the ACO plan and plan level
7 in Medicare, Medicaid, and in commercial health
8 insurance. This measure has also been adapted
9 for the all-payer claims data set in
10 Massachusetts, as well as in North Carolina, as
11 well as in Ohio, and in California. So this
12 measure is widely used right now.

13 We presented the information at the
14 county level, principally just so people here
15 could get a sense of why -- the theoretical
16 underpinnings of this measure. The variation in
17 opioid prescribing problems is widespread. Some
18 parts of the country have problems with dosage,
19 some parts have with duration, some parts have
20 with benzodiazepines combined. So, putting it
21 altogether was our solution to the problem.

22 The measure has been fully specified.

1 Those specifications also noncommercial. We
2 published them in Health Affairs last December so
3 they are widely available. Again, I want to
4 emphasize they are claims-based.

5 I also want to say one other thing,
6 which is what the public comments I believe were
7 not accurate about, which is that the CDC
8 intended these only for chronic pain, not for
9 acute pain. In other words, you have a child who
10 has had a wisdom tooth removal, our contention
11 would be that child should not be given 30 days
12 of 100 milligrams of oxycodone. That is acute
13 pain. There is a problem with that. We think we
14 should be doing something about it. This measure
15 actually addresses that.

16 And this measure by the way was
17 developed by an advisory board that was co-led by
18 Tom McLellan, the Deputy Drug Czar under
19 President Obama, as well as Mark Wallace, Chair
20 of Pain at UCSD; he was a member of the CDC
21 writing committee. I emailed him last night and
22 said that some members of the committee have said

1 this measure is only for chronic pain. He wrote
2 back and said this was extensively discussed by
3 CDC. It is not just for chronic pain. It is for
4 new opioid prescriptions.

5 The final thing I will say is two
6 pieces of information. I'll draw your
7 information to the last two slides in the deck we
8 distributed, which is why do we care about this
9 particular measure. Why is this one the one we
10 focused on?

11 The reason CDC put this together is
12 that each of these are correlated with a high
13 risk of long-term opioid use. In other words,
14 you get a seven-day prescription of opioids.
15 That's very different from getting a 10-, 15-, or
16 30-day in terms of the risk of becoming a long-
17 term opioid user. The same goes for MME and
18 others.

19 If we enforce compliance, we reduce
20 the risk of creating new long-term opioid use
21 that should not have happened.

22 I want to point out the second to the

1 last slide shows a pseudorandomized experiment.

2 In 2017, the summer, all of OptumRx, our PDM, one
3 of the top three, rolled out hard edits, meaning
4 if prescriptions are out of compliance at the
5 point of care, they are automatically edited at
6 the pharmacy down to a compliant prescription.
7 That actually rolled out in sort of a step-wedge
8 manner across all of America. So we have tens of
9 millions of pieces of data here.

10 Looking at those that were exposed to
11 the intervention versus not, the risk of becoming
12 a long-term opioid user in those individuals fell
13 by 50 percent. That is a massive public health
14 benefit and that is what was in the slides here
15 as well. That's now been adapted across all
16 lines of business at United Health Care earlier
17 this year and we're seeing the same thing now
18 occurring in Medicare, Medicaid, and our
19 commercial markets.

20 Finally, the last slide shows that
21 yes, we have not yet run this on the Medicare ACO
22 data, only because getting ahold of that data is

1 really hard. It takes years.

2 However, I want to emphasize two
3 things. The first is this measure is run on the
4 One PI platform at CPI and CMS currently. They
5 can run this at the ACO level, if they're asked
6 to do so and that can be shown to the committee
7 here at some point soon.

8 Secondly, we actually do run this
9 measure at the Medicare ACO level in our Medicare
10 Advantage markets. That's what the last slide
11 shows. And that also shows that in four major
12 markets -- I'm sorry, in the three major markets
13 where we did intensive QI efforts, we saw
14 improvement in the measure, as opposed to the
15 five market ACOs where we did not do QI measures
16 so we did not see improvement.

17 So in summary what I would like to say
18 is that this measure, we believe, has substantial
19 public health benefit, addresses an urgent
20 problem here, also has been used widely in tens
21 of millions of Americans already and we are sort
22 of pushing this forward only because we think

1 that there is an important public health argument
2 to made for putting this ahead.

3 So we would argue that this measure
4 should be put forth for rulemaking, at least for
5 additional comment to give CMS the opportunity to
6 do the additional work and put this out to help
7 Americans.

8 Thank you.

9 MEMBER FIELDS: What slides are you
10 referring to? Because I have no idea what slides
11 they are.

12 DR. SANGHAVI: Sorry. Reena, were
13 these distributed to the committee?

14 MS. KUWAHARA: That's correct, they
15 were distributed on December 5th.

16 DR. SANGHAVI: I have them right here,
17 so I can send them to anybody who needs them.
18 We're under the gun, I guess.

19 MS. KUWAHARA: And they are on the
20 public SharePoint site. Anyone following along
21 with this meeting can go to
22 public.qualityforum.org to access those

1 materials.

2 A link was emailed to you on December
3 5th.

4 CO-CHAIR MOYER: So we're going to go
5 to Rob for a comment but I also have a question.

6 So I mean we've heard from more than
7 one provider organization, including National
8 Association of ACOs that there is a challenge
9 getting the data on this. I appreciate that
10 Optum has large data resources and the ability to
11 do this but we're not necessarily looking at is
12 this a good measure, is it feasible in general.
13 What we're looking at is it feasible within the
14 context of MSSP, I believe.

15 So could you talk specifically to that
16 and does that help with what you were going to
17 raise?

18 MEMBER FIELDS: Yes. No, that's
19 exactly it. I mean just going on record that the
20 argument. I don't think anyone argues with the
21 public health implications of this and the need
22 for something, to take some action in regards to

1 opioid use. The issue for us is exactly what you
2 pointed out, that it is completely untested in
3 the ACO model, in terms of how we get that data.
4 It is relatively invisible or fractionated at
5 best in the ACO world. So I can completely
6 appreciate and it helps that it's purely a
7 claims-based measure. That absolutely helps and
8 I can understand in the health plan how that
9 would work really well.

10 It's just there are a thousand reasons
11 why the MSSP doesn't work like any other shared
12 savings arrangement with MA and information is
13 one of those reasons.

14 So that's our issue with it. It's not
15 the public health implications or the importance
16 of it. We actually for sure want to go on record
17 as saying we very much support it.

18 DR. SANGHAVI: I'll just say that
19 that's a really valid point. I think the pain of
20 sort of trying to get data that you can't get is
21 one that many people feel.

22 Our thinking would be two-fold. The

1 first is that it can be run -- as I said it's
2 being run at CPI, which has a consolidated Part B
3 and other sort of -- it's all put together and so
4 it is run now. It can be run at the ACO level
5 and reported back.

6 The second is that there's a chicken
7 and -- or cart and the horse issue here, which is
8 that until we say this is what we need to do,
9 nobody actually does it. And until somebody does
10 it, then -- do you see what I'm saying? We just
11 need to sort of take a stand that this is the
12 right thing to do and then rulemaking, other
13 stuff, there is a process to make that happen.
14 That's when resources are dedicated to actually
15 make this easier on everybody. But if we say
16 it's just hard to do, it's challenging to do so
17 let's not even get involved, that sort of seems
18 to cut against the fundamental goal of this
19 entire measures process.

20 CO-CHAIR MOYER: Helen and then we'll
21 go on to Peter.

22 MEMBER BURSTIN: Oh, no, I was

1 actually just going to ask if Peter can weigh in.

2 MEMBER BRISS: I'm not going to weigh
3 in extensively. What I am going to say is that
4 as I listen to the conversation, it's pretty
5 clear that nobody disputes the public health
6 importance of the issues and nobody seems to be
7 pushing back much on the need for measures. So
8 we also want to commend CMS for trying to move
9 some of this forward. As we're talking about --
10 there are also clearly feasibility concerns
11 around the table.

12 So one of the things that happens
13 frequently around these tables is that when
14 people have concerns, we're not necessarily very
15 specific about what would need to happen next to
16 actually mitigate concerns. So to the extent
17 that there are people around the table that are
18 going to have concerns today, it would be most
19 helpful for CMS and others that are trying to
20 move the fields forward to be as specific as you
21 can about what it would -- if you feel like it's
22 not getting over some bar, being as specific as

1 you can about what it would take would be really
2 helpful.

3 MEMBER FIELDS: Again, just responding
4 to the comments earlier. I mean I can also
5 understand the chicken and the egg or the horse
6 and the cart analogy to this. But having
7 measures that have not been tested and,
8 therefore, have the potential for pretty
9 significant flaws when it gets people that
10 actually have to operate ACOs and get and show
11 data to providers, it actually does damage, I
12 believe. You end up going backwards if you show
13 providers, even if it's reporting only.

14 I mean I would gather that if this
15 actually ended up in the MSSP program, it would
16 be reporting only until it was tested. But I
17 guarantee you that if it's fundamentally flawed
18 and it hasn't been tested, I get that we can do
19 it somewhere, that the data exists and we can do
20 it. But I think at least taking the minimal step
21 of proving that it can be done and visualizing
22 that at the ACO level is an important one because

1 if it somehow ends up that we can't do it
2 completely or accurately, providers not only
3 ignore it but I think actually revert backwards a
4 little bit. It causes a lot of tension among the
5 actual providers who are having to execute on the
6 outcomes of that data. I mean the data by itself
7 is meaningless if the providers don't take
8 action. And if you're actually discrediting the
9 measure and the initiative by showing data that
10 is potentially flawed, it is counterproductive to
11 the goal.

12 So I would just argue that at least
13 one step or one round of testing, whether or not
14 it can actually be done at the ACO level at scale
15 is an important one and at least a minimal
16 requirement of due diligence before we actually
17 put this out in some sort of MSSP program.

18 MS. SPALDING BUSH: Thank you for
19 that. This is Kim Spalding Bush from CMS. Could
20 I just respond on that concern? And I think we
21 do hear you. Certainly, we don't want to cause
22 any confusion or have people drawing conclusions

1 based on data that we put out there that might
2 not be accurate ones.

3 I just wanted to note that for the
4 three PQA measures, so 077, 078, and 079 that we
5 do currently have the data that's produced by our
6 Part B plan staff and is provided to our Part D
7 plan themselves. In an effort to help them have
8 someone to coordinate with, we wanted to share
9 the same data with our ACOs so that they can do
10 something about it.

11 So the plan is actually being held to
12 a different standard here. You are completely
13 correct. We are talking about providing for
14 information only, certainly as a start, until we
15 learn a lot more about these measures. And we
16 would have to go through a long process before we
17 could add them to our measure set.

18 And but we have worked closely with
19 the Part D plan folks at CMS around messaging,
20 what should the ACOs be taking away from this in
21 order to make sure that if they get the measure
22 data in a report they kind of know what it means

1 and what they can do. And we've run the data.
2 We've seen it's a pretty low instance that the
3 ACOs have beneficiaries hitting these marks, only
4 because they are a pretty high bar for potential
5 overuse and there is a lot of interest in being
6 careful not to share what some people call a
7 false positive with the ACOs, if it is in fact
8 someone who legitimately just had multiple
9 providers for some kind of legitimate reason.

10 So we've been pretty cautious in
11 working closely with the Part D plan staff and
12 making sure that the data that we put out there
13 are consistent with what the plans are seeing and
14 so that we are helping the ACOs with
15 interpretation as well.

16 So I don't know if that helps you
17 assuage some of those concerns. We do have that
18 data ran at the ACO level and we have reliability
19 information around that as well so for the PQAs.

20 CO-CHAIR MOYER: Okay, thank you for
21 your comments.

22 MS. SPALDING BUSH: Thank you.

1 CO-CHAIR MOYER: I see in the room I
2 have Bruce, Amy, and Ann.

3 CO-CHAIR BAGLEY: Yes, I'd like to
4 speak as a physician for a minute. And I want to
5 talk about the first three measures first and
6 they are to identify people who might be at risk
7 of opioid overdose. Isn't that the purpose?

8 So what clinician or organization in
9 this room wouldn't want to get a list of all the
10 people that need some attention like we get a
11 list of all the people that need a mammography
12 and you do something about it? Why wouldn't you
13 want to get a list from anywhere you can get it
14 and do something about it?

15 Now I don't know that everybody can
16 get that list but the PBM should be able to do
17 this. Your own internal EMR probably can do this
18 better than you think.

19 Why wouldn't you want to have a list
20 if you could have a list?

21 So my only comment about one, two, and
22 three is that there is absolutely no advantage of

1 the third one, I mean to do both, because you've
2 already got all those people identified on the
3 first two lists? So I would suggest that you
4 just use the first two because the real purpose
5 is I want a list of people who need some
6 attention. So that's how I see it as a
7 physician.

8 The fourth one is very different and
9 it really is to get at the root cause of getting
10 people addicted in the first place. It has
11 nothing to do with high dose, or long-term, or
12 anything. It's that first prescription. And for
13 people, for instance, who walk into a doctor's
14 office for low back pain and get an extended
15 prescription for opioids, there is one in five
16 chance that they will become addicted, or an
17 opioid-naive person.

18 If anybody has other -- is that about
19 right?

20 So this is a big deal. And to say
21 it's hard when you can have flags in your EMR for
22 all kinds of crazy stuff, to say it's hard to do

1 this is just, in my mind as a clinician, not
2 right. So if we put this in place -- first of
3 all, CMS wouldn't put it in place without
4 actually offering the data, right? There you
5 go. So I mean how could they do that? Well,
6 they've got the data. They've got to give it
7 away to make the measure work I think.

8 So I mean I agree with if you don't
9 put it in, nothing's going to happen. If you put
10 it in, it's going to be a little inconvenient for
11 some people. But to identify, you know get at
12 the root cause of the problem, they have all
13 kinds of problems with how to deal with people
14 who are already addicted. We're not talking
15 about -- you know it's more important to not get
16 them addicted in the first place. So why
17 wouldn't you want to do this?

18 CO-CHAIR MOYER: Do have a quick
19 response to that?

20 MEMBER SHALLER: Can I ask a question?
21 Because I appreciate your comment. I just want
22 to

1 understand the logic from your perspective as a
2 clinician in favoring the two first separate
3 measures as opposed to the combined measure.

4 It seems to me the combined measure is
5 a higher threshold.

6 CO-CHAIR BAGLEY: Yes, the combined
7 measure could miss people on the first two lists
8 because it has to be an and.

9 MEMBER SHALLER: Right.

10 CO-CHAIR BAGLEY: So I think if you
11 have the first and the second, you've covered the
12 third easily. There's nobody going to be missed
13 on the first two lists that will show up on the
14 third list.

15 MEMBER SHALLER: Got you.

16 CO-CHAIR MOYER: Amy.

17 MEMBER NGUYEN HOWELL: Good morning,
18 everyone. So Amy Nguyen from the America's
19 Physician Groups. So I appreciate the comments
20 from NAACOS and Premier. And we have ACOs in our
21 physician organization so I appreciate the
22 sensitivity around that.

1 My question is really more for CMS.
2 So as you move along the risk continuum for risk-
3 bearing organizations and as we step back and
4 look at Meaningful Measures Initiatives and the
5 burdensome for physicians, I want to ask, looking
6 at the bigger picture for CMS, are you looking at
7 these measures to be cross-cutting in the other
8 Quality Measurement Programs, especially Stars,
9 and given that this is potentially measured at
10 the plan level for Part D and also for other
11 measurement programs for CMS. Just so we -- if
12 you can answer that because I think it will give
13 us an idea, a general overall idea as you look at
14 SSP, ACOs, but then also as you move along the
15 continuum, how are other programs going to be
16 measured?

17 MEMBER DUSEJA: I think that's a
18 really great question. I'm glad you brought it
19 up.

20 I think from the agency perspective we
21 really are looking at alignment internally as
22 well as externally. So there is a Core Measure

1 Collaborative that you might be aware of that we
2 are trying to externally align with other payers
3 as well and internally, the same. I think we're
4 having a hard look in our next space of
5 Meaningful Measures. We looked at each of the
6 programs. We look at this burden reduction
7 effort in our first case.

8 The second really is looking at how do
9 we align across settings with the metrics that
10 we're using. With opiates in particular, I think
11 this is a high priority area. So I think we're
12 going to have, depending on the setting, and the
13 right setting, making sure that is specified at
14 the right place. So we want to be mindful of
15 that as well.

16 MEMBER NGUYEN HOWELL: Yes. Yes, so
17 we see it on the strengthening on the Core
18 Measures Collaborative so that's why I bring it
19 up because we talk about alignment a lot. And as
20 we look at these measures I know we're talking
21 just about SSP but I just ask that everyone in
22 the room look at it generally and more broadly as

1 we move forward with our measurement development
2 and quality assessment.

3 CO-CHAIR MOYER: All right, we're
4 going to go to Ann next. Trudy's on the phone
5 and she will be the next commenter, and then we
6 will be going to David.

7 MEMBER GREINER: Thank you. Point of
8 clarification for the gentleman from Optum. I'm
9 sorry I'm forgetting your first name.

10 DR. SANGHAVI: Darshak.

11 MEMBER GREINER: Thank you. Did you
12 say that you have successfully implemented -- I
13 know you said in Medicare Advantage plans but
14 have you also done it in private sector ACO
15 plans?

16 DR. SANGHAVI: We don't --

17 MEMBER NGUYEN HOWELL: The last
18 measure.

19 DR. SANGHAVI: Yes, the last measure.
20 So it's being run principally at the plan level.
21 And we run it more at the employer level, rather
22 than the private ACO level but it can be done at

1 that measure. It's reported but we don't
2 necessarily use that for anything just yet.

3 MEMBER GREINER: You know it seems to
4 me that we've kind of done this swing in terms of
5 you know our taste for measures. I've been
6 around measurement for a while, not always at
7 this table, but back in the day so many measures
8 were approved and we moved quickly to put
9 measures into programs and now we're completely
10 swung in the other direction.

11 However, this is one of the biggest
12 health issues that our country faces. And I
13 think that to walk away from an effort that is
14 going to be multi-year to get to actual public
15 reporting would be a mistake. And so I really
16 think that this committee should take seriously
17 the public issues that we're facing and get CMS
18 going on whatever it needs to do to get this
19 measure in place that we can get the proper data
20 and we cannot have this be very burdensome but
21 move this issue along.

22 And I appreciate all of your comments.

1 CO-CHAIR MOYER: Thank you. Trudy, on
2 the phone.

3 MEMBER MALLINSON: Thanks. There is
4 somebody, Chris, who had their hand up before me.
5 I don't know if --

6 DR. BEADLES: Hi, can you guys hear
7 me?

8 CO-CHAIR MOYER: Yes, we can.

9 DR. BEADLES: So I just wanted to --
10 I'm Chris Beadles. I work for RTI International
11 on behalf of the SSP ACO operations contract.
12 And I just want to kind of echo some of things
13 that have already been said this morning with
14 respect to these three measures, as Kim Spalding
15 Bush already alluded to.

16 We have looked at these measures, the
17 three PQA measures, the first three, and ACO
18 performance during the performance year for 2017
19 in terms of testing purposes in preparation for
20 sharing these measures with ACOs on an
21 informational basis. So we do have a pretty good
22 idea of what the spread across ACOs looks like.

1 And there is a sizeable spread there, some ACOs
2 that appear to be doing a lot in the opioid space
3 to improve opioid safety and then there are
4 others that I think there are opportunity for
5 improvement.

6 So we can say that this as a claims
7 measure is operationally feasible and is readily
8 adaptable to the Medicare Part B claims data. We
9 can also say with pretty high confidence that the
10 reliability that is listed in the NQF forms for
11 these measures I believe was tested on Medicaid
12 data in eight plans. We've tested reliability
13 and have similar reliability looking at the ACO
14 of a plan.

15 So with the exception of the OHD/OMP
16 measure, which is that combined measure of the
17 first two, where the reliability is lower as you
18 would expect, it's a smaller subset of
19 individuals that meet both of the first two
20 measures, the reliability is similar to what is
21 published in the NQF on the Medicaid data and at
22 the ACO plan during performance year 2017.

1 I think I would also just echo the
2 same comments that I think the other clinician
3 previously mentioned. As someone that is
4 prescribing opioids in that space, I would want
5 to know if I am one of five or six other
6 prescribers that are prescribing opioids to a
7 patient, to a beneficiary. And I think that one
8 in particular, being able to give ACOs this
9 information, being able to help them know the
10 full space of the patient -- of the providers
11 that their patients are seeing is really where we
12 need to move. I think based on what we've seen,
13 this is a -- these first three measures sort of
14 aim at the highest risk of non-beneficial opioid
15 uses, probably how I would characterize it,
16 opioid use that is at least, both in the Medicare
17 Part D plans, which is part of the reason they
18 use it there, but also in ACOs when you have
19 beneficiaries that have those dosages and that
20 number of different providers, prescribers
21 providing the medication, it's worth further
22 review.

1 MS. SPALDING BUSH: And this is Kim.
2 Since Chris didn't mention it, I will offer that
3 he is an anesthesiologist. And I'm sorry I'm
4 forgetting if that was in your bio but yes,
5 thanks.

6 DR. BEADLES: Right, yes. So having
7 gone through chronic pain and acute pain
8 rotations and being in those situations where we
9 think through a comprehensive approach to
10 managing chronic, I can say that with some
11 experience that yes.

12 CO-CHAIR MOYER: Okay, thank you.

13 Trudy, go ahead.

14 MEMBER MALLINSON: Thanks. I just had
15 a question for the clinicians. One of the public
16 comments asked about exclusion for palliative
17 care. And I just wanted -- are there situations
18 where there might be exclusions for I guess
19 palliative reasons for people who do not have
20 cancer but are receiving some kind of palliative
21 care. Is that a reasonable question?

22 CO-CHAIR MOYER: Okay, I am going to

1 start accumulating questions for the developer.
2 We have quite a few cards up in the room and I
3 want to make sure we get to everyone.

4 David, did you have a comment?

5 MEMBER SEIDENWURM: Yes, I just wanted
6 to say that maybe I'm coming at this from a
7 different direction. I'm not sure these go far
8 enough.

9 I mean I think this is a great first
10 step and you know the end gates swing out a lot
11 of people. If we approve 79, that would be a
12 smaller sample.

13 I think this is a circumstance in
14 which we would want to try to cast a wider net,
15 rather than a narrower net. So I'm going to
16 advocate going forward with these as they are and
17 hopefully as we get this population under
18 control, perhaps we could move further.

19 CO-CHAIR MOYER: Thank you.

20 Helen.

21 MEMBER BURSTIN: Just two brief
22 comments. Again, I think these measures are

1 incredibly important. We need to get some
2 measures here so I applaud CMS for picking up
3 some measures that are out there that could be
4 used.

5 Just again, some of the comments that
6 emphasize the importance of getting these
7 feedback reports, it's not clear this measure
8 includes feedback reports. It includes the rate.

9 So I would love the feedback reports
10 and I would love to see if CMS in fact puts this
11 forward it isn't just going to give a rate to an
12 individual MSSP but, in fact, provide that
13 information in a timely manner. Because
14 otherwise, it's just not very helpful to get the
15 rate.

16 And so again, I would love the
17 feedback reports, Bruce. I don't think that's
18 what this measure is about. So if CMS could give
19 us that, I think that would be really important.

20 And then lastly, I do think there is
21 a lot of action happening currently in this
22 guideline space. There's a lot happening and

1 just there's real potential for unintended
2 consequences. So I think as these measures go
3 into place, if they move forward, really
4 important to get continuous feedback from both
5 patients and clinicians as these measures are out
6 in the field.

7 CO-CHAIR MOYER: Bob?

8 MEMBER FIELDS: Yes, similar to that
9 because it seems like we're still having the
10 conversation, I'm a family doctor. I'm a
11 clinician also. No one is arguing. Of course, I
12 would love a list of patients that have multiple
13 providers but I don't think that's actually the
14 issue here.

15 I would like to separate, kind of
16 extending what Helen said. It's one thing to
17 have data and it's one thing to have a measure.
18 And you can have one without the other. And if
19 the goal here is actually to improve patient
20 care, we would love the data. It's just right
21 now we don't get it.

22 As I mentioned earlier, the most

1 actionable data that is close to real-time is our
2 controlled substance database is they tend to be
3 state run. It's when the patient fills the
4 prescription, I can look him up and you can tell.
5 It's very actionable at the point of care in that
6 context but it completely misses anyone that
7 prescribes out of state and those are invisible
8 to us.

9 Claims, when I get it 90 days later
10 and hope that I have an analyst that can actually
11 piece it together and give me the feedback that I
12 need to actually take action on it, there are so
13 many dependencies and it's so delayed by the time
14 I actually see it, it is not actionable in the
15 same way.

16 So if we're going to apply pressure,
17 I would love to see CMS or other -- it's probably
18 not in their purview but certainly on a federal
19 level in some way relax the interstate data
20 sharing guidelines so we can have a national
21 controlled substance database. That would
22 actually be much more helpful than having a

1 measure that is, at this point, the data has been
2 invisible.

3 I hear what everyone is saying that
4 it's been tested, and reliable, and all those
5 things. We haven't seen it. And so that's all
6 we're saying is that to put it as a measure has
7 real consequences and actually doesn't deliver by
8 itself, at least in the current format on the
9 things that we actually want to get done on
10 opioids. It's important to make that distinction
11 between the data and actually creating a measure
12 around it.

13 MS. SPALDING BUSH: Yes, I think we
14 certainly appreciate that. This is Kim and we
15 always are interested in hearing the ACOs'
16 feedback on what we give, what's useful and what
17 isn't, or could be more helpful to you. So
18 thank you for sharing that.

19 I don't know, Chris, I hate to put you
20 on the spot but do you know -- so we are planning
21 to provide feedback reports on these.

22 DR. BEADLES: Yes.

1 MS. SPALDING BUSH: And they would
2 have a breakdown so that they can be more
3 actionable. As I mentioned earlier, the Part D
4 plans will be getting the same information so
5 that it would be an easier thing to coordinate
6 between the plans and the ACOs because even
7 though as we mentioned it's just for information
8 purposes, for ACOs at this point in time, the
9 plans are actually -- and I don't work on the
10 plans, so I don't know really what their metrics
11 are, but they are held accountable for
12 performance on the rates currently.

13 So sorry, Chris, I didn't mean to cut
14 you off.

15 DR. BEADLES: Yes. No, I think the
16 prior comment is exactly right. I think it's one
17 thing to get a performance rate to know that at
18 an ACO level something is high, but what are we
19 doing from the CMS SSP side to really encourage
20 closer to real-time actionability?

21 I don't want to provide any false
22 expectations that these reports would be of the

1 same kind of point of service where you could
2 type in a prescription and instantly see in your
3 EHR that seven other providers have prescribed
4 this real-time. But I think what the reports
5 will contain and what we're planning to do is
6 send those reports and say this list of
7 beneficiaries has greater than four providers in
8 the last -- well, cumulative to date. So doing
9 it quarterly in every quarter, saying okay, in
10 the last three months, these prescribers -- this
11 list of beneficiaries had more than four
12 prescribers or four pharmacies. And here are the
13 MBIs. Here are the provider names of the
14 prescribers of the top six prescribers for this
15 beneficiary.

16 And I think yes, it would be great if
17 it was instantaneous. I think that's a
18 limitation that there's not an easy way around
19 but the idea is to get that information so you're
20 not having to sift through the claims yourself
21 but you're getting a beneficiary MBI, and name,
22 and date of birth, and the number of prescribers,

1 and who those prescribers are as close as we
2 reasonably can get it to you that goes beyond
3 just what's in your state and your prescription
4 drug board.

5 And yes, I think the suggestion about
6 relaxing the rules so that there's a single
7 national Prescription Data Monitoring Board is
8 also a great idea. So I completely agree with
9 that.

10 In the interim, I think there are
11 things that we can continue to do to move this
12 forward.

13 CO-CHAIR MOYER: Okay, Dale.

14 MEMBER SHALLER: Well, the last two
15 comments have really addressed the question that
16 I think Helen raised for me, which was kind of
17 almost startling. If there isn't a plan in place
18 implicit for all of these measures to include
19 periodic feedback, which I'm kind of interpreting
20 now that to be on a quarterly basis -- is that
21 correct through the standardized --

22 MS. SPALDING BUSH: That's correct,

1 yes.

2 MEMBER SHALLER: Okay. Yes, I just
3 want to -- you know I've done some work in the
4 prior feedback reporting space lately and I mean
5 I think that's why we want to do these measures,
6 it's to feed them back to the organizations, the
7 clinicians involved so that Bruce can know who
8 these patients are.

9 So I just think it's important to know
10 that that's actually part of all of the measures
11 that we're looking at and deciding whether to
12 move forward or not.

13 CO-CHAIR MOYER: Thank you. Amy.

14 MEMBER NGUYEN HOWELL: Just one last
15 comment. This is Amy again from America's
16 Physician Groups.

17 I just wanted to recommend that if CMS
18 decides to move forward with these measures to
19 consider eCQM for the measures, given promoting
20 interoperability.

21 Thank you.

22 CO-CHAIR MOYER: All right, seeing no

1 other cards in the room, I did have an
2 outstanding question on palliative care patients
3 and their inclusion or not inclusion in the
4 measure.

5 Do we have a measure developer who
6 could speak briefly to that?

7 DR. SANGHAVI: Yes.

8 DR. PEZZULLO: Yes, thank you. This
9 is Lynn Pezzullo from PQA.

10 So for 077, 078, and 079, currently
11 the measures exclude individuals with cancer and
12 those in hospice care. We certainly can explore
13 exclusion of palliative care, given the
14 recommendations from the group.

15 CO-CHAIR MOYER: Thank you.

16 Darshak.

17 DR. SANGHAVI: Yes, so I was just
18 confirming with my colleague, Stephan Dunning,
19 who is working us on this measure.

20 So our initial opioid CDC compliance
21 measure does in fact, I think as pointed out,
22 exclude individuals that are in institutions,

1 those with cancer, palliative care.

2 CO-CHAIR MOYER: Thank you.

3 Bruce.

4 CO-CHAIR BAGLEY: I would think that
5 although hospice care is coded, palliative care
6 probably is not. So that's a problem that would
7 have to be worked out.

8 CO-CHAIR MOYER: All right.

9 Girma.

10 MEMBER ALEMU: Just a quick question.
11 Unintended consequences were mentioned during the
12 discussion and I know and I understand that NQF
13 looks into such issues during the endorsement
14 process. Is there anything which was explained
15 about the unintended consequences during the
16 endorsement process for any individuals?

17 It may be difficult to answer the
18 question but we don't have the details but I just
19 want to make sure to the group that it is one of
20 really the criteria or the main points that needs
21 to be discussed in that.

22 CO-CHAIR MOYER: I do know that as a

1 discussion point during the CDP process for
2 endorsement and these are, I believe, all NQF-
3 endorsed. So they have all gone through that
4 process and had a committee that took a look at
5 that. I don't know what was discussed during
6 that committee but it is a point that would have
7 been raised.

8 DR. BERNOT: Yes, 077, 078, and 079
9 are NQF-endorsed; 106 is not.

10 DR. PEZZULLO: And this is Lynn again
11 from PQA. You know so our measures are also used
12 -- I know there was in the interest of aligning
13 across various programs, all three of our PQA
14 opioid measures are used in the Medicare Part D
15 program.

16 The high dose, so 078 measure is also
17 used in the Medicaid adult core set and 077 for
18 multiple providers has been recommended for use
19 within that program.

20 So you know through that use as part
21 of our feedback loop, as with all of our
22 measures, we assessed for unintended

1 consequences. So we do work closely with those
2 programs to understand their use and their
3 impact.

4 CO-CHAIR MOYER: Okay. I am not
5 seeing any committee cards up. I think we are at
6 the point we're ready to start moving toward a
7 vote.

8 Before we do that, we do want to open
9 it up to public comments. So we'll start with
10 anyone in the room who wants to make a public
11 comment on the measures. All right, I don't see
12 anyone in the room.

13 Operator, would you check for public
14 comment on the phone?

15 OPERATOR: Yes, ma'am. At this time,
16 if you would like to make a comment, please press
17 star-1.

18 And you do have a comment from Sandy
19 Pogones with the American Academy of Physicians.

20 MS. POGONES: I'm sorry, you can take
21 me off that. I'm in for the next round.

22 CO-CHAIR MOYER: All right, thank you

1 very much.

2 So I am not hearing in the room that
3 we're going to be moving forward en masse with
4 the recommendation. So I don't want -- I don't
5 think we have to do that vote.

6 So we're going to go ahead and vote on
7 these individually. We're going to start with
8 the first measure and just work through in order.

9 I want to check with the committee.
10 I am not hearing like yes, this is perfect, we're
11 all going to be voting for that first category.
12 I mean is there anyone who feels the need to
13 start the vote at full support for this? I'm
14 just trying to narrow down what we're going to be
15 working on.

16 MS. MUNTHALI: So yes, I think that
17 would be a cleaner vote and then go through the
18 rest of the categories.

19 CO-CHAIR MOYER: Okay. So first we
20 will vote to accept en masse the preliminary
21 analysis results. As a reminder for 077, that is
22 conditional support for rulemaking with the

1 condition of considering not duplicating
2 measures. For 078, conditional support for
3 rulemaking with the condition of considering
4 duplication; 079 conditional support with, again,
5 consideration -- okay.

6 MS. KOSURI: I'm unlocking the vote.
7 Voting is now open for MUC2018-077. Do you vote
8 to support the preliminary analysis as the
9 workgroup recommendation?

10 DR. BERNOT: I had a comment, just
11 before people put the vote in and you can't
12 change. If this goes through as a yes, 60
13 percent or higher, it locks in on the preliminary
14 analysis. If you want to add different
15 conditions or go to the other categories, you
16 would vote no here; you do not want the staff
17 recommendation to become yours. And then we will
18 continue vote in process.

19 I just wanted to make sure it's clear,
20 since it's the first vote on this one.

21 So not over 60 percent continues the
22 vote; yes, we lock in the staff preliminary

1 analysis as the workgroup's recommendation and we
2 would move to the next measure. For this measure
3 only, correct.

4 MEMBER DUSEJA: John, can I ask for
5 clarification?

6 If the workgroup decides to go with
7 the preliminary recommendation, they can also add
8 conditions on the conditional support. Like
9 that's how it was operating in the last two
10 workgroup meetings.

11 DR. BERNOT: It will be captured in
12 there.

13 MEMBER BURSTIN: It will be
14 summarized.

15 MEMBER DUSEJA: Yes, it's just to
16 summarize what the concerns are.

17 DR. BERNOT: Yes.

18 MS. KOSURI: And just to clarify that
19 the preliminary analysis recommendation would be
20 conditional support for rulemaking, with the
21 condition that duplication is considered between
22 the measurement for MUC-079.

1 Perfect. Okay, voting is now closed.
2 The committee recommendation based on 95 percent
3 of the vote is to support the preliminary
4 analysis of the workgroup recommendation with 18
5 supporting yes and one supporting no.

6 CO-CHAIR MOYER: All right, we'll move
7 on to voting on the next measure.

8 MS. KOSURI: Okay, so we're going to
9 vote on MUC2018-078. Do you vote to support the
10 preliminary analysis of the workgroup
11 recommendation? And once more, the workgroup
12 recommendation is conditional support for
13 rulemaking with the condition that duplication is
14 considered between the measure and MUC-079.

15 I'm going to unlock.

16 And voting is now closed.

17 The committee's recommendation, based
18 on 95 percent of the vote, is yes to support the
19 preliminary analysis as the workgroup
20 recommendation with 18 people voting yes and one
21 person voting no.

22 Now we'll move on to MUC-079. And so

1 voting is now open for MUC2018-079. Do you vote
2 to support the preliminary analysis as the
3 workgroup recommendation, which is conditional
4 support for rulemaking with the condition of
5 potential duplication between this measure and
6 Measure 077 and 078?

7 We're still waiting for one more vote.

8 Voting is now closed.

9 And the committee's recommendation,
10 based on -- there is 63 percent of the vote is no
11 for MUC-079 to support the preliminary analysis
12 as the workgroup recommendation, with -- let me
13 go back to the count -- seven supporting yes and
14 12 supporting no.

15 CO-CHAIR MOYER: Okay, I believe since
16 we voted on that measure to not support the
17 preliminary analysis, we are going to move on,
18 stay with that measure and move on to voting on
19 the next category down, which I believe is do not
20 support with potential for mitigation.

21 And so what we'll do is vote if we
22 believe that is what the measure should be. If

1 it does not receive support for that category,
2 the final category we would vote on is do not
3 support.

4 MS. KOSURI: So voting is now open for
5 MUC-079. Do you vote to do not support with the
6 potential for mitigation?

7 We're still waiting on a few more
8 votes. One more.

9 Okay, the committee's recommendation,
10 based on 72 percent of the vote is no for MUC-
11 079, do you vote do not support with potential
12 for mitigation, with 15 people on no and three
13 people on yes.

14 Voting is now open for MUC-079. Do
15 you vote do not support?

16 MS. O'ROURKE: So we did a little bit
17 of clarification with the other workgroup after
18 these votes and I just want to make sure that
19 we're tracking and that we're going to convey
20 your input correctly.

21 So this landed on a do not support and
22 my interpretation of the committee's discussion

1 was that you -- and of the voting was that you
2 think CMS should move forward with the first two
3 measures. To Dr. Bagley's point, this measure
4 may redundant with the others and would create,
5 perhaps a parsimony issue. So the group's
6 recommendation is the first two would be the ones
7 you'd like to see added to the program, this one
8 duplicative.

9 MS. KOSURI: Okay, voting is now
10 closed. The committee's recommendation, based on
11 67 percent of the vote, is yes for do not support
12 for MUC2018-079 with 12 people voting yes and six
13 people voting no.

14 MS. O'ROURKE: And apologies for
15 jumping in again but I do want to make sure that
16 everyone is aware that we do pass on all of your
17 comments, not just about the voting, but all the
18 questions and concerns the committee had about
19 the feasibility of the measures and the
20 availability of data. We provide that to CMS as
21 implementation guidance for the measures. It
22 goes into not only the spreadsheet of decisions.

1 We also produce a report that has all of the
2 summary of your conversation, that type of more
3 cross-cutting input, minority opinions. So that
4 all gets packaged up and goes to CMS out for
5 public comment and to the Coordinating Committee
6 for their consideration.

7 CO-CHAIR MOYER: All right, we're
8 moving on to vote on accepting the preliminary
9 analysis on the final measure, 106, the initial
10 opioid prescriptions.

11 MS. KOSURI: So voting is now open for
12 MUC2018-106. Do you vote to support the
13 preliminary analysis as the workgroup
14 recommendation, which is do not support for
15 rulemaking with the potential for mitigation?
16 Mitigation would include specifying the measure
17 at the health plan level.

18 MEMBER SHALLER: Is it possible to
19 just change the wording at the end of the
20 recommendation to ACO level and not plan level
21 because we just I think had that conversation?

22 DR. SANGHAVI: So just as a developer,

1 just understanding the feedback, so if it's a do
2 not support with condition, it meant that we'd
3 have to come back to the MUC with that
4 information or is it -- or is what would ideally
5 be requested is a support with condition of the
6 same thing with the obligation that we do this at
7 the ACO level and Fee-for-Service.

8 MS. O'ROURKE: Sure, I can clarify on
9 at least what the distinctions the decision
10 categories were intended to convey.

11 What the Coordinating Committee was
12 trying to say here with conditional support is
13 along the line of what Helen was saying. You see
14 this as a fairly minor update to the measure but
15 you're comfortable with it going forward for a
16 program at this time.

17 Do not support is a larger scale
18 change to the measure. We've use some of the
19 language from the CDP about substantive change,
20 something that the PAC and Hospital Workgroups
21 were using this for were to convey issues that
22 may require respecification and retesting might

1 change the score of a measure, things like
2 changes to the numerator, denominator, level of
3 analysis, exclusions, risk adjustment model, that
4 type of a wholesale change, if you will, to the
5 measure that would require some additional
6 testing and rework.

7 The point of how that gets
8 operationalized, that's really to CMS as to
9 whether things would need to go back on the MUC
10 list. That's out of MAP's control but that's the
11 degree of change where we've been
12 operationalizing the two categories.

13 CO-CHAIR MOYER: David.

14 MEMBER SEIDENWURM: So it's a question
15 on the order that you could have people wanting
16 to approve the measure completely and people
17 wanting to reject the measure completely are
18 voting the same way, the way this question is
19 framed. And is that intended? Is that a feature
20 of this system or a bug?

21 MS. O'ROURKE: That's a good question.
22 I would just -- whether it's a feature or a bug,

1 I'm still thinking through. But I would say if
2 you want to vote differently than the staff
3 preliminary analysis, vote here, even if you --
4 or vote no, even if you think you might
5 eventually end up in the same spot as the staff
6 decision.

7 It's really just putting forward
8 something for the workgroup to start voting on,
9 maintaining some of the spirit of the old
10 process, where we could just match with measures
11 that have broad agreement quickly.

12 So even if you think you might
13 ultimately go with the do not support with
14 mitigation for this measure but you want to keep
15 talking about it or you want to work through
16 different scenarios as a committee, vote no.
17 That opens us up to a full voting and any
18 additional discussion and then we'll just work
19 through the categories.

20 CO-CHAIR BAGLEY: Maybe I can clarify
21 that. As a procedural matter, you have a motion
22 on the floor which is the recommendation of the

1 preliminary analysis. And that's what we're
2 voting on.

3 If you after this vote, if we don't
4 get 60 percent approval, then you can offer an
5 alternative motion to approve.

6 MS. KOSURI: We're still waiting for
7 two more votes. Oh, perfect.

8 Voting is now closed.

9 The committee's recommendation, based
10 on 68 percent of the vote is yes for MUC2018-106,
11 do you vote to support the preliminary analysis
12 of the workgroup recommendation with 13 people
13 voting yes and six people voting no.

14 DR. SANGHAVI: So I guess -- I was
15 just talking to our CMS colleagues. I was just
16 trying to -- that's a confusing outcome for me
17 because I don't know what to do with that
18 feedback.

19 If the idea -- in other words, if
20 people here could specify what they want to see
21 that's different, it would be very helpful for us
22 to understand the nature of the objection here.

1 I will point out, by the way, that we
2 are not paid for this at all. This is all
3 volunteer time for us. So it's a fairly big lift
4 for us to keep coming back like this.

5 So the option for us is just to let
6 this go, CDC compliance just will not happen
7 here. Or if we understand specifically what the
8 issues are, then there's a chance I guess we can
9 go back to CMS to push this forward against this
10 committee's recommendations, potentially, to just
11 kind of not support it at all.

12 MEMBER BURSTIN: But nothing in this
13 recommendation means this has to come back to us
14 again.

15 DR. SANGHAVI: Oh, it doesn't? So
16 that is what's confusing to us. What does do not
17 support mean, then?

18 Maybe that -- I'm confused by what
19 this outcome means.

20 MEMBER BURSTIN: I think what the
21 committee had said was that it should be
22 appropriately tested and CMS, I think, has heard

1 that. So that's all for the right level.

2 CO-CHAIR MOYER: Yes, that was what I
3 heard and what my understanding of the vote of
4 the vote and the recommendation, that there was
5 concerns about the existing specification, or the
6 existing definition or testing of the measure
7 versus the population to which it might be
8 applied.

9 And so we want to make sure -- we want
10 to strongly recommend that that get reconciled or
11 addressed before use in the CMS program. That's
12 our recommendation.

13 We don't have the authority to make
14 that happen or to say how that happens. It's
15 just our feeling as a group. So that's my --

16 DR. SCHREIBER: First of all, thank
17 you for all of the input. In the other meetings,
18 it has been useful for us to kind of summarize
19 some of the comments. And I wrote them down or
20 you wrote them down. I would really appreciate
21 making sure that we captured everything, if I
22 could for a moment.

1 So on the first three, thank you, but
2 I've heard that there is some conditional support
3 that people would like to see improvements around
4 the following: 1) to ensure that there's
5 feedback on a reasonable basis in confidential
6 reporting; 2) making sure that there's no
7 redundancy with other measures, which I think you
8 did by taking out the third one; 3) trying to
9 exclude palliative care, if that's at all
10 possible; 4) ensuring that we are excluding
11 Suboxone and I can't pronounce -- sorry --
12 Suboxone but just to verify that; 5) obviously,
13 long-term following for unintended consequences,
14 considering this ultimately as an eCQM; 6)
15 including post-acute care settings in this
16 measure; 7) in the future, casting a wider net
17 and ensuring that we are aligning this across all
18 programs.

19 Did I miss anything, any major points?

20 And then in addition to the last
21 measure, looking at the CDC requirements for
22 initial opioids, those issues plus perhaps

1 seeking NQF endorsement, so testing, that there
2 were too many variables. There was some concern
3 about that. And there was some concern that the
4 CDC recommendations may be changing and it would
5 be hard to capture a measure wants the CDC
6 criteria if they are changing.

7 So that's what I heard.

8 DR. BERNOT: I apologize if I
9 misheard. The other thing I had down was to
10 ensure that that Part D data is readily available
11 for the --

12 DR. SCHREIBER: I assumed that under
13 feedback but yes, thank you.

14 CO-CHAIR MOYER: And again, we really
15 thank you. Having an opioid measure, quite
16 honestly, is important I think to all of us. So,
17 thank you.

18 CO-CHAIR BAGLEY: Okay, we're going to
19 move on to immunization. And John, do you want
20 to introduce that one measure?

21 DR. BERNOT: Yes, and for this
22 measure, the one thing that is a little unique to

1 it, this measure has been put for consideration
2 on both the Shared Savings Program as well as
3 MIPS.

4 So what we would propose to do is to
5 introduce it, because it is the exact same
6 measure, give our preliminary analysis, what it
7 would be for both programs. In this case, it is
8 actually different between the two programs.
9 Have one discussion and then two votes on it,
10 just for the efficiency.

11 So this will be the only MIPS measure
12 that we're moving forward at this point because
13 it's the same exact measure.

14 So if I can begin, the measure is the
15 Adult Immunization Status Measure. This is
16 MUC2018-062. It is the percentage of members 19
17 years of age or older who are up to date on the
18 recommended routine vaccines for influenza,
19 tetanus and diphtheria, or tetanus, diphtheria,
20 and acellular pertussis, zoster, and
21 pneumococcal.

22 For the Shared Savings Program we had

1 a conditional support for this with the condition
2 of NQF endorsement, which subsumes the test for
3 reliability, validity, feasibility, all of which
4 are part of the endorsement process. So for the
5 Shared Savings Program it is the conditional
6 support with the condition of NQF endorsement.

7 The same measure also, this is
8 MUC2018-062 Adult Immunization for MIPS.
9 Everything else is the same however, the
10 preliminary analysis for this is do not support
11 with the potential for mitigation and the
12 mitigation would be that it would have to be
13 tested at the clinician level with the program
14 differences between MIPS and the Shared Savings
15 Program.

16 Any clarifying questions on what I
17 said?

18 MEMBER BURSTIN: So what was the
19 preliminary recommendation for the MSSP program?
20 I just want to make sure I got that because it
21 says clinician level, which doesn't make sense.

22 DR. BERNOT: Yes, there is a version

1 of the discussion guide, I apologize, where it is
2 flipping one of the sections. I'm sorry. I very
3 much apologize.

4 For the Shared Savings, conditional
5 support with NQF endorsement. And MIPS is do not
6 support with potential for mitigation, with that
7 mitigation being demonstrating testing at the
8 patient level -- or excuse me -- clinician level.

9 CO-CHAIR BAGLEY: Okay, our lead
10 discussants, Rob, you're up.

11 MEMBER FIELDS: Yes, I actually had a
12 comment but actually first had a question from
13 CMS' point of view.

14 So recently some of the immunization
15 measures were removed from the measure set. And
16 I just wanted clarification on the logic of this
17 past year removing PNEUMOVAX off the measure set
18 and then now potentially reintroducing it in the
19 composite format.

20 I do have an additional comment on
21 this actual measure but I'm not going to say that
22 now. I guess we can respond to that.

1 But I think from our perspective, the
2 issue with this one is that two of those vaccines
3 are not a covered benefit under Medicare. So it
4 seems sort of illogical to create a financial
5 barrier for seniors by not covering the benefit
6 and then holding providers accountable for
7 completion of the measure. It just seems like
8 there's a discordance there that's a fundamental
9 flaw in this.

10 I mean it's obviously good health
11 care. Nobody's going to argue that. And tetanus
12 is actually not a covered benefit either.

13 So it's a little confusing and
14 illogical and, for that reason, we couldn't
15 possibly support it as written.

16 CO-CHAIR BAGLEY: Helen, do you have
17 comments on this one?

18 MEMBER BURSTIN: I'm not sure if CMS
19 heard the question.

20 CO-CHAIR BAGLEY: You're also a lead
21 reviewer.

22 MEMBER BURSTIN: Yes. Okay, I'll just

1 do mine, then.

2 So I thought this was a very
3 interesting measure, obviously really important.
4 Nobody would argue with the importance of doing
5 an adult measure of immunizations. It was very
6 difficult to look at this measure without
7 actually having the detailed specifications and
8 if I missed them, I apologize. But for example,
9 I don't know if it's an all or none composite,
10 you only get credit if you do all of them. I
11 don't know if it is a weighted composite. I
12 don't know how the composite is actually
13 structured.

14 And so my concerns actually relate
15 somewhat to what was said because in fact if it
16 is very difficult to get zoster, the zoster
17 vaccine, as an example, covered, then in fact the
18 overall composite may, if it is an all or none
19 composite, just reflects what is difficult to
20 get, as opposed to what the true immunization is.

21 So I would like some clarification as
22 to what the specifications actually look like.

1 And I think several people raised a
2 concern in comments about how the specifications
3 don't align with some of the other immunization
4 measures, in terms of time frame or in terms of
5 time frame for a flu vaccination or time frame in
6 terms of the pneumococcal vaccination. So I
7 guess whatever moves forward, hopefully that can
8 be harmonized going forward so we don't have
9 different measures going back and forth.

10 Again, this is currently tested at the
11 health plan level. I think the question is how
12 would this perform in an ACO.

13 I also have some concerns about the
14 ability to see so far retrospectively for
15 patients 19 and up to really be able to see
16 vaccines ten years previously or be able to keep
17 track across time and place. If people churn
18 through Medicaid to private to back, what does
19 that actually look like? And again, this is an
20 MSSP measure so the age issues were an
21 interesting question to me overall.

22 CO-CHAIR BAGLEY: And before we open

1 up to the general comments, do either Reena or
2 Michelle have comments from the CMS standpoint?

3 MEMBER DUSEJA: I'm sorry, I think we
4 did miss a question earlier.

5 MEMBER FIELDS: Yes, so my initial
6 question was just trying to understand the
7 rationale for removing PNEUMOVAX off the MSSP
8 program this past year but now reintroducing it.
9 There must have been a rationale for removing is
10 what I'm trying to understand so reintroducing
11 was confusing to me, in particular in this
12 format.

13 And then of course the comment I made
14 earlier about coverage benefits.

15 MEMBER DUSEJA: That's a good
16 question. So I think at least for this
17 particular program is for harmonization. So the
18 reason why that they just had to bring it back to
19 the committee was because of the updated
20 guidelines and to do an all or none measure to
21 reflect that, based on what we've been hearing
22 from stakeholders.

1 CO-CHAIR BAGLEY: Diane, you're next.

2 MEMBER PADDEN: I guess I would also
3 raise similar concerns if it's all or none. If
4 we think about where some of our patients get
5 immunizations, in terms of influenza, they're not
6 always at a clinician's office. It might be at a
7 health fair. It might be at a pharmacist. So
8 then how are we going to capture that as all or
9 none?

10 CO-CHAIR BAGLEY: Other comments or
11 questions? This is quite a group.

12 This is all okay, huh? Any other
13 comments? Yes, go ahead, Dale.

14 MEMBER SHALLER: Confirmation that
15 this is not a covered benefit under Medicare.
16 The question was raised. It is not a covered
17 benefit? That's an important question.

18 CO-CHAIR BAGLEY: Are you guys --

19 MEMBER FIELDS: It is not. I mean
20 Zostavax is absolutely not. You have to write a
21 prescription and there aren't on a Part D plan.
22 Some Part D plans with an NA covered as a

1 pharmacy benefit, for instance, but for a
2 straight Fee-for-Service Medicare, it's not a
3 covered benefit for many plans. And it's
4 certainly not within Fee-for-Service plans and
5 Tdap as well.

6 MEMBER SHALLER: Another question is
7 is zoster the one that is in short supply? So
8 that's an issue, too.

9 MEMBER GREINER: Can you repeat your
10 last question?

11 MEMBER SHALLER: Zoster is the one,
12 the newer one in short supply. It's very hard to
13 get, at least depending on where you live.

14 CO-CHAIR BAGLEY: Other comments? It
15 looks like we must be ready to vote.

16 Okay, let's move ahead. Now, should
17 we vote on the different programs separately?

18 Okay, I think the first thing we need
19 to do before we vote is to have a public comment
20 opportunity.

21 So is there anybody in the room who
22 would like to comment?

1 Anybody on the phone? Operator, can
2 you open up the line?

3 OPERATOR: Yes. At this time, if you
4 would like to make a comment, please press star,
5 then the number 1.

6 You do have a comment from Sandy
7 Pogones for the American Academy of Family
8 Physicians.

9 CO-CHAIR BAGLEY: Okay, Sandy.

10 MS. POGONES: Hi, this is Sandy
11 Pogones speaking on behalf of the American
12 Academy of Family Physicians.

13 In general, the American Academy of
14 Family Physicians opposes the use of all or none
15 composite measures in accountability programs.
16 The all or none measures don't award partial
17 credit. So as was mentioned earlier, they only
18 reflect what's the most difficult to get. That
19 is, a physician or a group that does very well in
20 six of the seven measures but poorly in one will
21 be scored the same as a physician or group that
22 does poorly in all measures. And we don't feel

1 that that offers equitable quality. We think the
2 difference in quality between the two groups
3 would be very different.

4 And at minimum, you know there are
5 other ways of scoring composite measures. As was
6 mentioned you might sum the numerators, sum the
7 denominators, and then calculate a composite by
8 dividing the numerator by the denominator. But
9 the all or none really does give a very harsh
10 penalty for doing poorly in one measure.

11 We feel that composite measures of
12 this type may be very useful for internal quality
13 improvement because they are quite sensitive to
14 differences in variations but we don't feel that
15 they're appropriate for accountability for the
16 reasons that I just mentioned.

17 In addition, when you look at these
18 vaccination composites, the numerators,
19 denominators, and exclusions for the influenza
20 and pneumococcal vaccine measures within this
21 measure are not consistent with those in the
22 annual wellness visit composite. And we have to

1 be absolutely certain that measures are aligned
2 to the extent possible prior to NQF endorsement
3 and prior to CMS using them in a quality payment
4 program.

5 When you look at errors in
6 measurement, they are amplified by composite
7 measures. And since five of the seven -- I'm
8 sorry -- since two of the seven vaccines are
9 often given outside of the physician office, in
10 fact in many office they aren't given in the
11 office at all but are given in the community as
12 was mentioned before, it can be extremely
13 difficult to which the lack of data sharing and
14 interoperability for a physician or group to get
15 that data. The lack of access to claims data,
16 the lack of access to interoperable information
17 is probably going to lead to very poor data and
18 very low scores for these measures. And so the
19 scores are more likely to reflect the extent of
20 the EHR documentation than they are actual
21 performance of the action.

22 And as we mentioned in the past,

1 insurance coverage may in fact impact patient
2 willingness to be vaccinated.

3 Thank you.

4 CO-CHAIR BAGLEY: Rob, go ahead.

5 MEMBER FIELDS: Yes, just for
6 confirmation on the Medicare.gov, I just
7 confirmed that both those are it is dependent on
8 your Part D plan. It's a pharmacy benefit, which
9 is different than flu and PNEUMOVAX. So that's
10 Tdap and Zostavax are covered via Part D. So
11 it's dependent if you have a Part D plan, and if
12 that plan covers it, you know what copays. It's
13 just fundamentally different than the way flu and
14 PNEUMOVAX are administered.

15 CO-CHAIR BAGLEY: And anybody else on
16 the phone for public comment?

17 OPERATOR: No, no public comments at
18 this time.

19 CO-CHAIR MOYER: So I was trying to
20 see if I could figure this out from the
21 specifications.

22 In terms of data source for the

1 measure, so I always get my flu vaccine someplace
2 other than my primary care office. And then when
3 I show up back at the health system, they say
4 hey, have you had your flu vaccine? And they put
5 the date in the system.

6 So I mean that feels like a fairly low
7 barrier and I realize patients don't always know
8 but if you don't know if your patient has had the
9 vaccine, then you don't know if the patient needs
10 the vaccine. I mean it feels like that is
11 information you would need to have for clinical
12 care.

13 And I guess just to provide a slightly
14 different perspective on the composite, I do
15 agree that an all or none, and especially with
16 the fractioned data from Medicare can be
17 challenging but I mean from a patient
18 perspective, if a patient were looking at this
19 and using this from a public reporting, get all
20 your vaccines is really easy to understand.
21 Several different vaccination rates is really a
22 lot more challenging.

1 And I do believe that achieving a high
2 rate on an all or none composite measure really
3 shows a mastery of a process and a very
4 consistent level of care in place. So I just
5 wanted to raise these points.

6 CO-CHAIR BAGLEY: Thank you. And if
7 I might, I'd like to correct something I think is
8 a misperception. I heard it said twice and that
9 is that if you have five components to a
10 composite all or none measure, that the lowest
11 rate is what is the determining factor.

12 If you have five components, I don't
13 care what measure it is, and you are doing 75
14 percent on every last one of them, the composite
15 rate is .75 times .75 times .75 five times and it
16 comes up to like 28 percent. So it's not just
17 the lowest measure. It's the rate of each one
18 multiplied together for all five components.

19 And I heard twice people to say that
20 that's not the case.

21 MEMBER BURSTIN: Except we don't
22 actually have the specifications of how the

1 composite is done.

2 CO-CHAIR BAGLEY: I mean I'm not
3 talking about this measure at all. I'm just
4 talking about the idea of an all or none
5 composite measure. That's how you end up with a
6 rate.

7 So the diabetes composite measure in
8 Minnesota started out with people getting rates
9 of like 15 percent, even though they were doing
10 fine on some other things. So and that caused
11 them to systematize, as Amy mentioned, to get a
12 systematic approach to getting all that stuff
13 done.

14 This one doesn't lend itself to that
15 kind of systematic approach very well but I just
16 wanted to get the math straight. It's about
17 math.

18 I'm getting a -- go ahead, Scott,
19 before we summarize.

20 MEMBER FURNEY: So I really enjoy math
21 and trying to figure out composites. Without the
22 measure specs, there are two different versions

1 of composites one could calculate. So one would
2 be considered perfect care. How often do you
3 achieve all of the measures so that that patient
4 goes from a zero to a one?

5 And then there's the composite that
6 you're describing and, again, I may have missed
7 it as well but there is not the level of details
8 or specificity in the linked materials that I
9 could find to figure out which version of either
10 perfect care or a rated composite awaited
11 composite, as you are saying this is.

12 DR. SCHREIBER: So let me just read
13 you what I have in the measure specs right now.
14 That it's the percentage of members who are up to
15 date on -- and it lists them one by one -- and
16 says all of them. So I think that this is trying
17 to capture all of them.

18 And it goes one by one, member in
19 denominator 1 who received influenza; member of
20 category 2 who received Tdap; and so forth and so
21 on. And it is all.

22 Does that help?

1 MEMBER FURNEY: Yes, so that sounds
2 like what we determined -- what we call perfect
3 care, which is a binary zero-one-one. You either
4 have all of them or you have one, two, three,
5 four, five of them but just shy. And those are -
6 - that does run the risk, especially with two of
7 the immunizations being either a non-covered
8 benefit or a co-pay eligible benefit of
9 disenfranchising providers or practices that have
10 a higher proportion of underserved patients. And
11 that's a concern.

12 I'm foreshadowing the conversation a
13 little bit about risk adjustment but if you have
14 a demographically challenged population versus an
15 affluent population, the ability to get perfect
16 care and afford the copays or the -- pretty
17 pricey, having recently sent patients for the new
18 shingles vaccination, the two-shot series, which
19 is SHINGRIX, it is very expensive. So I think we
20 run the risk with perfect care measure of having
21 pretty significant variation, just based on
22 demographics.

1 CO-CHAIR BAGLEY: Ira.

2 MEMBER MOSCOVICE: Yes, just seconding
3 that the Rural MAP Workgroup really raised that
4 point in terms of the population they're serving
5 often is underserved and has lower economic
6 status. And the lack of coverage for Medicare
7 would really disadvantage rural providers.

8 CO-CHAIR BAGLEY: I want to know if
9 anybody from NCQA is on the phone or in the room
10 to comment for the developer?

11 MS. WILLIAMS-BADER: Hi, this is Jenna
12 Williams-Bader from NCQA. Are you able to hear
13 me?

14 CO-CHAIR BAGLEY: We can hear you
15 fine, Jenna. Go ahead.

16 MS. WILLIAMS-BADER: Okay, so I am
17 with NCQA. I am not the actual measure
18 developer. I have her on a chat. She's been
19 trying to speak and hasn't been able to get
20 through, unfortunately. So I will have to try
21 and relay what she has told me.

22 Lindsey Roth is our measure lead here

1 and she actually said that the measure is not an
2 all or none composite. So we did want to make
3 that clear.

4 Let me see if I can get any more
5 information from her and see if she is able to --

6 MS. ROTH: Great, hi.

7 MS. WILLIAMS-BADER: -- join the line
8 maybe using a different number. Oh, there you
9 are Lindsey. I can hear you.

10 MS. ROTH: Yes, thank you. Sorry
11 about that. I apologize for not being able to
12 get through earlier.

13 So yes, I did want to clarify about
14 the composite rate. This has been a really
15 interesting discussion and I'm sorry I wasn't
16 able to chime in earlier but I did want to
17 clarify that the composite rate in this measure
18 is not an all or nothing rate. It actually
19 assesses each patient's opportunity for a vaccine
20 based on their age.

21 So for instance, adults 66 and older
22 would be eligible for four vaccines, the pneumo,

1 zoster, Td or Tdap, and flu versus a 19-year-old
2 adult who only has the opportunity for flu, or
3 Td, or Tdap.

4 So then the composite was calculated
5 by then adding up all the patient vaccine
6 opportunities as the denominator and then the
7 numerator is based on the total number of those
8 vaccines that were received or that they're up to
9 date on.

10 So essentially, you are summing up the
11 denominators across the individual vaccinations
12 and summing up the numerators and dividing. So
13 that would give you an overall snapshot of the
14 vaccination. And then there are individual
15 vaccine rates so you can understand what is
16 perhaps driving that composite rate.

17 And then I did want to also mention
18 that in our field testing of this measure we did
19 calculate the composite as an all or nothing in
20 addition to the way that it's currently
21 specified. And the all or nothing composite
22 rates were extremely low across the plans that we

1 tested them.

2 CO-CHAIR BAGLEY: Lindsey, thank you
3 for that clarification.

4 Anybody have questions of Lindsey
5 about that?

6 Scott.

7 MEMBER FURNEY: Sorry, I'm obsessed
8 about this but the way I understood the comment,
9 Lindsey, is it's not an all or none on all of the
10 vaccines but for each age group, if a younger
11 person is eligible for two or three, it is still
12 considered perfect care for that age appropriate
13 set of vaccinations. Same thing for someone who
14 is 65 or older.

15 So I think there's a difference
16 between a weighted composite with a percentage of
17 achievement on each of the immunizations versus
18 all immunizations for each age range.

19 PARTICIPANT: Actually, I think it
20 wasn't either of those. I think it sounded like
21 she was counting the number of vaccines eligible
22 as the denominator. So if you're 19, you only

1 get two. If you only got one of those, you get a
2 one in the numerator and you've got 50 percent.
3 If you're due for five, you only got three of
4 them, then you've got three out of five so that's
5 60 percent.

6 CO-CHAIR BAGLEY: Lindsey, did you
7 hear that?

8 MS. ROTH: Yes, and that's correct.
9 Exactly.

10 MEMBER FIELDS: It's not weighted or
11 perfect care. It's a raw percentage based on
12 opportunity.

13 CO-CHAIR BAGLEY: Any other comments
14 from around the table?

15 Okay, I think we're ready to vote.
16 And what I'd like to do is ask John to summarize.
17 And we're going to vote on the same measure for
18 two different programs. So we're going to vote
19 first for one program and then the other program.

20 So it is the same measure with the
21 same specifications but we're going to vote on
22 the different programs because we're charged with

1 determining the appropriateness of any particular
2 measure for a program. So we're going to do it
3 that way.

4 Any questions about that?

5 DR. BERNOT: Okay, so the preliminary
6 analysis, again, was the conditional support with
7 NQF endorsement. And now again, that endorsement
8 is a very broad process. Let me capture some of
9 -- or demonstrate some of the things I've
10 captured. And if there's anything that I'm
11 missing that we need to highlight, please let me
12 know.

13 Again, I think most of these would be
14 covered under that process but I want to make
15 sure that they are explicitly listed. In testing
16 at the ACO level, what was mentioned what I'll
17 consider the variability of benefits; that is,
18 the reimbursement of vaccines, the shortage of
19 vaccines issue which would have to go through
20 that process also, I can scratch the part about
21 the all or none, data availability, again with
22 pharmacy giving vaccinations versus them coming

1 through the clinical offices.

2 So I have all of those components.
3 Again, I do believe they would be largely
4 subsumed under endorsement but I wanted to
5 highlight those. And if there's anything else I
6 am missing as specific --

7 MEMBER BURSTIN: The issue that the
8 individual measures may have different time
9 frames or different specifications so there
10 should be -- I think they're all NCQA measures, I
11 think. So just some internal harmonization or
12 updating of the existing individual measures that
13 they're still in the program, depending on the
14 MSSP would be helpful.

15 DR. BERNOT: Okay.

16 CO-CHAIR MOYER: I apologize. I just
17 have one quick thought that is rattling around.
18 We were talking about the covered benefit of this
19 and the reason for that not to be care.

20 I don't know what flexibility there is
21 but we are seeing a lot of organizations who are
22 ACOs or Shared Savings type programs take on

1 things they wouldn't normally take on because
2 there is a cost benefit to it, I mean giving
3 people rides, housing, all kinds of things. It
4 would feel like if there is a cost benefit to
5 these vaccines, perhaps measuring on it would
6 help drive a shared savings because your patients
7 get the vaccine. And whether it's covered or not
8 or whether they can afford it, making sure that
9 happens might result in shared savings and
10 benefit from the program.

11 So I'm not sure if that is actually
12 the case. This is not really my core group or
13 vaccines but I was just curious about that and
14 how that might fit in the program.

15 CO-CHAIR BAGLEY: Lindsey, do you have
16 any comments on that? Any comments around -- oh,
17 go ahead.

18 MS. ROTH: I have no comments.

19 CO-CHAIR BAGLEY: Okay. Anybody
20 around the table want to comment on that? I
21 guess that's up to ACO to decide. Okay.

22 All right, John, you want to set up

1 the vote here? Let's just make sure we know
2 which program we're voting on first. SSP first.

3 MS. KOSURI: SSP first, yes.

4 CO-CHAIR BAGLEY: And the
5 recommendation is?

6 DR. BERNOT: Is a conditional support
7 with NQF endorsement and, again, highlighting the
8 items that I mentioned, including the addition
9 from Helen about the time frames.

10 MS. KOSURI: So voting is open for SSP
11 MUC2018-062. Do you vote to support the
12 preliminary analysis as the workgroup
13 recommendation?

14 Okay, I think we have our vote. I
15 think we have our 19 votes. So voting is closed.

16 The committee's recommendation based
17 on 68 percent of the vote is yes for support for
18 the preliminary analysis as the workgroup
19 recommendation with 13 people voting yes and six
20 people voting no.

21 CO-CHAIR BAGLEY: Okay, let's go on
22 the MIPS measure.

1 DR. BERNOT: Same measures as for the
2 MIPS program. Again, we'll start at the
3 preliminary analysis and, if you recall, this is
4 a different preliminary analysis. This was a do
5 not support with the potential for mitigation and
6 that would include testing at the clinician level
7 for the mitigation. And of course, all of the
8 other items I listed would carry over, unless we
9 hear otherwise, as points to note.

10 MS. KOSURI: Okay, voting is now open
11 for MIPS MUC2018-062. Do you vote to support the
12 preliminary analysis as the workgroup
13 recommendation?

14 Okay, I think we have our 19 votes so
15 voting is closed.

16 The committee's recommendation based
17 on 89 percent of the vote is yes to support the
18 preliminary analysis as the workgroup
19 recommendation with 17 people voting yes and two
20 people voting no.

21 MEMBER FIELDS: Can I make a quick
22 comment? Are there any -- I'm curious if there

1 are any consumer folks that could -- either
2 nonprofits or other advocacy groups either in the
3 room or on the phone.

4 CO-CHAIR BAGLEY: Robert is basically
5 a consumer person, as well.

6 MEMBER FIELDS: Okay. Again, it just
7 seems like a fundamental discordance, based on
8 what we just -- the vote's done and that's fine
9 but to not -- to raise the level of
10 accountability for vaccines that are not covered
11 under Medicare Fee-for-Service seems like you
12 know injustice might be overstating it but it
13 certainly seems fundamentally flawed as a
14 strategy for taking care of patients.

15 So from the consumer angle, just
16 someone who sees patients, and tries to prescribe
17 these, and tries to figure out how they are going
18 to get them paid for because they see all sorts
19 of commercials about they need to get this
20 vaccine or that vaccine and it's not a covered
21 benefit and they are having to shell out
22 sometimes over \$100 for ZOSTAVAX, that's the

1 reality out there in the world. So if no one is
2 going to raise that from the consumer angle, as I
3 just put it on record while there are CMS folks
4 in the room, I would hope that that is a
5 consideration that is taken back for those that
6 are able to act on them.

7 CO-CHAIR BAGLEY: Well said. Other
8 comments?

9 You know CMS has asked us also to
10 entertain a conversation about where there might
11 be gaps in the MSSP program in terms of
12 measurement.

13 MEMBER BURSTIN: Do you have the list
14 of the current MSSP measures? That might be
15 helpful.

16 MS. KUWAHARA: They are included in
17 the link in the email I just sent out. It's
18 under measure frameworks. We have the 2018 SSP
19 measure set as well as 2019.

20 CO-CHAIR MOYER: David.

21 MEMBER SEIDENWURM: Well, I've said
22 this every year since the first MAP and we're not

1 there yet so I'll say it again because I guess
2 this is my cue.

3 I think that one of the things that is
4 missing is when we have a performance metric in
5 the Shared Savings Programs for some clinical
6 activity, such as breast cancer screening,
7 colorectal cancer screening. We don't require
8 the underlying process to be monitored for
9 quality. And so I would advocate employing in
10 those two examples mammography quality metrics
11 and cohorts of cancer screening quality metrics
12 as components of the Shared Savings Programs.

13 So since we're essentially compelling
14 people to have these procedures done, we ought to
15 I think also ensure that they are done well.

16 CO-CHAIR MOYER: I'm going to go ahead
17 and echo that as well. Full disclosure, David
18 and I have done some work on this together.

19 One of our huge spend areas as a
20 purchaser is around colonoscopies because they
21 frequently start before people come on to
22 Medicare. And the level of quality information

1 that we can make available to our people because
2 if you're going to go through that, you want it
3 to be effective, to accomplish what it is
4 supposed to accomplish and you want it to be
5 safe.

6 And we do have you know the seven-day
7 hospital visit but in terms of consistent
8 availability of the quality of the procedure, the
9 adenoma detection rates, bringing people back at
10 appropriate guidelines for follow-up, that is
11 something that is really very scattered and
12 inconsistent.

13 And I have actually tried to help
14 family members who are on Medicare trying to
15 figure out where they should go and it's really
16 hard but if they needed smoking cessation, we
17 could go to the gastroenterologist. So I don't
18 expect you to magically fix that but it is -- you
19 know if we put a lot of effort into it to make
20 sure that we get that full benefit would be
21 terrific.

22 CO-CHAIR MOYER: Helen.

1 MEMBER BURSTIN: It's great to be
2 asked. I think it's a really important question.
3 I think you obviously want to try to get to the
4 measures that meet your Measures that Matter
5 piece.

6 You have many measures that are sort
7 of related to various settings of readmissions,
8 which I assume are intended to be proxies for
9 care coordination. They are really precious few
10 measures that actually get at coordination.

11 And I know we've talked about this
12 forever. A friend of mine notoriously said care
13 coordination is the Bermuda Triangle of
14 measurement. Many of gone in and few have
15 emerged with a measure. Credit to Eric Schneider
16 for that. I've always loved that and
17 unfortunately, it is true.

18 But I think the whole purpose of ACOs
19 is really intended to in fact be able to see more
20 of that direct clinician-clinician coordination.
21 And it just always make me sad when I look at
22 this list and it doesn't actually have anything -

1 - it doesn't have very much. I mean it does have
2 some in the CAHPS realm, of course, and
3 readmissions may be a proxy for that but the way
4 to really begin looking at that and maybe some of
5 that is getting back to Dave and Amy's point,
6 maybe even things like time to.

7 Some of the timeliness measures are on
8 patients with a new diagnosis. So they are
9 getting coordinated care. They are getting their
10 biopsy done. They are getting it done quickly.
11 Those kinds of measures may be more reflective of
12 what you intent is of having a truly coordinated
13 patient-centered system of care and these are
14 really just proxies for that and I recognize how
15 difficult that is to do.

16 CO-CHAIR MOYER: Amy.

17 MEMBER NGUYEN HOWELL: Yes, so I echo
18 that comment from Helen absolutely and I thank
19 CMS for asking the important question.

20 So I'd like to see more patient-
21 reported outcome measures for this program. And
22 along those lines, as we look at, especially the

1 LAN outline of how value-based care and value-
2 based payment should be made within this country
3 in the next few years, looking at risk and how
4 that follows with organizations, also trying to
5 align measures better, as we look at how these
6 organizations assume risk and then take care of
7 patients.

8 And so with that cost and resource
9 use, utilization measures are appreciated because
10 -- but in looking at that, we should hopefully
11 refine the attribution answer -- not question but
12 answer better to help define the attribution for
13 the intendeeds.

14 CO-CHAIR MOYER: All right, I am not
15 seeing additional cards in the room. And I
16 apologize because I haven't been able to find the
17 list. I'm just going to guess, though, that we
18 could use measures around perhaps the shared
19 decisionmaking process and making sure that we're
20 not just giving appropriate care to patients but
21 that they are involved partners in the discussion
22 around treatment, and that they understand what

1 they are getting into, and that it is in line
2 with their values, and what they expect to
3 obtain, and their goals for life, as well.

4 Ann.

5 MEMBER GREINER: This summer we, in
6 conjunction with The Graham Center, put out a
7 report that looked at the contribution of
8 advanced primary care to ACO performance. And
9 there's actually not a lot of research in this
10 area, which I was surprised at. And what we
11 found is that the ACOs that were most successful
12 had a strong foundation of patients under Medical
13 Homes.

14 So one suggestion, and this is a
15 structural measure, I believe, would be just to
16 find out from the ACOs what proportion of their
17 physicians are in a PCMH because that does appear
18 to provide the sort of infrastructure and the
19 foundation for the ACOs to manage patient care so
20 that they can get to the population health
21 outcomes that we all seek. So that's a
22 suggestion for consideration.

1 CO-CHAIR MOYER: I see no other cards.
2 I feel like I have this long list of demands.

3 This is suggestions, very, very true,
4 well and especially because I personally don't
5 know of any current existing measures but a lot
6 of what we do here is pinned on the idea that the
7 diagnosis the patient has received is correct.
8 And so getting at diagnostic error and that would
9 be -- I think it is an important frontier in
10 measurement that we haven't addressed or really
11 gotten our arms around yet at this time.

12 Dae and then David.

13 MEMBER CHOI: Yes, I just wanted to
14 echo those comments. We have a lot of measures
15 that are doing the screening, and they have the
16 eye exams et cetera. I think that's really kind
17 of the next frontier in terms of how we can
18 evolve these process measures is to look at what
19 are the things being done in those next steps
20 that are insured, and the appropriate care, and
21 timely care.

22 MEMBER SEIDENWURM: So with respect to

1 diagnostic quality and safety as opposed to
2 diagnostic error, I think the frame is really
3 important. So I think if we can look at the NQF
4 report and the NAACO report and try to develop
5 measures around that, that would be great.

6 It turns out to be enormously
7 challenging to do that. As a radiologist, we've
8 worked on that and we haven't really made a lot
9 of headway. I mean we'll take all the help we
10 can get.

11 CO-CHAIR BAGLEY: If I were running an
12 ACO, I would want a conversation started in my
13 ACO about diagnostic and therapeutic efficiency.
14 How do we get to the right answer? And how do we
15 get it treated as efficiently as possible?

16 You know, again, it's a proxy for the
17 clinical integration maybe but it really, instead
18 of talking about errors or where we fell down,
19 what is your diagnostic and therapeutic
20 efficiency in your organization? And I don't
21 have a measure to recommend but maybe we should
22 start calling it that instead of something else.

1 It really is what they should be about, I would
2 think.

3 MEMBER FIELDS: Sorry, I couldn't
4 resist.

5 You know it's interesting. I'm a part
6 of other committees that are thinking about
7 measure development around diagnostic accuracy
8 and it supposes or it assumes that it is a
9 somewhat black or white sort of outcome. And I
10 think all of us that are in the room that are
11 clinicians know that it's far from that. And it
12 is highly subjective and it evolves. And you
13 know there are varying opinions on if any one set
14 of symptoms and categories -- and safety I
15 totally get. You can get your head around safety
16 much easier. But the whole concept of diagnostic
17 accuracy, it implies that there's a single
18 outcome that we're looking for and it is much
19 more subtle than that, depending on the
20 complexity of the patient, which I think then
21 sort of says why everyone has struggled with it
22 is that having one measure, or even two, or

1 three, four measures probably doesn't get us
2 there.

3 I don't have an answer for it but I
4 think, to me just clinically, that's why we
5 struggle with it because it's hard to get it down
6 to something that is measurable either as a
7 numerator or a denominator really.

8 MEMBER BURSTIN: I agree it's a tough
9 area. And certainly when we did the work here at
10 NQF, and if you haven't seen it, we did a report
11 literally laying out what were the low-hanging
12 fruit of things you could at least begin to do.
13 They're not going to be the measures that look at
14 was there a diagnostic error but there are some
15 potential issues like timeliness of test result
16 follow-up that to me seem like they might be a
17 really nice one for this kind of program that is
18 supposed to, again, be about does the right hand
19 know what the left hand is doing, patient access
20 to information, handoffs, again goes back to care
21 coordination.

22 Those are the kind of things that I

1 think really reflect what we hope is the spirit.
2 What we hope ACOs do and you would know this
3 better than me, but those are the kind of
4 measures I think are ready.

5 The other thing is the Moore
6 Foundation is going to be putting out a massive
7 grant program to develop some of these measures.
8 We've had lots of conversations with them. So I
9 think this is a great time as well for CMS to
10 talk to -- you know see if there is a public-
11 private partnership there to get you something
12 quickly.

13 MEMBER SEIDENWURM: The Moore
14 Foundation is what, a \$75 million project that
15 they're putting forward on this exact topic. Is
16 that what you were referring to?

17 MEMBER BURSTIN: Yes.

18 MEMBER SEIDENWURM: Okay.

19 CO-CHAIR MOYER: All right, any --
20 please do.

21 DR. SCHREIBER: Are there any measures
22 around equity that you think are important?

1 MEMBER FIELDS: At the provider level?
2 That's where it gets a little tricky.

3 At the community level, I could
4 totally see that happening and I think the really
5 important one is from a public health standpoint.

6 It's a little trickier to do at the
7 provider level. You know when you think about
8 perinatal mortality, or pre-term labor, C-section
9 rates. I mean I see it in OB a lot because at
10 least in my prior community, that's where we see
11 the most disparity is actually in prenatal, and
12 OB, and perinatal care.

13 So that's my concern with it is that
14 at the provider level that gets tricky but
15 perhaps through other contexts, if that makes
16 sense.

17 MEMBER BURSTIN: Again, this is a
18 place where the work we did with CMS at NQF on
19 looking at measures that would get at the five
20 domains of equity I think are really important.

21 A big piece of this is also just
22 saying you may have existing measures that should

1 always be stratified or at least look to see
2 which one of them. So you want to begin to see
3 is that overall number really belying the fact
4 that underneath that is in fact some significant
5 differences. So that would be one thing.

6 I think a lot of the questions as well
7 around access to timely interpreter services I
8 think are particularly things that might be
9 something you want to take a look at. And again,
10 I think that those initial recommendations showed
11 there are some things you can kind of take now
12 that may not be the perfect ones but I would love
13 to see CMS try to move into getting more measures
14 that reflect the differential -- the differences
15 across populations.

16 And while I have the floor, I also do
17 think there are some interesting shared
18 decisionmaking measures that I think might be
19 sort of ready for prime time. NQF has endorsed
20 several in the last year, the last couple of
21 years. And again, fairly simple, getting back to
22 Amy's point about PROs. There are some very

1 simple tools that have been put together like
2 collaborate a very simple three-item measure
3 developed out of Dartmouth that is intended to be
4 done on a cell phone, as a patient leaves an
5 office.

6 So being able to think about maybe not
7 big, hairy difficult measures but maybe just
8 something simple that you could start to think
9 about incorporating in.

10 But I think you know the beauty I
11 think of many of those measures is they don't
12 just resonate with patients. They really
13 resonate with clinicians as well. And so I think
14 that might be a sweet spot.

15 CO-CHAIR BAGLEY: Okay, I think we're
16 going to move on to a presentation from the Rural
17 Health folks. Ira, are you prepared to do that?

18 Ira, do you mind if I have them do a
19 quick stand up, sit down break? Just stand up
20 and stretch in place. No conversation. Just get
21 moving.

22 Okay, we're going to let you break for

1 lunch pretty shortly. So let's keep going.

2 As I was just reminded, we did
3 actually have a presentation on our conference
4 call. Could I have your attention please?
5 Hello.

6 We did actually have a conversation on
7 our conference call about this presentation. And
8 this was supposed to be the follow-up discussion,
9 which we didn't actually have on our conference
10 call. So I apologize for misrepresenting that.

11 And what we thought we would do is
12 start with sort of a quick summary of the
13 presentation, the ideas that were presented at
14 that time and then open it up for conversation,
15 if that's okay with everybody.

16 So introduce yourself and take it
17 away.

18 MS. CHAUDHRY: Thank you.

19 Hi, everyone. My name is Ameera
20 Chaudhry. I am the Project Analyst on the MAP
21 Rural Health Project. I am here with Karen
22 Johnson, who is our Senior Director, and we also

1 have Ira Moscovice, who is our co-chair.

2 So we already had this presentation
3 over the phone. I'm sure everyone remembers.
4 Just as a quick reminder, there are 20 measures
5 in the core set that was developed in this last
6 phase of work; 11 of those are in the ambulatory
7 setting. And again the criteria I guess that we
8 used was that they would be NQF-endorsed, cross-
9 cutting, and resistant to low case volume.

10 Next slide. And again, here's just a
11 list of the measurement gaps that were addressed.
12 We did go over this in our last call. So we can
13 just keep moving.

14 And this slide, again, is going over
15 the access to care issue that was addressed
16 through this iteration of work.

17 So if we can just move on, again, to
18 the discussion. We have a few questions up on
19 the screen, if you would like to go off of those
20 or, Ira, if you have any comments that you would
21 like to start with, feel free.

22 MEMBER MOSCOVICE: The only thing I

1 would add to the discussion we had, which I'm
2 sure is just fresh in your mind, is the point
3 Helen raised about how challenging it is to get
4 care coordination measures.

5 And actually the fourth criteria that
6 wasn't on the chart, we wanted to have cross-
7 cutting. We wanted to look at the low volume
8 issue. We wanted to have the measures NQF-
9 endorsed but also care coordination measures were
10 a high priority.

11 And what was disappointing to me was
12 after a long deliberation with the committee, we
13 came up with one of all these measures related to
14 care coordination. So I just highlight and it's
15 a particularly important issue in the rural
16 environment, where you don't have specialists and
17 other kinds of providers necessarily available so
18 it even takes on a new dimension.

19 So I think that's an important area
20 and any feedback you have on that would be
21 greatly appreciated.

22 CO-CHAIR BAGLEY: Go ahead, Girma.

1 MEMBER ALEMU: I would like here to
2 mention some things that needs to be mentioned.
3 I would like to thank Ira's group for their
4 painstaking efforts to come up with the
5 recommendations of need.

6 So I was work on CMS for tasking
7 indicate to establish some workgroup, which is
8 really relevant and the federal office of Rural
9 Health Policy for serving as a government task
10 for the project. Really that was an important
11 step in considering there were issues that are
12 relevant to the rural providers and the rural
13 health in general.

14 Having said that, I want to point out
15 two issues from what I heard that may need to be
16 addressed by CMS, NQF, and measure developers.
17 And the first one is the issue of the level of
18 analysis. You know we have heard how
19 controversial and how important it is just today.
20 And there were many measures which they
21 considered that they would like to include in the
22 core set, you know where we saw 20 measures. I

1 don't know how many of you are inclined to use
2 that one. They came up with 20 measures in the
3 core set.

4 And there were other measures which
5 needed to be included, which are very important
6 in the core set but the issues was the level of
7 analysis. So the measures were mostly involved
8 and specified at the health plan level, so they
9 couldn't include those measures in the core set.

10 Just to give you an example, you know
11 controlling high blood pressure, which is an
12 important one, which is in MIPS and it's widely
13 used but they couldn't put that measure in the
14 core set because of just the level of analysis
15 that the measure was endorsed to that. So that
16 is one of the issues and CMS and measure
17 developers need to look into that.

18 The second issue is the gap they
19 mentioned, access to care. We know that access
20 for all your patients and providers is an
21 important issue. And we also know that
22 telehealth is getting more support from

1 policymakers, payers like CMS, and health plans.

2 So the group also discussed that in order to
3 solve that problem, one of the ways to get it
4 done is by expanding telehealth.

5 So what I wanted to say now about
6 telehealth is there is a lack of measures about
7 telehealth. You know we have to make sure that
8 the services we provide. So telehealth is
9 relevant for quality improvement and, at the same
10 time, it assures the quality actually is provided
11 by telehealth.

12 So I would like to mention that point
13 here, you know that CMS, measure developers, and
14 the like also are interested should look into
15 that.

16 A few years back, NQF has written a
17 report about the framework of measurement for
18 telehealth and I think measure developers need to
19 look into that and CMS -- with CMS help I think
20 something can be done.

21 So I just want to highlight those two
22 points and the level of analysis issue is also an

1 important issue for our group here.

2 So again, I thank the group for doing
3 that.

4 CO-CHAIR BAGLEY: Go ahead, Ira.

5 MEMBER MOSCOVICE: Yes, just one last
6 observation on the morning's discussion here.
7 You know my take on it is a lot of people here
8 are in the mindset of large ACOs serving urban
9 populations. You represent organizations that
10 are heavily oriented in that direction. I
11 understand that. We have 20 percent of the
12 population just about in rural environments.

13 And I'll just take us back to the
14 implementation of the PPS system and what we went
15 through for over a decade to try to finally
16 recognize that you know what, you can't do it the
17 exact same way in a rural environment with solo
18 or small group practices as in larger urban
19 environments. And I just hope as we move forward
20 in this whole discussion about relevant quality
21 measures and the pay for value orientation, that
22 we really do think about how is this going to

1 play out for that 20 percent of the population
2 living out there in rural areas. And that's what
3 was underlying really the formation of Rural
4 Health Workgroup.

5 CO-CHAIR BAGLEY: Other comments,
6 questions, concerns?

7 Michelle or Reena, any observations?
8 What has CMS done thus far?

9 MEMBER DUSEJA: So I think you know
10 from our perspective we believe the work that NQF
11 has done on this is really going to help us in
12 our next steps in thinking about how we apply the
13 Rural Health Core Measure Set across our
14 programs.

15 We find this work really incredibly
16 important. And you know the comments that were
17 made today with regard to care coordination,
18 telehealth, trying to think about how to
19 incorporate those concepts, we hear loud and
20 clear, particularly with the programs that we're
21 going to be discussing this afternoon because
22 that is actually part of our policymaking as

1 well.

2 DR. SCHREIBER: Just a couple of
3 points. So I think that most of us know that the
4 Administrator is really particularly interested
5 in the issues of rural health. It is an area
6 that is definitely different than it is to be in
7 the bigger cities or even in the communities that
8 have care that is easily accessible or the bigger
9 care that is available right down the road, as
10 opposed to 100 or 200 miles away.

11 And so the work that has been done for
12 the committee, both even in defining issues of
13 rural health, not just measurement development,
14 but issues of rural health and how this can be
15 translated into programs I think has been very
16 exciting. And we are very pleased, actually,
17 with the recommendations that are coming forward,
18 again, not just for measures but how we look at
19 and think of rural health in a holistic approach.

20 They are somewhat different and have
21 their own unique challenges.

22 CO-CHAIR BAGLEY: We are seeing more

1 and more ACOs in rural areas. Does anybody have
2 experience with that as part of your organization
3 and you could talk about that?

4 Yes.

5 MEMBER FIELDS: Not at Sinai or
6 Upstate but at my previous organization, Mission
7 Health in western North Carolina. Sort of the
8 largest proportion of our physicians were in
9 actually more of a suburban environment but it
10 gets very rural very quickly, leaving the central
11 county.

12 And yes, it's certainly an issue for
13 lots of reasons in little ways. Certainly, the
14 economic disparities are significant and cause
15 significant barriers to access, not just in lower
16 dollar amounts like vaccines, but in the
17 significant things like OB care, and even just
18 quality medical care.

19 It's definitely an issue and the rates
20 are higher. We'll call it the noncompliant -- I
21 hate that word -- but sort of those kind of,
22 anything that measures adherence to either

1 medications or care plans just become
2 proportionately more difficult in those
3 environments.

4 We also have a shrinking workforce in
5 those areas as well. So we may have attributed
6 lives by you know because they utilize somewhere
7 in our system some access point in the system but
8 when you look at ongoing real primary care or
9 ongoing care anywhere closer to home, we find
10 that they have none because their workforce is
11 shrinking.

12 So there are pretty dramatic
13 challenges and you have to get somewhat creative.
14 We would establish things like community
15 paramedic programs and all those things to try to
16 increase the access points but it's still in
17 telehealth and all those things. But it's
18 certainly challenging.

19 You know I always struggle should
20 there be -- sometimes I think -- this wasn't my
21 idea but somebody said should there be some sort
22 of risk adjustment based on that. I'm trying to

1 get my head around that.

2 You know I always struggle with having
3 disparate targets for those populations. We
4 shouldn't accept less quality. It just feels
5 like we should try to problem solve around it and
6 actually getting there just becomes really
7 difficult.

8 So I don't know if I have answers but
9 it is different and it is difficult.

10 CO-CHAIR BAGLEY: Michelle.

11 DR. SCHREIBER: I just wanted to say
12 one other thing, thank you.

13 When it comes to rural health, I think
14 one of the other challenges that we have, and I
15 say this now as we think of developing measures,
16 is that the N for them is frequently so small
17 that they fall off sometimes the measures. And
18 then it appears that you're not doing the care at
19 all, for example, or it's just kind of a blank.
20 And I don't know that that even sends the right
21 message.

22 And so I think one of the challenges

1 that we all have is even what is the statistical
2 modeling that we can come up with when the N is
3 really generally pretty small.

4 MEMBER FIELDS: Yes, it almost feels
5 like you need to take even more of a public
6 health approach in hyper urban, and hyper rural
7 environments, and somewhere in the middle.
8 Because urban environments, I'm finding, have
9 their own struggles. It's interesting the
10 similarities of -- you know Sinai is interesting.
11 The main hospital sits on some of the highest per
12 capita income demographic literally on one side
13 of the hospital and some of the lowest on the
14 other side of the hospital, with straddling
15 Harlem on one side and the Upper East Side \$20
16 million townhouses on the other side.

17 And it's just interesting to see the
18 similarities actually when it comes to access
19 even. And some if you know you are homebound in
20 a large high-rise in Harlem, it's actually still
21 an equally challenging thing to get you in for
22 your dialysis as it is in rural environments.

1 But it does feel like it requires like
2 bigger or wide-reaching public health approaches
3 to things and maybe the measurement should follow
4 that, as opposed to more operational clinical
5 process kinds of things. It's a vague thought
6 but that's sort of where I end up coming to
7 because when you do it at the patient level, you
8 end up with those tiny Ns and then it becomes
9 less relevant, when what you're really looking
10 for is how do you serve on those basic needs
11 across the entire population?

12 CO-CHAIR BAGLEY: Go ahead, Ann.

13 MEMBER GREINER: This is more granular
14 than what Robert and Michelle were just talking
15 about but I am curious this movement towards e-
16 consults and now that being recognized for
17 payment purposes. And it seems to me an exciting
18 development that really could help rural health.

19 I wanted to know if you wanted to
20 comment on that and I don't know if there is a
21 measurement implication here but it really does
22 help with the coordination, obviously, between

1 primary care and specialty care.

2 DR. SCHREIBER: Thank you for the
3 question. It's interesting it came up at
4 yesterday's Hospital MAP also about the e-
5 consults and telehealth.

6 I think this is an area that ripe for
7 exploration and opportunity. And I actually
8 think it may be that rural health leads the way
9 because they are the ones who have frankly had to
10 bring forward some of that care earlier because
11 of the distances involved. And I think this is a
12 great opportunity to study it, perhaps even
13 starting there.

14 So thank you.

15 CO-CHAIR BAGLEY: Michael.

16 MEMBER HASSETT: Thank you. I just
17 want to follow-up on that comment because I think
18 the telehealth question is a very interesting
19 question and very helpful but from a specialty
20 perspective, I think there are also unique
21 challenges.

22 So for example, radiation oncology, as

1 a treatment, is a cognitive decision to be made
2 but there are definitely access issues that
3 aren't solved by the telehealth question. And
4 how we deal with those two things I think the
5 concept of availability is an important concept
6 to have on a framework. How you measure
7 availability of services for something like
8 radiation oncology or really who is the
9 targetable audience for that sort of a measure I
10 think is very challenging.

11 CO-CHAIR BAGLEY: Go ahead, Chad.

12 MEMBER TEETERS: So speaking from an
13 ACO in western New York, we have seven hospital
14 affiliates of which four of them were actually in
15 rural areas across upstate New York, which gets
16 very rural very fast. And one of the things that
17 we found with MIPS and some of the other ACO
18 models is that there is so little money to be
19 made for successful practice and adherence to
20 metrics but there is significant money to be
21 lost. And for these hospitals that are operating
22 on the margin or worse, they're expending

1 significant financial resources to have the
2 services to provide in their communities that
3 actually cost them more than what they could gain
4 by providing those services to the patients in
5 their area.

6 And so if they are not a part of a
7 large ACO conglomerate, many of them were going
8 out of business. But by being a part of an ACO
9 conglomerate, they are either siphoning funds
10 from the larger system or the ACO is having to
11 send resources down to these rural communities,
12 where they're getting, especially when we're
13 talking about the subspecialty realms, and even
14 primary care, we have an aging provider
15 population, sending a limited resource into a
16 community, where it will be reduced as far as
17 utility to maybe 30 percent where it would in its
18 normal environment, obviously, is diluting the
19 resource pool even farther for the entire
20 population.

21 So, obviously good care and things
22 that we all care about but it makes it even more

1 difficult when it's to the financial detriment of
2 facilities.

3 CO-CHAIR BAGLEY: Other comments?

4 Okay, we're going to take a low tech
5 straw poll here. How many would like to break
6 for lunch now and come back at 12:30? And then
7 the next vote will be for 12:45.

8 So how many vote for 12:30, raise your
9 hand; 12:45? Get at it. You know we have a real
10 exciting conversation after lunch about cost of
11 care measures. So get tanked up.

12 (Whereupon, the above-entitled matter
13 went off the record at 11:53 a.m. and resumed at
14 12:34 p.m.)

15 CO-CHAIR BAGLEY: Okay, I'd like to
16 get started because the sooner we get started,
17 the sooner we'll be done, right? No, no, maybe
18 not, but let's start anyway.

19 We have a fascinating discussion this
20 afternoon about cost and care measures. I think
21 before we start that, I'd like Reena to do an
22 overview of the MIPS program and give us sort of

1 what are you looking for and what do you need
2 from us conversation.

3 MEMBER DUSEJA: Absolutely, yes.

4 Well, thanks, Bruce.

5 Good afternoon, everyone. It's a
6 pleasure to be here for this afternoon's session.

7 Again, my name is Reena Duseja. I'm
8 the Chief Quality Officer for the Quality
9 Measurement Value-Based Incentives Group.

10 What I wanted to do today before we
11 delve into the afternoon session with the quality
12 measures and the cost metrics was really to
13 provide the Workgroup some framing thoughts on
14 the Merit-Based Incentives Program, as you
15 consider the measures that we're putting forth
16 for your consideration for rulemaking.

17 Could you go to the next slide,
18 please?

19 All right. So, just as a reminder,
20 the Merit-Based Incentives Program sits under the
21 Quality Payment Program, and MIPS is just one of
22 the two tracks that clinicians can choose to

1 participate with in QPP. So, if a clinician is
2 MIPS-eligible, than he or she is subject to a
3 performance-based performance adjustment through
4 MIPS. And the other track is the Advanced
5 Alternative Payment Models, where a clinician can
6 earn an incentive payment if they participate in
7 a particular model.

8 Next slide.

9 Again, there are four performance
10 categories for MIPS in year three. Here, we
11 actually have the weight, so you can see what we
12 finalized for year three of the MIPS program.
13 So, there's the Quality Performance Category, the
14 Cost Performance Category, Improvement
15 Activities, and then, the newly-renamed Promoting
16 Interoperability Performance Category.

17 In the calendar year Physician Fee
18 Schedule this year, we finalized the weights,
19 such that the Quality Performance Category now is
20 45 points of a total of 100, and the Cost
21 Category is 15 points.

22 Next slide.

1 So, in the Quality Performance
2 Category, the clinicians have the choice to
3 select six measures, one of which must be an
4 outcome measure or what we define as a high-
5 priority measure. And we applied in our rule the
6 Meaningful Measures Framework to what was the
7 existing MIPS quality measures to identify what
8 was the high-priority areas for quality
9 measurement and quality improvement to assess the
10 core quality-of-care issues that we believe was
11 the most vital to advancing our work.

12 So, this year we actually finalized
13 removing 26 quality measures. Many of those were
14 process, duplicative, or what we defined as
15 topped-out. We also added eight measures, which
16 are four patient-reported outcome measures, and
17 six of those eight were actually high-priority
18 measures. So, we have a total of 257 quality
19 measures for 2019 that clinicians can choose to
20 report on.

21 Next slide, please.

22 Then, I also want to just focus on the

1 fact that we also have, similar to what we do
2 with our other programs, the topped-out analysis.
3 So, we apply that also for the MIPS program. Of
4 note, in this year's rule we also finalized what
5 we define as extremely topped-out, and that's a
6 measure that attains an average mean performance
7 within the 98 to the 100th percentile range.

8 And the next slide actually shows the
9 measures that we're going to put forth for the
10 Committee to discuss shortly after we talk about
11 the Cost Category. So, I would like to actually
12 spend a few minutes talking about the Cost
13 Performance Category.

14 Next slide.

15 So, we're required by statute to
16 develop the episode-based cost measures to meet
17 the mandate of the MACRA Section 101(f). These
18 measures really address the Meaningful Measure
19 areas of patient-focused episode of care and
20 risk-adjusted total cost of care. I want to note
21 these measures are claim-based. They do not
22 require any additional clinician burden and

1 calculations. And these measures that we're
2 putting forth for you today, just like we did
3 last year, really had extensive clinical input
4 through our clinician subcommittees.

5 Next slide.

6 So, as you can see in this slide,
7 we've utilized a broad range of stakeholders that
8 have provided input into each component of the
9 class measures throughout its development. Input
10 has been gathered through Technical Expert
11 Panels, through clinical committees, as well as
12 the subcommittees, measure-specific workgroups,
13 the Person and Family Committee, public comment,
14 and field testing.

15 And it's with all this input that we
16 are bringing you today 11 episode-based cost
17 measures that were selected by the clinical
18 subcommittees to develop, as well as two measures
19 that are currently in the MIPS program, the
20 Medicare Spending Per Beneficiary Measure as well
21 as the Total Per Capital Cost Measure, and they
22 were reevaluated as per our routine and

1 maintenance, as well as incorporating stakeholder
2 feedback for discussion today.

3 The next slide actually gives you a
4 sense of the input that we've had in this
5 process. So, our Technical Expert Panel includes
6 representatives from specialty societies,
7 academia, healthcare administration, person and
8 family organizations.

9 The TEP has met since 2016 to really
10 provide high-level advisory roles and providing
11 guidance on the overall direction of the measure
12 development and reevaluation. We also have had
13 the Clinical Committee meet. They convened back
14 in the fall of 2016, and it included over 70
15 clinical experts from 50 professional societies,
16 to provide us the experts to draft this initial
17 list of episode groups and trigger codes to
18 define these episode-based cost measures.

19 And the real work and the real meat is
20 really in these clinical subcommittees. I cannot
21 stress the smile factor I have in terms of the
22 engagement that we have had with clinicians and

1 specialty societies in helping us develop these
2 cost measures.

3 In Wave 1, we had seven clinician
4 subcommittees, approximately 150 clinicians,
5 representing nearly 100 societies. And in Wave
6 2, which is this year -- and this is actually
7 what we're going to be presenting, the 11
8 episode-based cost measures -- we had 10
9 clinician subcommittees meet and it comprised
10 over 265 clinicians affiliated with more than 120
11 societies.

12 The next slide, please.

13 So, I thought I would briefly, just
14 for the Workgroup, talk about what is an episode-
15 based cost measure, just for some level-setting
16 in how we are defining it. It represents the
17 cost to Medicare for the items and services
18 furnished to a patient during an episode of care.
19 And unlike TPCC and MSPB, they only include items
20 and services related to the episode for a
21 clinical condition or procedure, as opposed to
22 all of the services to a patient given in a

1 timeframe.

2 The episode-based measures have five
3 components, as you see here. It's defining the
4 episode group, then attributing the episode group
5 to the clinician, and then, assigning cost to the
6 episode group. Risk adjustment is a piece with
7 this as well in terms of risk-adjusting the
8 episode groups, and then, adjusting or aligning
9 the cost with quality as the fifth dimension.

10 As I mentioned last year, we submitted
11 to this Workgroup eight episode-based measures,
12 and we received conditional support for
13 rulemaking. We finalized those measures in the
14 rule for this year, and our intent is to submit
15 those for NQF endorsement in the spring of 2019.
16 And they will continue to be updated based on our
17 regular measure maintenance.

18 And in this year, we have 11 episode-
19 based cost measures that were developed in a
20 continuation of the same process for the
21 Workgroup to consider. And again, this really
22 was developed with extensive stakeholder input to

1 meet the mandate of MACRA.

2 Next slide, please.

3 So, the other two measures that we're
4 bringing forth today are a version of the MSPB
5 and the TPCC measures. These are currently used
6 in the MIPS Cost Performance Category and we're
7 also using the Value Modifier Program. What we
8 have done is reevaluated those measures as part
9 of our regular measure maintenance for the
10 blueprint for the CMS Measure Management System.

11 And the refinement process included
12 getting clinical input again from the Technical
13 Expert Panel through in-person meetings from 2017
14 to the end of this year. And we've also used a
15 MSPB Service Refinement Workgroup that was
16 convened during the summer of this year to help
17 us think through the MSPB revisions.

18 Slide 12, please, the next slide.

19 What we have done, after getting all
20 this input that I described to you, is actually
21 also go an additional step beyond by doing field
22 testing. We did this for our Wave 1 episode-

1 based measures. We did that again for our Wave 2
2 measures.

3 And so, we had actually, for this
4 wave, had over 700,000 field test reports that
5 were produced, and we got key areas of feedback
6 based on that field testing. I've listed here
7 some of the key areas for the MAP Group to see
8 what we received.

9 In addition, we got a lot of
10 stakeholder appreciation for the Clinician
11 Subcommittee process in developing these measures
12 and detailed suggestions regarding specific
13 trigger and assigned service codes that were
14 employed for the episode-based cost measures,
15 which our team has incorporated for consideration
16 for today.

17 Also, general support for the
18 reevaluation of the MSPB clinician measure
19 refinements, and there were also some questions
20 regarding changes to the service category
21 conclusions that we can discuss for the TPCC
22 measure.

1 Next slide.

2 So, this lists, again, the measures
3 that we're going to have for discussion. The
4 first 11 up there are the episode-based ones, and
5 the other ones are the reevaluated cost measures
6 for MSPB and TPCC.

7 So, I'll hand it back to Bruce to
8 start the discussion.

9 CO-CHAIR BAGLEY: I have just a quick
10 question. On the Wave 1 measures, can you tell
11 us a little bit about what your experience has
12 been with them? What do you know about them?
13 And do you have any feedback for how that's
14 working? As a corollary to that question, are
15 the ones we're looking at today similarly
16 constructed and specified? In other words, is it
17 kind of more of the same thing, and how is it
18 going so far?

19 MEMBER DUSEJA: Yes, I think it's even
20 getting better. I think these clinician
21 subcommittees are learning from that first wave,
22 and like getting comfortable with this concept of

1 cost and how do we actually measure it. And I
2 think there's been a lot of learnings from the
3 second group, especially the ones that have met
4 again from Wave 2.

5 And I'm looking over to our
6 contractors here. Acumen is here, so Sri and
7 Joel, who manage the contract with CMS. Feel
8 free to add as well.

9 DR. NAGAVARAPU: Yes, I think that's
10 exactly right. I think people who have been
11 involved in the first wave have become used to
12 the process. And so, that's led to the sorts of
13 improvements that Reena mentioned.

14 We've also been able to take into
15 account some feedback from Wave 1 about aspects
16 of the process people didn't like or wanted to
17 change, to refine. And we're able to take into
18 account some of that feedback.

19 So, one of the points that I'll bring
20 up just very quickly is that people asked for a
21 smaller group of people to work on the very
22 detailed aspects of measure specifications. And

1 so, we moved to an aspect of the process where
2 the broader Clinical Subcommittee, after
3 providing initial guidance as to which measure
4 should be developed, provided some input as to a
5 composition of what a smaller group would look
6 like, and we operationalized the smaller, more
7 targeted Workgroup, composed especially of
8 societies, partly from the clinical subcommittees
9 and partly recruited new expertise based on what
10 the Subcommittee told us, in order to do some
11 targeted refinement.

12 But the measures you'll see today are
13 all based on the same framework that people
14 seemed like in Wave 1 and that went through the
15 proposed rule process.

16 CO-CHAIR BAGLEY: To what extent were
17 the Wave 1 implemented and what's your
18 experience, I guess is what I really wanted to
19 know.

20 MEMBER DUSEJA: So, we finalized it
21 for this year's rule, and we are planning to go
22 through NQF endorsement. So, that will happen in

1 the spring of this year.

2 CO-CHAIR BAGLEY: For Wave 1?

3 MEMBER DUSEJA: For Wave 1, that's
4 right.

5 CO-CHAIR BAGLEY: Okay. Can you
6 introduce this?

7 DR. BERNOT: In a very minor deviation
8 to the way we had it laid out on the agenda,
9 we'll do the 11 cost measures as one group, and
10 then, talk about the total cost ones after that.
11 So, instead of introducing 13, as it looks on the
12 agenda, I'll just introduce the first 11. And
13 they are on the screen. But, for the record,
14 I'll just read the titles, not the description.
15 I know we've had a lot of time to look over this
16 material. And then, I will give the preliminary
17 analysis, which will be the same for all, and
18 I'll explain that. So, I'll just introduce the
19 measures first.

20 The first is MUC2018-115. That is
21 Inpatient Chronic Obstructive Pulmonary Disease,
22 COPD, Exacerbation.

1 Next is MUC2018-116. It's Femoral or
2 Inguinal Hernia Repair.

3 Next, MUC2018-117, Lumbar Spine Fusion
4 for Degenerative Disease. It's one to three
5 levels.

6 The next is MUC2018-119, Psychoses and
7 Related Conditions.

8 Next, MUC2018-120, Lumpectomy, Partial
9 Mastectomy, Simple Mastectomy.

10 The next one is MUC2018-121, Acute
11 Kidney Injury Requiring New Inpatient Dialysis.

12 Next, MUC2018-122, Lower
13 Gastrointestinal Hemorrhage.

14 MUC2018-123, Renal or Ureteral Stone
15 Surgical Treatment.

16 MUC2018-126 is Hemodialysis Access
17 Creation.

18 MUC2108-137 is Elective Primary Hip
19 Arthroplasty.

20 And finally, the 11th is MUC2018-140,
21 which is Non-Emergent Coronary Artery Bypass
22 Graph, CABG.

1 And so, I know that was a long list,
2 but, for the preliminary analysis for this, I
3 wanted to point out a couple of things. One, if
4 you noticed in the Discussion Guide, there is a
5 link to updated materials. The material that
6 came out of JIRA did not have test data in it.

7 Between the meeting and the JIRA
8 release, we were able to get some of the field
9 test data, and we did the PAs based on that field
10 test data, rather than having such a large
11 proportion of the measures say, well, we need to
12 update; we need to update in the meeting. So,
13 that's the PAs that we have done on this.

14 And the preliminary analysis from
15 staff for all 11 measures is a conditional
16 support with a condition of NQF endorsement. And
17 again, that is after analyzing that newer
18 supplement of the field test data that you can
19 see referenced either on the website or through
20 the link on the Discussion Guide.

21 Any questions, clarifying questions,
22 from what we did?

1 MEMBER SHALLER: Well, I don't know.
2 It's a big-picture kind of context question that
3 I think might help before we dive into the
4 details.

5 So, we moved forward eight measures
6 last year. There are 11 on the table. That's 19
7 episode-based measures. Any idea what sort of
8 percentage of total spending in the inventory
9 sector that represents? And kind of a related
10 question is, did you pick these off based on
11 their feasibility technically or because of their
12 cost burden, or some other combination? That's
13 the other question.

14 MEMBER DUSEJA: It's both. It's both
15 in terms of the decisionmaking and the pleasures
16 of the committees on what they wanted to actually
17 measure and focus on. But we do have the
18 percentage, I believe, of how much it covers in
19 terms of Medicare-based spending for the 19.

20 MEMBER SHALLER: The total?

21 MEMBER DUSEJA: Yes, the total.

22 DR. ANDRESS: Thank you.

1 So, our current estimate has the total
2 coverage for the 19 measures at about 7.8 percent
3 of total cost for Part A and B. Now I will note
4 that that does not account for clinicians who
5 aren't included within that center because
6 they're part of the APMs or for other reasons.

7 So, we've been talking a little bit
8 about how we might do an analysis in the future
9 that accounts for these factors as well and give
10 a percentage of coverage for what's actually
11 within the potential MIPS pool.

12 The reason we did the analysis as we
13 did is because that's a part of the statute that
14 underlies MIPS, that we're seeking to cover a
15 total of these measures and approximately 50
16 percent of Part A and B spending.

17 So, I think the kind of takeaway from
18 that is we developed the 19 measures. We're
19 clearly going to have a fair bit of work ahead of
20 us in identifying not only episodes that address
21 cost, but also the clinical needs of the patients
22 and aligned with quality measures that are

1 included in MIPS.

2 We're currently beginning Wave 3
3 development. We actually have a TEP meeting on
4 Friday to start that process. We'll be looking
5 at chronic care, and our anticipation is that
6 we're going to start taking some larger chunks
7 out of the overall cost, as a consequence of
8 that, moving forward.

9 DR. NAGAVARAPU: And one thing I'll
10 just quickly add on the measure selection is
11 this, to me, is a really unique aspect of this
12 whole process. The way that we went about this
13 is using NQF criteria as well as criteria
14 suggested by our TEP, including beneficiary
15 coverage, opportunity for improvement, the
16 potential for alignment with quality measures,
17 the feasibility of measures, the feasibility of
18 defining coherent clinician cohorts.

19 We took those sorts of criteria to the
20 clinical subcommittees in each of these clinical
21 areas, presented a bunch of data on what the
22 coverage looks like in terms of cost, clinician

1 coverage, beneficiary coverage, presented
2 information on the overlap with existing quality
3 measures, and then, went through a selection
4 process with the clinical subcommittees, where
5 they were able to vote for which measures they
6 wanted to start with in Wave 1 and in Wave 2.

7 So, that's how the measures that you
8 see here came about, is the clinical
9 subcommittees, with representation from the
10 professional societies, went through a voting
11 process, trying to weigh the tradeoffs of those
12 various factors, including quality alignment, and
13 so on.

14 CO-CHAIR BAGLEY: Okay. Before we
15 start the discussion, I want to just outline -- I
16 have you on my list, David -- I want to kind of
17 outline how I intend to try to get this done.

18 As noted, the first 11 are pretty much
19 the same; you know, plug in this diagnosis or
20 that diagnosis or that procedure. But, other
21 than that, they're similarly constructed, and
22 similarly constructed to the ones we dealt with

1 last year. As such, they all have the same
2 problems. So, I'll outline what I think the
3 problems are and the same kind of things that we
4 discussed last year, so you won't think we're
5 missing anything.

6 All of the measures have a concern by
7 clinicians of what do I do if I only have two
8 procedures. You know, small numbers in terms of
9 making it valid and reliable. Attribution is
10 always a concern.

11 The materials that we saw really
12 didn't specify the episode itself. In other
13 words, an episode has to have a trigger code and
14 a certain duration, and what's excluded from that
15 or included, whichever way you want to do it.
16 But it's actually pretty complex, depending on
17 the episode. But we didn't see any of that
18 information last year. We just trusted you. So,
19 we'll probably do that again.

20 But the other thing that's always a
21 concern for the clinicians, and that is risk
22 adjustment. A new twist on that is, does the

1 risk adjustment include social determinants of
2 health, access to insurance, and some of those
3 things that have become highlighted, more so at
4 least than it was when we had this conversation a
5 year ago.

6 So, to me, those are the big issues
7 that relate to all of these. I think what we'll
8 do is we'll start out with some of our lead
9 discussants and sort of talk about at least those
10 issues, and see if there are other particular
11 issues that kind of go through the whole set.

12 Before we vote, what I'm going to
13 suggest is that anybody can have the opportunity
14 to pull one off the list to be voted on
15 separately. In other words, as we have the
16 discussion, it will be about all of them because
17 of their construction, if you will. And then, if
18 somebody really needs to talk about one
19 particular disease or procedure category, then
20 you're welcome to pull of them off the list, so
21 that we can kind of talk about what the specifics
22 about that particular disease might be.

1 So, a general discussion about
2 construction and problems and how you guys have
3 decided to deal with that, and how people would
4 like to see you deal with that, is what we'll
5 start with. And then, we'll go on to talk about
6 particularly voting.

7 Is everybody okay with that? In other
8 words, we're going to have the same conversation
9 over and over again.

10 The other thing that I would like to
11 do is ask for public comment before we start,
12 because in the past there has been some feedback
13 from the public that, if we ask for public
14 comment after we're finished voting, then it's
15 really not input. So, we're going to give that a
16 try. And I think that we have some people
17 anxious to give us some public comment.

18 So, we'll start with people in the
19 room.

20 Do we have a microphone that's set up
21 and working?

22 I see some people moving to the

1 microphone. All right.

2 MS. McLAUGHLIN: Hello.

3 MEMBER WHITACRE: Is this public
4 comment on the overall group or on individual
5 measures within the group?

6 MS. McLAUGHLIN: These are overall
7 comments on the episode-based measures.

8 Good afternoon. My name is Jennifer
9 McLaughlin. I'm staff with the American Medical
10 Association. Thank you for this opportunity to
11 offer public comments.

12 Overall, the AMA supports the episode-
13 based cost measure development process and the
14 movement.

15 Are you having difficult hearing me?
16 Can you hear me?

17 CO-CHAIR BAGLEY: Yes.

18 MS. McLAUGHLIN: Excellent.

19 Okay. So, I'll just start over then
20 real briefly.

21 My name is Jennifer McLaughlin. I'm
22 staff with the American Medical Association. And

1 thank you for the opportunity to announce our
2 public comments today.

3 Overall, the AMA does support the
4 episode-based cost measure development process
5 and, also, the movement to episode-based measures
6 over broad cost measures. We do, however, have
7 some concerns that the rush to count as many
8 physicians as possible on cost measures may be
9 compromising the process.

10 And to the MIPS program in some
11 context, I do think it is important to remember
12 that, when the program is fully implemented in
13 2022, and the threshold is set at the mean or
14 median, about half of physicians will be required
15 -- or will likely fail. And the cost measures
16 will be a large contributor to those failures.
17 So, we think it is extremely vital that these
18 cost measures get it right before they do move
19 forward.

20 One area, in particular, where we
21 think there is room for improvement in the
22 episode-based cost measure development is the

1 timeline for developing and testing the episode-
2 based measures, which we think in this process
3 with the Wave 2 measures was rushed, and that the
4 ability of practicing physicians to engage was
5 limited. Stakeholder input was also hamstrung by
6 the complexity of the field testing reports and
7 challenges accessing the reports.

8 And for these reasons, we urge the MAP
9 to carefully consider feedback from the specialty
10 societies regarding the 11 episode-based measures
11 in front of you, and we recommend that the
12 highest level of endorsement from the MAP be
13 conditional support.

14 Thank you.

15 MS. BOSSLEY: Hi. Heidi Bossley, on
16 behalf of the American College of
17 Gastroenterology. We submitted comments, but
18 also just wanted to reinforce what the AMA said.

19 The feedback timeline was very short,
20 and members had a very challenging time getting
21 access to the reports. So, I'm not sure that you
22 have as much information, CMS, as would be

1 desirable.

2 The second thing is, ACG did provide
3 very substantive comments on the triggers, the
4 codes, all of that information. And we would ask
5 that those be looked at very carefully before
6 these measures go out.

7 Thank you.

8 CO-CHAIR BAGLEY: Is there anybody on
9 the phone? Operator, can you ask for comments?
10 Hello. Is the operator there?

11 OPERATOR: Yes. If you would like to
12 make a comment, please star, then the number 1.

13 There are no public comments at this
14 time.

15 CO-CHAIR BAGLEY: Thank you.

16 Normally, we would go to the lead
17 discussants next, but virtually everybody around
18 the table is a lead discussant on one of these,
19 right? So, we're going to skip that step on the
20 general conversation, if that's okay.

21 So, David, you've had your card up for
22 a while. You might as well lead us off.

1 Scott, I've got you on the list, too,.

2 MEMBER SEIDENWURM: Okay. So, I have
3 a question for our CMS colleagues. That is, how
4 do the episode cost metrics interact with the
5 more global cost metrics?

6 And I think that a question, and
7 perhaps a source of some confusion and angst
8 among the specialty societies, has to do with the
9 tradeoffs of either submitting, as it were, to an
10 episode measure or be subject, as it were, to one
11 of the more global metrics. My bias is I would
12 rather be measured on something in my own field
13 of interest, especially since there's been
14 severity adjustment and further refinements. But
15 could you clarify what would happen if the
16 specialty societies did not have these or what
17 happens to clinicians who are subject to an
18 episode metric or not?

19 DR. ANDRESS: Thank you.

20 So, the question you're asking about
21 is less a matter of the measures themselves and
22 more a matter of implementation of the measures

1 within the program. So, of course, we're a
2 little bit limited in terms of what we can say,
3 due to the rulemaking rules. That's not a good
4 way to say that.

5 So, I think the thing to keep in mind
6 is that we're aware of the potential, for
7 instance, for overlap, and we're also very much
8 aware of the preference within the community to
9 be as specific as possible rather than focusing
10 on the generalized to a broad overall population-
11 based cost measure.

12 I think the way that they interact
13 right now is that we have 19 measures that
14 represent a small subset of all episodes of care,
15 a relatively small subset of all costs of care to
16 be captured by episodes. And so, what we've done
17 up until now is to use those population-based
18 measures as a stop gap, essentially, to say we
19 have the capacity to look at cost with what we
20 have available.

21 Our focus has been twofold in terms of
22 the development of these cost measures. The

1 first has been development of episode-based cost
2 measures with as much rapidity as we can. And I
3 can vouch for, first of all, the development has
4 been very rapid and, also, that there are some
5 unintended consequences that go along with this,
6 which you have heard with some of the public
7 comments we just heard. And so, we're trying to
8 balance those needs.

9 On the other hand, we've also been
10 working to refine the two existing population
11 measures to address some of the overarching
12 concerns that we've heard about from stakeholders
13 regarding their implementation within the
14 program. I can't say for a certainty even now
15 exactly how they're going to interact, but I can
16 say that, as we're putting the measure set
17 together, our emphasis is on being as specific as
18 we can possibly can to the cost as it's being
19 assessed, and being mindful of the potential
20 consequences of, for instance, duplicating
21 attribution across multiple measures, episode-
22 based and population-based measures. And so, I

1 think our intention is to reflect that in the
2 policymaking that follows from, any policymaking
3 that follows from these measures going forward.

4 MEMBER SEIDENWURM: Is the unit of
5 analysis going to be the clinician or the
6 episode? And maybe you can't say this because
7 the rules haven't been promulgated yet. But
8 let's say you're a surgeon of some sort, and
9 there's an episode in your field and you might
10 have 30 of those, but you might have done 300
11 other operations during the year. Would those 30
12 be your cost component or would they only be, in
13 my example, 9 or 10 percent of your cost
14 component?

15 DR. ANDRESS: I think that's the kind
16 of decision that we have to put through
17 policymaking. But I can say that it's exactly
18 the kind of question we've been asking ourselves
19 as we're moving forward to the development of
20 measures and thinking about how they'll fit
21 within our programs potentially, yes.

22 MEMBER SEIDENWURM: Thank you.

1 CO-CHAIR BAGLEY: Scott, you're next.

2 MEMBER FURNEY: So, my question
3 -- first, a couple of comments. I understand
4 that my requirement, where the MACRA requires us
5 to come up with episode-based measures under a
6 very, very tight timeline. As I read through the
7 materials, which are a bit limited compared to
8 the workload, it's clear there was a lot of
9 stakeholder involvement. I have a couple of
10 specific questions.

11 One is, in last year's meeting, we
12 asked about the risk adjustment methodology and
13 didn't get a great deal of transparency around
14 that. So, the question of social determinants of
15 health, socioeconomic status, which is incredibly
16 important to do that risk adjustment, how
17 confident are we that we have an adequate risk
18 adjustment for that? The first question. I have
19 more.

20 (Laughter.)

21 CO-CHAIR BAGLEY: We'll take them one
22 at a time. It would be easier.

1 DR. NAGAVARAPU: Should I just go
2 ahead? Okay, great.

3 So, we have been aware of the interest
4 in looking at socioeconomic factors. We've done
5 testing with various socioeconomic factors. The
6 way we did this in risk adjustment is that we
7 linked the Medicare claims and enrollment
8 information and the measure information to the
9 American Community Survey, and at a very granular
10 level. So, the most granular level that the ACS
11 will allow for five-year averages, and we're
12 going to get estimates of socioeconomic status in
13 particular neighborhoods.

14 We, then, included variables based on
15 income, unemployment status, and education, in
16 addition to, for people's Census Block groups
17 from the ACS, linked that to our data, and, also,
18 had information on dual status, for instance, and
19 ran risk adjustment models to try to understand
20 the impact of including those variables that CMS
21 traditionally hasn't included in these sorts of
22 measures because of concerns about masking

1 disparities, and so on. Because we wanted to get
2 at exactly what you're saying of like whether
3 we're missing anything.

4 What you see across the measures this
5 year, as well as what we saw last year, was
6 almost no movement in R-squareds and invested
7 R-squareds. And so, I think, going forward, it's
8 something that routinely now we're keeping track
9 of because we realize that, if we ever do see a
10 change in predictive power, it's important to
11 flag. But, for the 19 measures so far, we
12 haven't seen that, but that's something we'll
13 definitely keep in mind.

14 MEMBER FURNEY: The follow-up comment,
15 that's, I think, more transparency and certainly
16 much more robust risk adjustment than I would
17 have expected. So, thank you for that.

18 The follow-up question is regarding
19 the tight timeline and the data. Many of the
20 comments that were registered for these 11
21 measures was about the limited access to data,
22 challenges in getting the data. Do you feel

1 there's adequate feedback on the data to say that
2 the risk adjustment is not inducing disparities?
3 I understand that the statistics look great. Do
4 we have feedback at the level of analysis to know
5 that the stakeholders who are seeing that data
6 are comfortable that they are being judged
7 equitably?

8 DR. NAGAVARAPU: Yes, and I think the
9 answer to that question really goes hand-in-hand
10 with the answer to some of the questions that
11 people have had about timeline so far. Maybe
12 what I can do is walk very quickly through what
13 the processes look like, and I think it will help
14 answer the question about risk adjustment.

15 Really, I think what you're asking is,
16 you know, we've done all the statistical analysis
17 for validity testing and risk adjustment. We've
18 looked at predictive ratios, tried to make sure
19 that those don't vary in unexpected ways across
20 the deciles of risk scores and all the standard
21 statistical analyses. I think what you're asking
22 is, what is the extent to which clinically what

1 we have makes sense, and that the measures aren't
2 going to leave unintended consequences.

3 I think the jumping-off point that I'd
4 like to start with -- and I think it will address
5 some of the public comments as well as some of
6 the points that Bruce made -- is about the
7 timeline and the way that the episode
8 specifications are done. This is a process that
9 started for this wave back in April with the
10 Clinical Subcommittee choosing which measures to
11 develop based on where there is alignment with
12 quality, what kind of cost coverage you could
13 get, what kind of beneficiary coverage, where is
14 there opportunity for improvement.

15 Then, they gave us guidance on how to
16 compose the Workgroups that actually built the
17 measure specifications. The Workgroups were
18 comprised of members from the clinical
19 subcommittees as well as additional types of
20 specialty expertise that the clinical
21 subcommittees told us would be important to have
22 at the table.

1 The Workgroups met in person in June
2 in order to go through in detail every single
3 aspect of how to build the measure. That
4 includes what sorts of risk adjusters should be
5 there, but really that meeting focused especially
6 on how to define the patient cohort, making sure
7 this is clinically homogeneous, making sure this
8 has the potential for being a clinically-valid
9 measure in terms of the types of treatment
10 tradeoffs that are available.

11 But they did talk about risk
12 adjustment, provided guidance on the service
13 assignment for what costs should be included in
14 the measure, as well as talked about how we
15 should think about making sure that the patient
16 cohort definitions are aligned with any quality
17 measures that are up there.

18 And so, that was an in-person meeting.
19 The Workgroup, then, followed up with a webinar
20 that we did where we presented information to
21 them, and they provided detailed additional input
22 on what types of costs should be included, so

1 what types of post-acute care, for instance, are
2 clinically-related to the treatment that's done
3 for the initial patient cohort -- that's starts
4 the episode -- in order to make sure that we're
5 only holding clinicians responsible for the types
6 of items that they have influence over.

7 That webinar also covered input into
8 risk adjustment. And so, what we did is we took
9 the standard CMS ACC model that's used in other
10 measures as a starting point. We realized that
11 people have felt that there's limitations of
12 those models for the purpose of these episode-
13 based measures. And so, starting with that
14 webinar as well as the in-person meeting before
15 it, we started collecting detailed input from
16 each Workgroup on risk adjusters that are
17 specific to a given measure.

18 So, particularly, there's certain
19 types of surgery you'll see here where people
20 felt very strongly in the Workgroup that frailty
21 measures should be there. And so, those were
22 included.

1 After that webinar, we went through
2 the field testing that people talked about. That
3 was a month-long field testing period. We do
4 appreciate the comments that we've heard on
5 problems accessing the EIDM portal in order to
6 get those field testing reports. Luckily,
7 there's sort of tens of thousands of reports that
8 were downloaded. We received public comments, on
9 the order of 70 public comments in that process
10 from specialty societies, and so forth.

11 We had a chance to summarize all of
12 those public comments after the month-long field
13 testing, take it back to the Workgroups, and say,
14 "This is what we've heard. These are the
15 concerns people are bringing up."

16 We had a webinar with the Workgroups,
17 walking through each of those concerns. For the
18 ones that got through all the concerns and
19 through their voting process -- and all the
20 Workgroups use a voting process with a 60 percent
21 threshold -- for the ones that got through the
22 concerns in the first webinar, we were able to

1 finalize the measure at that point. Some wanted
2 to keep going and do some additional discussions
3 in the second webinar. So, we held a second
4 webinar on the post-field-testing in order to go
5 through that feedback.

6 And so, I do recognize the timeline is
7 very tight. A lot of that is dictated by
8 statute. At the same time, I've never seen a
9 process like this in terms of amount of
10 touchpoints that we've had with the Workgroup
11 over that stretch.

12 And as Bruce mentioned, the cost
13 measures in general are very complex. And so,
14 from my perspective at least, the only way a cost
15 measure like this could be built is sort of the
16 way we did it, in the sense of having the
17 Workgroups that were immersed in the details of
18 the specific measures and could go through and
19 make those sorts of fine-grain decisions that are
20 hard for anyone to look at for an hour or two
21 hours and make decisions on.

22 So, I'll stop there, and I'm happy to

1 address some of the other points that you made,
2 Bruce, about small numbers and attribution down
3 the road at some point.

4 CO-CHAIR BAGLEY: I'm sure we'll get
5 to it, yes.

6 Patti, you've been very patient.

7 MEMBER WAHL: I had a comment. I
8 represent large purchasers.

9 I want to compliment CMS for all your
10 work on these cost measures. Cost measures are
11 very important to employers who are very
12 concerned about the rising cost of health care at
13 such an unsustainable rate and the impact on our
14 employees. So, we appreciate your work on not
15 only developing both procedure-based bundles, but
16 also condition-specific.

17 We're very interested, as employers,
18 working with providers and partnering with them
19 to continue to evolve this, and really, to
20 continue to push forward value-based purchasing
21 and all the different types of models along the
22 whole APM perspective.

1 Thanks.

2 CO-CHAIR BAGLEY: Mike?

3 MEMBER HASSETT: Thank you.

4 I have two questions. The first
5 relates to the risk adjustment, which I'm sure
6 will be a common source of questions. I assume
7 that your risk adjustment is looking at factors
8 for people who are in the measure, who are in the
9 denominator of the measure. My question is, how
10 do you deal with the situation where, let's
11 assume a large group of patients across all
12 measured entities become less likely to get a
13 specific treatment because everybody knows that
14 they're a higher-cost risk. So, the denominator
15 is actually changing over time as a result of the
16 measure, but you're not actually picking it up
17 because the risk adjustment is confined within
18 the denominator itself. Does that make sense?

19 I'll hold my second question.

20 DR. NAGAVARAPU: So, I think this is
21 one of the unique aspects of the episode-based
22 cost measures. It is that I do think that the

1 risk adjustment models have benefitted a lot from
2 the input that we've gotten from the Workgroups
3 as to very specific items. And so, to the extent
4 that the specific items that are closely
5 clinically-related that really belong in any
6 given measure are taken into account, we can
7 avoid the sorts of access-to-care issues that
8 you're talking about that would shift around
9 what's actually counted in the denominator.

10 And the other point that I think is
11 unique in the episode-based cost measures is in a
12 lot of ways the risk adjustment has to do less
13 than it has to do in a lot of other measures.
14 And the reason I say that is that there may be
15 patients who are particularly unique, for
16 instance, because they have very high-cost needs.
17 It could be the use of clotting factors. It be
18 the use of the especially high chemotherapy, and
19 so on.

20 And what the episode-based cost
21 measures do is only count costs related to
22 services that are clinically-related to the

1 beginning of the episode. That affects a
2 specific patient cohort. And so, I think that
3 helps a lot with the sorts of concerns about
4 especially complex, high-risk patients, because
5 the costs that are associated with those patients
6 that are unrelated that could show up otherwise
7 are not counted in those cost measures.

8 MEMBER HASSETT: I think I'm asking a
9 different question, though, and maybe I'm not
10 understanding your response. What I'm trying to
11 understand is, let's just assume I'm a surgeon
12 and I'm treating patients, and I know that
13 higher-cost patients -- or higher comorbid
14 patients are going to have higher costs. So, I
15 stop offering that surgery to that patient.

16 If that systematically happens across
17 the country, and patients who are at risk for
18 higher costs aren't getting treatments, is there
19 an unintended consequence of a cost measure when
20 we stop providing services to patients because we
21 know that they're higher cost in general?

22 DR. NAGAVARAPU: Yes, and I think to

1 the extent that the risk adjustment and sort of
2 the counting of cost ensures that people aren't
3 penalized for taking into the account those high-
4 risk patients.

5 MEMBER HASSETT: But I'm not talking
6 about penalizing the person who's being
7 evaluated. I'm talking about the impact on the
8 patients and the clinical care. Are we creating
9 an incentive to undertreat people who would have
10 otherwise benefitted from this therapy because
11 every physician knows that we don't want to touch
12 these patients because we know that they're going
13 to be higher cost and they're going to affect
14 their measures?

15 DR. ANDRESS: So, to Sri's point, I
16 think the issue that Sri is getting at is that
17 the more robust the risk adjustment, and the more
18 effective and appropriate it is for a particular
19 patient population, the less of a mathematical
20 incentive there is to not provide treatment to
21 those patients because that additional risk for
22 cost will be adjusted for within the measure. I

1 think that's what Sri is trying to --

2 MEMBER HASSETT: But that works in a
3 comparative way for surgeon one versus surgeon
4 two. I'm saying, what if every surgeon in the
5 country stops treating these high-risk patients?

6 DR. ANDRESS: So, the measure itself
7 can't address that directly.

8 MEMBER HASSETT: Okay.

9 DR. ANDRESS: That has to be a
10 programmatic thing on the part of CMS. What CMS
11 has to do is be proactive in monitoring shifts in
12 data trends, particularly in the kinds of
13 patients who are receiving certain kinds of
14 treatments, whether or not the treatments
15 themselves are becoming more or less frequently
16 used. And then, also, take into consideration
17 the extent to which a particular treatment may be
18 simply targeted toward a particular population,
19 one that is considered low risk as opposed to
20 patients who would be considered high risk.

21 I think the role that CMS plays in
22 that is to be cognizant of what the unintended

1 consequences of a measure limitation may be, and
2 then, to take appropriate steps to either
3 remediate the measure, address the issue through
4 additional policy, or consider withdrawing the
5 measure if it simply can't be addressed through
6 those other forums.

7 So, I think you're not going to
8 address the question you have through the
9 specifications of the measures, but the
10 infrastructure you put into place to monitor its
11 continued appropriateness in the program.

12 MEMBER HASSETT: And trying to figure
13 it out, and I guess I'm trying to just kind of
14 make that point, that with these sorts of
15 measures, trying to be sure that there are
16 parallel efforts to make sure that we're not
17 creating undesirable incentives as a result of
18 the measures I think is a critical component of
19 the whole program in general. I'm not saying
20 that it's going to be a problem, but I anticipate
21 that it is a potential risk.

22 DR. ANDRESS: So, consider the last

1 two measures we're going to be talking about for
2 cost measures, the MSPB and the TPCC. Those
3 measures are already in existence. What we're
4 currently undertaking is a part of our ongoing
5 maintenance of the measures. And that's going to
6 be true of all of the episode-based measures
7 going forward was well.

8 And a big part of that is
9 understanding the trends that we're seeing and
10 the utility of those measures when we're
11 undertaking maintenance, as well as taking into
12 account the feedback we get from the clinical
13 subcommittees, you know, physicians who tell us
14 this is an issue, but we also would be looking at
15 the data. And then, as we're maintaining the
16 measures, that's the process we already have in
17 place to, I think, do what you're talking about.

18 So, that system is certainly in place.
19 It's reinforced through the endorsement process
20 with NQF, but also the ongoing need to undertake
21 rulemaking in a program like MIPS on an annual
22 basis. If there's a problem, we tend to hear

1 about it not just once and, then, no more; we
2 hear about it consistently until we've been able
3 to take steps to address it.

4 CO-CHAIR BAGLEY: If I might just jump
5 in with sort of an add-on question to the same
6 topic, have you considered some kind of
7 truncation or stop-loss calculation that comes
8 from the aggregate data to use on individuals?
9 So that you kind of mitigate that at least a
10 little bit? It doesn't make it all go away in
11 their heads, but it does mitigate that problem a
12 little bit.

13 DR. NAGAVARAPU: Yes. We have an
14 exclusion for outlier cost. So, to the extent
15 that the risk adjustment model now is not able to
16 predict the cost very well for certain types of
17 especially complex patients, if you have a high
18 unpredicted variation for those patients, those
19 outliers are excluded from the measures, in order
20 to sort of protect the integrity of the measure,
21 as you're noting.

22 And this is something we could

1 definitely track over time. To the extent that
2 there's 10, 20 of these complex patients that are
3 in the sample, our risk adjustment model can pick
4 that up and reflect the increased cost for those
5 patients. But, if it is the case that the number
6 of those type of patients goes to zero, that's
7 something we can track over time.

8 CO-CHAIR BAGLEY: I have a long list
9 of Helen, Dae, Rob, Chad, Michelle. Anybody else
10 need to be on the list?

11 Helen, you're up.

12 MEMBER BURSTIN: Great. Thank you.

13 And thanks to CMS and Acumen for
14 obviously being very inclusive, bringing the
15 specialty societies to the table. I've heard
16 from many that they appreciated being asked,
17 although it was incredibly rushed. And this
18 stuff, even for those of us who have spent a lot
19 of time looking at it, is really complex, and I
20 think it was very difficult to really wrap their
21 head around it in the timeframe in which it was
22 presented.

1 So, I hope it won't be a "thank you
2 for your initial input," but I think, ideally,
3 you would actually keep these groups going.
4 Actually, I think the key thing here is going to
5 be the continuous input as the measures are out
6 in the field. Because, again, echoing a lot of
7 the concerns that have already been raised,
8 particularly for cost measures, particularly
9 going back to the issue that Scott raised about
10 social risk, we have not seen the analyses that
11 you're pointing out are small. There may be
12 differences at the margin for those who take care
13 of the folks who are certainly the most at risk,
14 where some of those differences might be
15 apparent.

16 The report by ASPE on social risks, we
17 did the work, the National Medicine did, all
18 really pointed to the fact that, particularly for
19 cost measures, this issue of social risk
20 adjustment is even more important potentially
21 than for quality measures.

22 And the concern, and going back to

1 Michael's point, is also not just that there may
2 be high costs, but, in fact, the concern is the
3 flip side of that. You may, in fact, see lower
4 cost because you're stinting, because you don't
5 want to provide care that patients really need.
6 So, it's a double-edged sword.

7 I think anything that CMS can do as
8 these measures going forward, first of all, get
9 them into NQF. We have been waiting a while,
10 actually now for these measures to come to this
11 process. We talked about some of them a year
12 ago. So, I think the more we can get these
13 measures in, get a really detailed look at those
14 very comfortable looking at cost measures with
15 the time to do it, I think that's going to be
16 key. I think really being able to look at those
17 social risk factors you've been able to look at,
18 potentially exploring what other risk factors
19 could be looked at if you took a more expansive
20 view, I think are all going to be really
21 important.

22 The issue of attribution is still --

1 I mean, I've read these measures several times --
2 it's still very complex to understand how it goes
3 across different clinicians and providers. So, I
4 think anything you can do to really be very
5 mindful of the potential of social risk here,
6 which I think is real, particularly on the cost
7 side; thinking about the unintended consequences;
8 really looking at whether some of these are truly
9 ready for implementation in a cost-based
10 environment, are really ready for additional --
11 put it out there; get additional feedback.

12 And I hope CMS will also consider a
13 set of balancing measures, I think particularly
14 on the cost side. This is where looking at cost
15 in isolation is terrifying because you can do
16 some things that look really low cost and they're
17 really low quality. I would really encourage you
18 to think about how these come together, and think
19 about is there a set of balancing measures, and
20 consider the outliers, both in terms of high cost
21 and also those for a low cost. Because I really
22 do worry a lot about how you can look good by, in

1 fact, doing bad for patients.

2 And again, try to keep that clinician
3 input all the way through the processes. These
4 will allow us to begin to see what the feedback
5 is. These are really important measures and
6 really complicated measures. And we all know we
7 need to get our arms around reducing cost, but we
8 can't do it at the expense of patients.

9 So, thank you.

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

11 MEMBER CHOI: Yes. I just share the
12 same concerns with these cost measures in
13 general. What kind of effect do they have on
14 quality and patient outcomes? I would just be
15 interested to hear, during your field testing, if
16 you had observed any decline in quality or
17 patient outcomes with the implementation of these
18 cost measures. But, even so, I think you
19 referred to testing care as one month. I think
20 that's not a sufficient period to really
21 understand the kind of long-term impact it might
22 have. So, again, I think just something to be

1 mindful of while we address these cost measures.

2 DR. NAGAVARAPU: And I'm happy to
3 respond. I think one thing that, Reena and Joel,
4 you should speak to more, if it would be helpful
5 -- but the balancing of quality has been sort of
6 an important aspect of the process from the
7 beginning in terms of how the measures were
8 selected. We're very cognizant of the fact that
9 the cost measure category is one category in
10 MIPS, and that there's a quality category as well
11 that these measures will be balanced against.

12 Something we wanted to make sure that
13 went into the decision process of which of these
14 measures are built is that people consider
15 whether there's quality measures out there that
16 they feel good about that could be balanced with
17 the measures. And that's something we'll
18 definitely keep taking into account going
19 forward.

20 Another aspect of this that I thought
21 was very useful in the Workgroup process, and the
22 sorts of decisions that the Workgroups made, is

1 that all of these measures include not only the
2 cost of initial treatment, but also the cost of
3 complications. That could be the admissions and
4 patient readmissions, the cost of the emergency
5 department visits, and so on.

6 And so, I think the costs of those
7 sorts of complications do help pick up some
8 aspects of quality that the Workgroups have found
9 important to include in the measures, to try to
10 balance that against the initial cost. So, I
11 think both the balancing with the quality
12 category as well as the design of the measures
13 has helped to kind of address this, and it's
14 something we'll certainly be keeping in mind
15 going forward.

16 CO-CHAIR BAGLEY: Thanks.

17 Rob, you're next.

18 MEMBER FIELDS: Yes, I'm not sure if
19 my comments will appear they're a comment or a
20 question. But it seems to me like these sort of
21 measures, I get the concern of potentially, then,
22 cherrypicking lower-cost patients. It's a real

1 concern.

2 However, like I think on the medical
3 side, in a world of risk, it actually changes
4 that completely, right, because that's where your
5 entire margin is actually in your more complex
6 patients. So, people that know how to manage
7 risk flow actually look, do you want to manage
8 the more complex folks? And I am curious about,
9 looking at these measures as a standalone, if you
10 run into these sorts of problems. But it seems
11 like in the context of a risk environment, then
12 it makes a ton of -- you have to do this. Like
13 you have to actually measure risk-adjusted total
14 cost in order to figure out what your performance
15 is.

16 And the reality is that your operating
17 margin actually comes in your ability to manage
18 those most complex folks, because it's normally a
19 high-cost environment, can reduce the cost by all
20 the different wraparound services you might
21 provide, right? So, I don't know if we're
22 supposed to look at them in the context of moving

1 towards risk. Would that be helpful or less
2 helpful, or is that irrelevant? We should just
3 look at the measures in and of themselves? I
4 don't know exactly.

5 MEMBER DUSEJA: I think we have to
6 think about the context of this program on the
7 overall quality payment program. So, we're
8 trying to get clinicians who participate within
9 MIPS to really get comfortable with this concept
10 of performance-based payment. And with that,
11 it's really about value.

12 So, there's a lot of thought, I think,
13 within CMS in making sure we align, for example,
14 to Helen's point, in making sure quality and cost
15 are aligned with what measures we are going to
16 continue with in the program, to try to make sure
17 that we are moving toward not having unintended
18 consequences.

19 But the other part of this in terms of
20 the policy perspective is to try to get
21 clinicians to take on more risk and go through
22 that glide path, getting into more APMs. So,

1 that would be the goal. It is a glide path. And
2 I think what we're trying to do in terms of
3 internal work is trying to make sure we also try
4 to align our measures across that continuum, if
5 that helps.

6 CO-CHAIR BAGLEY: Chad, you're next.

7 MEMBER TEETERS: I've got several
8 points. And I apologize, some of this is going
9 to get into the weeds of the individual measures,
10 but I think it will good for illustrative
11 purposes.

12 So, getting back to Michael's point,
13 aside from risk, one of the other concerns I
14 have, especially around the procedural measures,
15 is the potential to actually stifle technological
16 development in advance. So, CABG is a perfect
17 example. As we move into robotic or
18 thoracoscopic procedures, which are inherently
19 more costly but have less morbidity and mortality
20 to the patient, there's the potential that you
21 will stifle the development of those service
22 lines within institutions, which may actually

1 have a longer-term decrease in value to the
2 patient that would be unintended.

3 No. 2 -- and again, I'll use CABG as
4 an example -- the concern, and this is going to
5 cross since we get into total cost-of-care
6 measures, but the double jeopardy alignment. So,
7 you could be in a CABG bundle, but also be
8 adherent to the CABG MIPS metric. And that would
9 be potentially crossing over into two separate
10 spheres where you could either lose big or win
11 big potentially.

12 The final piece -- and I think this is
13 probably a little bit less of a concern in the
14 Medicare space because I think this is probably
15 more of a factor in commercial -- but we're
16 seeing more and more, especially with these
17 larger conglomerate ACOs that were developing
18 Centers of Excellence, patients are being
19 referred sometimes hundreds of miles from home to
20 get specialty surgeries, procedures, joint
21 replacement being a perfect example. And those
22 patients, you know, if we have an elderly patient

1 who goes 300 miles from home to get a joint
2 replacement, it's much more difficult to send
3 that patient home the day after surgery. So,
4 they may inherently need a couple of days' rehab
5 before they're suitable for discharge home, but
6 that encompasses a higher cost for that travel
7 from afar, so that patient can get higher-quality
8 surgical intervention.

9 So, again, these are kind of minor
10 points, but they do have factors when we talk
11 about quality and access for patients.

12 CO-CHAIR BAGLEY: Michelle, I have you
13 next on my list. I wasn't sure whether you were
14 going to comment on something that was said. You
15 guys have a special place at the table. So if
16 you need to jump in somewhere and give a CMS
17 perspective, it's okay to jump the queue. Just
18 flag me down, you know.

19 DR. SCHREIBER: I was really just
20 going to say thank you to Michael for bringing
21 this up.

22 I've been sitting here thinking

1 through all of these issues. I'm particularly
2 sensitive to them. As a general internist, I was
3 actually an HIV provider. So, you can imagine,
4 when you looked at me as a general internist, I
5 looked terrible as a provider. And so, what
6 would be the answer for me? Well, just don't
7 take care of those patients. That wasn't the
8 right answer for the patients.

9 The other thing that has happened --
10 and Helen knows this because I've share my story
11 -- is, when I wanted to look like a good
12 provider, all I did was move to the rich suburbs,
13 quite honestly, and I looked like a better
14 provider.

15 And so, I think what we put in for
16 balancing is really important, and I thank you
17 for bringing that up. Because if we start seeing
18 trends that nobody is taking care of some of
19 these patients, I think that's probably the
20 biggest disservice we can do.

21 So, thank you.

22 CO-CHAIR BAGLEY: Amy?

1 MEMBER NGUYEN HOWELL: Thank you,
2 Bruce.

3 I had a question and also a comment.
4 So, along the lines of what is an episode, and
5 how is that defined. I appreciate all of the
6 specialty comments, and I concur. As a family
7 physician, primary care, and from a risk-bearing
8 organization, I concur with Rob's statement. We
9 love all of this.

10 And so, what is an episode? Are we
11 going to be included in this, in MIPS? Because,
12 for us, when you look at an episode for, let's
13 just say, any of that, COPD, are you going to
14 evaluate and assess the quality in the delivery
15 of care of the provider as they have the
16 conversations on palliative care, as they have
17 the advanced illness management conversations, as
18 they have the obesity prevention conversations?
19 Because that is what needs to be a part of this
20 episode, looking at total cost of care, really
21 for all providers, specialty and primary care.

22 So, I didn't know, because in the

1 exclusion criteria it says that if it's not in an
2 outpatient -- or if it's in outpatient or ASC,
3 then it's excluded from the denominator, from
4 that episode.

5 DR. NAGAVARAPU: Yes, I could answer
6 a couple of the recent questions.

7 So, on that more recent question,
8 actually, on Friday we're meeting with our TEP to
9 discuss the development of chronic condition
10 episode-based measures. There are unique
11 challenges and opportunities for chronic
12 conditions, exactly what you're getting at. And
13 we have thoughts based on what we've heard from
14 the clinical subcommittees and Workgroups about
15 the acute and procedural measures that apply to
16 some extent to the chronic episode-based
17 measures. And so, we'll be talking with the
18 Technical Expert Panel about that on Friday, and
19 are hoping to move into the development of these
20 sorts of measures in Wave 3 coming up in the new
21 year. And so, that's an area we're really
22 excited about.

1 The point about technological
2 development, this is a point that we've been very
3 sensitive to during the measure development
4 process. In fact, some of our clinicians work
5 with CMS on thinking through those sorts of
6 issues.

7 Specifically, what we tried to do is,
8 if there are cases where there's new technology
9 that's developed, we try and talk to the
10 Workgroups about it and potentially deal with
11 that in two ways. One way is, if the new
12 technology is itself part of the procedure that
13 starts off the episode. And the Workgroup felt
14 that that new technology or the use of that
15 technology is not something within their
16 influence or should not be something within their
17 influence if it's best for patients.

18 Then, we have the option of
19 subgrouping the episodes in order to make sure
20 that only like episodes are compared to like
21 episodes. So, only episodes using new technology
22 compared with others using a new technology.

1 The other approach in cases where the
2 worry is about new technology that may count as a
3 cost in the episode, but not necessarily as part
4 of the initial procedure, is something, if this
5 ever came up, we talked with the clinical
6 subcommittees and Workgroups over the past couple
7 of years about, then, having the option to not
8 count it as a cost in the measure. And I think
9 there are tradeoffs to doing that. A lot depends
10 on exactly how you feel about how much discretion
11 there is to use this new technology and what are
12 the challenges with unintended consequences. But
13 they had the opportunity to kind of make that
14 decision.

15 And then, the last thing I was going
16 to note about especially complex patients, and
17 it's related to this point, is that, in the case
18 of the Workgroups, another point, another
19 dimension of trying to address this sort of
20 concern is we talked in detail with the
21 Workgroups about doing measure-specific
22 exclusions. So, if there were particular patient

1 populations that just seemed extremely complex,
2 they're extremely worried about the notion that,
3 if they were included in the measure, that there
4 would be access-to-care issues, the Workgroups
5 had an option to exclude those populations from
6 the measure.

7 And down the road, that's something
8 that Workgroups could revisit, but a conscious
9 decision was made by the Workgroups where, if
10 they're very concerned about access to care,
11 delineate those subpopulations very clearly in
12 the data and not include them in the measures at
13 this time.

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

15 MEMBER WHITCARE: I just had a
16 question about how to analyze reports with
17 limited data, specifically two to three patients.

18 CO-CHAIR BAGLEY: So, it's a low-
19 numbers question. Help us here.

20 MEMBER DUSEJA: Yes. For each of
21 these measures that we're bringing forth to the
22 Workgroup today, they do have case minimums in

1 order the meet the reliability and validity. And
2 so, if you want -- do you have a particular one
3 that you are concerned about? Was it included in
4 the materials to the Workgroup? Was it an
5 attachment?

6 MEMBER WHITCARE: Yes.

7 MEMBER DUSEJA: You should have it in
8 your attachments. While I speak, can we send it
9 to the Workgroup now? That would be great.

10 MEMBER WHITCARE: Yes, to me, that
11 would be great. Thank you.

12 MEMBER DUSEJA: Yes. But they have to
13 meet a threshold in order for us to feel
14 confident to be able to report on the measure, at
15 the TIN level or at the TIN/NPI level.

16 CO-CHAIR BAGLEY: Do you have a sense
17 what is the magnitude of that number? I mean, is
18 it 2, is it 10, is it 30?

19 MEMBER DUSEJA: Sri, keep me honest,
20 but I think it's NF 20, correct, for at the
21 TIN/NPI, and then, depending on the acute versus
22 the procedural, right?

1 DR. NAGAVARAPU: That's exactly right,
2 yes. No, that's exactly right. For the acutes
3 in the previous, in the Wave 1 measures, the case
4 bin was typically 20, and then, for procedurals,
5 it was 10. And that decision was made based on
6 reliability numbers, because the reliability
7 numbers of procedural episodes were particularly
8 high even at 10.

9 CO-CHAIR BAGLEY: Trudy, on the phone,
10 you're next.

11 MEMBER MALLINSON: Great. Thank you.

12 And I'm new to this Workgroup. So,
13 you may have discussed a lot of these things
14 before.

15 One of the risk adjustment, and I know
16 other people have expressed concerns about or
17 additional things that might need to be
18 considered in the risk adjustment. And I would
19 just sort of echo that in terms of thinking about
20 social demographics and social determinants of
21 health.

22 I had a question at least what I could

1 find online about the amount of variance and cost
2 that was explained by the current model, which I
3 think is about 13 percent. That, to me, seems
4 low. At least it seems that there's a lot else
5 going on in producing variance of cost that's not
6 explained by the model.

7 And I wasn't clear how much of that
8 additional variance does clinician behavior
9 actually explain. So, we've got these models.
10 Great. But how much does physician behavior or
11 clinician behavior actually change or explain,
12 you know, affect. So, we can implement these,
13 but, in fact, there's a lot of other things going
14 on that are influencing cost, and we're not going
15 to make a lot of dent in that. And yet, there
16 are these potential risks in terms of
17 particularly thinking on access to care that
18 could affect people. So, I'm just wondering if
19 someone could sort of talk about what impact we
20 think provider behavior really has and what other
21 things could be explaining sort of the -- what?
22 -- 87 percent variance that we haven't explained.

1 And the other question was about, if
2 these were implemented, the idea is they would
3 drive down costs, right? But they're not
4 associated with outcomes right now. And so,
5 what's the break on decreasing cost and,
6 therefore, potentially decreasing access to care,
7 and how do we stop that in a very timely fashion
8 if we think it's resulting in bad outcomes?

9 I heard someone say, well, we hear
10 about these on sort of a yearly ongoing basis.
11 But there could be potentially hundreds or
12 thousands of people who don't have access to care
13 before we get a break in place. So, I'm just
14 wondering if people have thought about sort of
15 the long -- like two or three years down the
16 line, how you would look at this reduction in
17 cost is actually affecting patient access to care
18 or outcomes.

19 CO-CHAIR BAGLEY: Do you want to take
20 that?

21 Thank you, Trudy.

22 DR. ANDRESS: Yes, I think this is a

1 really important point, because there's no
2 inherent link because these measures and quality.
3 It's all in how you combine them with quality
4 measures within the context of the program itself
5 and with other quality improvement efforts, I
6 think.

7 As Sri indicated earlier, one of the
8 criteria we use to choose the episodes that we
9 develop measures for includes consideration of
10 where we thought we had relatively solid quality
11 measures available for use in the program along
12 with them. And that continues to be a major
13 consideration.

14 In fact, CMS has been working
15 internally to think about how we can continue to
16 strengthen the alignment between quality measures
17 and cost measures, because they really do have to
18 function in tandem in order to, one, drive for
19 better value, but, also, to ensure that we're not
20 simply reducing costs by providing less care,
21 which flatly is one avenue that can be taken if
22 these measures are addressed in a vacuum, I

1 think.

2 That's one of the reasons that the
3 cost component within the MIPS program, even when
4 fully ramped-up, are a smaller consideration than
5 the quality components and the quality
6 improvement efforts incorporated with it. And I
7 think that's been built into the design of the
8 program as a whole.

9 I think we're certainly cognizant of
10 the risk, and that kind of helps us make
11 decisions about where we're going to target our
12 development of future episode-based cost
13 measures; and, also, to get a finer understanding
14 of what exactly it means to be aligned with
15 quality measures. Does that mean you just have
16 measures in the same specialty? Do you have
17 measures with the same denominator? Do you have
18 measures addressing the exact same episodes or
19 procedures? And then, think about how we can
20 move toward development of measures, both on the
21 quality and cost side, that meet those kinds of
22 alignment parameters. Because you're right, if

1 we don't, then that's a very serious risk that
2 we'll be facing as a healthcare system and as a
3 whole.

4 DR. NAGAVARAPU: And just to get at
5 the first question about risk adjustment, I think
6 this is a very important aspect of the measures
7 actually. Because the costs included in the
8 measures are costs that the Workgroups have
9 specifically said are clinically-related to the
10 procedure that's being done or the condition
11 that's being managed. And it could be
12 clinically-related as part of treatment costs,
13 but it also could be clinically-related as
14 downstream outcomes, so in patient readmissions,
15 in terms of department visits, and so on. And
16 so, a lot of the variation that is not explained
17 by the risk adjustment models is variation that's
18 really driven by costs that the Workgroups have
19 said are clinically-related to the procedure
20 that's being done or the condition that's being
21 done.

22 And so, to get specifically at the

1 question, because the Workgroup had this
2 opportunity to not include any costs that were
3 unrelated to the treatment, and include only
4 costs that were related to the treatment in the
5 measure calculations, a lot of the variation
6 that's not explained by the risk adjustment
7 models are picking up real differences in
8 provider behavior for services and costs that
9 happen to patients that the Workgroup itself has
10 said are related to that.

11 MEMBER MALLINSON: Right, but you
12 haven't modeled that, right? I mean, that's an
13 important question that's still hanging out
14 there?

15 DR. NAGAVARAPU: So, that's a question
16 that is -- empirically, I would say that that
17 question is more difficult to get at, to
18 distinguish what goes to a provider versus not.
19 And so, because of that, we really relied on the
20 clinical validity aspect of the measures and
21 trying to make sure that the Workgroups are
22 comfortable with the costs that are being

1 calculated, so that they know the costs that are
2 actually entering the measure. And if there's
3 costs that are outside of providers' influence,
4 that they can remove those costs from the
5 measure, and so, they won't show up in these
6 sorts of risk adjustment specifications.

7 DR. ANDRESS: I would also point out
8 that, in my experience in developing quality
9 measures in other settings, frequently when a new
10 quality measure gets into a payment program, it
11 tends to cause something of a flurry of research
12 into interventions and analyzing what potential
13 there is for different kinds of interventions to
14 affect the quality outcome. I think anticipating
15 that kind of information is also going to be
16 flying around with the new episode-based
17 measures, if and when they go into effect, will
18 also give us more information to link specific
19 activities by clinicians and what their impact on
20 the cost is.

21 I mean, admittedly, when you're
22 looking at claims, there are certain things that

1 you can look at fairly easily, but there are
2 other activities by clinicians that you can't
3 measure as readily. And so, I think one of the
4 things that we'll be looking for as we're doing
5 the measure maintenance and watching the
6 measure's performance is considering the
7 literature that is generated by the community
8 around the measures and clinicians' experience in
9 trying to respond to the measure-driven mandates
10 in the MIPS program.

11 CO-CHAIR BAGLEY: David, you've been
12 patient. Do you remember what your question was?

13 (Laughter.)

14 MEMBER SEIDENWURM: So, it had to do
15 with the other side of the risk adjustment coin.
16 Having participated in the spine surgery episode
17 development cost measure, we adjusted away the
18 patient selection part of the equation. And so,
19 I think that something that we risk, if we go too
20 far in risk adjustment, is that we allow people a
21 free pass at selecting patients who are unlikely
22 to benefit from the service or more likely to

1 have complications, and, therefore, are less
2 likely to behave like the patients in the studies
3 that justify those procedures themselves.

4 So, I think that we have to strike a
5 balance that, on the one hand, you know, we want
6 to be fair to people who have difficult
7 populations to care for; yet, at the other side
8 of the coin, we don't want everyone within the
9 ejection fraction of 10 to get cardiac surgery or
10 something -- that's hypothetical, of course -- if
11 we risk adjust for that.

12 So, I think that it's very important
13 that we not just look at the one side of the risk
14 adjustment coin. We absolutely have to look at
15 both sides.

16 DR. ANDRESS: I think you're driving
17 at a fundamental tension in the concept of
18 measure development, quality measure and cost
19 measure. You're never going to get an exact
20 assessment of attribution. What you're going to
21 get is either an overestimation or an
22 underestimation, and you can pick either one.

1 There are going to be consequences either way you
2 go.

3 I think one of the things that sort of
4 hasn't been done, as a broader measure
5 development and quality community, is the
6 decision about which one is preferable, if it's
7 always the same answer in the same context. But
8 I think you're hitting on the exact point. It's
9 like going all in one direction is not inherently
10 better, either for the clinicians or for the
11 patients in terms of the measure. It's
12 frequently something that has to be determined
13 within the context of the measure itself, and
14 with an understanding that there are potential
15 unintended consequences either way.

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

17 MEMBER SEIDENWURM: Yes, and I would
18 just like to follow up just to say that I think
19 that we've gone far enough in the direction of
20 protecting against avoiding risk, and we need to
21 maybe start being a little more cognizant in the
22 other direction.

1 MEMBER BURSTIN: I just want to go
2 back to Eric's other point about volume and
3 reliability and the small numbers issue, and
4 Reena's comment about procedural-based ones. So,
5 I actually went back through and looked through
6 it.

7 So, the differences in reliability are
8 dramatically different for the same end. For the
9 TIN/NPIs at 20, you can go from .8 for a spine to
10 .5 for COPD and GI bleed. So, I hope that CMS
11 will also consider the fact that these sample
12 sizes are going to need to be logically tied to
13 the underlying condition. I mean, I assume -- we
14 talked a lot about social risk -- there's also a
15 lot of unmeasured clinical complexity,
16 particularly probably for some of those patients
17 coming in with kidneys, COPD, GI bleed, that are
18 probably not accounted for. There's no way to
19 get at frailty, for example. That might be
20 driving a lot of costs, a lot of post-acute care
21 admissions as well.

22 So, I just hope it won't be a one-

1 size-fits-all and you'll consider both social
2 risk, but also unmeasured clinical complexity,
3 and then, adjust your thinking around the
4 reliability based on the given episode. Because,
5 I mean, clinically, as another fellow general
6 internists, I could easily see a totally
7 different trajectory for some patients coming in
8 for a more chronic-level issue, rather than
9 somebody healthy enough to come in for spine
10 fusion.

11 So, I think really being able to
12 balance that, and, also, understanding what's
13 going into those lower reliability estimates.
14 What other costs are going into those factors?
15 Why are we not able to get reliable estimates? I
16 think just a deeper dive into understanding those
17 differences between the procedural-based
18 reliability versus the non-procedural-based, I
19 think it will be an important learning that might
20 help us going forward.

21 CO-CHAIR BAGLEY: Amy?

22 CO-CHAIR MOYER: I had wanted to echo

1 a little bit what David had said. In the absence
2 of a good understanding of the appropriateness or
3 usefulness of the procedure, cost is one thing,
4 but there's no value if it wasn't needed in the
5 first place. So, it's really only the downside
6 of risk from the patient's perspective.

7 And the other thing I wanted to throw
8 out there, because I get concerned sometimes that
9 we who sit here in this room don't have front of
10 mind -- I don't know if you saw the Board of
11 Governors of the Federal Reserve Report of
12 Economic Well-Being that came out this year, but,
13 4 in 10 adults, if they're faced with an
14 unexpected expense of \$400, they literally have
15 no idea how they would pay for that.

16 We're not even talking high deductible
17 there. There's no limit on out-of-pocket on
18 Medicare for inpatient, and one-fourth of adults
19 are skipping necessary medical care in 2017.
20 We're already there with the access problem due
21 to cost.

22 Let's not just say people should have

1 access to technology; they should have access to
2 this, but, I mean, I want to make sure that we
3 remember why this important and what the impact
4 is to the average person who I am not always sure
5 is sitting here in this room.

6 CO-CHAIR BAGLEY: Okay. I'd like to
7 make a couple of observations, having looked at
8 episode-based care and reimbursement over a long
9 period of time, and especially with your meeting
10 coming up on Friday about chronic illness.

11 Episodes in the past have been most
12 useful, most effective, and have the highest
13 utility when there is a high cost-episode trigger
14 that's usually a hospital procedure, so some kind
15 of big deal in a hospital. It's got a pretty
16 defined beginning and a fairly defined end, and
17 you know what's associated with it and what's
18 not. That's way up there in terms of its
19 usefulness and utility and what you're trying to
20 accomplish.

21 Way down at the other end, the
22 marginal utility of using the episode technique

1 for chronic illness, when Mable has six different
2 things going on, becomes so complex that what
3 you're going to get back from it is not worth it.
4 That's my observation.

5 And I, as a family physician, would
6 rather be measured on the total cost of care than
7 I would on some kind of hocus-pocus thing about a
8 very complex set of things that go on in old
9 folks who have three or four things. So, just
10 for that.

11 The other thing, there was a high
12 expectation early on in the episode-of-care
13 movement that, just by having episode payment,
14 that would cause clinicians to talk to each
15 other, and they might actually do some clinical
16 integration. Well, that hasn't really panned
17 out.

18 If you have people that are already
19 talking to each other, okay, so they're in some
20 kind of a clinically-integrated system or a
21 highly-developed ACO, plugging them in there
22 makes a lot of sense. But to think that it's

1 going to make the people in the general kind of
2 population out there all of a sudden start
3 talking to the other people that would be
4 involved in the episode has just not panned out.

5 So, two observations as you're going
6 to move forward with this from somebody who has
7 been trying to see how it works for a long time.

8 I think that we've reached a point
9 that we're kind of finished talking about the
10 generalities. I guess at this point the next
11 thing I would like to do -- I don't think we're
12 ready to vote because I want to give you the
13 opportunity. Are there any of these measures
14 that have some specific commentary that you have
15 a commentary on because of its specific disease
16 or procedural content? So that, if you want to
17 kind of pull it off the list for at least some
18 casual discussion here, that would be helpful.

19 Eric?

20 MEMBER WHITCARE: Sure. First, a
21 disclosure. I'm sorry I didn't mention it
22 earlier. I'm a full-time breast surgeon. So,

1 the breast measure is interesting to me. For
2 that reason, obviously. I will abstain from
3 voting. But there are some things I would like
4 to say.

5 I hinted at the beginning in the
6 initial disclosures that I had some email
7 exchanges with some members of the different
8 Workgroups. This is not a criticism on reporting
9 information that's not available in the
10 materials, but it didn't go well. The breast
11 surgeons felt they were disenfranchised. They
12 felt this cookie-cutter-fits-all-type approach
13 that might work for hernia was not appropriate
14 for a disease such as breast cancer. Granted,
15 both surgeries, but very, very different in the
16 treatment path.

17 They weren't able to make many of the
18 meetings. They didn't feel the testing was
19 adequate. They didn't feel they had adequate
20 input. You have access to their comments, which
21 are really a very limited version of a 70-page
22 letter that was sent to CMS in late October.

1 So, the process -- I'm sure it worked
2 very well many times -- did not work well in
3 breast surgery. To me, one reflection of that is
4 the title of the measure. Can I ask about the
5 title for three operations?

6 Well, lumpectomy and partial
7 mastectomy are the same operation. They're the
8 same CPT code. Clinicians who do breast surgery
9 don't talk that way. And anyone participating in
10 a functioning committee -- Bruce, if that were to
11 happen here, I would raise my card. You'd say
12 fix it. If I felt it was more difficult, I would
13 come around with my computer and say, look,
14 here's a copy of the 2019 CPT Manual; they're the
15 same operation. And you would to turn to staff
16 and they would fix it.

17 So, that speaks to a level of
18 dysfunction that makes me worry of the measure.
19 Now could have found this under a rock. It may
20 have fell like manna from heaven. Maybe it's
21 still a good measure. Just because people had
22 trouble in the development process doesn't make

1 it bad.

2 The testing, although brief, may be
3 accurate and may be reinforced and validated in
4 subsequent testing. But I still have two very,
5 very critical issues.

6 One actually involves my own
7 understanding of the measure. I couldn't tell on
8 reading the measure -- and I think we have a
9 pretty well-defined group, right, or episode?
10 Thirty days before. You have specific breast
11 surgical CPT codes. Ninety days after. Is that
12 correct?

13 I couldn't discern from the measure
14 whether or not reconstruction or radiation
15 therapy was included. When I emailed the Chair
16 of the Committee, the Clinical Chair, he said he
17 didn't know.

18 Now, in terms of cost, that's huge.
19 Here's where I'm going to share some of the cost
20 information I have. In the picture of treating
21 breast cancer -- and if you look at the
22 supplementary materials, they talk about the cost

1 of treatment breast cancer in this country -- 30
2 percent of all new cancers in women are breast
3 cancer, but surgery is a small part of that. In
4 terms of cost, especially in the non-Medicare
5 population, it's chemotherapy. Then, it's
6 radiation. Then, it's surgery.

7 To put the numbers in perspective,
8 Medicare allowable for a mastectomy in Arizona,
9 which is where I practice, is about \$1100, a
10 little less. A lumpectomy, called in the Coding
11 Manuals "a partial lumpectomy," is about \$680.

12 The most important feature in the
13 surgery in the cost of the care is site of
14 service. Did you do it in a hospital or did you
15 do it in an outpatient center? The most
16 important component in the totality of care is
17 chemotherapy, but in deciding surgery, it's about
18 radiation. The cost of a course of radiation
19 therapy is about \$8,000.

20 The last thing I would want to happen
21 is to have clinicians not understand the measure
22 well. They need to know if these other measures

1 are included, radiation and chemotherapy. They
2 need to understand the site of service. None of
3 that is clear from the measure, as I read it.

4 But the last thing I want is to have
5 those cost differences impact the shared
6 decisionmaking process. Because I'm sitting
7 there -- you can fix my hernia with a scope or
8 you can do it through traditional mesh, and maybe
9 you can fix my hip with this or that prosthesis.
10 But most people care a lot about how we address
11 their breast cancer in terms of surgical
12 management of the breast.

13 So, if radiation therapy is included,
14 slam dunk, everybody gets a total mastectomy with
15 no reconstruction. Perfectly valid cost-
16 efficient care. Would I do that? I hope not.
17 But with people who misunderstand the measure, or
18 perhaps have less good understanding of the
19 situation, that could happen, and that will
20 influence the discussion.

21 Alternatively, if reconstruction is
22 included, it's delayed. I can get that off

1 because the plastic surgeons and I can make a
2 perfectly valid medical argument in terms of
3 reducing complications by delaying the
4 reconstruction. So, this is all good medicine
5 where I have equivalent outcomes, but huge
6 differences in costs and bigger differences in
7 individual patient care.

8 This is metric-specific. I won't be
9 voting on it. But I think it's important you
10 know the background of the breast surgeons'
11 participation and how it would impact someone who
12 sees this measure, and even reviewing it, can't
13 fully understand it, and could then make poor
14 decisions based on what I see.

15 DR. NAGAVARAPU: I could respond to
16 that. Fortunately, the Workgroup has discussed
17 the issues that you've brought up, actually. So,
18 in discussing the measures over the course of the
19 webinars, including the post-field-testing
20 webinars, the Workgroup decided not to include
21 reconstruction or chemotherapy or radiation as
22 costs due to concerns about being able to

1 influence those costs.

2 The Workgroup also was concerned about
3 site of service, what this might do to access to
4 care if it was the case that certain patients
5 particularly needed to be treated in an inpatient
6 setting. And so, the Workgroup decided to
7 eliminate the inpatient cases from the measure,
8 according to a vote.

9 And the discussion of sort of the
10 trigger codes, as well as the title of the
11 measure, is something that originally came from
12 the Clinical Subcommittee, but was discussed
13 during the Workgroup process to make sure that
14 the trigger codes were appropriate.

15 I definitely understand the time
16 pressure involved in the measure development
17 process. It was a rapid process in order to meet
18 the sorts of statutory timelines that CMS is
19 working under. And so, I definitely have
20 appreciation for the time that people put in, as
21 well as the challenges that are involved with the
22 speed of that process.

1 At the same time, we had a long
2 sequence of meetings with the particular
3 Workgroup. There is a Clinical Subcommittee in-
4 person meeting. There is a Workgroup in-person
5 meeting to start off. There is a Workgroup
6 webinar focused on service assignment of costs
7 and risk adjustment.

8 After the field-testing period, in
9 which the full measure specifications were laid
10 out for public comment, there were post-field-
11 testing webinars, two of those. We've also
12 offered the opportunity to talk with any of the
13 societies that had additional questions about the
14 measure, either the field-testing reports that
15 they received or not.

16 And so, I think in terms of the
17 opportunity to contribute to the process, the
18 Workgroup has had input at each step of the
19 process. And the Workgroup, in terms of
20 composition, had a full range of specialty
21 societies that were related to the episode of
22 care under consideration. So, beyond the

1 American Society of Breast Surgeons, it also
2 includes the Society of Surgical Oncology, the
3 American Society of Clinical Oncology, the
4 National Association of Clinical Nurse
5 Specialists, Anesthesiologists, the American
6 College of Surgeons, and so on.

7 So, I do appreciate that the process
8 is a challenging one, but I think that the
9 results of the measure have been very good. The
10 public comments that we received from the society
11 that you've mentioned didn't express concerns
12 about the process, but, notably, didn't express
13 specific concerns about aspects of the measures,
14 that they didn't have a chance to talk about and
15 change after field testing. And I think that, as
16 well as the fact of the reliability of the
17 measures, is high, anywhere ranging from .69 to
18 .75 for TINs at 20 or 30 episodes and .65 to .71
19 for TIN/NPIs at 20 and 30 episodes, really speaks
20 to the fact that, despite all the challenges that
21 I think are inherent to the speed of the process,
22 that we did end up in a good place with the

1 measure.

2 And I'll just end on a comment that
3 was submitted late on the measures by the
4 American Society of Clinical Oncology, where it
5 was a general comment in support of the EBCM
6 development process, sort of talking about the
7 usefulness of the EBCMs and appreciating the
8 opportunity to be involved in measure development
9 and looking forward to additional oncological
10 surgical measures.

11 And I think that the fact that we've
12 had a lot of re-engagement from specialty
13 societies that engaged in the first wave of the
14 process in the second wave, as well as re-
15 engagement from specific people, speaks to how
16 people felt about the process overall.

17 I think for any process like this,
18 there are definitely going to be challenges,
19 especially with timelines. And what we've tried
20 to do is, at the end of each wave, try to talk
21 with the societies, the participants as much as
22 possible and incorporate their input into the

1 next wave, and we'll continue to do that going
2 forward.

3 CO-CHAIR BAGLEY: Dave, is your card
4 up from your last comment or do you have a new
5 comment?

6 MEMBER SEIDENWURM: I would just like
7 to comment a little bit about the process as I
8 experienced it. And the first thing I want to
9 say is I've been in measure development
10 circumstances with various organizations and
11 specialty societies, and I thought that the
12 degree of both intellectual rigor and engagement
13 by the consultant was superior to that that I've
14 seen elsewhere or at least as good as the best.

15 I also think that the concerns of the
16 clinicians were answered in each case using the
17 most conservative decisionmaking process. In
18 other word, the process erred on the side of
19 allaying the concerns, even though in many cases
20 there were very strong arguments to be made
21 against adjusting away those risks or against
22 excluding certain categories of patients.

1 I also think that, despite this, I
2 think that a lot of the concerns seemed to come
3 from an overall skepticism with the whole concept
4 of cost measurement rather than from the specific
5 sort of technical aspects of the measure
6 development process that we're kind of discussing
7 now.

8 So, I think that the challenge going
9 forward is not so much in terms of the technical
10 specifications and the analytical rigor that was
11 brought to the problem. I think that we really
12 have to either explain to people that the law
13 says what the law says, and if they have a
14 problem, they should talk to their Congressman,
15 or we need to do a better job of educating the
16 clinical community now about the value and the
17 goals of cost measurement in the system.

18 So, I don't think that the
19 difficulties that we're experiencing in
20 understanding these measures have to do with the
21 process through which they were developed or
22 through any lack of intellectual rigor. I really

1 do think it's somewhere else.

2 CO-CHAIR BAGLEY: Robert and Chad, I
3 didn't see who put up first.

4 MEMBER FIELDS: Mine's just a quick
5 procedural question. It seems to me that you
6 shouldn't recuse yourself just because -- but we
7 all have conflicts on a lot of the different
8 measures by virtue of what we do. I think your
9 opinion is actually exceedingly valuable. So,
10 just a procedural question that probably the
11 Chairs need to comment on, but I would imagine
12 that you would not need to recuse yourself from
13 the vote.

14 CO-CHAIR BAGLEY: We've already
15 discussed that. We told him he didn't need to
16 recuse himself, but that's his decision. I mean,
17 he's a content expert, and that's his role on
18 this Committee, and he wasn't directly involved
19 in developing the measure. So, we know he's
20 opinionated.

21 (Laughter.)

22 CO-CHAIR BAGLEY: You know, he's

1 bringing his biases like I am, you know, but,
2 hey.

3 Chad?

4 MEMBER TEETERS: I have two separate
5 points. The first one is going to lump three
6 measures together. I guess this is really going
7 to be a question of -- and either I missed it or
8 I didn't see it in the measures -- what defines
9 the duration of the episode? So, I'm going to
10 lump COPD, lumbar spine fusion, and CABG for the
11 moment.

12 So, one of the biggest things that
13 determines outcome/readmission rates is access to
14 rehab. Right now, across the country only about
15 20 percent of CABG patients have access to
16 cardiac rehab. Only about 2 percent of patients
17 have access to pulmonary rehab, and only about 30
18 to 40 percent of patients complete PT rehab after
19 spine fusion.

20 So, those that do will have an
21 increased cost of care in the short term. If
22 it's 30 days post-procedure or post-inpatient

1 admission, there will actually be a higher cost.
2 And cardiac rehab is an example. It's about
3 \$3,000 a month. However, if looked at for a six-
4 month term, that group may have a lower cost of
5 care because they'll be less apt to be readmitted
6 after their procedure or incipient
7 hospitalization.

8 So, that's one and that's one of those
9 unintended consequences of the scope of the
10 procedure and, you know, kind of what Bruce
11 alluded to before. Looking at these things as
12 too finite of an iterative entity rather than a
13 duration of care of an individual makes it
14 difficult, and perhaps total cost of care is more
15 apt when what we're talking about, especially
16 complex care of elderly patients.

17 The next thing -- and I don't know if
18 this gets factored in, and again, I'm going to
19 use CABG as an example. I'm a cardiologist, so I
20 have a built-in bias to this. I'll admit that.
21 So, I can take two patients. They may be on
22 paper the same risk, but the difference in

1 whether I do two bypass grafts or one, whether
2 they have sufficient mammary artery to do the
3 bypass or I'm using GORE-TEX graft, that will
4 affect the cost. That will affect the type of
5 surgery that is done. And I don't know that that
6 would actually be factored into the risk of the
7 patient per se. That's almost a separate risk
8 calculation that I don't know if it will get
9 reflected.

10 And I could say the same thing about
11 hemodialysis access creation. It's a difference
12 between a branchial fistula versus a fistula
13 anywhere else in the body, for that matter. So,
14 those kind of nuances of the procedure or the
15 complexity of the patient may not get reflected
16 in their actual medical risk, but more so just
17 the technical difficulty of that particular
18 procedure.

19 CO-CHAIR BAGLEY: Okay. Yes, do you
20 have a comment on that?

21 DR. NAGAVARAPU: Sure. Yes, I can
22 make a quick comment just on the episode window

1 question you had. That's something that varies
2 by episode group just because, clinically,
3 because of the sort of tradeoffs that you're
4 talking about, that's going to be different for
5 each episode group. For COPD, the episode starts
6 at admission and continues for 60 days. For
7 spine fusion, there's a 30-day pre-trigger period
8 to help account for a small number of pre-op
9 services that happen, and then, 90 days post.
10 And then, for CABG, it's 30 days pre and 90 days
11 post.

12 The types of tradeoffs you're talking
13 about are the types that the Workgroup
14 discussions kind of went through, and there were
15 cases where, after the field testing, the
16 Workgroup looked at what they saw in field
17 testing and made a change based on that. So, I
18 think the psychoses measure, for instance, went
19 down from a post period of 120 days to 90 days
20 after what they saw in the field-testing results.

21 MEMBER TEETERS: I understand there
22 has to be a decision made. For each one of

1 those, I would almost say, for those patients who
2 get access to the superior quality with the rehab
3 service, they will be a higher cost of care in
4 that window, but actually will be a better
5 longer-term outcome for what CMS wants to
6 achieve. And that, unfortunately, won't get
7 reflected in those measures.

8 CO-CHAIR BAGLEY: Okay. I would like
9 to try to move to a vote on these measures. I am
10 going to propose that we vote on all 11 together.
11 Any member can ask for a division of the
12 question. So, if anyone wants to pull any
13 measure off of that list, now is the time to
14 speak up.

15 Okay. So, we will be voting on the
16 first 11 measures, and we'll be detailing the
17 numbers, and all that stuff, along with the
18 recommendations of the preliminary review and a
19 preliminary assessment. And then, we'll vote on
20 them en masse. All right.

21 DR. BERNOT: Sounds good. I will be
22 as brief as possible, but I do want to get it on

1 the record. We will do those 11. I will not
2 read the names, just the numbers.

3 So, MUC2018-115, 116, 117, 119, 120,
4 121, 122, 123, 126, 137, and 140.

5 So, to remind you, this was a
6 conditional support with a condition of NQF
7 endorsement. We have over 90 minutes of
8 recording and transcripts that we will be pooling
9 through looking for themes, dissenting opinions,
10 other relevant information. I will highlight a
11 couple right now, just to make sure there's
12 nothing I'm missing.

13 On the really, really high level, we
14 have risk adjustment, so social risk adjustment,
15 a lot about balancing measures. That's quality,
16 efficiency, access, appropriate use measures that
17 could balance the cost measures. Unintended
18 consequence, we have another theme of that.
19 Attribution, we've heard much about attribution.
20 Feedback and continued testing, this is an
21 iterative process. This is not a one-and-done
22 process.

1 The understanding and the transparency
2 of the measure for the clinician to know what are
3 the components. We've heard different parts
4 about the components. And then, making sure we
5 are always cognizant of that linking of the
6 clinician behavior to that cost, that it is
7 something that they can change. Again, I know
8 that's somewhat within the range of the
9 attribution. Again, much, much more, but I
10 wanted to at least highlight those are the types
11 of things that we would be passing along for
12 endorsement, that we expect these things would be
13 analyzed during an endorsement process.

14 Any questions or other points?

15 CO-CHAIR BAGLEY: Yes, and as part of
16 that special seat that you have here, do you have
17 any comments you wanted to make before we go
18 ahead and vote, Michelle? Did John cover most of
19 them? Okay, good.

20 All right. Without objection, we'll
21 proceed to a vote, and it should be on your
22 voting machine, if you still have that available.

1 They're called Group 4. They're on the screen,
2 if you need to see the numbers.

3 And by the way, on the screen, the
4 last two are not included in this, right? Okay.
5 Just to be clear about what we're voting on.
6 Okay.

7 MS. KOSURI: So, voting is now open
8 for the episode-based cost measures of Measure
9 Group 4. As we said, it's the first 11.

10 Do you vote to support the preliminary
11 analysis as the Workgroup recommendation, as John
12 stated earlier?

13 (Voting.)

14 MS. KOSURI: Okay. I think we have
15 our total 19. So, the voting has now closed.

16 The Committee's recommendation, based
17 on 79 percent of the vote, is yes, to support the
18 preliminary analyses as the Workgroup
19 recommendation.

20 Fourteen members have voted yes and
21 four have voted no.

22 CO-CHAIR BAGLEY: Okay. Thank you for

1 your patience with that. That was a good
2 discussion. Hopefully, that's helpful to all of
3 you going forward. You know, this is not simple
4 stuff, and to a great degree we're going to have
5 to see how it works.

6 We are going to talk about the last
7 two individually, if that's okay. First, we'll
8 talk about 18-148.

9 John, do you have some comments?

10 DR. BERNOT: Sure. Just to put on the
11 record, this is MUC2018-148, Medicare Spending
12 Per Beneficiary, a clinician measure.

13 The preliminary analysis from staff
14 was a conditional support for rulemaking with a
15 condition of NQF endorsement.

16 CO-CHAIR BAGLEY: Is there any
17 discussion from our lead reviewers? I'll have to
18 look up and see who that is. See who finds it
19 first. Oh, Amy and Diane. Okay.

20 Any comments from either of you?

21 MEMBER NGUYEN HOWELL: I'll be brief
22 because I think you alluded to my comment

1 earlier.

2 When we talk about the risk-adjusted
3 cost across all episodes, my comment relates to
4 the social determinants of health. So, how are
5 we accounting for these determinants in all
6 episodes as we look at these cost measures, the
7 MSPB and the Total Per Capita, TPCC?

8 Because I think if we're not
9 evaluating it, if we're not measuring this, then
10 how are we truly moving the dial on total cost of
11 care as it pertains and it is relevant to a
12 patient's outcome, total health outcome, as we
13 know it; and also, as it aligns to CMS's
14 Meaningful Measures Initiative with population-
15 based payment, with APMs, with patient-centered
16 care, outcome-based care, and high-impact
17 conditions?

18 CO-CHAIR BAGLEY: Diane?

19 MEMBER PADDEN: Nothing to add. I
20 also made note of the same thing. Thank you.

21 CO-CHAIR BAGLEY: Okay. Any comment
22 from CMS about this and about its current use?

1 Is it in use anywhere?

2 DR. ANDRESS: Sure. Thank you.

3 So, this measure is currently -- well,
4 I should say, the original form of this measure
5 is currently in use in the MIPS program as one of
6 the two cost measures, the other being the TPCC.
7 The version that we've brought to you today is a
8 modified form of this. It's undergone the
9 maintenance process, as we mentioned earlier.

10 The purpose of the maintenance process
11 was to take into account a lot of the feedback we
12 had gotten, particularly after we had taken these
13 measures into the arena for MIPS. They had
14 previously been used elsewhere, and we received
15 feedback there as well. We thought it was
16 important to think about how we could modify the
17 measures in a way to address some of the concerns
18 that were raised.

19 I think kind of the biggest overall
20 critique that we've seen of them is the fact that
21 they are not as specific as episode-based
22 measures. I think there are arguments to be made

1 for using generalized measures. Part of the
2 problem with episodes is that some of the cost is
3 not going to be directly attributable to an
4 episode, no matter how you define the episodes.
5 And so, of course, that's a potential opportunity
6 lost for controlling cost of care.

7 I think that in a program environment
8 where we have a relatively small percentage of
9 coverage, both in terms of total cost and in
10 terms of clinical episodes with our current
11 measure set, these kinds of measures play an
12 important role in helping us get started in
13 paying attention to the cost of care. We're
14 obviously going to be working on developing the
15 cost measures, but if you look at the coverage
16 numbers that we quoted earlier, I mean, you're
17 potentially looking at we've developed something
18 on the order of 100 measures in order to cover
19 the 50 percent mandated by statute. Not only
20 will that take time, but resources as well.

21 And even after we've completed that,
22 there will still be costs that are not covered

1 under those. There will be clinicians will not
2 be contained within the denominators for any of
3 those measures. And so, these are the kinds of
4 measures that I think play a role in potentially
5 filling that gap.

6 And so, that's one of the reasons that
7 we felt it was (a) important to bring them into
8 the program in the first place and (b) to expend
9 the resources to address some of the
10 methodological concerns that have been raised
11 with regard to the measures to ensure that, while
12 they're playing their role within the program now
13 and into the future, they are also as
14 methodologically robust as we can possibly make
15 them.

16 And so, I think that's what we've had
17 in mind with presenting these modified measures
18 for your consideration. I'd certainly suggest
19 that, as you're talking about them, you want to
20 take that into account, the fact that we have
21 already have these forms of measures in the
22 program. So, a big part of the question I think

1 should be, is the improvement to the measures
2 worth considering taking them forward into the
3 program or are we happy with the measures as they
4 currently are within MIPS?

5 CO-CHAIR BAGLEY: This may be my
6 problem, but what was changed and why?

7 DR. NAGAVARAPU: Sure. I could give
8 you a quick summary for each measure.

9 Starting with MSPB, the current
10 version of MSPB in MIPS is an all-cost measure
11 that's surrounded around inpatient episodes. The
12 measure currently counts all costs from three
13 days prior to an admission to 30 days after the
14 discharge, and then, risk adjusts those costs
15 using an adaptation of the CMS HCC model.

16 The measure is attributed to the
17 clinician or clinician groups that bill for the
18 plurality of Part B physician supplier costs
19 during the inpatient hospitalization. So, that's
20 the current version of the measure.

21 In terms of stakeholder comments that
22 we've heard over time, that CMS has wanted to try

1 and address with the reevaluated measure, the
2 comments centered around two things. One was the
3 inclusion of all costs in these measures. And
4 two was the method of attribution, because of a
5 concern that the plurality of Part B physicians'
6 supplier costs, like who's billing the most cost
7 in the inpatient hospitalization, may not
8 pinpoint the clinician or clinician groups
9 responsible for the costs that follow the
10 hospitalization.

11 And so, we went through the
12 reevaluation process. We discussed the
13 attribution methodology in detail with the TEP.
14 The TEP also suggested that we convene an expert
15 Workgroup in order to figure out what costs
16 should be excluded from being counted in the
17 measure. And so, we convened an expert Workgroup
18 with representatives from over 20 specialty
19 societies with focus on specialty societies
20 likely to have clinicians that would be
21 attributed in an MSPB measure. So, we met with
22 that Workgroup multiple times over webinars in

1 order to think about which specific costs should
2 be excluded.

3 The reevaluated MSPB measure on those
4 two dimensions has the following basic changes:
5 the first is in terms of including all costs.
6 Certain costs that the expert Workgroup
7 determined were unlikely to be clinically-related
8 to the care provided in the hospital have been
9 removed. Some of those costs are common across
10 all the different types of hospitalizations you
11 can get. For instance, most of the costs that
12 happen three days prior to the hospitalization
13 have now been removed because of a concern that,
14 regardless of inpatient hospitalization, many of
15 those costs are not in the control or under the
16 influence of the clinicians who are performing
17 the management during the hospitalization.

18 It's also the case that certain
19 clinical distinctions have been made. So, the
20 inpatient stays, after discussion with the
21 Workgroup, were divided up into different types
22 of categories, based on major diagnostic

1 categories, and some major diagnostic category-
2 specific exclusions were provided. We can go
3 into more detail on that, if people are
4 interested.

5 So, those were the costs that were
6 removed. The hope is to ensure that costs that
7 are very directly outside the influence of those
8 in the hospital would not be included in the
9 measure.

10 The attribution changes that we
11 discussed with the TEP and, then, looked through
12 public comments, and discussed with CMS, is the
13 program priorities. What we have in the
14 reevaluated measure is a distinction in
15 attribution depending on whether we're talking
16 about surgical hospitalizations, so surgical
17 DRGs, or medical DRGs in terms of medical
18 management of cases.

19 In surgical DRGs, the TEP felt
20 strongly that surgical DRGs, those episodes
21 should be attributed to those performing the core
22 surgical procedure in that hospitalization. And

1 so, what we did was go through/identify the core
2 surgical procedure that is billed in Part B
3 physician supplier claims that is tied to each
4 DRG for a Part A hospital stay, and attribute
5 based on who's doing those actual surgical
6 procedures. So, that's for surgical DRGs.

7 That's both for TIN reporting and
8 TIN/NPI reporting. And so, in MIPS there's a
9 distinction in that clinician groups can choose
10 to report as TINs, in which case they would get a
11 TIN-level cost measure, or they can choose to
12 report as individual TIN/NPIs, in which case they
13 would get individual TIN/NPI cost measures.

14 For surgical DRGs, whoever is
15 performing the surgery would be attributed the
16 episode. For TINs, that would be anyone in the
17 TIN performing the procedure. Each episode is
18 only counted once for each TIN. For TIN/NPIs,
19 that would be whichever TIN/NPI is performing the
20 procedure, and that's what would go into the
21 measure. So, that's for surgical DRGs.

22 For medical DRGs, the discussion that

1 we've had over the past year in terms of
2 attribution has to do with how to move away from
3 just the plurality of Part B physician supplier
4 claims. People have felt on the TEP, and other
5 sources, that using evaluation and management
6 claims is a potential solution, pending the wider
7 introduction of patient relationship codes.

8 And so, for the TIN-level reporting,
9 an episode for a medical DRG is attributed to the
10 TIN that bills at least 30 percent of those
11 evaluation/management claim lines during the
12 hospital stay. That's for TIN-level reporting.

13 For TIN/NPI-level reporting, the
14 episode is attributed to the TIN/NPI who is part
15 of the TIN that bills at least 30 percent of the
16 evaluation and management claim. So, that's
17 important. They're part of the TIN that's
18 helping to manage the case, and they bill at
19 least one evaluation/management claim in that
20 specific hospital stay, to indicate that they are
21 part of the episode.

22 This is something that over time we've

1 had a chance to look at in order to see how this
2 attribution rules compares to other
3 possibilities. And recently, we've been able to
4 do some comparisons of reliability and other
5 metrics between those using that rule for
6 TIN/NPIs versus using a narrower rule, such as
7 using the plurality of E&M claims for a TIN/NPI
8 during a hospital stay or just identifying one
9 TIN/NPI for every TIN during the hospital stay.

10 Both of those, conceptually, have
11 problems in the sense that they may not incentive
12 care coordination between the various TIN/NPIs in
13 a given TIN. But we did want to take seriously
14 that these are alternative possibilities that
15 people have brought up. And when looking at
16 reliability, the distinctions in the reliability
17 metrics are extremely small, less than .01 on
18 average.

19 So, given the conceptual advantage in
20 terms of identifying clinicians that are part of
21 a TIN managing the case and ensuring that there's
22 care coordination between all of them, we've

1 moved in the direction of the TIN/NPI attribution
2 rule that I just walked through. So, that's the
3 way that attribution works.

4 So, really, the reevaluation is
5 focused on those two items: removing certain
6 costs that are outside the influence of the
7 attributed clinician and reconfiguring the
8 attribution to be more in line with what
9 clinicians may expect for surgical DRGs and
10 medical DRGs.

11 CO-CHAIR BAGLEY: A long answer, but
12 good.

13 Kevin, you're next. Oh, I thought you
14 were trying to get my -- okay.

15 Any other comments before we vote?
16 Yes, go ahead, Dale.

17 MEMBER SHALLER: And we're going to
18 just vote on the MSPB measure first?

19 CO-CHAIR BAGLEY: Yes, we are, one at
20 a time, yes.

21 MEMBER SHALLER: But my question is,
22 we've talked a lot about the duplication or

1 potential duplication between the global measures
2 and the individual episodes. What I don't quite
3 understand is the overlap or tension between the
4 TPCC and the MSPB. Who gets counted? If you're
5 a clinician, do you get kind of once for one?
6 Or, potentially, twice for being in the MIPS
7 program? I don't understand how that works.
8 It's like an implementation question really.
9 It's not a measurement question.

10 DR. ANDRESS: Thank you. So we've
11 been talking a little bit about this. There is
12 potentially a policy decision to be made where
13 you attribute both to a clinician and the idea
14 that it's especially important. I don't think
15 that's how we approach development of the
16 episode-based measures with the idea that they're
17 just taking out the most important episodes on
18 top of the MSPB or the TPCC.

19 I think from a policy perspective
20 we've talked about a number of options for how
21 you can do this. You can potentially, for
22 instance, you know, only use the population-based

1 measures for people who don't have episode-based
2 measure attributed to them or you can set a
3 minimum threshold for the cost that's covered for
4 the denominator under the episode-based measure
5 for those clinicians. There are a number of
6 different ways you could do that.

7 (Off-microphone comment.)

8 DR. ANDRESS: The TPCC versus the
9 MSPB, okay, right. I'm sorry, I must have
10 misheard the question.

11 So I think in terms of having two
12 measures, they really focus on two different
13 areas as Sri has pointed out.

14 The MSPB deals with costs associated
15 with acute hospitalization, whereas the TPCC is
16 dealing primarily with primary physician care.
17 And so the expectation is that the individual
18 measures, while there is some overlap, they're
19 really focusing on different considerations.

20 Different aspects of the care, there
21 is some overlap, but not -- but it's not a focus
22 of the measures. And we haven't taken steps

1 within the measures themselves to separate them
2 out from one another, so there is the potential,
3 for instance, that a particular set of billing
4 could be captured in both measures at the current
5 time.

6 I think is your question is how are we
7 planning on implementing the measures?

8 MEMBER SHALLER: If you're following
9 both, do you -- how do you reconcile them in a
10 kind of a payment-based program setting?

11 MEMBER DUSEJA: Well, as of now, if
12 you're counted in terms of attribution, then you
13 will be measured on both as it stands for the
14 cost category.

15 Now moving forward, as these measures
16 go in and we do more analysis based on this
17 reevaluation period, I think we need to consider
18 like the overlap. I don't think we have the data
19 at this point to be able to determine that
20 because we're still trying to get the input from
21 yourselves, as well through public comment, on
22 these measures, as well as going the NQF

1 endorsement process.

2 But there will be some overlap. I
3 think you're right to point out that there could
4 be some clinicians that will be measured on TPCC
5 over that one year length time frame, versus
6 those that are practicing in the in-patient
7 setting and might be attributed to the MSPB
8 depending on the episode.

9 DR. NAGAVARAPU: And then just
10 speaking to the details of the measure
11 specification and to the extent that they feed
12 into that implementation issue, there is an
13 effort as Joe and Reena are saying to ensure that
14 the measures are trying to measure different
15 things. And so, for instance, one very clear way
16 in which this is operationalized is that
17 evaluation and management claims that are billed
18 in the in-patient setting do not count for the
19 attribution of a TPCC. The TPCC is really
20 focused on management in an office setting and so
21 on.

22 And so the notion is to try and create

1 the TPCC measure as something that's focused on
2 care outside of the in-patient setting and focus
3 on MSPB as care that's triggered by the treatment
4 episode and to the extent that there's overlap,
5 there's significant benefits to that in the sense
6 that a measure that looks at management in the
7 out-patient setting can speak to whether or not
8 someone is doing things that can keep a patient
9 out of the hospital, but once a patient is in the
10 hospital, then the MSPB measure is able to speak
11 to whether that care that's happening in the
12 hospital is happening in an appropriate way.

13 CO-CHAIR BAGLEY: Okay, let's have a
14 few more comments. I have Helen, Eric, Ira, and
15 Peter.

16 MEMBER BURSTIN: Just a brief
17 question. It was helpful to hear the changes
18 that were in the attribution model. I have to
19 say it's really hard to just hear them. This is
20 something, it's really complex. I can't fully
21 wrap my head around whether the changes had a
22 positive impact or not. We haven't seen the

1 changes in reliability. So again, to me this
2 just screams for why this measure needs to come
3 for NQF endorsement.

4 And unlike what you said earlier about
5 the episode-based measures, you haven't stated
6 that's the case, but I certainly hope this
7 measure will come forward as it did from the
8 hospital level because again, I think the
9 attribution methodology is really critical here
10 and even if you look at the reliability and the
11 supplemental materials you put forward, I don't
12 know how often clinicians get to 20 episodes as a
13 minimum, but even that is only a reliability of
14 .6.

15 So again, there's a lot of opportunity
16 here that needs a much deeper dive with a lot of
17 folks around the table who feel very comfortable
18 looking at what this all means and whether the
19 changes have, in fact, improved the attribution
20 approach, but again, hearing this verbally
21 without a lot of this, you know, to really review
22 and see the differences and a table that explains

1 what's in, what's out, compared to the prior
2 measure is really difficult to process. I just
3 have to be honest. So for me, it just would
4 really need to come forward for a full review
5 again.

6 DR. ANDRESS: And to clarify on the
7 point about NQF, our intention is certainly to
8 bring these measures to NQF for endorsement.
9 Unfortunately, we took away one measure. We
10 actually had to bump one of our sister programs
11 back to the second set of submissions in the
12 year, so we're going to need to talk about things
13 with NQF staff about capacity for taking measures
14 and when the timing will be appropriate for that.
15 But we're planning on having those conversations.

16 MEMBER BURSTIN: Just one more comment
17 on that. These measures are already out there.
18 So again, anything you can do to look at
19 unintended consequences, feedback from the
20 community, even if it gets in in the spring, it's
21 still awhile until you actually get a decision or
22 at least deliberations out of NQF. As fast as

1 they have become, it's still not an easy process,
2 especially for these kind of measures.

3 CO-CHAIR BAGLEY: Eric.

4 MEMBER WHITACRE: I, too, was getting
5 lost a little bit in the verbal discussion and I
6 had a question again about risk adjustment. Is
7 it still independent of socio-economic status?

8 DR. NAGAVARAPU: So for MSPB, there is
9 no socio-economic status that's included in the
10 risk-adjustment model right now. We did perform
11 the same testing that we did for EBCMs using the
12 American Community Survey as well as enrollment
13 information on dual status. And also see similar
14 conclusions that there is very little impact on
15 that. It's just negligible. So that's helpful,
16 but it's something that we'll continue tracking
17 for MSPB.

18 For Total Per Capita Cost, what we
19 wanted to do, and I can walk through if there's
20 time in a moment, I can walk through the
21 improvements for TPCC relative to the current
22 measure, but what we wanted to do was really

1 focus on the items that stakeholders brought up
2 as detailed concerns and keep other aspects of
3 the measure as similar as possible.

4 And so the risk-adjustment model we're
5 using is the same approach for risk adjustment
6 that's used in the current TPCC measure which
7 uses the Medicare Advantage risk-adjustment model
8 and coefficients and dual status is included in
9 that in the Medicare Advantage model.

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

11 MEMBER MOSCOVICE: First, I do want to
12 commend CMS in terms of trying to do sensitivity
13 analyses in these kinds of issues. They're
14 really important.

15 The only thing I would -- just two
16 things. First, if the people around this table
17 are having a hard time understanding what's going
18 on, you can imagine what primary care providers
19 who are out there who think they're totally being
20 taken advantage of in any attribution method. So
21 I think when we do get to a final state on all of
22 this, it really lends itself to -- it's going to

1 be very important to have a dissemination process
2 that really embraces primary care providers and
3 gets them to at least try to hopefully understand
4 what's going on. Depending what you're doing,
5 your work is really important.

6 The second part is it's hard for me to
7 believe that risk adjustment for socio-economic,
8 socio-demographic variables doesn't have any
9 impact. It's hard to believe.

10 DR. ANDRESS: So I think one of the
11 things to keep in mind with this, I have had this
12 come up with, for instance, readmission measures
13 in the post-acute and ESRD settings a lot which
14 is that frequently you'll find the factors will
15 be predictive at the end of the dual patient
16 level. A lot of that variation tends to be
17 explained away, something like a third to half
18 when you take into account the comorbidities and
19 other conditions of the patient's age, and so
20 forth.

21 And then it becomes a question for the
22 measure, what is the impact for the setting or

1 clinician when you wrap it into the model and
2 that's where the impact tends to dissipate in
3 most of the measures where I've done those kinds
4 of analyses.

5 I think it's important to keep in mind
6 it's not that those -- the analyses don't
7 demonstrate that those factors aren't relevant.
8 I think that would be incorrect to say and it's
9 certainly counter-intuitive. I think it's more
10 to say that once you have taken into account the
11 other factors of the models and you've aggregated
12 the assessment to the provider level, the impact
13 of these factors is negligible in terms of how
14 they affect the assessment and then the payment
15 determinations associated with it. And that's
16 been our experience in looking up these measures.

17 So it's not a statement that social-
18 risk factors don't matter. We would absolutely
19 disagree with that statement. It's just that a
20 lot of the stuff is baked into what we think of
21 as patient risk, patient condition when we're
22 risk -- and the more robust the risk adjustment,

1 the more that you're going to be accounting for
2 in the model.

3 MEMBER NGUYEN HOWELL: So is that data
4 -- does that change at the organizational level?
5 Have you looked at that, versus the provider
6 level?

7 DR. NAGAVARAPU: Could you clarify,
8 actually, what you mean by organizational level?

9 MEMBER NGUYEN HOWELL: So let's just
10 take the TIN. You know, you were talking
11 specifically provider level, so the actual NPI
12 level, so at an organization at an ACO, at a
13 medical group level, at an IPA level.

14 DR. NAGAVARAPU: So the data that
15 we've looked at in estimating these risk-
16 adjustment models using the base model for their
17 re-evaluated measure, as well as alternately
18 adding dual status and other socio-economics
19 status variables, those are all risk-adjustment
20 models at the episode level and so it doesn't
21 distinguish between sort of levels of
22 characteristics that let's say a TIN model versus

1 an NCI. I think that's an area we have
2 experienced with in thinking about an MSPB
3 measure in a hospital context.

4 Here, we really wanted to focus on the
5 question that Joel was getting at which is that
6 we know that these factors can be significant
7 predictors of spending, but how much do they add
8 in our ability to capture expected cost above and
9 beyond what we're already including. And so
10 absolutely, as Joel mentioned, these factors are
11 important to track over time, as well as to
12 analyze in this way. And what we're seeing is
13 that while they may individually explain episode
14 costs, later we're talking about TIN or TIN/NPI
15 that the predictive power models in terms of the
16 standard measure people use like R-squareds and
17 just R-squareds are not changing very much like
18 on the order of less than .001.

19 CO-CHAIR BAGLEY: Okay. I think we
20 need to wind this conversation down so we can
21 have a vote.

22 Peter and Raj, any new material you

1 want to bring? I'm going to stop looking for
2 cards here pretty soon.

3 MEMBER BRISS: I can be quick.

4 CO-CHAIR BAGLEY: I hope so.

5 MEMBER BRISS: All right, I had three
6 reactions to the conversation. One of them is I
7 think I heard you say that you're thinking about
8 for these measures that have been in play for a
9 while whether you use the improvements and so my
10 gut reaction is you those don't need to go back
11 to NQF, but you've done a lot of work to do to do
12 stakeholder process and technical process. And
13 if you've tried to make improvements, you should
14 use them as point one.

15 Point two is it strikes me that both
16 these more global measures and the more specific
17 episode measure, both have strengths and
18 weaknesses. And if I were CMS, I might try to
19 pair them up to take advantage of both. So the
20 episode things are more specific, but more
21 reliable for gaming, for example. The more
22 global measures might include a lot of costs, and

1 a lot of providers that aren't otherwise included
2 in it. And including both might not make any one
3 measure a little bit lower stakes. And so if I
4 were CMS, I would be trying to pair them up.

5 And then on this last point about risk
6 adjustment, even if it doesn't matter as a
7 technical matter, in epidemiology we used to talk
8 about political confounders. Sometimes you've
9 got to -- sometimes you've got to include a
10 confounder in your model to help people believe
11 the results you're getting. And you guys might
12 have political confounders here. I might try to
13 risk adjust even if it doesn't matter, so you can
14 tell people you did.

15 CO-CHAIR BAGLEY: Rob.

16 MEMBER FIELDS: Two super quick
17 comments. One is on the -- I noticed on 13, it's
18 measure 149 on the Part B costs, traditionally
19 you try to risk adjust by chronic condition
20 management, right, and get your RAF score up.
21 But increasing what we're seeing is Part B drug
22 spend doesn't carry as significant ACC weight.

1 So things like macular degeneration, for
2 instance, don't carry a kind of weight you can't
3 risk adjust away its pretty intense cost. We're
4 seeing macular degeneration treatment beyond par
5 with SNF costs in many cases in parts of our
6 network. So it's no joke, and it's getting
7 worse. So just be cautious that it's going to
8 screw up the Part B cost methodology and
9 benchmarking because you can't risk adjust away
10 some of that Part B cost.

11 The second piece just supportive on
12 the statistics, we're doing some work with
13 artificial intelligence and social determinants
14 using purchase data like credit agency and
15 consumer data to predict the risk of a new
16 admission in the next 30 days. It's kind of fun
17 to be able to predict it, but it turns that we
18 can do using AI just as well as just claims and
19 social determinants just to support what you're
20 saying, didn't add a ton of predictive value on
21 top of that. It was a helpful operation, but
22 didn't add a ton of predictive value to your

1 claims.

2 CO-CHAIR BAGLEY: Okay. John pointed
3 out to me that when we ask for public comment
4 initially, there may have been some confusion
5 about whether we were asking for public comment
6 on the entire list or just the 11. So I guess I
7 would invite at this time any public comment on
8 the last two in case you thought we were going to
9 let you do that later.

10 Okay. I guess we guessed right. Good
11 job, John.

12 MS. McLAUGHLIN: Hi. Is this on?
13 Jennifer McLaughlin with AMA again. And thank
14 you for offering us a second opportunity to make
15 public comments. I appreciate it. And again, I
16 want to say that we appreciate the efforts of CMS
17 and Acumen to bring forward these measures that
18 were originally used in the value modifier and
19 revised them according to a number of concerns
20 that have been heard. It varies in the modifier
21 and often now under MIPS.

22 And in particular, I want to spend

1 some time talking about the total per capita cost
2 measure which I know you have it in speaking
3 about a lot yet, but I'm sure you.

4 So we have a number of concerns with
5 the revisions and first, I want to say we do have
6 a concern that the proposed revision is extremely
7 complex in tracking patients. Under the new
8 attribution methodology, in particular, we think
9 it's going to be nearly impossible because the
10 new attribution is based on a combination of
11 specialty and also a series of services or costs.
12 And the new episodes are based on month-long
13 periods. My understanding is that those month-
14 long periods can extend through a full year, but
15 there may be TPCC episodes that run concurrently
16 during the next performance year and also TPCC
17 measures that leak over from one MIPS performance
18 year into another MIPS performance year and so
19 those costs will be prorated, I believe. That's
20 my understanding for different MIPS scoring
21 systems.

22 We also have concerns about the equity

1 of the revised measures. We question the
2 elimination of the specialty adjustment and also
3 question the exclusion based on specialty or
4 service threshold. And it's not entirely clear
5 because we have received some information since
6 the field testing, solicitation of comment and
7 through this meeting today it seems to indicate
8 that some of the attribution discussion is in
9 flux, but what seems to potentially raise an
10 equity issue for your consideration is that
11 eliminating the specialties, that may be the ones
12 who are routinely performing services such as
13 chemotherapy or radiation therapy and not
14 excluding those costs or those services from the
15 measure means that a primary care physician, as
16 opposed to the physician who is routinely
17 performing those services, will be held
18 accountable for those costs.

19 Another issue that we do want to raise
20 is our understanding is that the attribution
21 change from the original TPCC measure to the
22 revised measure would increase the number of

1 physicians who are attributed the measure and
2 based on information provided throughout this
3 process, it appears that the number of physicians
4 who would be attributed TPCC would be more than
5 double and so this gets to a point raised by this
6 workgroup earlier today about the "double
7 jeopardy" or "double counting" issue. We think
8 not only does it raise that issue again here when
9 talking about the TPCC measure, but also again
10 gets to this issue of complexity and tracking
11 patients because you are attributing the same
12 patient, the same episode to multiple physicians
13 in the same TIN, but also in different TINs and
14 then it just becomes more challenging to sort out
15 who is responsible for the costs and the measure.

16 For these reasons, we do recommend
17 that the MAP, the highest level of endorsement
18 for the Total Per Capital Cost we do not support,
19 but it's essential for mitigation. And then
20 again due to concerns about the double counting
21 of the MSPB and the Total Per Capital Cost along
22 with the more precise Episode-Based Cost

1 Measures, we would recommend that the MAP also
2 consider urging CMS to evaluate whether there
3 would be a possibility to use the more precise
4 Episode-Based Cost Measure when two points raised
5 today, when that Episode-Based Cost Measure is
6 reliable, is valid, it is understandable and
7 actionable, when that measure does exist and can
8 be applied, whether it does make sense to
9 continue using the MSPB and TPCC measures. Thank
10 you.

11 CO-CHAIR BAGLEY: Thank you, Jennifer.
12 Heidi.

13 MS. BOSSLEY: I have comments on
14 behalf of two groups and I'm going to kind of do
15 it together for sake of time.

16 So for the American College of
17 Gastroenterology and then also the American
18 Society of Clinical Oncology, just want to
19 confirm our support for the AMA comment. We
20 think it's very important for you all to weigh in
21 and provide this information to CMS on the
22 concern of double counting.

1 I do think it could really send mixed
2 messages, both to providers, as well as to
3 ultimately those who may see this information, if
4 you're double counting and applying different
5 cost methodologies to the same item that triggers
6 an episode.

7 Also, agree that the recommendation
8 for the TPCC measure should be the do not support
9 with potential for mitigation. We are having a
10 hard time explaining this measure to our members.
11 We cannot actually tell them what triggers an
12 episode, how all the costs get attributed. So we
13 think this needs more work and a lot of more
14 education. So thank you.

15 CO-CHAIR BAGLEY: Okay. We'd like to
16 go to a vote on 18-148. That's the Medicare
17 Spending Per Beneficiary.

18 DR. NAGAVARAPU: Bruce and John, I'm
19 happy to walk through the TPCC improvements and
20 answer some of the comments that have been made
21 after that as well.

22 CO-CHAIR BAGLEY: Thank you.

1 DR. BERNOT: Okay, so this is for just
2 the one measure. This MUC 2018-148. Remember,
3 this is the vote to accept the staff preliminary
4 analysis which was conditional support with the
5 condition of NQF endorsement. The highlights,
6 just for summary, were really to evaluate this
7 change in these costs that are unlikely related
8 to the clinician and the attribution. So with
9 that, we can move to the vote.

10 MS. KOSURI: Voting is now open for
11 MUC 18-148. Do you vote to support the
12 preliminary analysis as the workgroup
13 recommendation?

14 (Pause.)

15 MS. KOSURI: Okay, I think we have our
16 total. Okay. Voting is now closed. The
17 Committee's recommendation, based on 79 percent
18 of the vote, is yes to support the preliminary
19 analysis of the workgroup recommendation for MUC
20 18-148. We had 15 who voted yes and 3 who voted
21 no. Oh, four, sorry.

22 CO-CHAIR BAGLEY: Okay. Let's move on

1 to the last one 18-149, Total Per Capital Cost.
2 And you guys are all out of ideas here, right?

3 (Laughter.)

4 CO-CHAIR BAGLEY: Are there comments
5 about the total cost of care measure that might
6 be specific to that as opposed to very similar
7 kind of comments that we had for the last
8 measure? I'm not trying to stifle debate. I'm
9 just trying -- if you've got something new, bring
10 it on, you know?

11 I don't see anybody jumping up. I
12 guess you guys needs a break.

13 (Laughter.)

14 CO-CHAIR BAGLEY: In order to get a
15 break, you're going to have to vote.

16 (Laughter.)

17 CO-CHAIR BAGLEY: Did you have
18 something? It's okay. No punishment.

19 CO-CHAIR MOYER: The only thing that I
20 was going through on here because we're doing
21 work in this area for self-insured commercial
22 groups is we feel like if there's an expectation

1 of holding that primary care clinician
2 accountable for that cost, then it's on us to
3 give them some information about the cost
4 implications of choices they make, whether that's
5 facility A, facility B.

6 In our case, that's a little
7 complicated because it varies a lot more, I
8 suspect, Medicare's costs. But you and Pat are
9 going back to that feedback, I feel like if there
10 is this expectation of information in that area
11 could be helpful.

12 CO-CHAIR BAGLEY: I certainly would
13 concur with that. Whenever we in the past have
14 been able to give primary care physicians the
15 information about both cost and quality to the
16 extent we could do that, they would respond to
17 that very nicely.

18 Okay, any other comments on this?
19 Helen.

20 MEMBER BURSTIN: Again, I think
21 because this measure previously failed NQF
22 endorsement as opposed to not been submitted, I

1 think it very important we need a closer look,
2 particularly since again it's very difficult to
3 track the changes that have been made.

4 Many of the same issues that have
5 already been raised, but I think certainly the
6 issues you've heard about risk adjustment, social
7 risk, double counting are probably even more so
8 with this measure. So again, I don't think it's a
9 simple "just submit it" issue.

10 DR. NAGAVARAPU: If it would be
11 helpful, I could walk through the changes, kind
12 of analogously to MSPB.

13 Sure, yes. Or people can just use
14 this as a break.

15 (Laughter.)

16 CO-CHAIR BAGLEY: So there are
17 basically four dimensions of TPCC that we have
18 improvements on. The current TPCC measure, the
19 way it works is that there's a list of E&M codes
20 that are often associated with primary care, but
21 aren't billed only by primary care practitioners.
22 What they do is the current measure looks for the

1 clinician that bills the maximum number or value
2 of those E&M codes over the course of a calendar
3 year and then attributes the entire year of a
4 patient's Part A and B costs to that clinician,
5 that billed the plurality.

6 The stakeholder concern that we've
7 heard about in this regard is that if a clinician
8 sees a patient, for instance, for the first time,
9 later in the year such as in October or November,
10 they would still get all of the costs for the ten
11 months before they saw the patient attributed to
12 them. So that's one core problem that the
13 reevaluating measure fixes. The way it fixes it
14 is by looking for the evaluation management
15 claims that a TIN is billing or appearing in
16 evaluation management equipment with a primary
17 care service, like a diagnostic test. And then
18 initiating the one-year period from that point
19 forward, rather than looking backward before a
20 clinician may have ever seen the patient.

21 But the second dimension is on risk
22 adjustment. The current measure looks at risk

1 adjustment based on comorbidities that are found
2 in Medicare claims data in the previous year.
3 This measure looks on a month-by-month basis and
4 looks at the comorbidities that are found in the
5 year prior to each month under consideration.
6 What this allows for is the evolution of
7 comorbidities over the course of time so that a
8 general practitioner, for instance, isn't
9 penalized for items that may have been outside of
10 the general practitioner's control that changed
11 over the course of the year.

12 The third point is about the specialty
13 list. The way the current measure works is that
14 there's a two-step process. They first look for
15 a primary care practitioner that satisfies one of
16 those criteria about the E&M claims I mentioned.
17 If they can't find one, they move to specialists.
18 So it's possible for specialists to get
19 attributed the measure, even if the specialist is
20 unrelated to primary care management.

21 The way that we've -- originally, we
22 in the field testing excluded specialties based

1 on the performance of global surgery claims,
2 anesthesia, therapeutic radiation, and
3 chemotherapy. We had a post-field testing
4 webinar with a test. We got comments from the
5 AMA and others that emphasize that the specialty
6 coverage was still too broad in the measure and
7 so since then we've worked with CMS to pare back
8 the specialty list dramatically and that was the
9 change that was being referred to in the public
10 comments because we took seriously that too many
11 -- a broader set of specialties were getting
12 attributed than preferred, and so the updated
13 empirical analyses that went to the MAP on
14 December 1st incorporated those changes.

15 And finally, for care coordination,
16 and multiple attribution, a concern with the
17 current measure is that by identifying only one
18 person over the whole course of the year, it
19 doesn't recognize the fact that there may be
20 handoffs of care between primary care
21 practitioners over the course of the year or that
22 there may be multiple physicians that are

1 managing a patient in different aspects of
2 comorbidities in coordinating with each other and
3 this measure is an effort to take that into
4 account and attribute months of care to both
5 types of people.

6 And the last thing I'll say is for the
7 risk windows, the way this works in terms of
8 which months are counted for the measure --

9 CO-CHAIR BAGLEY: You're running out
10 of time.

11 DR. NAGAVARAPU: Okay, well, you take
12 one year from the point at which the initial
13 attribution happens and then you look only at
14 those months that are in the performance period
15 and we're counting average monthly costs risk
16 adjusted just for those months that are in the
17 performance period.

18 CO-CHAIR BAGLEY: Thank you. Okay,
19 additional comments before we vote?

20 All right, let's go to the vote.

21 DR. BERNOT: So I can summarize for
22 this, this is for MUC 2018-149, the Total Per

1 Capital Cost. Again, the preliminary analysis
2 was conditional support with the condition of NQF
3 endorsement and we would be voting for the
4 workgroup to accept that recommendation as the
5 workgroup's recommendation.

6 MEMBER GREINER: Can I speak. I just
7 want to clarify. So basically, we have an
8 existing measure in the program which has a lot
9 of the flaws that we just described, so this
10 would be voting for an updated measure that has
11 these improvements. But the measure that's
12 existing in the program is not NQF endorsed.

13 CO-CHAIR BAGLEY: All right.

14 MS. KOSURI: Okay. Voting is now open
15 for MUC 2018-149. Do you vote to support the
16 preliminary analysis for the workgroup's
17 recommendation? And I think we had a member step
18 out, so.

19 (Pause.)

20 MS. KOSURI: So I think I'll close
21 the voting. So based on the results of the
22 Committee's recommendation, based on 67 percent

1 of the vote is yes to support the preliminary
2 analysis as the workgroup recommendation. We had
3 12 votes for yes and 6 votes for no.

4 CO-CHAIR BAGLEY: So let's try a ten-
5 minute break, if that could ever happen. And
6 then we'll head for the final, the home stretch,
7 if you will. So let's have you back at 20 after.
8 How about that?

9 (Whereupon, the above-entitled matter
10 went off the record at 3:09 p.m. and resumed at
11 3:21 p.m.)

12 CO-CHAIR MOYER: All right. We're in
13 the home stretch and I know we all want to get
14 through this before people have to leave and we
15 lose the quorum. So we're going to get started.
16 So last set of measures we have are quality
17 measures under consideration for MIPS.

18 And I'm going to turn it over to John
19 to quickly introduce these. We are going to go
20 through these measures individually because they
21 really lump together in any easy sort of way.
22 But we'll be efficient.

1 DR. BERNOT: I apologize for the
2 delay. So for the first measure here again,
3 we're going to do these one by one for the sake
4 of the discussion is MUC 2018-063. That's
5 Functional Status Change for Patients with Neck
6 Impairments.

7 So this is -- the preliminary analysis
8 for this was a conditional support for rulemaking
9 with a condition of NQF endorsement. So I'll
10 turn it back to you, Amy.

11 CO-CHAIR MOYER: All right. Lead
12 discussants on this were Rob and Diane. Any
13 additional thoughts on this that you want to add?

14 MEMBER FIELDS: I don't have a lot to
15 add. I plead ignorance on this one other than
16 the specs have no contest. It seemed reasonable.

17 (Laughter.)

18 CO-CHAIR MOYER: Diane, anything.

19 MEMBER PADDEN: No. I didn't have
20 anything on that one.

21 CO-CHAIR MOYER: No. Okay. Dare we
22 just go to a vote?

1 MEMBER BURSTIN: Again, this is a FOTO
2 measure. I know the FOTO measures haven't been
3 in NQF. This is a proprietary functional status
4 measure. It's an incorporated instrument that I
5 don't believe is open and available. It's just a
6 question if somebody chooses to use this, what
7 are the arrangements with FOTO?

8 MS. HAYES: Hi. This is Deanna Hayes
9 from FOTO. I'd be happy to answer that.

10 CO-CHAIR MOYER: Go ahead.

11 MS. HAYES: There is a free public
12 access version. It's posted on our website and
13 the link to that site is in the measure
14 specifications.

15 MEMBER BURSTIN: Is that a pen and
16 paper survey or has that been updated?

17 MS. HAYES: I beg your pardon?

18 MEMBER BURSTIN: Is the free version
19 literally pen and paper?

20 MS. HAYES: Yes. There is a pen and
21 paper. It can be used as pen and paper. Is that
22 what you're asking?

1 CO-CHAIR MOYER: Can it be used
2 through other methods than pen and paper, for
3 instance, is there an electronic version or are
4 there any limitations on how it's given to
5 patients?

6 MS. HAYES: There is a Computer-
7 Adaptive Testing version on the website, so
8 that's -- not only electronic, but that's the CAT
9 item response series version.

10 I'd like to define the word
11 proprietary. You know, it just means the measure
12 is owned and stewarded. It doesn't necessarily
13 mean inaccessible. And it's important in today's
14 healthcare environment that high-quality measures
15 have an owner and a steward or they cease to be
16 high-quality measures. This is the same for the
17 FOTO system. The PROMIS measure is out of
18 Northwestern University, the AM-PAC out of
19 Boston. Every measure that's going to be high
20 quality and good for healthcare today needs to be
21 taken care of and I think that's an important
22 point to keep in mind.

1 MEMBER BURSTIN: I stand corrected.
2 Proprietary is fine. I guess the question is is
3 there an associated cost for using the CAT
4 version of the survey. Sorry for my imprecision.

5 MS. HAYES: Not at all. Thanks for
6 the chance to address it. There is not a cost
7 for using the CAT version on the website.

8 CO-CHAIR MOYER: Robert.

9 MEMBER KRUGHOFF: Who in the
10 government is using this now? Is the government
11 getting any data out of this system now? I mean
12 out of this measurement type now? I asked that
13 question too late, didn't I?

14 DR. GREEN: So we are not using this
15 particular -- we are not using this particular
16 measure. I don't recall off hand if it's a QCDR
17 measure. It is not. So we have not -- we have
18 some testing data that was supplied to us by the
19 measures steward, but we don't have any official
20 use data that was submitted to us.

21 MS. HAYES: This is Deanna from FOTO
22 again. This will be the first time that it would

1 be directly entered into CMS' handpicking data.
2 We offered data to CMS and we're told that they
3 preferred to gather their own. It was just
4 endorsed as the 2019 QCDR measure and
5 additionally we are working in the NQF
6 endorsement pathway at the same time.

7 CO-CHAIR MOYER: Any additional
8 comments or questions or discussions on the
9 measure?

10 DR. BERNOT: Okay, it sounds like we
11 can move to a vote then. I'll just do the
12 summary again so we know what we're voting on.
13 This is MUC 2018-063. That's the Functional
14 Status Change for Patients with Neck Impairments.
15 Again, the staff recommendation through the
16 preliminary analysis was a conditional support
17 with the condition of -- in this case the
18 completion of NQF endorsement.

19 CO-CHAIR MOYER: My apologies. Just
20 to make it be a little more efficient, do we have
21 anyone in the room who'd like to make public
22 comment on these measures before we vote? I

1 don't see anyone in the room.

2 Operator, can you check if there's
3 anyone on the phone who would like to make public
4 comments on this measure?

5 OPERATOR: Yes. Ladies and gentlemen,
6 if you would like to make a public comment,
7 please press star-1 on your telephone keypad.
8 Again, that's star-1 to make a public comment.

9 (Pause.)

10 CO-CHAIR MOYER: So I don't think you
11 have any?

12 OPERATOR: And at this time we have no
13 public comments.

14 MS. KOSURI: Perfect. I will be
15 opening the vote for MUC 18-063. Do you vote to
16 support the preliminary analysis that is the
17 workgroup recommendation?

18 So we're waiting on one more vote. I
19 think we have 17. We lost two. So we should get
20 17. So anyone else? Perfect. Okay. We have
21 our total of 17.

22 So voting is now closed. The

1 Committee's recommendation based on all of the
2 votes, so 100 percent of the votes is to support
3 the preliminary analysis of the workgroup
4 recommendation for MUC 2018-063 with 17 members
5 voting yes, and zero voting no. Thank you.

6 MS. HAYES: This is Deanna. Could I
7 ask for some clarification?

8 CO-CHAIR MOYER: Sure, go ahead.

9 MS. HAYES: First, I'd like to thank
10 you for your review of the measure and for this
11 opportunity to share it with you and for the
12 support. We appreciate that very much. I wanted
13 to ask about the conditional support, pending
14 NQF's endorsement.

15 Is that a standard that other
16 measures, similar measures, are being held to?
17 I'd also like to mention that the science of this
18 measure follows the exact sophisticated, high
19 rigor science that the other seven NQF-endorsed
20 FOTO MIPS become followed. Does it need to wait
21 for NQF endorsement and experience that delay in
22 light of that?

1 MS. O'ROURKE: Sure. This is Erin
2 from the -- one of the staff supports for the
3 Coordinating Committee. And I can try to clarify
4 this.

5 To your second point, it's really CMS'
6 decision on whether the measure would need to
7 wait to be proposed for rulemaking or not. As
8 far as if this is a standard that other measures
9 are held to, yes, it's been MAP's precedence that
10 conditional support is often the highest category
11 that the workgroup feels comfortable giving a
12 measure that hasn't had NQF endorsement. It's
13 almost always one of the most common conditions
14 for the conditional support category and it's
15 been exceptionally rare that a measure has gotten
16 a full support without NQF endorsement. That's
17 felt pretty strongly about the need for multi-
18 stakeholder review of the evidence and the
19 scientific accessibility behind the measure that
20 this process doesn't allow adequate time to fully
21 address.

22 MS. HAYES: Oh, very good. Well, thank

1 you for that clarification then and telling me
2 that it's being held to the same standard. We are
3 very supportive of NQF endorsement being the gold
4 standard for all measures. We think it's the
5 highest level of scientific rigor and it's best
6 for everyone. That's why we continue to support
7 it. Thanks for the clarification and your time
8 today.

9 CO-CHAIR MOYER: All right. Thank
10 you. We will move on to the next measure on the
11 list, the Time to Surgery for Elderly Hip
12 Fracture Patients.

13 DR. BERNOT: All right. So this is
14 MUC 2018-031 which is the Time to Surgery for
15 Elderly Hip Fracture Patients. The preliminary
16 analysis done by staff gave this a rating of a
17 conditional support for rulemaking, again, with
18 the condition of NQF endorsement.

19 I'll turn it back to you, Amy, for
20 public comment.

21 CO-CHAIR MOYER: All right, lead
22 discussants on this measure are Trudy and Chad.

1 Chad, do you have anything?

2 MEMBER TEETERS: Yes, I'll jump in,
3 why not? So first clarification, I don't think
4 this really is a conflict, but I was on the Pre-
5 Surgical Evaluation Committee, pre-approval,
6 whatever they called it, for the American Academy
7 of Orthopaedic Surgery which was referenced in
8 the guideline, but I don't think that would
9 impair.

10 Overall, I think it's perfectly --
11 it's strong, scientific evidence. I think it's a
12 great measure. Two minor details that I wanted
13 to point out. Number one, we're talking about
14 taking elderly hip fracture patients to surgery
15 within 48 hours. We do have to be mindful in our
16 rural community hospitals if someone comes in on
17 a Friday night, what's the availability of an
18 orthopedic surgeon within 48 hours to do the
19 case? So that's one consideration.

20 Two, I didn't see any stipulation. A
21 lot of these patients are frail and elderly and
22 sometimes there's a decision to move toward

1 palliative care or hospice with the fracture
2 being the incipient issue. And that patient
3 would not go to surgery because they would
4 transition to that palliative care realm, but
5 that would be a failure of the metric that would
6 not be excluded. So those were two concerns that
7 I had.

8 CO-CHAIR MOYER: All right. Trudy,
9 anything to add to that?

10 MEMBER MALLINSON: No, actually, that
11 last comment about frail, elder adult to
12 potentially might make the decision to move them
13 to palliative was also my question for should
14 that be included in the exclusion criteria.

15 CO-CHAIR MOYER: All right. Do we
16 have a measure developer available to speak to
17 that?

18 MR. PEZOLD: Hi. This is Ryan Pezold
19 with the American Academy of Orthopaedic
20 Surgeons. I'm not sure. I may have one or two
21 of the surgeons who was included on this as
22 chairs on the line. Are either of you guys here,

1 Dr. Olson or Dr. Brox? That's fine if they're
2 not.

3 I think as far as this measure goes,
4 it's a reasonable concern and it's something that
5 I think that we would be interested and willing
6 to address in future updates and iterations in
7 making sure that we're not counting that against
8 patient providers who would report on this
9 measure for those frail patients.

10 CO-CHAIR MOYER: All right. I would
11 expect that as well and see if there a
12 recommendation of condition as NQF endorsement
13 for this and I would expect that would be
14 something the CDP process would bring up.

15 Any other discussion in the room from
16 the Committee on this?

17 Any public comments in the room? I'm
18 sorry, Ira.

19 MEMBER MOSCOVICE: Just following up
20 on Chad's comment. The Rural Network Group
21 really wanted to know more about are transfers
22 included in this measure or not? For instance,

1 if you had an emergency department clinician who
2 saw a patient who needed this and had to transfer
3 a patient out, when would the time actually
4 start?

5 CO-CHAIR MOYER: That's an excellent
6 question. Go ahead.

7 MR. PEZOLD: Sorry, again, I think
8 this is something that will probably be addressed
9 when we're going through the NQF endorsement
10 process, but I'm happy to touch on it now. I
11 don't believe transfers are covered in this
12 explicitly and I believe the time starts, if I'm
13 not incorrect, at the time of admission.

14 CO-CHAIR MOYER: Okay. Robert, I see
15 you have your card up. Do you have a comment on
16 this? No? Okay.

17 Any public comments on the phone on
18 this one?

19 OPERATOR: Ladies and gentlemen, if
20 you would like to make a public comment, please
21 press star-1 on your telephone keypad. Again, *1
22 to make a public comment.

1 And no public comments at this time.

2 CO-CHAIR MOYER: All right. Putting
3 on my committee member hat, not speaking as a
4 chair at the moment, I could see making the case
5 further being substantial changes needed on this.
6 I know we usually say hey, it needs to be NQF
7 endorsed and I trust that consensus development
8 process, but I'm wondering about dealing with the
9 transfers and dealing with some of the potential
10 valid exclusions that aren't currently in place
11 in this.

12 You all, of course, will vote however
13 you feel, but I wanted to make that comment as a
14 committee member, not as a chair instructing you.
15 I think we can move forward with the vote now.

16 DR. BERNOT: Okay, just to introduce
17 this, so this is MUC 2018-031, the Time to
18 Surgery for Elderly Hip Fracture Patients. Just
19 to remind the preliminary analysis recommendation
20 was a conditional support and that condition
21 being NQF endorsement and did flag here the
22 exclusion concerns, as well as the definition of

1 that to the start time in the episode as concerns
2 here.

3 MS. KOSURI: Voting is now open for
4 MUC 2018-031. Do you vote to support the
5 preliminary analysis as a workgroup
6 recommendation?

7 (Pause.)

8 MS. KOSURI: We're waiting for one
9 more. If there is anyone who hasn't voted yet -
10 -- oh, perfect.

11 Okay, voting is now closed. The
12 Committee's recommendation based on 94 percent of
13 the vote is yes for MUC 2018-031. Do you vote to
14 support the preliminary analysis of the workgroup
15 recommendation? And that is with 16 voting yes,
16 and 1 voting no.

17 DR. BERNOT: Okay, the next measure is
18 MUC 2018-032. This is Discouraging the routine
19 Use of Occupational and/or Physical Therapy after
20 Carpal Tunnel Release.

21 This particular measure has a
22 preliminary analysis result of do not support for

1 rulemaking with the potential for mitigation.

2 And that mitigation would include specifying the
3 measure at the clinician level.

4 I can give a couple of sentences of
5 background to this. This is a measure that was
6 brought forth into the CDP process that testing,
7 those intended uses for the clinician, the
8 testing at this point is at a metropolitan and
9 statistical area so it's actually testing it
10 comparing essentially cities to each other rather
11 than the individual clinicians.

12 We have talked to the developer. They
13 were responsive, but the preliminary analysis is
14 based on the information that was presented to us
15 for this process. Again, that was a do not
16 support for rulemaking with potential for
17 mitigation and that would include specifying and
18 testing the measure at the clinician level.

19 CO-CHAIR MOYER: So our lead
20 discussants on this are Patti and Dale.

21 MEMBER WAHL: So I agree with the
22 preliminary analysis of do not support. In

1 addition, to the concern I have about the
2 comparisons be done at the MSA level and not at
3 the Commission level. The other concern I have
4 is that there are currently no exclusions and so
5 basically any patient who would have any physical
6 therapy or occupational therapy within six weeks
7 for non-related reason would be included in this
8 measure.

9 CO-CHAIR MOYER: Dale, do you have
10 anything to add? All right.

11 Any other comments, discussion,
12 concerns from the Committee?

13 MEMBER MALLINSON: This is Trudy.

14 CO-CHAIR MOYER: Go ahead, Trudy.

15 MEMBER MALLINSON: I would also echo
16 the concern about there not being exclusions and
17 so essentially any patient having a carpal tunnel
18 release who got OT or PT in that six-week period
19 would be included even if there were legitimate
20 reasons for that.

21 And so for a number of patients with
22 co-occurring conditions like fracture or

1 arthritis is that all who are having issues with
2 scar tissue or any unresolved -- you know, if
3 there was continued numbness or tingling might
4 actually be a legitimate and reasonable approach
5 to refer them to OT or PT.

6 And so while certainly we would agree
7 that perhaps every patient doesn't need OT or PT,
8 there certainly are legitimate and valid reasons
9 why individuals might need those services in that
10 six-week time frame.

11 CO-CHAIR MOYER: Helen.

12 MEMBER BURSTIN: Just one brief
13 comment. There are two approaches to measure
14 development, one of which is to load them up with
15 exclusions and expect 100 percent and one of
16 which is not to load it up with exclusions
17 particularly around appropriateness and just
18 expect that the rate won't be 100 percent. So
19 just to counterbalance that comment, because I'm
20 not sure everything needs to be an exclusion.

21 CO-CHAIR MOYER: And Chad -- okay.

22 Any other comments or discussion among the

1 Committee? Any public comments in the room? And
2 any public comments on the phone?

3 OPERATOR: And ladies and gentlemen,
4 if you'd like to make a public comment press
5 star, then 1 on your telephone keypad. Again,
6 that's star-1 to make a public comment.

7 We do have a public comment from the
8 line of Heather Smith.

9 MS. SMITH: Hi, good afternoon. Thank
10 you. This is Heather Smith. I'm the Director of
11 Quality at the American Physical Therapy
12 Association and I just wanted to thank the
13 Committee for allowing public comments on this
14 measure.

15 And I would echo a lot of the comments
16 that have already been made in the room. We
17 actually did outreach to the measure developer
18 and we would be happy to work with them further
19 in trying to refine the measure so that it
20 appropriately targets this patient population.
21 Thank you.

22 OPERATOR: And at this time we have no

1 further public comments.

2 DR. McCOLLAM: Wait, wait, wait. We
3 do. We do. We have some more. Can you hear me?
4 Hello?

5 OPERATOR: Yes, sir. I was referring
6 to no further public comments on the phone.

7 DR. McCOLLAM: I'm sorry, we do have
8 more public comments.

9 CO-CHAIR MOYER: Is this a measure
10 developer?

11 MR. PEZOLD: That's Dr. McCollam who
12 is one of our -- on the -- one of the chairs for
13 the measure developers.

14 CO-CHAIR MOYER: Okay, go ahead.

15 DR. McCOLLAM: I'm sorry. And I'm
16 going to ask Ryan Pezold who was with the Academy
17 to talk about the MSA versus the clinician data.
18 We ran the data yesterday.

19 Ryan, are you on the phone?

20 MR. PEZOLD: Yes, yes. I was just
21 going to speak about that in a moment here. So
22 again, this is Ryan Pezold with AOS. We do have

1 an update on this measure. We have had the
2 opportunity to test this measure at the clinician
3 level now and I do feel that that's been shared
4 too recently to have been included in materials
5 for the preliminary analysis for this measure.

6 As indicated in the introduction for
7 this, the measure was always designed for
8 limitation at the clinician level. So the
9 decision to test the measure at the regional
10 level was based on that being the most readily
11 available clinical data at the time. Again, we
12 did retest this at the clinician level using the
13 five percent TMS outpatient sample data set and
14 sent that to the mailbox literally just yesterday
15 afternoon.

16 I'll try to stay away from the
17 statistical aspect of the analysis, but in the
18 data set that we looked at the signal-to-noise
19 analysis statistic was .99, looking at 1683
20 clinicians who'd be included in the denominator,
21 so we would certainly interpret that as being
22 reliable. We also used face validity for this

1 and the interdisciplinary panel evaluating the
2 measure determined that it did have face validity
3 when used as the intended clinician level
4 analysis.

5 As far as the exclusions go, I
6 appreciate Heather Smith speaking out on behalf
7 of the APTA and the other comments that we've
8 received. And I think the comment that was made
9 previously about throwing in inclusions versus
10 expecting that there's not going to be 100
11 percent rate is something that is reflective of
12 our approach to this. And we appreciate that
13 there would not be 100 percent compliance with
14 this because you would end up with some of those
15 odd timing issues where someone happened to have
16 something that required physical therapy within
17 that same window.

18 The workgroup from looking at this
19 measure felt that the chance that that was going
20 to happen was going to be such an uncommon
21 situation that they deemed not to include it in
22 the exclusion criteria, although again, we

1 certainly would be open to working with the APTA
2 or other comments and seeing how the rates played
3 out to identify areas that we would want to
4 exclude going forward.

5 DR. McCOLLAM: Can you all hear me?
6 This is Dr. Steve McCollam who is the chair of
7 the workgroup on this. Can I say a word or two
8 of follow up?

9 CO-CHAIR MOYER: Go ahead.

10 DR. McCOLLAM: So thanks for being
11 able to speak up here. So we had a 16 member
12 multi-stakeholder workgroup, including therapy,
13 and we did discuss this exact issue. And based
14 on our -- there are a number of hand surgeons on
15 this committee as well as therapy, and we felt
16 like the risk, if you want to use that word, of
17 prescribing therapy in the first six weeks was so
18 small that it wasn't worth listing a whole series
19 of exclusions knowing that we wrote the measure
20 so that we would not be expecting 100 percent
21 compliance. So that's why we wrote it that way.
22 Although we're open to listing several

1 exclusions, we didn't feel like it was necessary
2 and it might clutter the measure a little bit
3 more than needed.

4 CO-CHAIR MOYER: Okay.

5 DR. McCOLLAM: And as far as -- one
6 more thing. As far as ordering therapy for a
7 different condition during that 42 days, the work
8 flow that physicians usually perform is to if you
9 order a therapy for a given condition, you have
10 to attend that or attach it to a certain ICD-9 or
11 ICD-10 diagnosis. So if for some reason within
12 that 42 days, you order therapy for a different
13 condition, I physically cannot order therapy with
14 my EMR unless I append it to the current
15 diagnosis and for the reason for therapy.

16 So if somebody, for example, had
17 shoulder arthritis and needed therapy within that
18 42 days, I would be appending the therapy
19 prescription to the shoulder arthritis ICD-10
20 code, not to a carpal tunnel code which limits
21 the likelihood there would be any confusion or
22 conflation with the therapy for carpal tunnel.

1 Again, we don't expect 100 percent of
2 patients not needing therapy. We specifically
3 didn't write it that way. We just don't expect
4 every person who has carpal tunnel surgery to
5 need therapy and that's supported in the
6 literature.

7 CO-CHAIR MOYER: Thank you, that was a
8 helpful clarification. Any other discussion or
9 questions from the workgroup?

10 MEMBER BURSTIN: So is the only reason
11 it was not given conditional because it wasn't
12 yet tested? And if so, just to be consistent,
13 should that then be conditional rather than do
14 not support with --

15 DR. BERNOT: That is the reason why it
16 was given conditional was because of the testing.
17 It sounds like -- Susan, is it okay if we point
18 to you? Susan does have the document that was
19 sent yesterday, if there's anything that you can
20 glean from it at this point.

21 MS. ARDAY: Yes, this came into us
22 around five o'clock yesterday Eastern Time. What

1 I'm looking at here is your data. This is Susan
2 Arday. I'm directing this to the measure
3 developer.

4 The table that says discouraging
5 routine use of occupational and physical therapy
6 after carpal tunnel release initial analysis.
7 2017, your N for number of physicians was 1,683.
8 Your reliability statistic from general to signal
9 noise, you said was .99 with a variation of .99
10 to .99. Pretty tight.

11 CO-CHAIR BAGLEY: There's no gap in
12 care?

13 MS. ARDAY: That's what I would
14 preliminarily --

15 MR. PEZOLD: I wanted to make a
16 clarification on that. That's not a performance
17 rate. That's not the calculated compliance to
18 the measure. That's using a signal-to-noise
19 reliability statistic to identify how well back
20 in -- successfully the measure as specified can
21 identity the signal from the noise.

22 MS. ARDAY: Okay.

1 MR. PEZOLD: As part of the
2 reliability analysis.

3 MS. ARDAY: Okay, this is Susan Arday
4 again. I'm an epidemiologist. Could you then
5 give me what your performance rate is?

6 MR. PEZOLD: So I don't have the rate
7 in front of me for the CMS data that we looked at
8 yesterday as we were focused on the reliability
9 analysis. But when we were looking at the MSAs,
10 and the variation there, this was all somewhere
11 between about 80 and 95 percent, depending on how
12 you look at the data, different data sets.

13 CO-CHAIR MOYER: So this is Amy. I'm
14 going to recommend that we move forward and vote
15 on the measure. It sounds like the mitigation is
16 already under way, so if we were to put that out
17 there as a condition it's in process. But I do
18 want to make sure that we get through all the
19 measures again before we lose quorum because I
20 know people have flights to catch.

21 DR. BERNOT: I can introduce it for
22 everybody. Just for procedure sake, we do need

1 to vote on the staff preliminary analysis which
2 is the mitigation. So if you think that this new
3 information from a procedural point of view will
4 change your mind and potentially, as Amy said,
5 could be a condition of NQF endorsement, rather
6 than do not support for mitigation, you would
7 vote no.

8 If you vote yes here, you would be
9 saying the workgroup's recommendation is do not
10 support with the potential for mitigation. If
11 you want to continue both, you would vote no in
12 this instance.

13 I'll turn it over to you, Vaishnavi.

14 MS. KOSURI: Okay, voting is now open
15 for MUC 2018-032. Do you vote to support the
16 preliminary analysis that the workgroup
17 recommended?

18 Perfect. I think we have our 17.
19 Voting is now closed.

20 DR. BERNOT: Okay, because we went to
21 under 60 percent, we'll continue moving and you
22 can decide if you want to do a straight support

1 vote.

2 (Pause.)

3 CO-CHAIR MOYER: All right, I'm going
4 to suggest that we start the vote at conditional
5 support with a condition of NQF endorsement
6 unless there's an objection from the workgroup.

7 MS. KOSURI: Okay. Voting is now open
8 for MUC 2018-032. Do you vote conditional
9 support?

10 (Pause.)

11 MS. KOSURI: We are waiting on one
12 more vote. Perfect. We have the 17 that we
13 need. So voting is now closed.

14 So the Committee's recommendation,
15 based on 88 percent of the vote, is yes for
16 conditional support for MUC 2018-032 with 15
17 members voting yes, and 2 voting no. Thank you.

18 DR. BERNOT: I'll try to keep this
19 moving because I do know I am sensitive to making
20 sure we maintain a quorum if anyone has to leave
21 early. But this next measure is MUC 2018-038.
22 That is the International Prostate Symptom Score

1 or the American Urological Association Symptom
2 Index.

3 The change in 6 to 12 months after
4 diagnosis with benign prostatic hyperplasia.
5 This is preliminary analysis from the staff is a
6 conditional support for rulemaking with the
7 condition of NQF endorsement and also as
8 background knowledge, this measure is in the
9 process of NQF endorsement.

10 CO-CHAIR MOYER: Terrific. Our
11 discussants are Patti and Diane.

12 MEMBER PADDEN: Okay, I just had two
13 things. As it notes that it is a quality measure
14 that not all electronic health records would have
15 this measure available to them. And the second
16 was clarifying for me not being a special -- in
17 this specialty area, but in primary care, is the
18 6 to 12 months adequate time in terms of seeing
19 the score change 3 points? And what difference?
20 I mean is it three points, four points, five
21 points in that six months? I guess I was just
22 wanting a little more information there.

1 MS. PARKER: This is Colleen Parker.
2 I'm representing the Large Urology Group Practice
3 Association and Oregon Urology Institute. And I
4 can address both of your questions.

5 The first one on the electronic
6 medical record, this was tested in two electronic
7 medical records that do have the ability to
8 register the information for the urinary symptom
9 scores. They are numbers. They have appropriate
10 SNOWMED codes associated with both the IPSF, also
11 the AUA score and there's another code for a
12 bother score that would combine with the AUA
13 score, but also equals the IPSF.

14 So an HL7 qualified EMR should be able
15 to register those SNOMED codes. It might require
16 some programming by that EMR vendor, but this was
17 tested in two EMRs that did have that capability.

18 Your second question, will you repeat
19 that second question for me?

20 MEMBER PADDEN: It states that there
21 would be a change of three points in the symptom
22 score from the time of diagnosis and start of

1 treatment within a remeasure of 6 months to 12
2 months.

3 MS. PARKER: Right. Okay. This was
4 discussed by the technical expert panel. There
5 is literature to support that a three point
6 difference is significant. So a three point
7 change is significant. And that in 6 to 12
8 months there should be the ability to determine
9 whether there was improvement or whether was
10 actual additional, you know, intervention,
11 medication, procedures, in order to show
12 improvement for that patient. So those were
13 determinations by the technical expert panel.

14 CO-CHAIR MOYER: Patti, did you have
15 anything you want to add?

16 MEMBER WAHL: The only thing I want to
17 add is I'm pleased to see this was a patient
18 reported outcome measure.

19 CO-CHAIR MOYER: Any other committee
20 member discussion, questions, comments?

21 Any public comments in the room? Any
22 public comments on the phone?

1 OPERATOR: Ladies and gentlemen, if
2 you'd like to make a public comment over the
3 telephone, please press star-1. And no public
4 comments on the telephones lines.

5 DR. BERNOT: Okay, I'll just introduce
6 this measure for voting. This is measure MUC
7 2018-038 again. It's the International Prostate
8 Symptom Score or American Urological Association
9 Symptom Index having a change within 6 to 12
10 months after diagnosis of benign prostatic
11 hyperplasia.

12 The preliminary analysis for this was
13 conditional support with the condition of NQF
14 endorsement.

15 MS. KOSURI: Okay, voting is now open
16 for MUC 2018-038. Do you vote to support the
17 preliminary analysis of the workgroup's
18 recommendation?

19 (Pause.)

20 MS. KOSURI: Okay, I think that's our
21 total. We just have lost one more member.
22 Voting is now closed and the Committee's

1 recommendation based on 100 percent of the vote
2 is to support the preliminary analysis of the
3 workgroup's recommendation for MUC 2018-038 with
4 16 people voting yes, and zero voting no.

5 DR. BERNOT: All right, there's been a
6 request for this to be divided into two, so I
7 will just introduce the first one which is MUC
8 2018-047. That is Multimodal Pain Management.
9 The preliminary analysis for this is also
10 conditional support for rulemaking with the
11 condition of NQF endorsement. So we'll talk
12 about this measure first, do the vote, and then
13 talk about 048 separately.

14 CO-CHAIR MOYER: So the lead
15 discussants for this measure, David had to leave
16 early, but Patti do you have anything?

17 MEMBER WAHL: I talked with David
18 before he left and we were both in agreement with
19 the preliminary analysis of conditional support.
20 And we noted that the steward is the American
21 Society of Anesthesiologists and this is an
22 anesthesiology-type measure.

1 CO-CHAIR MOYER: Is there any other
2 discussion, comments, or questions among the
3 committee members? Okay. Any public comments in
4 the room?

5 And any public comments on the phone?

6 OPERATOR: Ladies and gentlemen, if
7 you'd like to make a public comment over the
8 phone, press star-1. And currently no public
9 comments on the phone lines.

10 DR. BERNOT: Okay, I can introduce
11 this for voting. Again, MUC 2018-047, that's the
12 Multimodal Pain Management. Right now, we would
13 be voting for the workgroup to accept the
14 preliminary analysis result which is condition
15 support for rulemaking with the condition of NQF
16 endorsement.

17 MS. KOSURI: Okay, voting is now open
18 for MUC 2018-047. Do you vote to support the
19 preliminary analysis of the workgroup
20 recommendation?

21 (Pause.)

22 MS. KOSURI: I think we're waiting for

1 one more vote. There we go. Voting is now
2 closed. The Committee's recommendation based on
3 100 percent of the vote is yes in support of the
4 preliminary analysis of the workgroup
5 recommendation from MUC 2018-047 with 16 people
6 voting yes and zero voting no. Thank you.

7 DR. BERNOT: Okay. Next is the
8 measure MUC 2018-048. That's the Potential
9 Opioid Overuse measure. The preliminary analysis
10 for this is conditional support for rulemaking
11 with the condition of NQF endorsement.

12 CO-CHAIR MOYER: Michael and Dale are
13 the lead discussants on this.

14 MEMBER HASSETT: I closed my notes,
15 but I don't have any major comments and agree
16 with the recommendation of the NQF.

17 MEMBER SHALLER: There were quite a
18 few pushback comments on this and I guess to
19 summarize what I gleaned, there would be broad
20 exclusions for this particular measure. But some
21 sort of philosophical arguments that it's
22 addressing the wrong issue and that the focus

1 should be on pain management, sort of the flip
2 side of what we just said as opposed to
3 prescription or prescribing behavior. So I'm not
4 quite sure where the truth lies because there's
5 very significant stakeholder concerns on this
6 one.

7 CO-CHAIR MOYER: I will throw out
8 there that I found myself looking at this against
9 the measures that we just put into MSSP and
10 particularly the kind of individual that initial
11 prescription one, and noticing that they weren't
12 necessarily really harmonized and so I have a
13 concern with putting differing measures into the
14 two different programs, would be my comments on
15 that.

16 MEMBER BURSTIN: I just put my card
17 down, but I was going to say the exact thing.
18 Amy, thank you. I just think it would be really
19 confusing for clinicians to have measures that
20 are -- were at the MSSP level and at the MIPS
21 level that are different.

22 CO-CHAIR MOYER: Any other workgroup

1 comments, questions, or discussion? I don't know
2 if we have a developer on the line who cares to
3 address that?

4 MEMBER TEETERS: I mean would we go so
5 far as to say we would not approve this measure
6 just because we don't want to -- I mean I realize
7 that's -- but from my take, I would even say
8 we're adding complication that we're approving a
9 measure that is distinctly different from another
10 measure that we're putting on the list.

11 CO-CHAIR MOYER: I would be concerned
12 about that. I mean ideally if they both go
13 through that NQF endorsement process there would
14 be like a measure harmonization discussion if
15 everything plays out the way it's supposed to. I
16 thought the initial prescription one --- okay.
17 But I do have concerns about that and we've seen
18 that happen with measures and then it's been very
19 difficult to change what type of --

20 MEMBER FIELDS: It's happening right
21 now, formerly known as MU thing, we have two
22 different roles in MSSP versus MIPS. So as much

1 as we could say that CMS would have to negotiate
2 that between MIPS and MSSP, history would tell us
3 if that doesn't happen smoothly. And so to be
4 perfectly transparent, I don't trust that process
5 well enough yet to leave it to the two parts of
6 CMS to talk to each other and do that well. So I
7 would actually vote against it for that reason.

8 CO-CHAIR MOYER: Do we have someone
9 from Mathematica on the line that would like to
10 comment on that?

11 MS. BANDYOPADHYAY: Hi, this is Jay
12 from Mathematica. Can you all hear me?

13 CO-CHAIR MOYER: Yes, we can hear you.

14 MS. BANDYOPADHYAY: Okay, wonderful.
15 Yes, so I just wanted to say that we have
16 undertaken efforts to harmonize the measure to
17 the extent possible to the Pharmacy Quality
18 Alliance measure around high dose opioids.

19 Can you restate the title of the --
20 this measure and the other program that you're
21 talking about?

22 CO-CHAIR MOYER: So the one I was

1 thinking of was Initial Opioid Prescription
2 Compliant with CDC Recommendations. And that had
3 been MUC-106 in case you happen to have the MUC
4 list. It was Afton Labs was the steward.

5 MS. BANDYOPADHYAY: Okay. We can look
6 into what -- how we can all harmonize on that or
7 with that measure further. But the efforts that
8 we have undertaken so far, we've -- across the
9 claims-based measures and the other eCQMs that
10 have this -- have a similar concept area and
11 focus, we've tried to align to the extent
12 possible to ensure that we're both harmonizing,
13 but there aren't any kind of redundancies or
14 conflicting specifications. So we can look into
15 that further.

16 MEMBER BURSTIN: It would also be the
17 high-dose ones from PQA. That's actually what I
18 thought you were referring to, so actually both
19 of them are related. It would be good to see
20 them harmonized before they get put in the
21 program.

22 MS. BANDYOPADHYAY: Yes, and with the

1 high dose one that you're referring to, we have
2 been in conversations with the PQA and we have
3 aligned, for example, the opioids within the
4 scope of the measure to the extent possible.

5 One of the differences between the
6 measures are that you've aligned with the CDC
7 guidelines threshold and you've got as the
8 strengths of the evidence base for this measure
9 whereas I believe the other PQM measurement gets
10 120 MME. Our expert workgroup did confirm that
11 aligning with the CDC guideline would be
12 appropriate for this measure which is an
13 electronic health record-based provider level
14 measure.

15 CO-CHAIR MOYER: All right. Thank
16 you for that. Any other workgroup comments or
17 discussion? Any public comments in the room?
18 Any public comments on the phone?

19 OPERATOR: Again, to ask a public
20 comment on the phone line press star-1.

21 DR. GREEN: Sorry, I just want to
22 double check to make sure I'm following along.

1 The measure that we're talking about in MSSP was
2 an initial -- was that initial prescription? I
3 think this is directed toward chronic, so a
4 little bit different. Thanks, Helen. Thank you.

5 OPERATOR: And currently no questions
6 on the phone lines or excuse me, public comments
7 on the phone lines.

8 DR. BERNOT: Okay, I think everybody
9 has got this by now, but we're going to be voting
10 on MUC 2018-048. This is Potential Opioid
11 Overuse. The first vote would be to accept the
12 staff preliminary analysis which is conditional
13 support with a condition of NQF endorsement.
14 Voting yes would accept that as the workgroup.
15 If you would wish to continue voting for other
16 categories, you would vote no at this point.

17 MS. KOSURI: Voting is now open for
18 MUC 2018-048. Do you vote to support the
19 preliminary analysis as the workgroup
20 recommendation?

21 (Pause.)

22 MS. KOSURI: Okay. We have our 16, so

1 voting is now closed. The Committee's
2 recommendation based on 69 percent of the vote is
3 no to not support the preliminary analysis as the
4 workgroup recommendation for MUC 2018-048.

5 Sorry, with 5 voting yes, and 11 voting no.

6 CO-CHAIR MOYER: Okay. Based on the
7 discussion in the room, it sounded like the next
8 vote we would most likely want you to consider is
9 a do not support with potential for mitigation.
10 Are there any objections to that of the workgroup
11 if someone would like to start with a different
12 vote? Seeing none, we will move to that vote.

13 DR. BERNOT: For the record also, just
14 the mitigation would include what the discussion
15 that occurred here which was largely around the
16 harmonization of the measure with other measures
17 specifically the ones we've talked about for the
18 shared savings program.

19 MS. KOSURI: Okay, voting is now open
20 for MUC 2018-048. Do you vote do not support
21 with the potential for mitigation?

22 (Pause.)

1 MS. KOSURI: Voting is now closed.
2 The Committee's recommendation based on 88
3 percent of the vote is yes for MUC 2018-048, do
4 you vote do not support for the potential for
5 mitigation, with 14 voting yes and 2 voting no.
6 Thank you.

7 DR. BERNOT: Okay, looks like one more
8 and this is MUC 2018-057, this is the Annual
9 Wellness Assessment. I will read the description
10 on this because it is a composite measure and
11 that's the percentage of patients 65 years of age
12 and older with an annual wellness visit who
13 received age and sex appropriate preventive
14 services, the measure's composite of seven
15 component measures that are based on
16 recommendations for preventive care by the
17 USPSTF, ACIP, and AGS. And the preliminary
18 analysis was the conditional support for
19 rulemaking with the condition for NQF
20 endorsement, but also for the harmonization of
21 this measure as some of the seven noted
22 components are already in the program.

1 CO-CHAIR MOYER: All right. The lead
2 discussants on this are Helen and Eric.

3 MEMBER BURSTIN: I'm happy to start.
4 I had a couple of questions, again, the detail of
5 what kind of composite it is was still not clear.
6 I can't tell. It sounds like it's also an all or
7 none. We had a very long discussion about all or
8 none composites this morning. So some further
9 detail there would be very helpful.

10 I guess I have one question since we
11 did have that very long discussion about the
12 composite measure this morning and immunizations
13 about whether it makes sense to have
14 immunizations in this measure as well. We're
15 going to talk shortly about having the composite
16 measure immunizations in this program as well as
17 we talked about for MSSP. And it might just be
18 cleaner to have a screening measure and
19 immunization measure rather than having them in
20 there twice. And I was very pleased to see that
21 it was e-specified. Thank you. I think those
22 are my only concerns.

1 MEMBER WHITACRE: I agree completely.
2 Initially, I had a question about how this would
3 be documented, but obviously with existing
4 measures for fall risk and depression, there must
5 be a way to do that readily in the EMR. So that
6 was the only other question I had.

7 CO-CHAIR MOYER: All right.

8 MS. WILLIAMS-BADER: Hi, this is Jenna
9 from NCQA, could I speak to the type of composite
10 this measure is before we get much further?

11 CO-CHAIR MOYER: Go ahead.

12 MS. WILLIAMS-BADER: Great. So this
13 is actually called a patient -- wait -- patient
14 level linear combination, sorry. So basically,
15 what we're doing is we're averaging -- we're
16 averaging for each patient how many of the
17 screenings and immunizations they get that
18 they're eligible for. So it's not an all or none
19 composite. It basically averages across all the
20 patients the percentage of screenings and
21 immunizations they're getting that they're
22 eligible for. Does that make sense?

1 CO-CHAIR MOYER: Yes. Thank you,
2 Jenna.

3 MS. WILLIAMS-BADER: Sure.

4 CO-CHAIR MOYER: All right, any other
5 questions or discussion on the Committee?

6 MEMBER CHOI: Just sort of a real
7 quick comment. I really support this measure,
8 but I think it would be also great to see a
9 component of brain health in terms of
10 establishing baseline for kind of detecting
11 cognitive impairment moving forward. Just a
12 suggestion.

13 CO-CHAIR MOYER: Michael?

14 MEMBER HASSETT: I may not have seen
15 it, this is more of a question for the measure,
16 but based on the cancer space, we have a lot of
17 patients who are not necessarily on hospice, but
18 have a relatively limited life expectancy and
19 have been first time screen program such as
20 mammography and colonoscopy, but trying to avoid
21 these procedures in these patients. So I'm
22 wondering if the measure addresses those

1 particular issues that actually become part of
2 our choosing measures to recommend against
3 treatment and again, if these two things are
4 happening at the same time it may be confusing.

5 But my point is besides excluding
6 hospice, I have a lot of patients who may have an
7 18-month life expectancy who are not on hospice,
8 but I don't want to send them for a colonoscopy.

9 CO-CHAIR MOYER: Jenna, are there any
10 components to this measure around palliative care
11 and limited life expectancy?

12 MS. WILLIAMS-BADER: So as I said
13 we've -- or as has been pointed out, we have
14 aligned exactly or as much as we can with the
15 existing measures that are already in the
16 program. The only changes we've made is that our
17 measure is limited to those patients 65 and older
18 and we obviously have an annual wellness visit
19 requirement in ours.

20 NCQA is the parent -- is the steward
21 of several of the parent measures including
22 colorectal cancer and breast cancer screening on

1 which the annual wellness component measures have
2 been based. And we are actually working through
3 the annual update process this year with our eCQM
4 to include some -- or to have some exclusions to
5 the measure that are addressing like some of the
6 things that have been brought up.

7 We've actually at NCQA been developing
8 some exclusions that try to take out patients who
9 are frailer or might not benefit from screening
10 such as breast cancer and colorectal cancer
11 screening. So they're not in the annual wellness
12 assessment yet, because we are letting the parent
13 measure stewards lead, but once those things are
14 incorporated into the parent measure and those
15 follow that we would be able to incorporate those
16 exclusions into the annual wellness assessment
17 measure.

18 CO-CHAIR MOYER: Terrific. Thank you.
19 Any other Committee comments or discussion?

20 Any public comment in the room? Any
21 public comment on the phone?

22 OPERATOR: And again to make a public

1 comment on the phone line press star-1. And we
2 do have a public comment. Go ahead, caller.

3 MS. POGONES: Hi. This is Sandy
4 Pogones calling from the American Academy of
5 Family Physicians. We have concerns with this
6 composite measure that are similar to what our
7 concerns were for the other. It did help to have
8 it explained that this is not an all or none
9 composite measure. So that certainly does help.

10 Our main concerns now are with the
11 exclusions. They don't seem to be consistent
12 across the seven measures. For instance, there
13 are exclusions for patient refusal for the
14 influenza immunization, but not for the
15 pneumococcal immunization. And there are no --
16 well, you can refuse measure number two, the
17 screening for depression and you can refuse
18 influenza. You can't refuse a mammogram or a
19 colonoscopy.

20 And we think that patient refusal is
21 an important exclusion in all of these measures.
22 We know that patients do not follow through on

1 recommendations and orders from their primary
2 care physician to get mammograms, colonoscopies,
3 particularly because these are done outside the
4 primary care office. So we do have a concern
5 with that.

6 I think those are the main concerns
7 that we have. Thank you.

8 MEMBER FIELDS: I may be disagreeing
9 with my own specialty society on this, so as a
10 family doc, but we get this complaint from docs
11 constantly. I just had this argument with a
12 physician in our network in the last week about
13 the ability to count patient refusal as an
14 exclusion which I completely disagree with.

15 Our job as primary care physicians in
16 a huge way is behavior change, and so you know,
17 we often have two or three ways of presenting a
18 needed service to patients and sometimes it works
19 and sometimes it doesn't. It really depends on
20 the mood of the patient that day. We catch them
21 the next day and we readdress it or use different
22 words. It seems to -- did the patient really

1 grasp on to that and actually changes her mind?

2 We're not going to get everybody, you
3 know, not everyone is going to be adherent to our
4 recommendations. That's absolutely true. But it
5 is absolutely our job to find new ways of
6 approaching patients that get them from Point A
7 to Point B for necessary services. So I am
8 intensely against anything that just says any
9 sort of flippant patient refusal is proprietary
10 for exclusion.

11 MEMBER FURNEY: I'll just add that
12 internal medicine perspective that I agree
13 wholeheartedly. If the expectation would be that
14 the measure would be at 100 percent and topped
15 out in two years, then having refusals count, I
16 think would be appropriate. For most of these
17 measures, if you take colorectal cancer
18 screening, the top decile gets to about 80
19 percent of your eligible population.

20 So I think as long as we understand
21 the goal is not 100 percent and that is often
22 what I'm talking about with our docs is you won't

1 get all of these measures to 100 percent, but
2 your job is to get as many patients as far along
3 the pathway as is feasible. So I agree.

4 CO-CHAIR MOYER: All right. Any other
5 discussion among members of the Committee? Okay.

6 One last vote.

7 DR. BERNOT: All right, so this is MUC
8 2018-057. That is the Annual Wellness Assessment
9 for Preventive Care. Just to remind you, the
10 preliminary analysis that you would be voting to
11 accept is conditional support for rulemaking with
12 a condition for NQF endorsement and making CMS
13 aware for the harmonization necessary of this
14 measure with existing subcomponent measures
15 already in the MIPS program.

16 MS. KOSURI: Voting is now open for
17 MUC 2018-057. Do you vote to support the
18 preliminary analysis of the workgroup
19 recommendation?

20 (Pause.)

21 MS. KOSURI: We have 16 votes. So I
22 will -- voting is now closed. The Committee's

1 recommendation based on 88 percent of the vote is
2 yes for MUC 2018-057 to support the preliminary
3 analysis of the workgroup recommendation with 14
4 voting yes and 2 voting no.

5 CO-CHAIR BAGLEY: Well, we're going to
6 wrap it up -- pardon? Oh, we did that earlier.
7 We did both. Yes, we did. It zipped right by,
8 Helen. You don't usually miss much.

9 It's customary to have a quick meeting
10 evaluation and just any comments? What did you
11 like about the meeting or what could we have done
12 better? And it goes everything from the room
13 temperature to food to meeting time back to
14 preparation materials and stuff like that.
15 Anything that you want to call out as a great job
16 or things that you think we should work on for
17 the next meeting? Go ahead, Diane.

18 MEMBER PADDEN: I would just like to
19 commend you on the new voting software, very
20 quick, easy to see, easy to use. Excellent.

21 CO-CHAIR BAGLEY: Other comments?

22 DR. GREEN: I'd like to say thank you

1 for having us last because this is the most
2 painless MAP meeting. Thank you, guys.

3 CO-CHAIR BAGLEY: We can fix that next
4 time.

5 (Laughter.)

6 DR. BERNOT: I want to make one
7 comment about -- something to think about and
8 we'd love the feedback is the use of the measure
9 developers, their ability to answer questions
10 beyond the phone. We apologize. We had a little
11 bit of a hiccup getting the first NCQA person on
12 line, but other than that, it's just something
13 that it does not have to be right now, but after
14 on your way home on the airplane, let us know
15 what you think how much of a stage influence
16 would we like that to be part of the MAP meeting
17 so we can really address that as a concrete item
18 going forward, one of the NQF takeaways that we
19 have.

20 MEMBER PADDEN: Of course, I have to
21 thank the staff who did a fabulous job and really
22 I think the discussion guide was really, really

1 well done. A couple of thoughts, I thinks
2 perhaps as a measurement geek, things shouldn't
3 be called measure specifications unless I can
4 really click through the actual specs I need to
5 see.

6 A lot of the questions we had today
7 were, in fact, about things that would have
8 actually been in something labeled measure spec.
9 Those are really just measure detail descriptions
10 and it's hard to make a lot of decisions.

11 And also just back to the discussion
12 of the very complex cost measures. You know
13 there are times when we've gotten slides and sort
14 of descriptions of things that would have just
15 made that discussion so much easier. It's a very
16 hard conversation to listen to without anything
17 on paper. So a couple slides here and there
18 would have just made the world of difference
19 instead of trying to process and I was not tired
20 then, Dan, process the fact that very complex,
21 what changed, what didn't change. So just
22 anything you can do to make the information

1 easier to see, particularly when it's new. We
2 literally just got that information the last
3 couple of days on these incredibly complex
4 measures. So again, visuals help.

5 CO-CHAIR BAGLEY: I actually made that
6 recommendation to them before they left about
7 picking, we had a whole long list, pick one and
8 do a detailed analysis to show the detail level
9 that they get to. And then we could assume
10 they're doing the same thing on the other end.
11 So yes, exactly. Other comments? Ann.

12 MEMBER GREINER: I think we didn't
13 have time for this, given the number of measures
14 that we had to review, but I am cognizant of such
15 a large number of measures and how did the ones
16 that we vote on today sort of fit into it and at
17 the end of the day, what does it mean for either
18 the ACOs or really more of the clinicians that
19 are reporting those measures.

20 I don't have a good sense of that and
21 I know that generally you like to provide that,
22 but we just had a lot of issues to review. So I

1 think it's a challenge.

2 CO-CHAIR BAGLEY: It is a challenge.

3 I think it's a good idea and we probably should
4 include that in sort of the opening remarks, now
5 here's the big picture, here's the program and
6 that sort of thing, so we probably should do that
7 in the future.

8 MEMBER BRISS: You could actually do
9 that efficiently in the pre-meeting webinar
10 actually. That might save a lot of discussion
11 time.

12 CO-CHAIR BAGLEY: Okay, any other
13 comments or recommendations for improvement?
14 Opportunities for improvement?

15 MEMBER KRUGHOFF: Well, I came late
16 enough that I thought all the things you're
17 suggesting had been done, so I gave you 100
18 percent credit.

19 CO-CHAIR BAGLEY: We're supposed to
20 summarize the day a little bit so I'll give it a
21 whack at it. It will be brief.

22 I think this is very important work

1 that we're doing and CMS is generally interested
2 in hearing this conversation, you know, probably
3 even more than the letter of the actual measure.
4 It's helpful to them as they try to refine them
5 and rework them or get them in the right program
6 or get them working properly.

7 So Michelle and Reena, thank you for
8 listening and your staff, I mean you had a number
9 of your staff here as well, either here in the
10 room or on the phone so thanks for that.

11 The issues we dealt with, the opioids
12 is a critical issue for our country as a public
13 health issue. This year we heard the news that
14 because of the number of overdose deaths that the
15 life expectancy in our country is actually
16 dropping and it's attributed to so many young
17 people dying of this problem. So it's serious
18 business and I think we made some tiny bit of
19 progress.

20 The cost of care is another critical
21 issue for our country and although we talk about
22 it all the time, if we're not willing to measure

1 it and promote transparency, it will not change,
2 so once again, we're taking a step in that
3 direction.

4 It was nice to see some -- the last
5 set of measures, I'll call it sort of patient-
6 centered and patient-reported outcome. I think
7 we need to see more of that and start to see some
8 of the feedback that we get from that and see how
9 they're working out. So with those comments,
10 thank you for your time. Thank you for your
11 commitment and thank you for your contribution.
12 We hope you had so much fun this year that you
13 might consider coming back next year.

14 (Laughter.)

15 (Applause.)

16 (Whereupon, the above-entitled matter
17 went off the record at 4:35 p.m.)
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