

NATIONAL QUALITY FORUM

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MAP AFFORDABILITY TASK FORCE

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MEETING

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WEDNESDAY

MAY 7, 2014

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The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:15 a.m., Chair Mark McClellan presiding.

PRESENT:

MARK McCLELLAN, MD, PhD, Chair

BETH AVERBECK, MD, Minnesota Community
Measurement

JOANNE CONROY, MD, Association of American
Medical Colleges

CHRISTOPHER DEZII, RN, MBA, CPHQ,
Pharmaceutical Research and Manufacturer
of
America

JAMES DUNFORD, MD, Emergency Medical Services

NANCY FOSTER, AB, American Hospital
Association

HELEN HASKELL, MA, Mothers Against Medical
Error

APARNA HIGGINS, MA, America's Health Insurance
Plans

DAVID HOPKINS, PhD, Pacific Business Group on
Health

GERRI LAMB, PhD, Care Coordination
KEVIN LARSEN, MD, Office of the National
Coordinator for HIT
DOLORES MITCHELL, RN, State Policy
SEAN MULDOON, MD, MPH, FCCP, Kindred
Healthcare
EUGENE NELSON, MPH, Dsc, Population Health*
DAVID SEIDENWURM, MD, American College of
Radiology
CARL SIRIO, MD, American Medical Association
MARGARET TERRY, PhD, RN, Visiting Nurses
Association of America
JENNIFER THOMAS, PharmD, American Society of
Consultant Pharmacists
SALLY TYLER, MPA, American Federation of
State, County and Municipal Employees
RONALD WALTERS, MD, MBA, MHA, MS, Alliance of
Dedicated Cancer Patients
WEI YING, MD, MS, MBA, Blue Cross Blue Shield
of Massachusetts

NQF STAFF:

CHRISTINE CASSEL, MD, NQF CEO
KAREN ADAMS, PhD, MT, Vice President of
National Priorities
YETUNDE ALEXANDRA OGUNGBEMI, Administrative
Assistant, Strategic Partnerships
ERIN O'ROURKE, Project Manager, Strategic
Partnerships
ROBERT SAUNDERS, Senior Director, Strategic
Partnerships
AMARU SANCHEZ, Project Analyst, Strategic
Partnerships

* present by teleconference

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

(9:16 a.m.)

DR. MC CLELLAN: Okay, well, I'd like to welcome everyone to this morning's in-person meeting of the NQF MAP Affordability Task Force. I would like to thank everyone for bearing with us on the sound issues and thank the NQF staff, especially, for coming up with a very fast work-around.

We have a lot of ground to cover today. And based on how the group has operated so far, now that I actually get to see you all in person, no doubt that we will have both a lot of interaction and, hopefully, get through all these materials very efficiently.

Before we get started, though, I would like to turn to Chris Cassell, the head of the NQF for some introductory comments about the role and the importance of this group. Unfortunately, Chris can't stay with us the whole day because of some other major

1 NQF commitments but thank you for joining us
2 the first part of the meeting.

3 DR. CASSELL: Thanks, Mark. And I
4 will keep these remarks very short because I
5 know you have a busy schedule and I really
6 appreciate the creative technical work that
7 went into getting us set up to record this
8 meeting.

9 As you probably know this has been
10 a very busy time frame, more than we have this
11 room in years, almost constantly for the last
12 month or more. And so today, we are actually
13 having simultaneous meetings. I was quipping
14 that entirely jokingly that the
15 musculoskeletal meeting that is going on next
16 door could probably offer some affordability
17 opportunities.

18 (Laughter.)

19 DR. CASSELL: But that is for your
20 discussion.

21 But you have had a couple of
22 meetings already via virtual technology and

1 you are well into this work. And so I just
2 want to reiterate two obvious things. One is
3 how important this is and particularly how
4 important it is that you kept the interests
5 and the voice of the patient and consumer
6 really primary as we think about is affordable
7 and how you define it. But there is no doubt
8 that it is a peak agenda for the nation, both
9 the public and private sector stakeholders in
10 healthcare. That is to say, everybody can
11 figure out ways to reduce waste and make
12 healthcare more affordable.

13 And to thank Mark and all of you
14 for taking the time, the considerable time,
15 not only at these meetings but the paperwork
16 that we do in preparation for the Board
17 deliberations here. So, my thanks to you, as
18 well as that of all of the NQF staff.

19 I wanted to just, I think I see a
20 lot of familiar faces around the room but make
21 sure that everyone knows that we actually have
22 a whole portfolio of work on affordability and

1 the cost issue, including endorsement in
2 measures of cost and resource use,
3 understanding affordability from a patient
4 perspective, linking cost and quality, that
5 important concept we now call value, which
6 increasingly we are being called upon to
7 define. And also some of the more technical
8 aspects of how do we measure episodes and
9 episodes related to cost to our nation and
10 innovative and needed, in my view, new payment
11 techniques.

12 So, you will hear more about these
13 but I think that I just wanted to center this
14 families of measures work in the larger
15 context which exists.

16 I also want to just, for those of
17 you who haven't yet heard, pretty soon there
18 is going to be anybody has figured out that is
19 NQF's strategic plan. But to point out
20 particularly for MAP, that there is a -- the
21 Board is really supportive and strongly
22 endorsed several important new directions for

1 us. And one of them is to make our work
2 internally more efficient. We have worked
3 with our federal colleagues about not only the
4 contracting process but also how the
5 endorsement process fits into the MAP
6 selection process and beginning to identify
7 whether it is possible to endorse measures for
8 certain purposes. For example, if you have
9 more information come to MAP from the
10 endorsement process, so that the conversations
11 don't have to be frequently repeated at both
12 sides and that staff level could be more
13 seamless and efficient.

14 Also, the endorsement side is
15 starting with dramatic advances in using some
16 lean techniques that Kevin is taking part in,
17 two major big Kaizen exercises to identify and
18 reduce waste in our own processes and to
19 reduce cost and improve the efficiency in the
20 process. So, some of that you are already
21 seeing in terms of the open pipeline for
22 measures without having to wait for a call for

1 measures every two years but trying to
2 encourage people to identify measures that
3 matter and NQF becoming more involved upstream
4 in helping measure development get it right
5 the first time. So, there isn't a constant
6 need to doing a lot of technical work to keep
7 bringing measures back, particularly the high
8 priority measures, and address some of the
9 gaps that you and I know all too well.

10 In addition, we have made a big
11 commitment to putting even more attention into
12 advancing measurement science. As the
13 accountability framework gets more and more
14 kind of inevitable and both rich but also
15 chaotic and confusing for a lot of people, we
16 want to really contribute to trying to make it
17 more streamlined and more effective and to
18 advance the science of quality and performance
19 measurement as part of that. You have seen a
20 recent example of that in the release of our
21 report on the use of socioeconomic status for
22 risk adjustment and performance measures.

1 That report has gotten a lot of attention, the
2 most ever responses to our public comment
3 period, and let me tell you, these responses
4 are five and six pages -- paragraphs. So, the
5 staff has had a lot of work. And they were
6 helpful in working in adjusting those
7 responses. And it will be brought back to the
8 committee in June and finally publication.

9 But that is just one example of
10 many places where I think these issues are
11 very complex, very nuanced. One-size-fits-all
12 is not, ultimately, going to give consumers
13 the information that they need. So, I am
14 pleased that there is the help for discussion.

15 And you will see other such
16 activities related to some underlying
17 questions with regard to these measures.

18 And then the last thing I want to
19 say is that the National Quality Partners,
20 which is taking advantage of all of the
21 stakeholders, but particularly the members,
22 420 some organizations that are members of NQF

1 that can actually make things happen on a
2 national scale by bringing the right
3 stakeholders and regulators, the buyers, the
4 consumer groups to align certain activities
5 around specific quality goals. And we have
6 had success, as you know, in the maternity
7 care area, related to that. And Karen Adams
8 is leading our staff effort now to really
9 increasingly use that National Quality
10 Partners framework to actually drive the
11 improvement in collaboration with our members.

12 So, we are excited about all those
13 new and important activities but at the core,
14 really, the work of NQF is this vitally
15 important multi-stakeholder examination of the
16 consensus process around the measures that are
17 used in public programs, which MAP is set up
18 to address.

19 And the last thing I want to say
20 is that we are increasingly having, I think,
21 very productive discussions with our health
22 plan partners, Aparna is aware of this, about

1 efforts towards alignment and working with the
2 Buying Value Coalition and other organizations
3 to bring both public and private sector
4 approaches to measurement together to make a
5 clearer, stronger signal to the providers, as
6 well as to consumers and reduce some of the
7 unnecessary work that goes into our reporting
8 in multiple ways.

9 So, things like determining
10 families of measures really could be a vitally
11 important resource to that process. And so,
12 we value your work and I am pleased to be able
13 to join you for a little while this morning
14 and I look forward to the discussion.

15 Thank you.

16 DR. MC CLELLAN: Great. Thanks
17 very much, Chris for joining us and for that
18 overview. As you could hear from Chris's
19 description, the scope of the NQF's work
20 covers a range of very important topics for
21 improving healthcare and cutting across all of
22 that, increasingly, is affordability. So, the

1 work of this group is absolutely essential to
2 the overall agenda that Chris just laid out.

3 I just was going to spend a minute
4 with an overview of the day. So, we are going
5 to start out with a little bit of discussion
6 and review, really, of the objectives of the
7 Task Force and this meeting and how it fits
8 into some of the broad themes that Chris
9 described. You all have gotten together now
10 on the phone several times, starting last
11 fall, and also contributed by email as well,
12 but this is our main time to get a lot of our
13 key issues resolved in person.

14 So, we are going to do a little
15 bit of level setting to begin with. Then, we
16 are going to turn to a review of the high-
17 leverage opportunities for affordability
18 measures. And this is going to build directly
19 off the discussion that we had on our call
20 back in February on the key opportunities, as
21 well as the homework exercise that I want to
22 thank just about everybody for completing and

1 contributing to.

2 After that, we are going to focus
3 on a couple of areas, key areas for measure
4 selection and gap identification. That
5 includes the overall cost measures and cost-
6 buy episodes, cost to patients.

7 Then, we are going to start going
8 into some of the other key areas, key leverage
9 opportunities. Some of that is going to be
10 done by break out groups. Basically this
11 afternoon, we will be going over overuse and
12 appropriateness, unnecessary use of high-cost
13 providers and utilization and coming back
14 together later in the afternoon to report out
15 on those.

16 And then tomorrow's agenda is
17 going to cover the other high-leverage
18 opportunity areas and a number of specific
19 interfaces between the work of this group and
20 some of the other NQF and collaborative work
21 related to affordability measures.

22 So, at the end of this couple of

1 days, we will hopefully have a pretty clear
2 idea of what measures we think are most
3 important, where the gaps are, and how this
4 fits into the broader agenda on getting to
5 affordability measures.

6 We are not done, at this point,
7 but this will be our last in-person meeting.
8 Based on the results of this meeting, the
9 staff are going to draft the initial version
10 of our report. That will be out for comment
11 in June. We will have a chance by email to go
12 over revisions to the report, at that point.
13 And the report is scheduled for release in
14 July. So, this is all coming up pretty soon.
15 My point is that now is the time to try to get
16 not only the big issues on the table, as we
17 have been doing for the last six months, but
18 try to get to some resolution about specific
19 paths forward.

20 So with that in mind, I would like
21 to go around. I know we have all been working
22 together for a while but the first time in-

1 person. And I think a lot of people here know
2 everybody else but I want to make sure
3 everybody is putting the name with the faces.
4 So, Rob, I guess we will start with you and
5 just go around the table.

6 MR. SAUNDERS: Sure. I'm Rob
7 Saunders. I am Senior Director at NQF. I
8 have been here -- oh, excuse me. I am
9 violating our own rules.

10 I have been here about eight weeks
11 now and I appreciate meeting most of you over
12 email and look forward to working with you.

13 DR. CASSELL: Since I'm next in
14 the queue, Mark, I will take this opportunity
15 to remember to thank all the NQF staff who are
16 here. Rob is new to NQF, having joined us
17 from the Institute of Medicine but has hit the
18 ground running, I think it is fair to say.
19 But everyone has worked so hard on putting
20 this meeting together. So, I want to thank
21 them for that.

22 DR. LARSEN: Hi, I'm Kevin Larsen.

1 I am the Medical Director of Meaningful Use at
2 the Office of National Coordinator for Health
3 IT. I have been participating periodically in
4 here as a Federal Ex Officio member. The key
5 interests I have in this would be work on the
6 electronic quality measures using clinical
7 data and I am now starting work on what we
8 call hybrid measures, which are combined
9 measures of claims and clinical data. So, I
10 think that will fit very nicely into this as
11 sort of what we think of as the next set of
12 work for us.

13 DR. WALTERS: Ron Walters,
14 Alliance of Dedicated Cancer Centers and my
15 paycheck comes from MD Anderson.

16 DR. YING: Wei Ying. I am from
17 Blue Cross Blue Shield of Mass. I am the
18 Director of Performance Measurement Method and
19 Population Health.

20 MS. FOSTER: I'm Nancy Foster. I
21 am the Vice President of Quality and Patient
22 Safety Policy at the American Hospital

1 Association, sitting in for Rich Umbdenstock.

2 DR. THOMAS: Hi, I'm Jennifer
3 Thomas, Delmarva Foundation for Medical Care,
4 Quality Improvement Organization, Maryland,
5 and I am representing the American Society of
6 Consulting Pharmacists.

7 DR. LAMB: Good morning. I am
8 Gerri Lamb. I'm from Arizona State
9 University. I am here related to expertise in
10 care coordination. And I either co-chair or
11 sit on several National Quality Forum Care
12 Coordination Committees.

13 DR. CONROY: Joanne Conroy. I am
14 from the Association of American Medical
15 Colleges and I also sit on the Clinician MAP
16 Committee.

17 DR. AVERBECK: Beth Averbeck from
18 Minnesota Community Measurement and also on
19 the Clinician Workgroup in MAP.

20 DR. SEIDENWURM: I am David
21 Seidenwurm and I am a neuroradiologist. As of
22 the last three months, with Sutter Health in

1 California and I am also on the MAP Clinician
2 Council.

3 DR. HOPKINS: Good morning. David
4 Hopkins, Senior Advisor for the Pacific
5 Business Group on Health. I am also
6 representing the Consumer Purchaser Alliance.
7 And I am part of this little corner here that
8 sits on the Clinician Workgroup as well.

9 MR. DEZII: Hi, I'm Chris Dezii, I
10 work at Bristol-Myers Squibb, Director of
11 Healthcare Quality Performance Measures. I
12 have been selected to represent Pharmaceutical
13 Research and Manufacturers of America. I have
14 doing QA and QI since 1978, believe it or not.
15 And that's it. So, it is a pleasure meeting
16 you.

17 DR. TERRY: Good morning,
18 everybody. I am Peg Terry and I represent the
19 Visiting Nurses Association of America, which
20 represent non-profit Home Health and Hospices
21 all over the country. And I also sit on the
22 HQ Workgroup.

1 COURT REPORTER: I'm sorry, ma'am,
2 could you repeat that?

3 DR. TERRY: Can you hear me now?

4 COURT REPORTER: Yes.

5 DR. TERRY: Okay. Peg Terry,
6 representing the Visiting Nurses Association
7 of America, which represents non-profit Home
8 Health and Hospices around the country. And
9 I am also on the HQ Workgroup.

10 DR. LARSEN: Hi, I'm Sally Tyler.
11 I am with AFSCME, which is the American
12 Federation of State, County, and Municipal
13 Employees. I am the Senior Health Policy
14 Analyst there. And I am also on the MAP for
15 Dual Eligibles.

16 MS. HIGGINS: Hi, I'm Aparna
17 Higgins, Senior VP for Private Market
18 Innovation, Center for Policy and Research at
19 AHIP. And I also sit on the MAP Coordinating
20 Committee.

21 DR. MULDOON: Good morning. Sean
22 Muldoon from Kindred Health Care, representing

1 the transition of patients who require post-
2 acute care.

3 DR. SIRIO: Good morning. I'm
4 Carl Sirio, Chief Operating and Clinical
5 Officer of the University of Toledo. Also, I
6 am on the MAP Coordinating Committee and
7 Director of the American Medical Association.

8 MS. HASKELL: I'm Helen Haskell,
9 Mothers Against Medical Error. And I am also,
10 like several people who have acknowledged, I
11 am on the Hospital Workgroup.

12 DR. DUNFORD: Good morning. I'm
13 Jim Dunford. I am an emergency physician. I
14 have been on the faculty at UC San Diego since
15 1980. So, I am one of those expensive ER
16 doctors.

17 And I am also the Medical Director
18 of the City of San Diego, so I coordinate the
19 Fire Department and the EMS services for the
20 City. And I am the Dual Eligibles MAP
21 Committee.

22 MS. MITCHELL: I'm Dolores

1 Mitchell. My apologies for being late. The
2 good news, we landed a half an hour early.
3 The bad news is we sat on the tarmac for 45
4 minutes because there was no gate.

5 And I also want to apologize in
6 advance. I have to go back to Massachusetts
7 tonight because the Connector Board, which I
8 have the occasional pleasure to sit, is eating
9 public crow about our exchange problems. And
10 I have to be there sort of show the flag to my
11 colleagues.

12 I also, in my day job and my
13 relevance for today's meeting is that I am the
14 Executive Director of the Commonwealth's
15 Employee Benefits Program called the Group
16 Insurance Commission and I am not an expert in
17 measurement either on any of the measures that
18 NQF deals with.

19 But what I am is an impatient, and
20 very impatient purchaser. And we are now in
21 our 11th year of tiering physicians and
22 hospitals using measures that we went out and

1 bought since the ones that came out of the
2 great federal government, who are a little
3 slower than we were.

4 So, now that having offended
5 absolutely everybody, I will turn it back to
6 Mark.

7 (Laughter.)

8 DR. MC CLELLAN: I would like to
9 introduce the NQF staff who have been involved
10 in this. Erin, starting with you.

11 MS. O'ROURKE: Hi, I'm Erin
12 O'Rourke. I am the project manager. Thank
13 you all for your participation and putting up
14 with my many, many emails over the past few
15 months.

16 MS. OGUNGBEMI: Hello. I am
17 Alexandra Ogungbemi. I am sure you have
18 received some emails from me as well. I
19 support pretty much most of the workgroups
20 that participate in MAP. So, welcome.

21 MR. SANCHEZ: Amaru Sanchez. I am
22 the analyst on the MAP Task Force Commission

1 Workgroup and Coordinating Committee.

2 DR. ADAMS: Hi, good morning.

3 Karen Adams, the Vice President of National
4 Quality Partners. I know I have had the
5 pleasure of working with many of you over the
6 years but I really want to thank you for this
7 work. And I know we have been talking about
8 how in the context of portfolio and
9 affordability in helping us pave the way
10 through it. Thank you.

11 DR. MC CLELLAN: Thanks, very
12 much, Karen.

13 So, where are we going now? Just
14 a reminder about the meeting of objectives.
15 This is sort of a key meeting for establishing
16 an affordability family of measures that fits
17 into the framework that Chris described at the
18 outset. As you know, we have done a good deal
19 of work before now around the definition of
20 affordability and around the kinds of
21 considerations, especially, now we paying more
22 important than non-specific words are the fact

1 that there is a patient-centered element to
2 this but also that we emphasize the role of
3 all stakeholders in reducing costs, avoiding
4 waste, and thereby contributing to the
5 affordability of care across the spectrum
6 today and in the future.

7 So, today is about the measures
8 that can help fill that out. This is no
9 longer talking about sort of the general
10 concepts and the need to include all
11 stakeholder perspectives but actually
12 establishing a more specific set of measures
13 and measure gaps to fill that in.

14 Then, we are also going to spend
15 some time, while we are doing that, I hope, as
16 well as tomorrow, on discussing implementation
17 pathways, opportunities to move forward on
18 achieving the implementation of these measures
19 as well.

20 So, this is going to go together
21 over the next couple of days. It is a lot of
22 effort but, again, we have got a lot to build

1 on.

2 We are going to start right now by
3 reviewing what we have done so far. And I am
4 going to turn it over to Rob to lead that
5 discussion.

6 MR. SAUNDERS: And before I do
7 that, just as a housekeeping matter, I always
8 like to explain what pieces of paper we put in
9 front of you, just because sometimes we put a
10 lot of paper in front of you.

11 So, in addition to the agenda, we
12 also have this discussion guide and that is
13 serving two purposes. One, it has got a very
14 short, hopefully, three-page summary of what
15 the Task Force has done, along with a
16 preliminary table of measures. But you will
17 notice there is a -- it is a little large and
18 that is because there is actually material for
19 each session and it is organized by that. So,
20 we will ask you to use that during the
21 meeting, especially when we move to break out
22 groups, where we are moving around the

1 building, to try to take this with you because
2 it will have additional information in there.

3 One of the things that we did with
4 this discussion guide was try to provide
5 additional background on the measures that
6 were under consideration and we will talk
7 about that in a second. And then finally, we
8 also included the list of participants who are
9 involved in this work.

10 So, that is what is in front of
11 you.

12 So, let me turn very quickly,
13 being responsive of time, to where we are and
14 what we have done. So, hopefully everyone
15 knows about why we are doing families of
16 measures. The goal is to improve alignment by
17 coming up with pre-screened measures on
18 specific topics. And in this case, we have
19 got the important measure concept of
20 affordability that we are shooting for.

21 And so, we will skip through that
22 a little bit. We had one meeting at the end

1 of last year that really focused on a set of
2 principles. And those principles I think, as
3 Mark laid out, are that everybody has a role
4 in improving affordability and their rising
5 costs are affecting everyone but there is a
6 special sort of issue with the patient. And
7 this group sort of called that out, while
8 recognizing the role that everyone plays and
9 the fact that rising costs are affecting
10 everyone.

11 So, I am going to shoot through a
12 little bit just to show you where the
13 measures, the preliminary table of measures
14 that you have in front of you came from. So,
15 based on the February web conference that this
16 group had, we came up with a list of the
17 highest leverage opportunities, along with a
18 list of measurement concepts that the group
19 felt were important to think about. The staff
20 took that back and went through a list of 1600
21 measures that the MAP has inventoried over
22 time, both public sector measures and private

1 sector measures, and looked through those to
2 see which ones could possibly fit and address
3 those highest leverage opportunities or those
4 measurement concepts.

5 That got us down to a list of 400
6 measures. And in then the Excel spreadsheet
7 that staff sent out beforehand, we included
8 all of those 400 measures as background.

9 Recognizing that we didn't want to
10 ask you to look through 400 measures and
11 provide guidance on each individual one,
12 although we appreciate that if you would have,
13 but the staff took the next step of trying to
14 really review that list and narrow it down,
15 based on the previously established MAP family
16 selection criteria, which are the three I's of
17 importance, improvability, and inclusiveness.

18 And so, staff took a first pass of
19 reviewing all those measures and came up with
20 a list of 60 that we sent out over homework.
21 And we appreciate the in-depth feedback that
22 you provided in that homework, not only

1 looking at those individual 60 measures but
2 also taking another look at the highest
3 leverage opportunities and the measurement
4 concepts.

5 And from that feedback that we
6 got, both on the importance and also there was
7 a ranking exercise for each of those measures,
8 the staff put together the preliminary table
9 that is included in your discussion guide. I
10 think we are down to 40 some measures in this
11 family.

12 As we go through each over the
13 next two days, we are going to talk about each
14 of the highest leverage opportunities and the
15 measures that are associated with those. We
16 have included the measures that folks
17 suggested during the homework as an extra
18 input, where there were extra measures
19 suggested, as well as the measures that were
20 included in the homework that didn't make into
21 this preliminary table. We wanted to make
22 sure you had all the references available,

1 even though at the beginning, we just wanted
2 to show you a clean table to show sort of
3 where it seems the group is.

4 So, let me stop there, in the
5 interest of time, and turn it back over to
6 Mark.

7 DR. MC CLELLAN: Okay, thanks.
8 Any questions about how we got to where we are
9 now? Ready to dive in?

10 So, we have got a little bit more
11 review on the next couple of slides in terms
12 of the high-leverage opportunities.

13 So you all will remember from our
14 meeting back in February we discussed a range
15 of areas where we felt measures should be
16 included in this affordability family. The
17 results here came from not just our
18 discussions but our review of the National
19 Quality Strategy, review of other important
20 reports related to this topic of
21 affordability, like the IOM Healthcare
22 Imperatives Six Domains of Waste, as well as

1 a number of other relevant NQF reports,
2 Measurement Framework on Evaluating Efficiency
3 and Voluntary Consistent Standards for Cost
4 and Resource Use and so forth.

5 And the results of that was a set
6 of proposed high-leverage opportunities, which
7 you all saw in the homework exercise that I
8 think just about -- I think we had 17
9 responses -- which is a great response rate
10 from this group. Thank you all very much --
11 that included what the table divides into
12 affordability in the short-term.

13 This focuses on measures of cost
14 and utilization, things that are in front of
15 us right now when we are making choices and a
16 set of areas related to keeping care
17 affordable for the long-term. So,
18 opportunities to avoid waste and unnecessary
19 spending through reforms in care and other
20 steps over time. I was talking to Rob before
21 the meeting, I'm not that short- and long-term
22 distinction really works. It is really all

1 about moving towards a greater efficiency in
2 value and care. But this group includes
3 prices, overuse and appropriateness,
4 unnecessary use of services, person- and
5 family-centered care, errors and
6 complications, lack of care coordination, and
7 prevention.

8 So, these were what went into the
9 exercise, the homework exercise that you all
10 completed before this meeting as a reflection
11 of our discussion back in February. And I
12 turn back to Rob to go over the results of
13 that.

14 MR. SAUNDERS: Sure. And so one
15 of the reasons why we put the time frame
16 there, in the homework exercise, a few people
17 pointed out that there was some confusion
18 about comparing say cost of care coordination
19 for affordability. And so staff were trying
20 to sort of explain the difference between the
21 sort of two buckets. One was about reducing
22 excess cost and waste and one was about

1 understanding where we are now. And we can
2 certainly change that. That is sort of a
3 preliminary way of categorizing the two.

4 In terms of homework, we heard a
5 few things. There was some general support
6 for most of these categories and I am not
7 going to read each of them but there was still
8 support for a lot of these categories as being
9 useful.

10 I think I want to focus on the
11 bottom where we were hearing some folks say
12 maybe this isn't necessarily somewhere we want
13 to focus. And those were really on those
14 bottom three, unnecessary use of high-cost
15 providers, workforce, and prevention, not
16 necessarily in that order.

17 In terms of workforce, I think the
18 concern was understanding what that would mean
19 and how we would necessarily get measures out
20 of there. Not that it is not an important
21 concept but just how would we address the
22 issues of reducing costs through helping the

1 workforce.

2 On the issue of prevention, there
3 were some concerns raised about trying to
4 understand the evidence of what has been
5 proven to reduce cost over the long-term
6 because there is still debate among economists
7 on what could be useful there.

8 And then unnecessary use of high-
9 cost providers, I think there were questions
10 about what was a provider in that situation.
11 What was a high-cost provider? And while that
12 was brought in the IOM's six domains of
13 phrase, there are still some questions about
14 how you operationalize that.

15 And so, based on that, the staff
16 --

17 DR. SIRIO: I have a question.

18 MR. SAUNDERS: Sure.

19 DR. SIRIO: Do you want questions
20 as we are going through these, Mark?

21 DR. MC CLELLAN: We can do it
22 either way. I think right now if it is a

1 clarifying question. We are going to be
2 discussing all of this at some length in just
3 a minute.

4 DR. SIRIO: Okay. Let's go back
5 to that question. So, two questions. Each of
6 these buckets, high, middle, and low buckets,
7 are they ranked within these categories or are
8 they just basically randomly located?

9 DR. MC CLELLAN: They are not.

10 DR. SIRIO: Okay. So, the second
11 question is then, are we going to have an
12 opportunity to discuss whether or not the
13 consensus of the survey necessarily makes
14 sense when we actually look at it?

15 DR. MC CLELLAN: Yes.

16 MR. SAUNDERS: And in fact, that
17 is the next slide.

18 The most major change that was
19 made to the list of high-leverage
20 opportunities was removing the workforce
21 bucket. The remainder of the high-leverage
22 opportunity are still there. They may be more

1 of a discussion about filling gaps because we
2 may not have the measures that we can use
3 right now. But maybe this at least sends the
4 signal to the field that there should be
5 measures and that we should think about it.

6 And so, staff came up with a list
7 of some questions you might want to consider
8 but this is definitely an opportunity to think
9 about whether this is the right list of high-
10 leverage opportunities, whether some should be
11 removed, whether there is any other changes
12 that need to be made.

13 DR. MC CLELLAN: Right. So, if
14 you are following along in the document in
15 front of you, this is a few pages in. There
16 is a list of the time frames of short- and
17 long-term and then a list of these high-
18 leverage opportunity areas that made the cut.
19 So, we do want to talk about the issues around
20 workforce. But the ones that were regarded as
21 significant by most of the people reviewing
22 the preliminary list are included here. It is

1 also there.

2 So, this is --

3 DR. SIRIO: What page?

4 MR. SAUNDERS: It is under Session
5 2, so Review and Finalize High-Leverage
6 Opportunities. It is the table right at the
7 top of that.

8 DR. MC CLELLAN: Right. Everybody
9 finding it? Table 1. All right, it is under
10 Session 2, Table 1.

11 And again, in our subsequent
12 sessions, we are going to go through specific
13 measures and measurement gaps in each of these
14 areas. The purpose for right now is just
15 confirm or revise that these are the high-
16 leverage opportunity areas.

17 And back to the first question
18 there. Everybody getting there? Make sure
19 you are awake and can count to 18.

20 The first question is about the
21 removal of workforce as a high-leverage
22 opportunity. As Rob mentioned, most of the

1 comments suggested not that it is an
2 unimportant issue. It is a very important
3 issue but in terms of high-leverage focus for
4 this group and measurement opportunities. Any
5 further thoughts on that?

6 Go ahead, Dolores and then David.
7 And if we can do the card thing as usual, I'll
8 make sure not to miss you guys.

9 MS. MITCHELL: Since I would
10 assume that workforce includes who is
11 available out there and what are the
12 shortcomings or shortfalls, and one of them
13 has been widely reported, namely, insufficient
14 number of primary care physicians and an
15 expressed desire to utilize, to a greater
16 extent, nurse practitioners and so on, it
17 seems to me it links intimately with the first
18 one, which is the use of less expensive, less
19 costly providers. So, in throwing out one,
20 you are compromising two measures, both of
21 which have wide publicity, wide concern. One
22 can measure how many primary care physicians

1 are out there. One can measure the use of
2 nurse practitioners. So, why are we saying it
3 is not feasible or not high priority?

4 DR. MC CLELLAN: David and then
5 Jeff.

6 DR. SEIDENWURM: Well, I have
7 always taken the attitude that they taught me
8 to do it so they can teach everyone. And I
9 think that we really need to focus on what the
10 real levels of skill and competency are that
11 are required to perform a particular task at
12 a high level. And I think it would be really
13 a shame to give that up.

14 And I think, Dolores, you had
15 mentioned some ideas that we could look at
16 workforce composition, you know density of
17 primary care, density of nurse practitioners.
18 We could look at to what degree a system had
19 everyone working to the maximum level of their
20 licensure. It would be a shame to give that
21 up.

22 I don't know exactly how you do

1 that today but we should certainly, at a
2 minimum, put this as a comment for future
3 direction.

4 DR. MC CLELLAN: Beth?

5 DR. AVERBECK: I have two
6 comments. One, I think we might get to the
7 mix of different types of providers by the
8 total cost and price so that however a medical
9 group decides to allocate the different tasks
10 that would get that based on total cost or
11 price in that group.

12 And then how that is stretched to
13 do on a national level, I see differences are
14 different by state and so I think this would
15 be a challenge to trying to work at the
16 national level but it is an area to explore
17 further.

18 DR. MC CLELLAN: Helen and then
19 Sean.

20 MS. HASKELL: Yes, is there a way
21 to access the survey? Because I am not quite
22 sure what we voted on or what the conclusions

1 were, what you mean by removing workforce,
2 Rob.

3 MR. SAUNDERS: Sure, and so in the
4 survey what we had done is put up each of the
5 high-leverage opportunities and then asked
6 folks on a Likert scale from one to five how
7 important it was, and then looked at sort of
8 where those fell out.

9 I think you bring up a good point,
10 though, on what exactly was workforce.

11 MS. HASKELL: What measures are we
12 talking about?

13 MR. SAUNDERS: Right. And so the
14 measurement concepts that were identified were
15 largely around injuries. So, workforce
16 injuries.

17 MS. HASKELL: Okay.

18 MR. SAUNDERS: And so then some of
19 the other concepts may be a little bit more in
20 line with the unnecessary cost, use of high-
21 cost providers. But I will turn to my
22 colleagues over at the table. Did I leave any

1 measures out that were also under workforce
2 besides the injury issues?

3 MS. O'ROURKE: Staffing also had
4 it mentioned as a measurement area but we did
5 not have measures to actually bring to the
6 Task Force for consideration.

7 MS. HASKELL: And was it
8 consistent with the group that staffing
9 levels was something that should not be part
10 of this?

11 MS. O'ROURKE: When we asked them
12 to take a look, this fell to the bottom of the
13 high-leverage opportunities. And we were
14 looking for a more parsimonious approach and
15 proposed removing it.

16 MS. HASKELL: Yes, I just not
17 recollecting. I do recall the injuries.

18 MR. SAUNDERS: Sean?

19 DR. MULDOON: Yes, I was skeptical
20 about this one because I couldn't tell the
21 difference between workforce and staffing.
22 And I did not think we were ready to take a

1 staffing stand where there appears to be a
2 sweet spot, not a unidirectional improvement
3 with more staffing. And, I was a little
4 skeptical about, knowing how much of the cost
5 of the care is in fact that labor line, to put
6 pressure on people to reduce the cost, which
7 would mean to, ironically, reduce the
8 staffing.

9 So, I dropped that to the low side
10 for that reason.

11 MR. SAUNDERS: Thanks. Sally?

12 MS. TYLER: Yes, thank you.

13 Overall, it seemed like a workforce issue,
14 that could be a bigger one to explore but it
15 just sort of may not fit into -- since we are
16 doing so many other than measures. But I did
17 want to flag it, as several other people have,
18 at least with staffing levels, since we are
19 talking about errors as well, if that is
20 something should be addressed, I don't know,
21 but maybe not as a separate measures in this
22 process. I hope we can further address it.

1 DR. MC CLELLAN: Thank you. Ron?

2 DR. WALTERS: So, that is what I
3 felt, too, is that workforce is very important
4 but it best kept as a measure gap right now
5 and we can expound on that innovative gap
6 comment in section. But we need more proposed
7 measures to really address some of the things
8 that we are talking about in here.

9 DR. MC CLELLAN: I'm getting a
10 general sense that while the group thinks
11 workforce composition and other issues can
12 have an important impact on affordability, the
13 measures that you have seen so far don't
14 really get at that and, it sounds like may be
15 suitable for sort of a broader general
16 directional comment about developing measures
17 in that area. As I think several of you
18 mentioned, there are a number of measures that
19 we do need to cover and a number of
20 measurement areas that we do need to cover.

21 Also maybe for a follow-up from
22 this group, the NQF staff could look at the

1 degree to which affordability measures like we
2 have discussed here are covered in other
3 activities, in other families that together
4 would make sure that that is not a gap, even
5 if it is not sort of point on with some of the
6 high-leverage affordability opportunities.

7 Sound okay, David?

8 DR. HOPKINS: Yes, so Mark, I
9 think we all see what happened here. We were
10 looking at a very sparse set of measures that
11 didn't really fit the concept that some of us
12 pointed out is very much connected
13 affordability, the solo practice and making
14 best use of staff, staff levels.

15 So, I would hate for our report to
16 come out saying this is an area of low
17 priority because we didn't find measures
18 there. So, I hope we say it is important and
19 is a gap area.

20 DR. MC CLELLAN: Okay, sounds
21 good.

22 Moving on to the next question on

1 the list. So, you have got the list.
 2 Hopefully everyone has found Table 1, at this
 3 point. Are there other high-leverage areas
 4 that should not be on this list? So, the 11
 5 here, do these all look appropriate? These
 6 are the ones that got moderate to high ratings
 7 from the Likert process that we undertook with
 8 the homework exercise.

9 Do these look good, Carl?

10 DR. SIRIO: So, my question is in
 11 Table 1 we have got prevention under the
 12 bucket keeping care affordable for the long-
 13 term. And then in the text below, we have got
 14 it was high-leverage opportunities indicated
 15 as lower ranking by respondents.

16 What does that mean and what are
 17 we going to do for that measure?

18 DR. MC CLELLAN: So, we will come
 19 back to more discussion around prevention.
 20 So, some of this can, perhaps, be held for
 21 that. But I will ask Rob, if you have any
 22 other comments to make.

1 MR. SAUNDERS: Sure. I think the
2 staff didn't feel comfortable necessarily
3 pulling those out yet. That they were more on
4 the edge. The workforce one was one that we
5 saw sort of more of a clear signal. And so
6 staff were being conservative and leaving that
7 list together. But it is certainly a topic of
8 discussion whether this group feels it is
9 appropriate to keep that in.

10 I think the issue there was an
11 issue of evidence-based recommendations that
12 can be used now for the prevention, not
13 necessarily a signal to the field.

14 DR. MC CLELLAN: Nancy?

15 MS. FOSTER: Thank you, Mark. I
16 appreciate it.

17 So, I want to say this very
18 carefully. I am not advocating that these two
19 issues be removed. But I think as we address
20 errors and complications and lack of care
21 coordination, what we need to do is make sure
22 that when we talk about it in this family of

1 measures, affordability, that we do not convey
2 to anyone that the most important issue to be
3 addressed around this is that we can save
4 money if we had fewer errors. The most
5 important issue is, obviously, doing the right
6 thing for the patient. Making sure patients
7 aren't harmed.

8 So, it just makes me a little
9 nervous to think of this as being a high-
10 leverage measure on the affordability thing
11 without expressing that caveat.

12 DR. MC CLELLAN: Thank you.
13 Joanne?

14 DR. CONROY: Yes, I just have one
15 question about price in the definitions. So,
16 we adopted this great HFMA definitions around
17 charges, costs. Price is actually what the
18 provider expects to be paid for their
19 services. But if we are taking it from the
20 patient's perspective, it is cost. What are
21 their out-of-pocket costs? And maybe the
22 insurer's perspective -- what is the total

1 cost of care?

2 So, I guess talk to me a little
3 bit about why price is still on here. I am
4 worried that it will be confusing. So, what
5 does price mean here in this context?

6 DR. MC CLELLAN: We are going to
7 come to this in more detail -- a more specific
8 discussion around price and cost. I am sure
9 these distinctions between price, cost,
10 charges will come up in the later discussion.

11 So, my inclination would be to
12 table that for later. I think there is enough
13 interest in getting more meaningful
14 information on price out there that the group
15 is going to want to have that longer
16 discussion. But I think you are right up to
17 bring up these distinctions and we do need to
18 be clear about them.

19 David?

20 DR. SEIDENWURM: Well, from the
21 point of view of affordability, I think we did
22 make the right decision about moving

1 prevention downward because, for the example
2 that I'm familiar with, you are front-loading
3 your cost. So, there is very little way that
4 you could actually become affordable doing
5 that. But still, it is a valuable thing to
6 do.

7 So, I think that just saying that
8 something goes to a lower priority in
9 affordability, doesn't mean that it goes to
10 the lower priority for society.

11 DR. MC CLELLAN: Peg.

12 DR. TERRY: I have just two
13 comments. One is, on the unnecessary use of
14 high-cost providers. And of course I
15 represent an organization that is focuses on
16 care especially at home. And I think that
17 there is a lot going on in this area right now
18 of appropriate placement, appropriate use of
19 the appropriate provider, right time, right
20 place.

21 And so, I think we -- I don't know
22 what it means to be in the lower ranking but

1 I would hate to see this being really removed
2 yet because I think it is closer to the world
3 that is really evolving and changing very
4 quickly. So, I would like to see that in.

5 And other thing I want to mention
6 is, as we talk about affordability, and this
7 is what keeps coming into my head every time
8 we have this conversation, is the link to
9 quality, of course. To make it affordable, we
10 have to really have quality in there. And of
11 course I always talk about risk adjustments.
12 We have to have a way to take care of our
13 multiple patients somehow. And so that we
14 have that as part of the discussion or
15 somewhere, it is all connected.

16 DR. MC CLELLAN: Yes, thanks for
17 highlighting that. You all made that very
18 clear in our previous web meetings and I am
19 sure that is going to be reflected in our
20 report. And in fact, we will talk some
21 tomorrow about some of the accompanying NQF
22 activities to try to help match up on quality

1 and affordability information together.

2 And with respect to the first
3 point, I am going to save that for a more
4 detailed discussion when we get to looking at
5 the measures and the measurement gaps in this
6 area. Chris?

7 MR. DEZII: Yes, I will be quick.
8 I just wanted to give folks a sense of where
9 my head was. I had great deal of difficulty
10 doing this assignment because it wasn't just
11 what is important and what is not important.

12 It was a rating of how the
13 measures would impact affordability. And I
14 was always stuck on the patient perspective,
15 which by the way, AHRQ just came out with a
16 new report this week for comment on cost
17 measures and patient-centeredness of which --
18 I guess the trouble is cost efficiencies,
19 research utilization, all critical, all
20 viable. I guess I am still having problems
21 with the word affordability. For example,
22 coordination of care, I'm not sure that

1 translates into patient affordability.

2 That's all. I just wanted to let
3 you know that that is where my head is, so I
4 don't mean to be totally contrary in anything.

5 DR. MC CLELLAN: All right and you
6 should keep up that theme as we go through
7 specific measures in each of these areas.
8 That sounds fine. Beth.

9 DR. AVERBECK: May I just make one
10 comment on prevention? I think there might be
11 a longer term in a gap area that might be
12 looking at the intervals and the ages. And so
13 looking at our overuse of the screening test,
14 as opposed to underuse screening might be a
15 potential area to have everyone trying to
16 discuss.

17 DR. MC CLELLAN: Yes, these
18 overuse and underuse areas do overlap with
19 prevention. David.

20 DR. HOPKINS: So, I am not sure
21 where we are leaving this unnecessary use of
22 high-cost providers.

1 DR. MC CLELLAN: I think we are
2 leaving it on for further discussion but we
3 are going to flag that.

4 DR. HOPKINS: We are not going to
5 necessarily leave that in the low bucket.

6 DR. MC CLELLAN: Yes.

7 DR. HOPKINS: So I will just
8 mention like unnecessary use of emergency
9 department care, which is very costly.

10 DR. MC CLELLAN: Yes, I think that
11 the buckets were more for our internal guiding
12 our discussions, at this point, highlighting
13 where you all thought that has been less the
14 opportunities were. We are going to discuss
15 each of these in more detail as we go through
16 topic-by-topic. Rob.

17 MR. SAUNDERS: That is exactly
18 right. So, the buckets are merely here for
19 your internal use. And so, we were trying to
20 do this as almost a modified job. We were
21 showing you what the results of the survey
22 were but Table 1 is what is currently sort of

1 a preliminary family.

2 And so the only one that got
3 removed was workforce but we wanted to at
4 least open conversation of does anything else
5 need to be removed from this list. Is
6 everyone happy with this list, before we go
7 through each of these buckets one-by-one,
8 discussing measures.

9 DR. MC CLELLAN: I think this has
10 been a good discussion for also highlighting
11 what we want to be looking for when we go
12 through each of the bucket areas. Dolores?

13 MS. MITCHELL: Just a quick one
14 about overarching issues, before we get into
15 the individual ones. I am saving my fire for
16 prices.

17 (Laughter.)

18 MS. MITCHELL: But you talk about
19 person dash family and I said what on earth
20 does that mean. I mean, who is left after
21 either individuals or families? What does
22 that mean?

1 DR. MC CLELLAN: Do you want to
2 answer that?

3 (Laughter.)

4 DR. MC CLELLAN: Yes. Again,
5 maybe we should get back to this one when we
6 get to person and family.

7 MS. MITCHELL: Well, I looked for
8 a separate one on it and I couldn't find a
9 separate one.

10 MR. SAUNDERS: And I think this is
11 merely trying to reflect, coordinate with
12 other NQF activities that there is actually an
13 on-going NQF task force, very similar to this
14 one, looking at person- and family-centered
15 care and coming up with a family of measures.

16 And so we were trying to make sure
17 we were using similar language. So, that is
18 where the language came from.

19 MS. MITCHELL: The only people
20 that are left are dead.

21 DR. LARSEN: I can speak to that a
22 little bit. So, one of those person- and

1 family-centered task orders is one that I am
2 very involved in. We know that for a number
3 of people, in fact especially the elderly, 34
4 percent of their medical decisions are made
5 actually by family members and not by
6 individuals. So, they are deferring a lot of
7 their decision-making to family members or
8 collaborating with family members for the key
9 healthcare decisions that they make.

10 So, as we only think about things
11 through the lens of an individual, we missed
12 this working context that the research tells
13 us really key to many people to the decision-
14 making.

15 So, that is the reason to say
16 person and family. It gets to intentionally
17 talk about the unit of shared decision-making
18 and shared information.

19 MS. MITCHELL: Okay. Very good.
20 That helps. Thank you.

21 DR. MC CLELLAN: Thanks. Aparna.

22 MS. HIGGINS: So, I have been

1 sitting here listening to this conversation
2 and I am going to suggest a way for us to
3 think about these different buckets and I will
4 put on my Congress hat here.

5 I think we are sort of talking
6 about two different things. One is just
7 measures of cost or spending or utilization
8 like the national spending projections and
9 things of that nature that are published
10 periodically and overused at that, just say
11 oh, we are spending too much. And then a lot
12 of these areas that we are talking about are
13 kind of what drives that spending.

14 And so, maybe one way for us to
15 think about this is not in a time dimension
16 but more ways of saying okay, we have price
17 and quantity, which is total cost. And then
18 there is lots of things that drive price. And
19 there is lots of things that drive
20 utilization, some of which are listed here as
21 important. And I think that all of the issues
22 that we have found high importance, medium,

1 and low importance, all kind of drive our
2 spending. And that might be an alternative
3 framework that you want to think about in
4 terms of how you frame these high-leverage
5 opportunities.

6 And what we don't know, and I was
7 struck by what Chris said, I think the
8 challenge I had in filling out the surveys is
9 the same thing, is trying to figure out which
10 of these drives spending more than others.
11 And so for example, there are estimates out
12 there that say 30 percent of the spending is
13 unnecessary. But all of these other areas,
14 how much does workforce contribute to
15 increased cost? We don't know the answer to
16 that.

17 So, it is hard to rank relatively
18 because there is no evidence when you know
19 that all of these matter. So, just an
20 alternative way of thinking about it.

21 DR. MC CLELLAN: Rob and I alluded
22 to that earlier, instead of short- and long-

1 term, total spending is prices times quantity.
2 I guess it would make needing to pay some
3 attention, perhaps to the difference between
4 cost, cost incurred and price. And then a lot
5 of these other areas are what goes into making
6 up that total spending. And that gives you
7 kind of a metric, perhaps, for where the
8 biggest opportunities are in terms of drivers
9 for impacting spending.

10 MR. DEZII: But I guess the extra
11 boulder on top of that is then does it
12 translate into affordability for the patient.
13 Right? Because if it doesn't do that, then --

14 DR. MC CLELLAN: Right. And it
15 should be clear, too, as we discuss that link
16 around definition of affordability, while we
17 do have a patient-centered focus, we want to
18 also consider measures related to
19 affordability throughout the system and that
20 also gets at what all different stakeholders
21 insist that we do about affordability.

22 Okay, thanks, Aparna.

1 Any other comments on -- we have
2 mainly talked about -- this is nice. The
3 discussion about what is to be removed led to
4 the discussion of clarifying, in general, what
5 should be on the list and why.

6 Is there anything else that should
7 be added, any big concept areas that you think
8 are not covered here and that as we start
9 going into these specific areas we would miss?

10 It is kind of the last chance in
11 that we discussed this in February. Now a
12 chance to comment on them.

13 MS. MITCHELL: Just a quick
14 question.

15 DR. MC CLELLAN: Yes.

16 MS. MITCHELL: Are you assuming
17 that wellness is part of prevention or does it
18 deserve a separate category? I mean I have my
19 own cynical reservations about it as a
20 purchaser but I mean, certainly purchasers all
21 over the country are putting money in it. I
22 don't know. Does it deserve a spot of its

1 own?

2 DR. MC CLELLAN: Or can it be
3 incorporated? Nancy, do you want to -- I'm
4 sorry. Karen, do you want to talk about that
5 and how it fits in?

6 DR. ADAMS: I would like to
7 comment on this bringing the work from the MAP
8 Conservation Count Task Force as they are
9 considering wellness, as well as some of these
10 areas of prevention.

11 MR. NELSON: Mark, this is Gene
12 Nelson.

13 DR. MC CLELLAN: Go head, Gene,
14 and welcome. I'm sorry I didn't introduce you
15 on the phone earlier. Gene is joining -- are
16 you up at Dartmouth today?

17 MR. NELSON: Yes, I'm sorry I
18 can't be there with you in person.

19 One possible topic to keep on our
20 radar screen sometimes people call the
21 indirect process healthcare. So that if I
22 have a bad back and if I am employed and if I

1 am out of work, there is the direct cost to
2 me, the patient, or the payer and there is
3 indirect cost to the employer.

4 So, a potential gap is this whole
5 area of indirect costs that are associated
6 with illness and injury that the community and
7 the employer bear and it is often hidden. It
8 is often as large as the direct cost. We may
9 want to footnote that in some way. There are
10 some rather brief good measures of indirect
11 costs, absenteeism, an associate illness an
12 injury, something we may want to take account
13 of in some way.

14 DR. MC CLELLAN: Okay. I think
15 that is something that we can definitely
16 acknowledge, Gene, and maybe there are, as we
17 go through the specific measures, some
18 opportunities to illustrate that with, as you
19 said, maybe currently available measures.

20 To Dolores's point, too, obviously
21 there is a lot of attention out there around
22 wellness potentially being a path to

1 affordability of coverage and it does seem
2 like the report would need to at least address
3 that in some way.

4 David.

5 DR. HOPKINS: I was looking at
6 this list and the first item on it is cost.
7 And I suddenly realized what was troubling me.
8 When we are talking about affordability, what
9 matters is spending. It should say total
10 spending. And then we can get into an
11 interesting discussion about who is spending
12 what portion of the total of it.

13 So, I don't think that my
14 colleague Dolores, there, is saying she is
15 spending a lot of money for the insurance of
16 a whole lot of people in Massachusetts and
17 yet, those individuals, when they receive
18 care, also pay out-of-pocket.

19 And I just hope as we go further
20 into this that this group can really hone in
21 on those two aspects of spending that
22 ultimately almost define affordability, and

1 see what we can do to come out a family of
2 measures that is purposeful.

3 DR. MC CLELLAN: Well, let's stick
4 this for a minute. So, back to Aparna's
5 comment if the total spending is prices times
6 quantity, that can be broken into the part of
7 the price or the part of the spending that is
8 paid for by the patient directly out-of-pocket
9 and elsewhere.

10 I would like to go to Joanne right
11 now because I would want you to maybe
12 articulate the cost-price difference and we
13 maybe we can think about how to capture that.
14 Yes, I do think total spending and who pays it
15 is really important but that doesn't
16 necessarily match up with cost.

17 DR. CONROY: I have a big
18 semantics issue. The HFMA has done a lot of
19 work on defining the terms we are going to use
20 around charges, costs, price. And it is a
21 little -- it is not intuitive because we are
22 talking about cost here but they really mean

1 price.

2 So, prices in and cost is in the
3 eye of the beholder. So, for the patient, the
4 cost is going to be the out-of-pocket, whey
5 they pay out-of-pocket. For the provider, it
6 may be their total cost of care for that
7 covered life -- the payer, excuse me, over
8 that year. For the employer, it may be the
9 premiums.

10 So, they have actually spent a lot
11 of time and I know when we think about cost we
12 say do we really know our costs. So, we are
13 using the term cost to talk about price, what
14 people are paying from the four different
15 perspectives.

16 So, I would suggest that we kind
17 of -- we agree on how we are going to talk
18 about it because I think we will start arguing
19 about what it means. And they have got some
20 great definitions that were attached to the
21 document that I suggest that we actually start
22 using because then we are not going to argue

1 about something that is really a semantics
2 issue.

3 DR. MC CLELLAN: I would just --

4 DR. HOPKINS: I am suggesting that
5 spending tends to be pretty unambiguous.

6 DR. MC CLELLAN: I think we have
7 got the concept, David. But Joanne is right,
8 that HFMA did have sort of definitions of
9 these terms. What are you talking about
10 spending is what they were talking about in
11 terms of cost.

12 I would like to postpone the
13 detailed discussion of that until right after
14 the break when we are going to be covering --
15 you know you can see the next item on the
16 agenda is total cost measures. And that will
17 give us a chance to make these definitions
18 real around actual measure opportunities.

19 Nancy?

20 MS. FOSTER: So just to clarify,
21 Mark, this may be coming up not until later.
22 I wanted sort of call for us to look at not

1 just what is on there as total cost and cost
2 for the patient, but also cost for all of the
3 other parties that are engaged in this. We
4 have a unique opportunity now that we have
5 some standardized language about what
6 constitutes different levels of coverage.

7 So, making that clear to the
8 public is probably the most important thing we
9 can do right now.

10 DR. MC CLELLAN: Yes, that is
11 clearly important to a lot of the members of
12 this group. And I would like to have the
13 specific discussion around that in the next
14 section on cost measures.

15 Yes, Carl.

16 DR. SIRIO: So, I think this
17 dovetails off the other comments. But there
18 is two things I want to say.

19 The first is if we are going to
20 look at the Table 1 and the buckets of the
21 short-term and the long-term issues, it
22 strikes me that whatever you call cost, it is

1 difficult to envision that without a
2 conversation about underuse and
3 appropriateness. And that is only in the
4 long-term bucket.

5 So, I guess my question is is this
6 framed correctly? If we are going to talk
7 about total expenditures, whatever the charge,
8 then it is kind of hard in the acute setting
9 to not think about overuse and
10 appropriateness.

11 So, I would just comment in terms
12 of where that belongs there.

13 The second issue in terms of the
14 longer term issue as it relates to cost, and
15 you may want to save this for the next
16 conversation, if you are going to talk about
17 long-term cost, the issues around prevention,
18 it seems to me that at some point, maybe not
19 today, maybe not this round, you would want to
20 have a conversation about the larger cost of
21 lost productivity. And I mean this is not
22 just the healthcare spending but it is loss of

1 life, loss of wages, loss of being employed,
2 whatever. But there are larger economic costs
3 than just the actual policy spending on
4 services provided.

5 DR. MC CLELLAN: Right. And that
6 is a part of the real value of healthcare.
7 So, on the former, I kind of liked, and we can
8 keep discussing this as we go along, Aparna's
9 reformulation of total spending equals the
10 HFMA definition of cost and the components of
11 that, and then looking at things like overuse
12 and inappropriate use as potential key drivers
13 of that too high spending. So, it is not
14 really short- and long-term but measures of
15 the really overall affordability opportunity
16 and the drivers of that and this would be one
17 of the important drivers. We can see how that
18 plays out as we go on today.

19 And I take the point about overuse
20 and underuse, too, and productivity and
21 indirect measures. We don't have very many
22 measures, as you will see about productivity

1 and some of the work-related cost that Gene
2 mentioned a few minutes ago. But we can
3 certainly mention that in the report and there
4 will be some opportunities that come back to
5 that.

6 I did want to spend a couple
7 minutes before the break on the -- I'm sorry,
8 Kevin, go ahead.

9 DR. LARSEN: Just in addition, I
10 am going to add on to Gene in our thinking
11 about costs to patient. And a concept that I
12 have been really interested in for a few years
13 is treatment burden. In treatment burden, it
14 is the same outcome and have a very similar
15 intervention but the course of treatment --
16 and it could be very similar to cost. The
17 cost might be borne very differently between
18 patient and provider.

19 So, an example of this would be
20 the newer therapies for thinning the blood.
21 So, in the cheap old medicine, you get a pill
22 and you drive to the doctor every month and

1 get a blood test. And so from a patient
2 standpoint, that treatment burden and all of
3 the trips and all of the missed days of work
4 and all of the extra excess activity is
5 actually cost-shifting to the patient.

6 The newer medicines are cheaper --
7 are far more expensive but they don't require
8 all of this extra stuff as part of the
9 treatment. The outcomes are the same.

10 So, that there is an opportunity
11 not just to think about traditional cost
12 shifting but also how we are cost shifting
13 some of this to patients in a non-healthcare
14 space. What are their transportation costs?
15 What is their cost of home care that they are
16 bearing themselves or family care? And I
17 think that it is important not to lose that
18 because when I talk to families, those costs
19 are very important to them.

20 DR. MC CLELLAN: Thanks. And I
21 appreciate there have been a number of
22 comments about other dimensions of cost that

1 are not well-captured in many of the measures
2 that we have now that I think should be folded
3 into the report, too.

4 I do want to spend a minute before
5 we break on this last question about what we
6 mean by providers. So, there are some
7 questions about this in the homework exercise,
8 it gets to the topic of unnecessary use of
9 high-cost providers. How inclusive should
10 that be? Does it include, for example,
11 unnecessary specialist referrals, site of care
12 issues, things like that, too?

13 I see heads nodding, yes. Okay, I
14 should have known that with this group.

15 (Laughter.)

16 DR. MC CLELLAN: All right, so
17 well another area of consensus.

18 Any final comments before we start
19 diving into the specific areas? Yes, go
20 ahead, Sean.

21 DR. MULDOON: For an alternative
22 view, on a high-cost provider, that does not

1 take into -- have any effect on this measure.
2 So, we want to leave open the possibility that
3 the hospital, a doctor, or a visiting nurse
4 company could in fact be high-priced but
5 highly effective and highly worth it.

6 DR. MC CLELLAN: Right.
7 Absolutely. Go ahead.

8 MS. HASKELL: Well, that is sort
9 of my issue. When you are talking about
10 limiting referrals I think you have to be very
11 careful. People need to be able to have
12 choice in their healthcare and patients may
13 well understand a need for a referral more
14 than the general practitioner that they have
15 seen. I was thinking we need to keep issues
16 like choice and risk as part of the equation.

17 DR. MC CLELLAN: And for
18 affordability we are, not surprisingly,
19 focusing a lot on cost. But I think these are
20 good comments about how it really is about
21 value.

22 MS. HASKELL: But you can have

1 lower valued healthcare.

2 DR. MC CLELLAN: That's right.

3 Jim?

4 DR. DUNFORD: And I think that it
5 is important to remember that it is, sometimes
6 you call it high cost to provider but it
7 really is the site the provider works in that
8 really generates the cost.

9 In the emergency department, my
10 bill is a tiny fraction of the entire bill.
11 It is really the bill is generated by the
12 hospital. The reason the patient comes to me
13 is because the primary care physician doesn't
14 have a CAT scanner in his office and the
15 patient has abdominal pain and they need to
16 know right now what is going on.

17 So a lot of the costs in the work-
18 up that I have to deal with every day when I
19 evaluate complicated patients is because the
20 primary care physician is sending that person
21 to me with cancer trying to figure out whether
22 there is a new metastasis or not and I am just

1 the one who is using the expensive technology
2 but my bill is not even a percent of that.

3 So, the way we use high-cost
4 centers is really the issue. It is not the
5 doctor that is in the facility necessarily
6 generating the bill.

7 MS. HASKELL: And then I would add
8 part of what I was trying to say is you need
9 to provide opportunities for people to have
10 lower cost care, rather than we want to take
11 their abilities to have higher cost care. So,
12 we need opportunities for people to have
13 things done and not to have to pay the high
14 price.

15 DR. MC CLELLAN: Thanks. Beth?

16 DR. AVERBECK: One other way of
17 looking at it might be to see what is the
18 efficiency within the high-cost providers as
19 opposed to whether or not somebody who's
20 seeing one or a dozen, but once a patient sees
21 somebody who is higher cost than how a patient
22 proceeds with that episode of care.

1 DR. MC CLELLAN: Jennifer.

2 DR. THOMAS: Yes, I wonder if the
3 issue of higher cost providers would also
4 entail the use of specialty pharmaceuticals.
5 Some of the categories where we are looking at
6 the biologics, particularly in cancer, maybe
7 in --

8 DR. MC CLELLAN: Whether they are
9 going to be less costly alternatives.

10 Sean, is that still -- David.

11 DR. SEIDENWURM: Well, just on the
12 topic of high-cost providers and high-cost
13 sites of care, I do think that there is value
14 in limiting the -- you would have to call it
15 access and I will make the strong case.

16 There is, I think, a value of
17 limiting access to some of these high-cost of
18 care sites because they create cascades that
19 take on a life of their own. And arriving at
20 an academic medical center or arriving at an
21 emergency room, or arriving at a hospital
22 instead of a doctor's office or a specialist

1 instead of a primary care physician sets off
2 imperatives of its own and start chains of
3 events that result in very costly care often.

4 So, at some point, one has to say
5 that yes, there needs to be the opportunity
6 for the lower cost of care to be convenient
7 and to be accessible but there also needs to
8 be some way of preventing these cascades from
9 starting. So, I think we need to leave that
10 on the table.

11 DR. MC CLELLAN: Dolores and then
12 Aparna.

13 MS. MITCHELL: Just a quick note
14 on this issue of lower price providers as it
15 relates to something that Kevin said. And I
16 speak out of total ignorance. So, you will
17 forgive me.

18 But going back to have a blood
19 test every month to the same doctor or
20 hospital that initially diagnosed you may not
21 be the most efficient way to get your blood
22 test. It might be that your local CVS can

1 take a blood and can report the results.

2 So, that I think we have to think
3 about workflow and how it happens and how
4 changing workflow patterns can, in fact,
5 without compromising patient care or access to
6 the appropriate person to read the results or
7 to look at the results of that blood test can
8 in fact accomplish what is needed.

9 So, it means a mindset in which
10 you look at things and say how do we do this.
11 Do we have to do it this way? Is there a
12 better, cheaper, easier way to get the same
13 results without spending all that money?

14 DR. MC CLELLAN: Aparna.

15 MS. HIGGINS: So, I just want to
16 echo Jennifer's comments on specialty drugs
17 and devices. And I think one area that is
18 kind of missing that is a cost driver that was
19 not explicitly called out. We are talking
20 about utilization of existing technology. But
21 a huge cost driver is new technology entering
22 the market. And I think that is -- we aren't

1 calling it out separately but, obviously, that
2 is a huge cost driver. So, I think we should
3 do that.

4 DR. MC CLELLAN: Yes, maybe we can
5 make sure to that discuss that as part of the
6 utilization discussions. I'm trying to think
7 of where it fold it into the areas we have
8 now. I think that might be where it most
9 likely to end up fitting or maybe we are
10 likely to identify some gaps.

11 Gerri?

12 DR. LAMB: Just following up with
13 what Dolores was asking about. As we get into
14 the discussions of the lack of care
15 coordination at the recent measurement gap,
16 there was a lot of discussion about re-looking
17 at synchronization, organization and the
18 processes of care. And that was identified as
19 a huge gap in care coordination.

20 So, perhaps the link here to the
21 families of care coordination measures may
22 address some of this.

1 DR. MC CLELLAN: Okay, let's try
2 to discuss that when we get back from care
3 coordination. Chris, then Peg.

4 MR. DEZII: I will be brief. One
5 thing I am starting to learn in daily practice
6 -- I work across all therapeutic areas and
7 different specialty societies. What is
8 paramount is the payer structures are far
9 ahead of their performance measures. So what
10 someone said about the higher price or
11 whatever price you are paying, let's see what
12 value and quality you are getting, the
13 measures are far behind.

14 And the comment I make to you is
15 that, as we go through this day, we are
16 probably going to find gap. That is going to
17 be the big thing we find is gap.

18 DR. MC CLELLAN: We are going to
19 find some gaps, yes.

20 MR. DEZII: So, just to point to
21 Kevin and Dolores, so using the
22 anticoagulation model, which, by the way the

1 newer alternatives, frankly, are better than
2 the older ones. But what is most important
3 about all this, one, is I agree with the site.
4 Where do they need to go? But then there is a
5 lot of evidence that the patients aren't
6 getting the necessary blood work.

7 And two, I guess the whole thing
8 that really matters about this, cost and all
9 that stuff is nice but the stroke rates. What
10 is happening here? Which goes to my point
11 about the movement of measures and all this
12 stuff. It is a tough program.

13 DR. MC CLELLAN: So, Peg.

14 DR. TERRY: Just to follow up on
15 what Gerri was talking about, when you get
16 into care coordination and processes, you
17 really get into IT. So, as we are struggling
18 with IT, especially, again, in a post-acute
19 world, it is not connected, I think that is a
20 really critical part. And it is technology,
21 too. It costs money. So, I just wanted to
22 add that.

1 DR. MC CLELLAN: I appreciate the
2 comments about coordination. I think that is
3 good. I mean it is all great guidance for the
4 group. So, we don't need to, for example,
5 solve all of the issues with measures of care
6 coordination. But to the extent that they tie
7 into things like measures of whether there are
8 or should be less costly ways of coordinating
9 care more effectively or providing more
10 integrated services from a patient standpoint,
11 those do seem like they are within our scope.
12 And we will get into that with measures later.

13 Well, we did get a bit afield from
14 the questions on the table for consideration.
15 I think that was good for this session to make
16 sure we are getting all of the major issues
17 that you would like to see as we go into the
18 specific areas of measures and measurement
19 gaps.

20 So, we are going to do that
21 starting after the break and starting with the
22 big topic of cost measures. But right now, we

1 are going to take short break. We started a
2 bit late. So it is really efficiently, so I
3 am going to aim to starting at 10:50, so less
4 than 15 minutes.

5 (Whereupon, the foregoing meeting
6 went off the record at 10:34 a.m.
7 and went back on the record at
8 10:53 a.m.)

9 DR. MC CLELLAN: All right. So,
10 welcome back. We have had a few microphone
11 adjustments. But again, the same rules apply.
12 Try to speak into the microphone so everybody
13 can hear you, including Gene and the other
14 listeners on the phone.

15 So, we are now moving from the
16 general discussion of high-leverage areas into
17 the specific high-leverage areas. And based
18 on your comments this morning and in the
19 exercise and previously, what better place to
20 start than measures related to cost.

21 So, if you are following along in
22 the now numbered handout for today, we are on

1 page 20, Session 3. And we are going to start
2 out with the measures -- remember, the way
3 this goes is that staff tried to review
4 measures that were available, NQF-endorsed,
5 others that were in use, and then also tried
6 to take your comments about measurement gaps.

7 So, there are two tables here.

8 The first we will talk about is on actual cost
9 measures that are endorsed or that are
10 potentially in use that could be recommended
11 by this group, the specific measures in this
12 area. And say that the total cost of care,
13 population-based PMPM Index. To go back to
14 Joanne's terminology, by cost here, it means
15 spending. So, this is total spending measure.
16 And then you see several others listed in this
17 table as well.

18 Just as a prelude, I would like to
19 talk about these measures first. But,
20 obviously, there are some gaps in this area
21 and Table 3, which we will get to in a few
22 minutes, goes over those. And in fact, my

1 guess is we are going to want to spend most of
2 our time talking about the measure gaps, not
3 the measures.

4 But if we could start with just a
5 discussion of the preliminary measures for the
6 family, these are the ones that received
7 positive feedback, the ones that are on the
8 left column here are the ones that received
9 positive feedback in the pre-meeting exercise.
10 And the preliminary question is do we include
11 these in our final measure list?

12 And then should any of the
13 additional measures in this table, so the
14 staff picks that were not recommended for the
15 family and the additional measures that were
16 suggested during the exercise, should those be
17 included as well. And then we are going to
18 get to measurement gaps, of which there are
19 clearly significant ones.

20 Okay, Peg? Is that left over?

21 DR. TERRY: It is. I have nothing
22 to add.

1 DR. MC CLELLAN: Okay, Nancy.

2 MS. FOSTER: So you can gavel me
3 out if you want, if you actually had a gavel,
4 Mark. But in terms of total cost for care,
5 there are some other opportunities here, like
6 the Medical Expenditure Panel Survey, the MEP
7 survey out of AHRQ and there is a similar one
8 out of NHSN. It is not every patient but, as
9 you know, there is samples of patients from
10 across the country.

11 DR. MC CLELLAN: And so you are
12 talking about for just generally tracking --

13 MS. FOSTER: For general -- for
14 total cost.

15 DR. MC CLELLAN: -- for total cost
16 as opposed to measures that like particular
17 patients or payers or others.

18 MS. FOSTER: Right.

19 DR. MC CLELLAN: Okay.

20 MS. FOSTER: And I am wondering if
21 we are being a little limited in our sight
22 here by specifying these measures without even

1 thinking about those very valuable national
2 surveys that go one and have been going on for
3 many, many years.

4 DR. MC CLELLAN: Beth?

5 DR. AVERBECK: One question I
6 might have is what is the unit of measures?
7 Is this for medical groups, or hospitals, or
8 for communities? If we want to look at people
9 under 65 with out-of-pocket expenses over ten
10 percent, where would we measure that? I think
11 it might just help the discussion if we sort
12 of knew the endpoint who we were measuring.

13 MR. SAUNDERS: Sure. And so one
14 of the goals of the families is that they are
15 inclusive over multiple settings. And so the
16 idea is that if someone was putting together
17 a set of measures and wanted affordability
18 measures, they could turn to this family and
19 pull some out. So, the hope is that it
20 actually should stand. And then we got
21 measures that represent and we have done just
22 a back of the envelope calculation on the

1 staff level to make sure we have got some
2 standing.

3 I think your point is well taken,
4 especially for this line, where there are
5 fewer measures available at different settings
6 when we are trying to measure total cost.

7 DR. MC CLELLAN: Aparna?

8 MS. HIGGINS: So, I just wanted to
9 comment on what Nancy said. In addition to
10 MAP surveys, because obviously, all the
11 expenditures that CMS puts out, so to kind of
12 get a big picture, they also break it down by
13 what kind of insurance is of that total out-
14 of-pocket costs and so forth.

15 So, we should look at that.

16 DR. MC CLELLAN: And just so we
17 are being clear on where these directions are
18 headed, it is important to have measures at
19 the national and the regional level --

20 MS. HIGGINS: National level, yes.

21 DR. MC CLELLAN: -- that can be
22 derived from these surveys both for tracking

1 overall cost and components of those costs.
2 Are you all also suggesting that these might
3 be good models for where the more detailed
4 measures should head, in terms of filling
5 measurement gaps?

6 I am just trying to connect the
7 measures we have in the list that can be
8 calculated at the level of plans, provider
9 groups, in these different more detailed
10 levels with the national measures. It seems
11 like it would be nice if there were some
12 convergence on that.

13 MS. HIGGINS: I don't know what
14 that relationship is yet. I know it has been
15 studied in terms of the least specific
16 measures versus the big picture. And I think
17 starting with, for example, the NCQARU
18 measures the question always comes up with
19 somebody is measuring this but nobody knows
20 how these really affect total cost.

21 So, I think those relationships
22 are still fuzzy to me, at least, and I don't

1 know that there is enough evidence but I think
2 the goal should be to come to look these up,
3 so just kind of a framework that fits into --

4 DR. MC CLELLAN: Heading towards
5 convergence around really meaningful measures
6 of spending and components of spending.

7 Do we want to follow -- the staff
8 may want to follow up with you all after the
9 meeting on which specific measures to look at.

10 Ron?

11 DR. WALTERS: Yes, so this group,
12 probably more than other, challenged one that
13 the principles I have had since joining the
14 Hospital Workgroup and that is that we look
15 primarily at endorsed measures. And I think
16 the conversation we just started to get into
17 there is this may be a prime candidate for a
18 family that somehow in the report we have to
19 point out that there are good measures that
20 aren't necessarily endorsed. And I like the
21 term we used the linkage to what they mean and
22 how they could be used.

1 And while we focus predominantly
2 on endorsed measures, there are endorsed ones
3 that really, really might be useful.

4 DR. MC CLELLAN: So, I do want to
5 challenge you all in this session to try to be
6 as specific as you can about measures that do
7 that and maybe one in that category is the not
8 endorsed total per capita cost measure you
9 guys were all saying --

10 DR. WALTERS: I really hated to
11 vote against that one for all those reasons.

12 MR. SAUNDERS: Actually, Erin,
13 would you like to talk a little bit more about
14 that specific measure, the total -- the non-
15 endorsed total cost measure?

16 DR. MC CLELLAN: The non-endorsed
17 total per capita cost measure? One that was
18 staff picks not recommended for the family, I
19 think on account of Ron's point about these
20 are not currently endorsed. On the other hand
21 --

22 MS. O'ROURKE: Yes, I think

1 DR. MC CLELLAN: -- as Ron also
2 added to that, do seem to address important
3 area measuring.

4 MS. O'ROURKE: So, I think we had
5 put this not in the not selected because there
6 was less strong agreement than some of the
7 others, I think perhaps because it was not
8 endorsed. And as Ron was pointing out, this
9 tension of how do we want to use non-endorsed
10 measures.

11 So, do you want me to go into the
12 specs, Rob?

13 MR. SAUNDERS: Sure, just a quick
14 description of it.

15 MS. O'ROURKE: Yes, so this
16 reflects a mix of factors such as patient
17 illness, burden, service utilization and
18 negotiated prices. The total -- oh, I
19 apologize. I didn't see the first one.

20 The ratio of all actual Medicare
21 fee for service Parts A and B payments to a
22 physician or medical group for beneficiaries

1 attributed to them over a calendar year to all
2 expected payments to the physician or medical
3 group multiplied by the payment for the
4 average beneficiary in the sample.

5 MR. SAUNDERS: So, that sounds
6 like that is a little different than what you
7 are talking about Ron, but maybe we should
8 make sure that we are capturing some of these
9 national health measures is what I am hearing,
10 some of these national healthcare policy
11 measures need to be captured in the report in
12 some fashion.

13 And then the question fits into is
14 that necessarily in the family or is that an
15 adjunct to the family as a tool to help
16 whoever is reading this report?

17 DR. WALTERS: Yes.

18 DR. MC CLELLAN: Chris.

19 MR. DEZII: Just a point. It is
20 nice to get a description of that measure to
21 find out the important information of why it
22 is not endorsed. We went through the process.

1 But the point I wanted to make,
2 this isn't a measure but support, I guess, the
3 AHRQ measure, I mean as far as I know, the
4 Affordable Care Act, does define affordability
5 in the Act with the minimal essential benefits
6 that I think not to exceed nine and a half
7 percent.

8 So, I don't know if we put that in
9 there or if it has to be a measure or
10 whatever. Just a thought.

11 DR. MC CLELLAN: Thank you. Sean?

12 DR. MULDOON: A process question.
13 And this is the measure versus metrics debate.
14 Are you looking for approval of a measure or
15 all the way down to the metric? What is the
16 numerator? What is the denominator? What is
17 the DRGs? What is the definition of adequate?
18 What is the definition of comparable health?

19 DR. MC CLELLAN: Yes, I don't
20 think we get to there, not today. But to the
21 extent that we can identify specific measures,
22 at least start filling out this family, it is,

1 obviously, going to be really helpful for
2 encouraging implementation.

3 So, the way that the tables are
4 set out, Table 2 and 3 together, and we are
5 kind of shifting between both. I'm not sure
6 if that is the most efficient way to do it but
7 you all are highlighting some of the gap
8 areas.

9 I think the report is going to end
10 up, hopefully, having some specific measures
11 that the address this cost area that can be
12 used now, and then priority gap areas as well.
13 And I don't think we need to specify the exact
14 measures, especially in the gap areas, but to
15 the extent that there are some that we can
16 identify, that would be helpful.

17 DR. MULDOON: Well, it struck me
18 that it would be hard for this group not to
19 have a total cost, however formed.

20 DR. MC CLELLAN: Yes, good point.
21 Dolores?

22 MS. MITCHELL: This has been

1 troubling me all along in this process, not
2 just today's meeting but in previous meeting,
3 and a little bit in NQF itself I had the same
4 problem sometimes.

5 We talk about total cost. That is
6 a good thing to know but it doesn't help you
7 identify where in the chain of players
8 aberrations are or places for improvement.
9 So, is it the providers? Is it the hospitals?
10 Is it the doctors? Is it the ancillary
11 charges? Is it pharmacy? It is sort of like
12 when everybody is guilty nobody is guilty.

13 So, it is a little hard to think
14 in terms of amelioration or change that is
15 needed, if you don't dig down a little more
16 with the total. That is the first point.

17 So, I guess it is almost a formal
18 presentation. I mean this is an important
19 group. This is an important report. I think
20 you have to be very careful what language you
21 use. And saying -- and I think David referred
22 to this a little earlier, saying non-endorsed

1 sends a very negative message that may not be
2 appropriate when the problem is not that the
3 measures is bad or unworthy, but rather that,
4 shame on us and the society, we haven't come
5 up with a good enough measure. And just
6 saying there is a measure gap, I think doesn't
7 quite cut it.

8 So, I would like to suggest that
9 all this smart staff spend some time thinking
10 about more useful language in describing why
11 some measures aren't there, when your common
12 sense tells you they need to be there. And
13 they may not be there today but we are working
14 on it.

15 And whether it is measures still
16 under development, or looking for a bad
17 measure, or a call for measures in this field
18 will soon be made, whatever it might be.

19 But I think, as I say, so, two
20 points there, one, I think you have to try
21 very hard to dig down. Yes, you must have the
22 total cost. But two, beneath that, you need

1 to say what are the points. How did you
2 aggregate that and where are the areas for
3 improvement? And secondly, a form of
4 presentation that does not appear to say that
5 the measure is in fact not important or not
6 worthy of consideration.

7 DR. MC CLELLAN: Okay, just to
8 pick up on that, going back to Aparna's
9 comments about being able to look at the
10 drivers behind the total cost. And it would
11 be helpful to have a few more comments around
12 how would you like to be able to break down
13 that total cost measure.

14 There is a start at it, albeit
15 just a start, in Table 2. For example, the
16 next measure down is in the category of cost
17 by episode. So one way of looking at total
18 cost is how much is spent on treating
19 different conditions, how that varies.

20 The national surveys, as you
21 mentioned before, also break down costs by
22 type of provider, service area, inpatient,

1 outpatient, drug, and so forth. So, comments
2 that help make the connection that Dolores is
3 describing between total cost and actionable
4 decisions or policy areas are being really
5 helpful. And we got a start of that here but
6 we didn't need any more. David, you are up
7 next. Maybe you have something. David
8 Hopkins.

9 DR. HOPKINS: I don't know if I
10 solved that problem. But I am struck with the
11 presentation here that sort of brings me back
12 to what we were discussing earlier. If what
13 brings us together here is issues of
14 affordability and I look at the way this is
15 structured, just the left-hand side of this
16 chart, I still think that it would more
17 helpful and more to the point if we started
18 out with total spending and then broke it down
19 into who is paying, so we end up being able to
20 track them. I mean that is the whole point of
21 this exercise, right, is being able to track
22 things that are important.

1 So, total spending by purchasers,
2 total spending by patients. Total spending.
3 It seems like that is where the whole focus
4 should be on here. Everything else is
5 derivative from that.

6 The other point that is obviously
7 in this chart is it's all about gaps. And we
8 are going to say that over and over today.

9 So, I mean looking at cost by
10 episode and, by the way, Mark, that is another
11 interesting and worthwhile dimension of
12 discussion for us, I think, is how do we want
13 to look at spending. Spending by episode,
14 yes.

15 There are 500 or 600 potential
16 ETG-based cost measures, two of which have
17 been endorsed, apparently. So, whether we
18 look upon the rest of them as gaps or
19 opportunities, I am not sure which.

20 And I guess, if we are going to
21 talk more about episode-based measures, then
22 I guess at some point we have got to talk

1 about the work that is going on with the
2 Medicare episode group, since what we here to
3 do today, I think, is mainly to advise CMS.

4 DR. MC CLELLAN: Thanks.

5 MR. NELSON: I have a comment.

6 DR. MC CLELLAN: Yes, go ahead,
7 Gene.

8 MR. NELSON: Thank you. I agree
9 with what was just said. It seems to me that
10 the most important starting place is what was
11 just said, total expenditures or total
12 spending and to be able to break that down
13 first by the purchaser standing behind the
14 patient and then by the patient.

15 And just to further note that the
16 total spending measure should be available for
17 all populations, to the extent that data is
18 available. So, it is all populations, all
19 payers, public and private. And that that
20 should be cascadable down to different levels
21 of the system. So, how far down it goes, gets
22 difficult. But after you let's say health

1 plan level at the provider level, the provider
2 being perhaps a health system like Dartmouth-
3 Hitchcock, that is an accountable care
4 organization or a provider group, such as
5 Dartmouth-Hitchcock Clinic, a group practice,
6 and then it gets more difficult at the
7 individual, for example primary care or
8 principle care provider level, due to
9 attribution problems that may be overreaching.

10 But I agree with the comment that
11 it should be all payer and it should be
12 cascadable at different levels of provider
13 systems.

14 DR. MC CLELLAN: Thanks, Gene.

15 Nancy?

16 MS. FOSTER: Thank you, Mark. So,
17 I am going to need a little staff help with a
18 measure here because as I am looking at the
19 total cost per member per month measure that
20 is NQF-endorsed, it is -- there is a breakdown
21 by resource use service categories. And I am
22 wondering if that helps us get at where David

1 and others were going.

2 Can we look beneath the covers,
3 essentially, of this measuring to be able to
4 look at resource use in inpatient facilities
5 and evaluation and management procedures and
6 surgeries the way it is pulled out in this
7 measure, in which case we could probably check
8 that as a victory and move on. Or is it just
9 not tested out at that level and so more work
10 is needed?

11 DR. MC CLELLAN: Beth, do you want
12 to say something on this?

13 DR. AVERBECK: Yes. So, this is a
14 measure that is in the Minnesota market and we
15 have used it. The measurement is drillable to
16 place of service, inpatient, outpatient,
17 ambulatory, to a medical group. It has been
18 used in our market and now we are actually
19 seeing some of the improvement. So, you might
20 not see it from the title but you can get
21 very specific information for comparative
22 purposes and for improvement.

1 MS. FOSTER: So this measure, if I
2 may follow up on that, it does sound like it
3 gets us where we want to go, if we can use it
4 appropriately.

5 DR. MC CLELLAN: Yes, I have heard
6 comments along two dimensions in breaking down
7 cost. One is this one, which is the sort of
8 type of care involves, ambulatory, inpatient,
9 drug and so forth. The other is more patient-
10 focused, so type of conditions like the
11 hip/knee replacement measure. It seems like
12 both of those are viewed as important. And
13 this measure does help a lot, certainly with
14 the focus and maybe can be applied to the
15 episodes as well.

16 MS. FOSTER: And I think, Mark,
17 there may be a third which is the actual who
18 paid.

19 DR. MC CLELLAN: Yes. And getting
20 back to David's point, so the patient's third-
21 party purchaser division as a general
22 principle seems to be recurrent in here, too.

1 MS. FOSTER: And just one other
2 point I want to make, which is as the report
3 is working its way through the NQF on
4 sociodemographic factors, if that were to be
5 adopted, one might want to think about whether
6 it is, indeed, applicable to this.

7 I can imagine a setting where they
8 are caring for a lot of people who have no
9 primary care physician, who have little or
10 limited access to care. When they do access
11 care, they have many more needs. So if you
12 are looking at that, it may influence it. I
13 don't think we would want to hurt those
14 settings.

15 DR. MC CLELLAN: Okay, great.
16 Thanks. Joanne?

17 DR. CONROY: So just an
18 observation from our work in the Medicare
19 bundle project. It actually was quite helpful
20 when we got all of our information across all
21 of our medical centers on the cost methods.
22 Even though it is only the first step, it is

1 really the --

2 DR. MC CLELLAN: We want to say
3 cost buckets.

4 DR. CONROY: So, basically, they
5 looked at hospital costs. They looked at
6 physician costs. They looked at post-acute
7 costs. We didn't have pharmacy costs but that
8 would be fabulous if we had that. That
9 actually begins our conversations where you
10 actually look at where your costs are.

11 And so, that would be one
12 recommendation is if when we look at health
13 costs, if you ask what do you want to look at
14 underneath, I think if we could bucket the
15 site of service, that actually would be quite
16 helpful.

17 And then as the measures develop,
18 I think they become more sophisticated and you
19 actually are able to look at primary care and
20 specialty costs, et cetera. So, just a
21 recommendation.

22 DR. MC CLELLAN: Okay. And it

1 seems like we are getting there in terms of
2 the general direction to go. So, hopefully,
3 it will be helpful for our gap discussion,
4 too. Measures like the Minnesota total cost
5 of care endorsed measure do get that those
6 buckets that you were just describing.

7 In addition, we talk about
8 breaking those measures down by payments from
9 patient versus payments from third-party
10 sources. And in addition, we have also talked
11 about the episode-based measures or measures
12 that are more centered on patient conditions
13 and then specific types of patient care that
14 make up these buckets.

15 So, this is helpful for an overall
16 framing and we do have, if you look at at
17 least the top two measures, the total cost of
18 care measure and the new replacement measure,
19 those fit into this framework. So, this is
20 getting somewhere now.

21 Aparna?

22 MS. HIGGINS: So, just to

1 logically with David and Gene said in terms of
2 the framework and starting have the
3 breakdowns.

4 And so rather than trying to
5 reinvent the wheel, I guess it might be
6 helpful in the report because that is paints
7 the natural picture and then figuring out how
8 these fit into the markets. It is well-
9 recognized methodology David. So, I
10 understand it is not endorsed but I would
11 offer it.

12 DR. MC CLELLAN: And also, just
13 back to your original comment about being sure
14 that these categories match up with the
15 national survey statistics.

16 MS. HIGGINS: Yes.

17 DR. MC CLELLAN: Ron?

18 DR. WALTERS: So, this is why I
19 have become a believer in total cost of care,
20 too.

21 I think like David said, you have
22 to be able to do it both ways and slice and

1 dice it, depending on what the particular need
2 is at the time. Because if you take like the
3 episode treatment grouper, everybody knows
4 that a diabetic who has come in that has two
5 or three heart attacks and has a knee
6 replacement done is going to have different
7 costs than someone who hasn't. We call that
8 risk-adjustment from the perspective of the
9 knee replacement.

10 But the total cost of care for
11 that person can be sliced up in a lot of
12 different ways if they have a knee done and a
13 hip done and even a pneumonia during that
14 year. And so it gets very complicated.

15 We talk about attribution to a
16 provider. We don't even have the fields that
17 attribute it to a particular disease grouping,
18 unless we are looking from the perspective of
19 that episode of that disease.

20 And going through the definitions
21 of all those is just a nightmare that I
22 wouldn't care to do, which is why you have to

1 have the roll-up figure, which is what was the
2 total cost of care over some period of time,
3 probably per beneficiary, certainly on a
4 population basis. Because at some point, the
5 systems are not going to support attribution
6 down to that level. They are important and it
7 all depends on perspective. It also means
8 that no matter what perspective he takes, the
9 total of all those different viewpoints won't
10 add up to the total cost of care.

11 In fact, they will probably exceed
12 the total cost of care because, again, when
13 the diabetic comes into the hospital and needs
14 a bunch of things done for their hip episode,
15 that will be quote double counted, so to
16 speak, in an episode of treatment group for
17 their diabetes as well as an episode of
18 treatment group for their hip care.

19 And so, I agree completely. And
20 we have got to kind of point all of that out
21 somewhere in this as far as all these
22 different perspectives are very important and

1 the ability to capture those different
2 perspectives.

3 But the pie is going to be bigger
4 than the sum of the slices. I guarantee you.

5 DR. MC CLELLAN: Okay, so now it
6 all sounds really hard and complicated.

7 DR. WALTERS: It is hard and
8 complicated because I am doing it right now.

9 DR. MC CLELLAN: So what I am
10 taking away from this is there is at least on
11 a conceptual level an agreement on framework
12 going forward. As you pointed out eloquently,
13 Ron, filling in the details of that is really
14 hard and we are a long way from it. And I
15 think that is reflected in the brevity of
16 Table 2 and the length of Table 3 and your
17 comment, and other comments that have added on
18 to the length of Table 3.

19 I was going to come to you in just
20 a second but your card keeps going up and
21 down. I like that kind of efficiency by the
22 way. Thank you, David.

1 What I guess I would like to do
2 now is try to finish up Table 2, so kind of a
3 re-framing of Ron's point is that there is not
4 that much stuff we can put in Table 2 now,
5 despite this general sense of where we would
6 all like to go. And I would like to spend the
7 rest of the time on Table 3.

8 From what I have heard so far,
9 just to throw this out, the endorsed total
10 cost of care measure, thank you very much,
11 Minnesota, has a lot of support from this
12 group because it gets at total cost and it
13 looks at different components of cost that
14 start getting toward actionability. It would
15 be nice if that could be broken at least into
16 total cost paid by the patient and total cost
17 paid by third-party payers. So, we can add
18 that comment, too.

19 I think there is kind of general
20 support for the ETG hip/knee replacement
21 measure as a sort of one out of five hundred,
22 David, of the episodes that could potentially

1 add up to a more comprehensive patient-focused
2 look at where the opportunities for improving
3 affordability are. So both of those go on our
4 list. It is not clear from the discussion,
5 and maybe we need to go back and look more
6 closely about whether the not endorsed total
7 per capita cost measure adds anything else
8 there. And I don't know if we need to do that
9 right now if we are not ready to look at that
10 measure in detail.

11 But I would like to ask about
12 there are two costs to patient measures in
13 this table that don't really fit in the
14 framework we have been discussing. So, do we
15 want to include those or not? And then I want
16 to spend the rest of the time on Table 3 and
17 thinking about how to move forward on filling
18 the gaps. Sound okay?

19 So first, these two costs to
20 patient measures, should those be included in
21 our specific recommendations? Again, I am not
22 saying they are unimportant. I am just not

1 clear how they fit in that framework we just
2 described.

3 David?

4 DR. HOPKINS: So, I would propose
5 the one on the lower right that AHRQ has
6 highlighted is squarely aimed at the spend by
7 patient, at least --

8 DR. MC CLELLAN: And that is close
9 to what we were talking about earlier, the ACA
10 definition of affordability.

11 DR. HOPKINS: Yes, and it should
12 be synch up with that.

13 The endorsed measure, that is
14 pretty important but it is a little of a
15 stretch from affordability to that.

16 DR. MC CLELLAN: So no on that
17 one? Important but not core to our purposes
18 here.

19 Kevin?

20 DR. LARSEN: I have just two quick
21 things. I agree about the one on the lower
22 right. I am wondering if you could suggest

1 that they look at potentially grouping it in
2 the same way that the total cost to the health
3 plan would be. I think it would be a really
4 elegant solution if we had some way to compare
5 the same kind of drilldowns that we have at
6 the health plan level; what is inpatient, what
7 is outpatient, what is labs to patients'
8 costs.

9 The second question I have, and I
10 am sure that the group knows this better than
11 I do, but the last time I was in these
12 discussions in the State of Minnesota and we
13 had a lot of discussions about which of these
14 groupers would we use. And some of that
15 discussion was around were they were
16 proprietary or not and what was the burden of
17 implementing the measure because you had to
18 pay the proprietary cost of using a grouper.

19 And can anyone remind does ETG, is
20 it free or do you have to pay?

21 MS. MITCHELL: You have got to
22 pay.

1 DR. LARSEN: You have got to pay.
2 So, I think that is something that, at least
3 at the State of Minnesota, was a very hot
4 topic in conversation and when we had a very
5 similar meeting on this a few years ago. I
6 wanted to raise that to hear about whether or
7 not calling out a proprietary paid for grouper
8 is something that we want to asterisk somehow.

9 DR. MC CLELLAN: Nancy.

10 MS. FOSTER: So, I'm a little
11 puzzled about the measure in the lower right-
12 hand box. I think it is part of the MEPS
13 family of measures. I can't type fast enough
14 to double check that. And if it is, that is
15 good and helpful but it doesn't get at that
16 whole question that we have been trying to get
17 at.

18 DR. MC CLELLAN: The whole
19 question of what?

20 MS. FOSTER: Of who is paying, and
21 what, and all of that.

22 DR. MC CLELLAN: I think it is a

1 MEPS measure. It sounds like something that
2 MEPS would pass or you would be able to
3 calculate from MEPS.

4 MS. FOSTER: Yes, I think so. And
5 that would be useful.

6 But we may also want to encourage
7 them to go to the over 65 population and
8 figure out how many people have expenditures,
9 more than ten percent of their income as well.

10 DR. MC CLELLAN: Okay, so with
11 that qualification, it sounds like we are
12 leaning towards the two top left measures,
13 plus this one and not the others.

14 MS. HASKELL: I have a question as
15 to why the measure for inadequate insurance
16 coverage for children would not be measuring
17 affordability.

18 DR. MC CLELLAN: So, let me see if
19 I can frame an answer and this is just for
20 discussion purposes.

21 What it seems like we want to
22 highlight in cost measures is being able to

1 get at a real measure of total spending on
2 care and how it is paid for by the patient or
3 the family that may have significant out-of-
4 pocket costs for the children, how it is paid
5 by third-party payers, and how those costs
6 break down.

7 This measure may get inadequate
8 insurance coverage. I am not exactly sure how
9 it is defined in here but it sounds like what
10 we are aiming for is a more systematic
11 quantitative and actionable approach to -- if
12 families are paying a lot out-of-pocket for
13 their children's care, why is that? You know
14 where are those costs to provide more of a
15 clear sense of what to do about it.

16 MS. HASKELL: Well, I guess my
17 concern is if this is what is available for
18 this other study, the --

19 DR. MC CLELLAN: If we go to David
20 and Erin or others if there is anything you
21 want to add about the NQF 0723 that would be
22 helpful here, then I will come to you next.

1 DR. SEIDENWURM: Were you
2 suggesting that we leave off the episode
3 grouper measures?

4 DR. MC CLELLAN: No. I was
5 suggesting leaving on this particular endorsed
6 episode grouper measure. And then since for
7 the other episode measures, they are not yet
8 either ETG or others are not yet endorsed.
9 There is a lot of activity going on around
10 them but basically that activity is running
11 into the challenges that Ron described. And
12 on top of that, Kevin noted that proprietary
13 grouper measures may have problems with
14 broader adoptions.

15 So, I am pushing all of that
16 except the ETG hip/knee replacement measure
17 that is endorsed to our discussion of Table 3,
18 which is coming after we settle on whether
19 there are any measures besides top left two,
20 bottom right one that we want to specifically
21 include in our measure set right now.

22 And we were just talking about

1 whether children having adequate health
2 insurance coverage should be added to that
3 list or not.

4 Yes, please, jump in.

5 MR. SAUNDERS: Sure, on the
6 children with inadequate health insurance
7 coverage, the reason that measure went in is
8 that staff struggled a lot with this category.
9 The feedback that we heard from the group was
10 that there was an interest in looking at out-
11 of-pocket costs. And so when we did our
12 measure scan, we looked through all NQF-
13 endorsed measures and any measure we could get
14 our hands on that tried to get at that. There
15 just aren't very many well-defined numerators
16 and denominators. And this at least had the
17 mention that not only was it about insurance
18 coverage but whether out-of-pocket cost for
19 that insurance coverage were reasonable.

20 So, this was a staff -- we were
21 reaching, just to be blunt. So, it is on here
22 for that reason. But that was why it is

1 there.

2 DR. MC CLELLAN: Can you guys say
3 a little bit more about the measure in case
4 people aren't completely clear on that?

5 MS. O'ROURKE: So, the measure is
6 designed to ascertain whether or not the
7 current insurance program coverage is adequate
8 for the child's health needs, whether out-of-
9 pocket expenses are reasonable, whether the
10 child is limited or not in choice of doctors,
11 and whether the benefits meet the child's
12 healthcare needs.

13 The numerator is percentage of
14 children whose current health insurance
15 coverage is adequate for meeting healthcare
16 needs. Adequate insurance is defined by a
17 child who currently has health insurance
18 coverage and the benefits usually or always
19 meet the child's needs and usually or always
20 allowed the child to see needed providers, and
21 either no out-of-pocket expenses or out-of-
22 pocket expenses are usually or always

1 reasonable. The denominator is children ages
2 0 to 17 with current insurance.

3 The care setting is national
4 population. So, this is a population-based
5 measure.

6 MS. HIGGINS: What is the data
7 source?

8 MS. O'ROURKE: The data source.

9 DR. MC CLELLAN: That was one of
10 the national surveys.

11 DR. HOPKINS: So, reasonable is a
12 word that is used in the survey and not the
13 respondents' interpretation.

14 MS. O'ROURKE: Correct. Yes, this
15 is used for the National Survey of Children's
16 Health.

17 DR. MC CLELLAN: All right.
18 Sounds like David doesn't like it.

19 Okay, Sean?

20 DR. MULDOON: On the cost to the
21 patient, I am going to move a little bit from
22 the muddled head into the simpleminded.

1 But doesn't an annual out-of-
2 pocket expense per person get close enough to
3 whether it is greater than ten percent of your
4 income, because nobody knows what your income
5 really is, or whether that was adequate? It
6 would be obvious to identify those without any
7 insurance or without inadequate insurance
8 because it would just be a real hot number.

9 It is pretty simple. It is pretty
10 blunt.

11 DR. MC CLELLAN: Basically you are
12 saying the bottom right version but not just
13 greater than or less than ten but what the
14 number is.

15 DR. MULDOON: Right. Wouldn't
16 that be a nice number for the --

17 DR. MC CLELLAN: That would be
18 nice.

19 DR. MULDOON: Well you have to
20 know it in order to get to either of those.
21 You have to know it to get to the bottom
22 right.

1 DR. MC CLELLAN: Yes, I mean that
2 is certainly not an endorsed measure. It
3 seems like it is not a very big leap from this
4 AHRQ measure.

5 DR. MULDOON: But it is very
6 meaningful to the consumer to say that if you
7 know that it costs \$6,000 per person to insure
8 them and oh, by the way, \$2,200 of that came
9 out-of-pocket --

10 DR. HOPKINS: That is a spending
11 measure as well.

12 DR. MULDOON: Okay.

13 MR. SAUNDERS: And I think then
14 the issue just is whether that is a gap.
15 Because we don't necessarily have a well-
16 defined measure there with numerators and
17 denominators and risk exclusions and the like.
18 But it is certainly something that we could --

19 DR. MC CLELLAN: I think what we
20 are trying to say is technically it is a gap
21 but it is not a very big gap from at least
22 this measure that is listed here. Why can't

1 we just get this version?

2 I think we can find a way to
3 capture that in the report. Now, there are
4 some things in gaps that are going to be
5 bigger lifts but that seems like it could get
6 there.

7 I do want to turn to gaps but back
8 to NQF 0723, which I guess another way to put
9 this is that it includes a lot of subjective
10 judgments from a national survey. It is not,
11 by itself, going to get where we want to go.
12 But if we want to say anything positive about
13 that, helping in the short-term or just noting
14 that it is there and maybe not, endorsing it
15 so strongly. Any sense of the group on that?

16 DR. CONROY: So, I'm just confused
17 how this could create some action accepted
18 from the federal level is horrible. I mean
19 how can you actually take this information and
20 actually change how we deliver care within the
21 system? I just am not seeing where --

22 DR. MC CLELLAN: Okay, I get that

1 the theme that people want here is getting to
2 actionability and that there are some
3 measures, these first two, this modified
4 version on the bottom right, that seem like a
5 very good start at that. And that is where we
6 want to really push. There is some, maybe a
7 few other measures that could be used in the
8 meantime but we really think there can be
9 progress fast to get to at least some total
10 cost and cost breakdown measures for patients
11 and for third-party payers.

12 Okay, --

13 DR. HOPKINS: Hey, Mark, did you
14 mean to exclude the second ETG measure?

15 DR. MC CLELLAN: The one on column
16 two or row two?

17 DR. HOPKINS: Yes, there is two of
18 them.

19 DR. MC CLELLAN: No, I didn't mean
20 to do that. Those are both okay from my
21 standpoint and from the standpoint of the
22 group, it seemed like.

1 Yes, Peg?

2 DR. TERRY: This may be very naive
3 but if we look at the one on the right, the
4 lower right, I mean we talked about getting
5 this out for a survey. And so I don't know
6 how the survey reaches the low income. And so
7 I assume that is part of all of this. But to
8 me, that is a critical facts on how you reach
9 those people. Other measures are based on
10 what providers provide but this is really --

11 DR. MC CLELLAN: Yes, I think that
12 is right. And several people have already the
13 comment of seeing what specifically the lower
14 socioeconomic groups for these measures. Now,
15 they are not endorsed measures for that now
16 but that clearly should be an important
17 message to report.

18 Okay, let's turn to Table 3. And
19 I think we have talked a bit about how it
20 would be nice to have a much more
21 comprehensive set of episode or more patient-
22 focused breakdowns in these total cost of care

1 measure. And by patients I don't mean just
2 patient out-of-pocket costs. I mean total
3 cost that particular kinds of patients incur
4 and whether they paid them or a third-party
5 pays them.

6 As David mentioned, there are
7 potentially 500 ETG groups. There are a lot
8 of measures listed here for -- or a lot of
9 areas listed here for cost by episode. So, it
10 seems like generally we want to say something
11 about moving towards making those kinds of
12 measures more widely available.

13 But I would also like you to look
14 at the other items in this table and see if
15 there are any additions or modifications to
16 including them as cost gaps as well.

17 And if there are any comments as
18 well about relatively low-hanging fruit, so
19 talk about modification of that out-of-pocket
20 payment measures being a relatively small
21 step for measures that are available. If
22 there any particular areas to highlight here,

1 that would be helpful, too.

2 Kevin.

3 DR. LARSEN: I don't know where
4 kind of transparency of information versus
5 measurement kind of the space is. But I would
6 be curious from Beth, for example, I was just
7 looking at the Minnesota Community Measure
8 which does cost by procedure, for example, and
9 does that across the state and state medical
10 groups. And it is similar to the kind of work
11 that Caslight is doing now around aggregating
12 lots of claims and doing really granular
13 comparisons of costs by service provider or
14 procedure.

15 And I think that is really key.
16 Whether or not it is measurement or whether it
17 is just transparency is not as clear to me.

18 DR. MC CLELLAN: And for our
19 purposes, I would focus on is there a measure
20 that could be made available that would then
21 mean transparency.

22 And do you want to say something

1 about the procedure or measures that you use?

2 DR. AVERBECK: Yes. So that is
3 sort of like an average cost or price per
4 procedure and number of CPT codes, some
5 procedures, some office visits. And then it
6 is aggregated across all of the health plans
7 within that. It is listed by -- grouped by
8 procedure with a comment call your own
9 insurance plan to find out what your
10 particular benefit structure is. So, it
11 happens to be the page that gets the most hits
12 compared to any other page.

13 We are trying to do a total cost
14 of care that would also be transparent at the
15 provider level with all the payers in the
16 state. And that is in the pilot phase right
17 now. So, we think it is the both "ands" --

18 DR. MC CLELLAN: So, where are
19 these measures in terms of NQF endorsement and
20 that sort of thing?

21 DR. AVERBECK: The procedure
22 wasn't NQF endorsed. It was just a community

1 effort to get some transparency while they
2 were working on the total cost of care. The
3 procedure occurred before the total cost of
4 care measure was endorsed. Now that the total
5 cost of care measure is endorsed, the
6 community is working around getting the total
7 cost of care measure transparently reported as
8 well.

9 DR. MC CLELLAN: Aparna?

10 MS. HIGGINS: Just a couple of
11 reactions to the table. So, in terms of the
12 gaps that are listed, I think again we just
13 talked about one measure where you can get to
14 a grouper that is shown in the previous table.
15 Similar to that, I think for the example, as
16 we were talking about just looking for that
17 ETG report. So, things are listed in the
18 gaps, some of those are reported at the
19 national level. So, that is something that
20 would get to and not wait a long time for --

21 DR. MC CLELLAN: When you say
22 some, do you want to --

1 MS. HIGGINS: So for example, you
2 know the NAG reports on how much private
3 business pays for health expenditures, their
4 total share -- total spending for health in
5 this country, what share of that is paid for
6 by employers, what share is paid for by
7 households. So, those kinds of things
8 currently exist. I don't know if they are
9 necessarily gaps but could we fill them,
10 potentially?

11 And in terms of, I think, from
12 Kevin's point about the cost per episodes or
13 cost per procedures and so forth. There are
14 third-party tools at Caslight. You know a
15 number of plans have their own tools where
16 they make this kind of price information
17 available. And as Joanne has pointed out,
18 this is price information that a lot of times
19 it is based on negotiated rates, takes into
20 account benefit structure. So, it tends to --
21 it is going to vary. So, I don't know that we
22 get to an informed definition because a lot of

1 things going into determining we are not
2 talking expenditures is going to fall on the
3 individual.

4 DR. MC CLELLAN: So, two things I
5 would like to highlight there for the group.
6 One is the point about what there are, at
7 least at the national level, reports of things
8 like employer versus household share of
9 spending. So, we can actually include that as
10 a measure now, at the national level, and one
11 that could be a basis for trying to extend out
12 more to a regional group provider and so forth
13 levels.

14 And I guess the second point about
15 copays and deductibles and patient payments
16 depend a lot on plan structure. So, it is
17 hard to come up with one generally meaningful
18 measure for all patients. And as Aparna said,
19 there are a lot of activities by plans and
20 employers now to try to create more
21 transparency around that.

22 I'm not sure what that means for

1 what this group can best do to -- obviously
2 transparency is good. Consistent transparency
3 would probably be better but there are a lot
4 of differences among the ways that kind of the
5 episodes are constructed or the out-of-pocket
6 payments are calculated from plan to plan and
7 system to system.

8 I don't know if you want to
9 comment further on that.

10 MS. HIGGINS: Well, there are
11 differences. A lot of it is driven by what is
12 negotiated price, what is the individual's
13 benefit structure, and so forth.

14 I mean while some consistency I
15 think is good, it is hard to get sort of
16 perfect consistency. And you know Joanne
17 brought up the HFMA report and we were
18 certainly involved in that process but that
19 rather trying to reinvent the wheel, we should
20 look at that report because it has some good
21 principles for how things could be reported.

22 So, there is some level of

1 consistency in the reporting and consumers may
2 look at the information, understand what is
3 included and what is not included, and
4 estimates, and so forth. But I think that is
5 much more of a transparency rather than a
6 measure issue from my view.

7 DR. MC CLELLAN: Well, I am just
8 trying to make this report as useful as
9 possible. We want to say something about that
10 direction is good. Do we want to just
11 encourage it? Is there anything else that we
12 should add to that kind of push towards to
13 transparency. I mean transparency and
14 availability of these measures is what
15 affordability measurement -- is what the goal
16 of this Task Force is. Right?

17 MS. HIGGINS: Well, I mean
18 speaking for myself, I guess I don't see any
19 harm in sort of highlighting transparency, the
20 importance of that, and then also lead to
21 other efforts like HFMA qualities and actually
22 report out there with some principles.

1 DR. MC CLELLAN: Great. Go ahead.

2 DR. LAMB: I'm struggling a bit
3 with the role of cost by episode and where are
4 the boundaries and how to build the narrative
5 to look at that.

6 I am thinking about whether it was
7 David or Chris who said there is like 500 of
8 these, which is, these are defined by high
9 prevalence and high cost. And certainly, they
10 do drive a lot of cost, per your discussion
11 before, but this, for me, is where the
12 prevention piece comes in. Many of these
13 episodes may be very preventable.

14 And so, I am wondering if there
15 needs to be some aspirational narrative that
16 as we look at what are these episodes costing
17 right now what proportion of them could be
18 avoided.

19 DR. MC CLELLAN: Thanks. David?

20 DR. HOPKINS: So, this is a good
21 list. And actually my intention was dropping
22 on that list of cost by episode on the

1 obstetrical cost because a lot of this here
2 and in a lot of other places are working on it
3 and making it better for mothers, babies and
4 also lowering costs at the same time.

5 So, my comment on this one is it
6 is interesting how we continue to think of
7 siloeing returning here. So, this is the cost
8 of the mother having the baby but the baby is
9 nowhere in the equation. If you are going to
10 look at an episode, shouldn't we be looking at
11 mother and baby together? Because a lot of
12 these kids are born early and some of that is
13 for reasons that are preventable. And when
14 they are born early, it is very high cost.

15 So, we are really missing that
16 boat if we don't put the two together here.
17 And it seems like breaking out of a paradigm
18 to suddenly start thinking about mothers and
19 babies together when you look at the total
20 cost of maternity care.

21 DR. MC CLELLAN: Thanks. Beth?

22 DR. AVERBECK: I think one way of

1 looking at some of the costs or separating the
2 cost of care and cost of coverage. And
3 sometimes we might be mixing them a little
4 bit. So, I think that with premiums, those
5 kinds of things, that is the cost of coverage
6 for the care. So, I don't know if there is
7 any way to kind of separate those concepts to
8 some extent as we get our report prepared.

9 DR. MC CLELLAN: Thanks. Wei.

10 DR. YING: One comment on the cost
11 of episodes. So, what the measure, even the
12 existing measures only tells us what the total
13 cost is. What we found is more helpful is
14 actually do the driver analysis even
15 underneath that. So, it is similar to the
16 discussion happened with the total cost. And
17 so, just knowing the total cost is not
18 necessarily useful but knowing whether it is
19 inpatient, outpatient or ED or office visit as
20 a driver is more important.

21 So, for the cost by episode, if we
22 are just reporting some numbers it may not be

1 actionable. But if you can do a further drill
2 down and then see whether it is surgical cost
3 or it is a pharmacy cost, it will be more
4 meaningful.

5 And then the other comment is on
6 employer spending. I think it was mentioned
7 in the earlier discussion from an employer
8 point of view is not just how much dollar is
9 spent on the payment, another aspect of it is
10 indirect costs. So, what is the productivity
11 of the productivity and the absenteeism?
12 There is no measure there right now. Thank
13 you.

14 DR. MC CLELLAN: Thank you.
15 Nancy?

16 MS. FOSTER: So, I am a little
17 worried about the mental disorders cost by
18 episode measures, only because our lack of
19 infrastructure for mental health care in this
20 country has blinded us to a lot of the cost of
21 not treatment of mental disorders. And I
22 worry that we are going to skew it by looking

1 at the costs that we can measure. I don't
2 know how to get around that but it is a
3 cautionary note I would put out there about
4 using that particular episode of care measure.

5 DR. MC CLELLAN: Thank you.
6 David?

7 DR. SEIDENWURM: Yes, when we look
8 at these cost of episodes, I would like to
9 focus on those that can be used for shopping,
10 so to speak, because I think that for example
11 we had the hip and knee and we had the
12 pneumonia.

13 The hip and knee is a great
14 episode to look at because you have a choice.
15 You have got a plan. You have got some kind
16 of plan that you can go through, you can look
17 at the results, for example, of the CALPERS
18 experiment. You can really change people's
19 behavior and change cost.

20 When you have your pneumonia, you
21 don't have as much choice about where you go.
22 So, I would like to focus on the conditions,

1 maybe cancer, you have a choice of where you
2 go once your diagnosis is made. Rather, for
3 example, cardiovascular, at least, you don't
4 have much of a choice about where you go when
5 you have your MI.

6 So, I wonder if that might be a
7 way to prioritize.

8 DR. MC CLELLAN: Thank you.
9 Dolores.

10 MS. MITCHELL: Just a quick
11 question. Why are neither diabetes nor
12 arthritis on this list, particularly since, as
13 I remember from our instructions, we are
14 supposed to think about what things are good
15 for what federal programs? And a lot of old
16 folks have those two diseases. And at their
17 early stages, they may not be very high cost
18 but over time, they are very expensive.

19 DR. MC CLELLAN: Okay, thank you.
20 Aparna?

21 MS. HIGGINS: So, Nancy's comment
22 kind made me think about -- I know we are

1 talking about gaps and identifying existing
2 measures and so forth but I wonder if we
3 should also have a discussion about current
4 barriers to measurement and how to measure
5 measurement.

6 Mental health is a real issue
7 where it is not just a health system function
8 but there are lots of state laws around
9 sharing information across providers, cost
10 barriers to measurement as well. So, on one
11 hand I think we should have a discussion about
12 some of these issues that also need to be
13 addressed to enable us to implement measures
14 going forward.

15 And I wanted to react a little bit
16 to what David suggested in terms of
17 prioritizing, as well. I think that is a good
18 framework to think about if we were maybe
19 thinking about from the patient standpoint
20 because obviously --

21 DR. MC CLELLAN: So you are
22 talking about the ability of patients to take

1 time and choose once they have a diagnosed
2 disease.

3 MS. HIGGINS: I think if we are
4 trying to look at this from a different light
5 in terms of you know improvement as Joanne was
6 talking about or trying to drive efficiency
7 and figure out which are the more efficient
8 providers, then we may want to kind of
9 prioritize. So, I think that is a discussion
10 we should have.

11 DR. MC CLELLAN: Thank you. Chris
12 and then Sally.

13 MR. DEZII: Yes, I wanted to
14 follow up on the -- I think also the multi-
15 morbidity one is one of the bigger ones
16 because I think it gets to the diabetes -- I
17 guess my question is multiple morbidity with
18 functional cognitive impairment cost, is that
19 a subset of a multi-morbidity group or -- I
20 guess I don't understand what that means.

21 Another point I would like to make
22 care withheld due to patient's inability to

1 pay. Should there be sub-bullets care
2 provided, despite patient's inability to pay?

3 See, I don't know how care
4 withheld is identified because a lot of folks
5 will just make -- because they can't afford
6 the care will just opt not to do it and then
7 get sick and die or whatever. And I don't
8 know how that gets captured.

9 DR. MC CLELLAN: Yes, it would be
10 hard to capture directly. And I think that
11 does highlight the importance of matching
12 these costs or other affordability measures
13 with quality measures in the same area.

14 Sally?

15 MS. TYLER: Right. I wanted to
16 follow up because Nancy's comment on mental
17 disorders made me think about just a question
18 to the group about how appropriate measuring
19 cost by episode is to chronic illness in
20 general or how inappropriate it is. Because
21 obviously, you have to get some measurements
22 here. But I think when we say by episode,

1 what does that mean for someone with chronic
2 illness, the various types of chronic illness?
3 Because I believe you are measuring sort of
4 what are the price point and there is more
5 intervention needed. With chronic illness, it
6 is ongoing cost of treatment, which is
7 longitudinal. And I don't think that is
8 captured in cost by episode in the way I think
9 about it, at least. Does that make sense?

10 DR. MC CLELLAN: It certainly is a
11 challenge in defining episode well.

12 Sean?

13 DR. MULDOON: The same comment
14 about just cleaning up the language around the
15 term episode for chronic disease.

16 DR. MC CLELLAN: Do you want to
17 try stating this?

18 Well, we have got the general
19 problem.

20 DR. MULDOON: Well what you are
21 really -- I think you are asking for an
22 exacerbation of a chronic disease. You are

1 smoldering along and you have costs that go on
2 for years and years and then something happens
3 and you decompensate. Now, if that is a cost
4 you're interested in, hopefully it didn't
5 happen or happens at a lower rate for all the
6 reasons other people say. But otherwise, you
7 don't have a way to start a clock on it.

8 And it is pretty blunt but if you
9 are concerned about the cost of that little
10 exacerbation, that is all you have got.
11 Otherwise, you have an ongoing annual cost and
12 that is a different -- you don't use the word
13 episode for an ongoing annual cost of chronic
14 disease.

15 DR. MC CLELLAN: Kevin?

16 DR. LARSEN: Yes, I second that.
17 I think that there is a chronic disease burden
18 cost that is important and not well-captured.
19 And then again, I think we need some
20 sophisticated work around this for people with
21 multi-morbidity or chronic, have got multiple
22 chronic conditions. I serve on a workgroup at

1 HHS that has been trying to tackle that for a
2 while and have had the pleasure of trying to
3 build measures around it.

4 And we have some fundamental
5 definitional challenges about what equals
6 multiple chronic conditions. And how do we
7 know that Group A is identified in the same
8 way as Group B. And there is an exceedingly
9 long tail of variance in what is covered in
10 that. So, just a word of caution.

11 I think it is important. And so,
12 we have thought about reframing it in more
13 like age categories or something, saying
14 people over age 80, we can assume they are
15 going to have one or more condition for the
16 most part. And so thinking of -- turning it
17 a little bit on its head because it is really
18 hard with the variability of how many
19 different diseases and combinations there are.

20 And an opportunity, I think, and
21 the only place you can look is the high-volume
22 health collaborative, who has been defining

1 some really actionable measures across a
2 number of health systems in this very space,
3 and looking at both improving the outcomes at
4 the same time is becoming more efficient.

5 So, I would point us to them and
6 say that that is a potential other place to
7 look at measures that may be ready for prime
8 time. They just haven't come through an NQF
9 process.

10 DR. MC CLELLAN: Dolores?

11 MS. MITCHELL: Well, just a
12 comment. We use EGGs and we do episodes,
13 gallbladder from the first belly ache to
14 discharge after you have had your gallbladder
15 taken out. And chronic COPD, we just use
16 annual cost, the same with asthma. As long as
17 you are diagnosed with a chronic condition,
18 just add them up. I don't know why that is so
19 hard.

20 DR. MC CLELLAN: Aparna?

21 MS. HIGGINS: So, just one area
22 that occurred to me that maybe we should call

1 out. It is the end of life care. I think
2 there is events that shows there is a lot of
3 unnecessary utilization. And so I am
4 wondering if maybe, I know it is not
5 explicitly listed in here. Some of these
6 episodes could capture that, potentially, but
7 they may not so that might be something that
8 we focus on.

9 DR. MC CLELLAN: Okay. I do think
10 it has been a really helpful discussion. I
11 just wanted to check with Rob and the NQF team
12 and make sure they are getting what they need.

13 Again, it seems like we have an
14 overall framework that we would like to apply
15 and a recognition that there are a lot of
16 challenges and gaps in getting there. And I
17 think that may be, in an expanded version, the
18 main conclusion from this section. I think we
19 can try to incorporate the range of comments
20 that were received about specific areas of
21 clinical care and specific episodes and
22 different ways of handling that.

1 Dolores described that the cost
2 that those patients incur and a lot of support
3 for the kinds of steps that are happening now
4 around transparency at the level of specific
5 plans at some state and regional efforts.

6 Are there any other -- so this is
7 not going to be real definitive on specific
8 measures. It is going to be more directional.
9 Are there any other specific comments to add?
10 Nancy.

11 MS. FOSTER: Just one quick one,
12 Mark. Echoing back to something that Joanne
13 said a little while ago. I mean, we are
14 fairly new in the use of these kinds of
15 measures. And I think given that, and given
16 the fact that most of the measures aren't
17 perfect, which I would say about virtually
18 every measure, but most of them aren't
19 perfect. I think it would be important in
20 this report to suggest that one of the
21 critical first steps here is to begin to delve
22 down and understand what these measures tell

1 us, rather than automatically assume that
2 whosever is at the high end is there because
3 they are really doing poorly. They may be.
4 That may, indeed, be the conclusion but I
5 think we need to at least honor the insecurity
6 we have around these measures by saying let's
7 look first and understand what these measures
8 are telling us and then act appropriately.

9 DR. MC CLELLAN: Yes, and as more
10 of these measures are being used, or the
11 different versions these measures are being
12 used, there are opportunities to do that. And
13 again, I think the theme of linking these
14 measures with quality measures are very
15 important to do. It gets to your point.

16 Helen?

17 MS. HASKELL: My question is just
18 when you talk about doing what Dolores was
19 suggesting, which I think is extremely
20 sensible and valuable, just measuring that
21 condition, essentially, that is a different
22 category. That category isn't here. We

1 talked about creating another category of
2 gaps.

3 DR. MC CLELLAN: Well, I think
4 yes, the way I took Dolores' comment as
5 fitting with this general theme of we want to
6 get to more actionability and do it in a way
7 that is feasible. One way of looking at these
8 episodes is not trying to break out for a COPD
9 patient, which of their costs were quote
10 unquote COPD which were related to some of
11 their other conditions but maybe with some
12 kind of risk adjustment is to look at their
13 total cost. So, that would be one possibility
14 listed in moving forward on this, along with
15 general caveat or the general comment along
16 the lines to what Nancy said that we haven't
17 we don't have a tremendous amount of
18 experience with a lot of these measures yet
19 but there are more and more of them in use.
20 That is generally a good thing, if we are
21 learning from them about how they really do
22 identify gaps and quality and efficiency of

1 care, and thus, opportunities to really
2 improve affordability and value.

3 So, something along those lines,
4 as a way of trying to capture a lot of these
5 broad comments. We really needing to move in
6 this direction but it is challenging. And
7 there is a lot going on.

8 David.

9 DR. HOPKINS: Just to follow up on
10 what Nancy was saying, when someone is a high-
11 cost provider, a difference from peers, as a
12 high-cost provider, we know that something bad
13 is happening because cost -- what we should
14 think about is whose responsibility is it to
15 show -- is it the measurement's responsibility
16 to show that that person's care is not
17 different from the person who is less costly
18 or is it the costly provider's responsibility
19 to show that their care is better?

20 So, I think if we can comment,
21 maybe in the report put a comment or provide
22 the tools for making those distinctions.

1 Because we know when you are spending people's
2 money on something that isn't valuable you are
3 probably facing conflict.

4 So, whose responsibility is it to
5 explain themselves. Is it the measurer's
6 responsibility or is the person whose costing?

7 DR. MC CLELLAN: And that also
8 goes with fitting in quality measures. And we
9 are going to come back with discussion of
10 high-cost providers a bit later so we will
11 have another chance to get that this, too.

12 Okay, I think now is the time to
13 go to -- first of all, thank you for this
14 discussion.

15 Gene, if you are still on the
16 phone, any final comments from you?

17 MR. NELSON: Most of my thoughts
18 were picked up by others. One condition was
19 high prevalence, high cost high variation of
20 low back pain might be added to the list of
21 potential weight important groups.

22 DR. MC CLELLAN: Thanks.

1 DR. DUNFORD: If I could add just
2 one last comment?

3 DR. MC CLELLAN: Yes, go ahead.

4 DR. DUNFORD: Just morbidity,
5 mortality, we have reported out the five most
6 common causes of death in the United States
7 for people under five and unintentional
8 injuries is number five. And so, trauma, I
9 think, in associating costs of trauma would be
10 worth focusing on.

11 DR. MC CLELLAN: Add a trauma
12 measure and cost. Yes, thank you.

13 Okay, thanks very much for a good,
14 wide-ranging discussion. We are going to come
15 back to a number of these issues in the next
16 day and a half.

17 I think we are, right now it is
18 time for public comment. So, Operator, if you
19 can hear me, can you open the phone lines,
20 please?

21 OPERATOR: Yes, sir. At this time
22 if you would like to make a comment, please

1 press * then the number 1.

2 DR. MC CLELLAN: So, if anybody
3 listening has a comment, please let us know.
4 I don't think we have any comments in the
5 room.

6 OPERATOR: There are no comments
7 from the phone.

8 DR. MC CLELLAN: Okay. So, we are
9 now at the lunch break. Now, after we return
10 from the lunch break, are we going to come
11 back here or are we going to go straight to
12 the break out groups?

13 MR. SAUNDERS: So, we will go to
14 the break out groups, although, we will eat
15 lunch in here. So, we will move from here to
16 the break out groups. But after lunch, we
17 will split into three different rooms. One
18 group will stay here. One group will move
19 downstairs and another group will -- actually
20 two groups will move downstairs and we will
21 discuss three different topics. And we have
22 got the break out listing up right now. We

1 will describe more in details on where to go,
2 how to go, when we continue lunch. But just
3 expect that when we come back from lunch, we
4 will be heading off into break out groups.

5 DR. MC CLELLAN: And I hope
6 everybody is happy with their assignments.
7 All very important groups and we want you to
8 go to the one you are assigned. This isn't
9 one where you will just like wander and go
10 wherever you want. Please go to the assigned
11 group.

12 And the basic structure is going
13 to be similar to what we just described. So,
14 we will start with a list of measures in each
15 of these areas where there are endorsed
16 measures, where the feedback from the homework
17 exercise was pretty positive. And we will
18 also have a discussion of measurement gap
19 areas.

20 And after the break outs, we will
21 be asking for somebody to report back. As Rob
22 said, after or while you are eating lunch,

1 there are more details about how exactly this
2 work. It seemed like a good way to handle
3 three areas where it would make sense to get
4 into a little bit more detailed discussion
5 while still enabling us to move through the
6 agenda pretty expeditiously.

7 MR. SAUNDERS: Are we going to
8 announce which group gets to stay here or is
9 that a surprise?

10 DR. MC CLELLAN: That's all
11 coming. For now, lunch is here. Actually,
12 lunch is where in the hall? And bring it back
13 here. Thanks.

14 (Whereupon, at 12:04, p.m., a
15 lunch recess was taken.)

16

17

18

19

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (2:25 p.m.)

3 DR. MC CLELLAN: All right, thanks
4 everyone. Thanks for productive contributions
5 to the break outs. I see everybody had a
6 pretty lively discussion in their respective
7 groups.

8 So, the plan for the rest of the
9 afternoon is to hear back from what each of
10 the groups discussed and had an opportunity
11 for the larger workgroup to comment on that as
12 well.

13 We are scheduled to end at four,
14 and that is with some time for public comment
15 before we actually wrap-up.

16 So, each of the groups has asked a
17 lucky and well-qualified presenter to do the
18 initial overview of the presentations. And on
19 top of that, the NQF staff have helped them
20 put together a summary slide in real-time.
21 So, fast PowerPoints here.

22 We are going to start with Group

1 C. And Kevin, I think you are doing the
2 report out for that.

3 DR. LARSEN: Yes, I got nominated
4 by our group.

5 We had the utilization. And a
6 couple of framing comments that we realized
7 that utilization and appropriateness had a
8 fair bit of overlap. We also realized that
9 there was a real need to think about
10 utilization in a way that this might be just
11 a visibility measure, as opposed to at the
12 beginning being a kind of judgment-based
13 measure. Because we don't really know what
14 the right utilization will always be but we do
15 think it is important to be able to measure
16 utilization.

17 So, we realized that it is going
18 to be really important to pair utilization
19 with quality for it to really mean anything
20 because some might be underutilizing, some
21 might be over-utilizing.

22 We also want to ensure that

1 broader utilization is broken down into some
2 specific categories. We just talked, it was,
3 I think, Wei that was saying that these global
4 measures are really great but you can't really
5 take action on them unless you have a way to
6 drill into them to see what are your kind of
7 priority areas.

8 And we also heard that there is a
9 big opportunity to tie the utilization into
10 NQF care coordination work so that
11 utilization, we think one of the primary ways
12 to drive down utilization is to improve care
13 coordination. And so to think about what the
14 linkage is between care coordination in
15 relation.

16 We brought up that the innovation
17 model worked that is happening out of CMS is
18 really looking at utilization in an all-payer
19 way in the states with value.

20 And then we talked about, I
21 brought up some framework that has been done
22 under a federal advisory committee, thinking

1 that ACL measurement. And that framework is
2 to try to think about moving to holistic
3 measurements of patients and then grouping
4 patients by populations, instead of what we do
5 now, which is either program or site-specific
6 measurement or condition-specific measurement.

7 So, it is kind of helpful to think
8 about an example there. And one example that
9 our group came up with was care for the frail
10 and elderly. If we had a way to measure
11 utilization of the frail and elderly care
12 outcomes of the frail and elderly, that gets
13 us to a more longitudinal holistic idea about
14 that measurement and pulls it out of
15 individual conditions, pulls it out of
16 hospitals versus doctors versus somebody else
17 and into a more population-based framework.

18 So, then we did our work on the
19 specific measures. And really all of the ones
20 that we looked at, we put them almost all of
21 the votes were in the high impact and high
22 priority category. We did leave one off the

1 list where we thought it was, of all of the
2 measures we looked at, the least important.

3 So, the two we prioritized at the
4 top were the overall measures of utilization.
5 So that number one was the payment
6 standardized Medicare spending per
7 beneficiary. We like this because it is
8 crosscutting across programs, across patients,
9 across care conditions and settings. So, that
10 was our number one.

11 The second one we liked is the
12 total resource use population-based PMPM
13 index. And that one, remind me but I think
14 that was more hospital-specific, if I remember
15 the details. And so that was part of the
16 reason it was the second choice measure.

17 And then we looked at the
18 condition-specific. And the additional
19 condition-specific one that we left off is the
20 relative resource use for COPD. And we kind
21 of prioritized these by what we thought would
22 be the impact based both on the population

1 affected and the amount of change in
2 utilization we might be able to have.

3 So, cardiovascular is number one,
4 asthma is number two, diabetes is number
5 three, and then COPD we left off the list,
6 although we are kind of marginal on it. It
7 wasn't like a we hate this. It was sort of
8 like the marginal edge and we voted for parts
9 of it.

10 The opportunities that we saw, I
11 think one of the early opportunities is to
12 find a way to use the same subgroup analysis
13 that is present in the total cost of care
14 measure. We do that subgroup analysis in the
15 total utilization measure. So that if we are
16 looking at total cost of medications, we could
17 look at total utilization medications with the
18 same kind of breakdowns. And so we think that
19 is an early opportunity we would have to
20 really be able to pair these measures in ways
21 that would help people drill into
22 opportunities.

1 We also talked about the
2 opportunity around the new SGR requirement for
3 radiology decision support and that CMS will
4 be helping the country to all of a sudden have
5 a lot of new data about the types of
6 radiology, the indications for certain types
7 of radiology use and it is matched to
8 guidelines. And so that will be, I think, a
9 near-term measurement opportunity at scale.

10 A lot of interest in the choosing
11 wisely measures. And again, this is kind of
12 our appropriateness and utilization cross-
13 over. And then continuing to build on the
14 work of readmissions, hospitalization, et
15 cetera.

16 From a more longer term
17 standpoint, again, Wei told us that the high
18 priority items for Blue Cross Blue Shield of
19 Massachusetts are in outpatient utilization,
20 which is actually a higher total spend for
21 them in patient utilization. And the areas
22 that they are currently doing some active

1 development around our cancer, orthopedic,
2 mental health, and mother/baby. And so we
3 really liked those as important and likely a
4 place that I think would be high priority for
5 many, many other domains. So, we really would
6 request that those be some of the places that
7 we do some of our next steps of development.

8 And then I mentioned that this
9 idea about the frail elderly and a way of
10 getting at, for example, the dual eligibles.
11 So, under 65 and disabled, thinking that was
12 a population, rather than thinking about them
13 as a program.

14 Some additional discussion around
15 relative resource use for Medicaid and
16 Medicare top 20 spending conditions. We
17 thought that would be well-aligned with CMS
18 priorities.

19 And then some discussion about
20 opportunities for measurement around end of
21 life utilization and how that is important but
22 also has challenges.

1 Okay, questions for our group?

2 DR. MC CLELLAN: Thanks, Kevin.

3 MS. HIGGINS: On the previous
4 slide, I had one question of clarification, I
5 guess. About the benchmark, maybe it would be
6 helpful if you could clarify so why the group
7 felt that it was less about benchmark. To
8 some extent, if you look at some of the work
9 like variations that Dartmouth has done, it is
10 sort of a bench marking type analysis. So, it
11 would be curious to hear why.

12 DR. YING: From our work, what we
13 noticed is that a lot of time when you talk
14 about utilization, there is no hard line to
15 say whether there is a problem or not.

16 For example, the simplest one of
17 generic versus brand name use for a drug
18 medication. What we notice is if we come up
19 -- first of all, we don't have enough
20 literature evidence to say where to set the
21 line. And if we do come up with a line, the
22 doctor actually will push back. They

1 basically will question the validity of the
2 data and the validity of the bench mark. What
3 we found that is mostly useful for them is we
4 actually show them the variation curve and
5 don't set a bench mark, just say this is the
6 business or network average but we don't say
7 whether this is a right or wrong answer. We
8 just say we show you the variation curve; you
9 decide within your physician group.

10 Because again, for utilization,
11 the risk adjustment is a big deal and there is
12 no good risk adjustment for a lot of the
13 utilization measure. So, that is why we focus
14 on the reporting and the physician can figure
15 out to what is the best for their group, for
16 their circumstance, for their patient
17 population, instead of saying universally,
18 this is the red line.

19 DR. MC CLELLAN: Jennifer?

20 DR. THOMAS: Yes, and a point that
21 you make on the differentiation for
22 utilization and overuse and, in some cases, we

1 would like to see higher use, particularly
2 with the drug therapies, so with adherence
3 measures and we talked a little bit about it
4 in our group. But any discussion there from
5 the standpoint of the measures is for a
6 portion of days covered for medications and
7 including it from the standpoint of including
8 adherence to medication to have more use. We
9 are going to pay more for the drug side but
10 then there is a Congressional budget office
11 study, at least from Part D data that I guess
12 there is an offset of medical spending in
13 total. So, was that discussed or any thoughts
14 on that?

15 DR. LARSEN: I think we would
16 agree. We didn't get into that level of
17 detailed discussion but that is, I think, the
18 reason we said it is real important to be
19 measuring utilization. But we should have
20 this caveat that an average in the country may
21 actually be not enough utilization for some
22 services and will be too much utilization for

1 other services. And so that utilization
2 measure itself should be just clearly labeled
3 as utilization. And that is different from
4 appropriate utilization.

5 DR. MC CLELLAN: So, we will come
6 back to that with the overuse and appropriate
7 use group.

8 Dolores?

9 MS. MITCHELL: Well, I see David
10 Hopkins giving me the evil eye.

11 (Laughter.)

12 DR. HOPKINS: Don't take it
13 personally.

14 MS. MITCHELL: No, no, no. It is
15 a partners in crime look, actually, because he
16 knows exactly what I am going to say, which
17 is, I think it is -- I am trying to think how
18 to say this without sounding insulting.

19 DR. HOPKINS: Oh, go ahead. We're
20 used to it.

21 (Laughter.)

22 MS. MITCHELL: I think it is an

1 abnegation of professional responsibility not
2 to use benchmarks. I am not saying you should
3 be irresponsible in using them and that if
4 there is no evidence that is even close to
5 colorably accurate, fine, of course, you
6 shouldn't.

7 But I think it is our job to do
8 benchmarks. And you are going to tell me
9 well, they aren't absolute. You are right.
10 They aren't. I can name you at least six
11 conditions that once were considered
12 absolutely appropriate and that six years'
13 later we said oh, why did you do that terrible
14 thing. It is not appropriate, all the way
15 from estrogen replacement to what you call it
16 PE -- whatever those prostate things are. So,
17 levels for A1C3 where the evidence has changed
18 over the years.

19 But not ever to draw a line and
20 say this is where we think you should be I
21 think is -- and just to say well, we thought
22 you would like to see the curve, it doesn't

1 change behavior. And being measured is
2 something that physicians, of all people who
3 got to be physicians because they were
4 measured their academic lives, should just get
5 over their anxiety about it.

6 DR. LARSEN: So, I happen to agree
7 with you on that.

8 (Laughter.)

9 DR. LARSEN: I happen to agree
10 with you, however, I think that there are two
11 steps to the same process so that you first
12 need the data and that is, to my mind,
13 utilization. And then you have to layer on to
14 that some additional information about what
15 the right number is because we can't just
16 statistically derive from what the right
17 number is, I don't think. It is a complex
18 consensus process with some modeling, some
19 ties to evidence.

20 And so I am going to look at where
21 that fits into -- what other impacts has it.
22 So, sometimes we drive utilization down in one

1 area and we drive it up in another area. And
2 until we know those things, it is hard to set
3 the benchmark of what is right. So, to my
4 mind, if you are issuing those issues pretty
5 quickly, that we can get to the sort of
6 appropriateness over time.

7 DR. MC CLELLAN: Is there any best
8 case for where Dolores would be most right in
9 any particular clinical areas that you all
10 discussed where you would be, at least
11 relatively speaking, more comfortable in
12 saying that this benchmark weight or range
13 area is most likely to be clinically
14 appropriate or as in other areas, as you said,
15 it is hard to know without considering other
16 factors.

17 DR. LARSEN: I don't think we
18 talked about that. I mean I think many of us
19 probably have our own particular opinions
20 about it. So, I think it could be done. And
21 I think that is has been done in a number of
22 different measurement areas. So, from a pure

1 measurement standpoint what I will tell you,
2 having tracked a number of these
3 appropriateness measures is that typically we
4 don't capture all the data that tells you
5 whether it is clinically appropriate. We are
6 going to capture it in ways that are really
7 easily leveraged by measurement.

8 A lot of our guidelines say if all
9 else, if other treatments have failed it is
10 okay to use this one. And that is really hard
11 to build a measurement structure around,
12 unless you are really willing to use a lot of
13 abstractors. And then we go through
14 everything to make sure everything else has
15 failed.

16 So, there are some methodological
17 challenges on top of the fact that we don't
18 have all the science yet to tell us what the
19 right answer is. I do think there is lots of
20 low-hanging fruit that we could get quickly.
21 I know that this would take longer.

22 DR. MC CLELLAN: Sean. Oh, I'm

1 sorry, were you waiting?

2 DR. YING: I just wanted to
3 comment on one thing. I think reporting is
4 definitely like the first piece. I think that
5 is the reason why we say it is very important
6 to pair the utilization with the outcome.

7 So, if we pair that, at the end we
8 will get to the definition of what is a proper
9 use, what is overall underuse. But if we love
10 the outcome, it will be utilization itself.
11 No one will have the best answer what is the
12 right line control.

13 DR. MC CLELLAN: Yes, I think
14 Dolores would feel better if we could at least
15 point to one example of that being feasible.
16 It is challenging.

17 DR. LARSEN: Well, so I think that
18 the orthopedic bundle is, in many ways, have
19 some really great patient-reported outcomes
20 around total knee and total hip surgery. We
21 have the total cost of care groupers and some
22 utilization data. There is some great work in

1 the high-value healthcare collaborative
2 looking at what is possible for lowest cost,
3 best outcome of total knee and total hip
4 surgery.

5 So, I think that we have some
6 examples that, there being some terrific work
7 that we can absolutely do. But I think many
8 other places have not had as much focused
9 energy to know what is scalable and
10 appropriate.

11 DR. MC CLELLAN: Sean?

12 DR. MULDOON: A short comment and
13 just a short question, I think. The comment
14 on the benchmark, I agree with Dolores. And
15 at Kindred we have had the experience of you
16 have got to set a benchmark. But the way you
17 communicate the benchmark is not so much this
18 is where you should be but this is where
19 somebody else has gotten. And that puts it on
20 the radar but lets the measurement and the
21 judgment of the doctor get you there.

22 But the question for the group,

1 was there any discussion that the use of the
2 MAP behind the relative resource is okay.
3 Were people pretty happy with how that is
4 calculated?

5 DR. HOPKINS: Are you talking
6 about the NCQA, the whole outcome?

7 DR. MULDOON: Yes, the idea of the
8 MAP behind finding something relative.

9 DR. HOPKINS: It got endorsed.

10 DR. MULDOON: Okay. So, the
11 answer is then that people are okay with it.

12 DR. HOPKINS: Yes.

13 DR. MULDOON: Thank you.

14 DR. MC CLELLAN: Nancy.

15 MS. FOSTER: So, it is not on your
16 list. I don't remember it on your list but
17 early elective deliveries, the right answer is
18 probably not zero because there are two things
19 that we have captured in the measure but it is
20 a hell of a lot closer to -- sorry -- a heck
21 of a lot closer to zero than we are right now.
22 So, directionally we know where to go. And to

1 your point, I may not be able to set exactly
2 the right benchmark, per se, but close to
3 zero, if that is close enough as a benchmark,
4 then we can probably go there.

5 DR. MC CLELLAN: Yes, and I think
6 these concrete examples are helpful.

7 David?

8 DR. SEIDENWURM: Well, I'm, in
9 general, sympathetic to the idea of benchmarks
10 when we really need them. The problem is how
11 we set them. And the way they have been set
12 up to now is not as a -- well, primarily is
13 some threshold that one should not cross. And
14 that that allows the median to creep toward
15 the extreme. So, you wind up giving people
16 permission to slack off, so to speak, and not
17 be vigilant about whatever the task is.

18 Because just to use concrete
19 examples that I happen to be familiar with,
20 the mammography recall rate. That is
21 something that can be concretely measured.
22 The data are unassailable.

1 DR. MC CLELLAN: There is a right
2 rate?

3 DR. SEIDENWURM: Yes. I will say
4 and make a strong case, again, there is a
5 right rate. And in the hawks, I don't know
6 the measure, they said well anything under 14
7 could be -- I mean over 14 could be a problem
8 when the real rate, the better rate, is
9 probably closer to eight, which is the average
10 in the Medicare Physician Compare Dataset or
11 if the 10 that used to be in the BI-RADS
12 manual that now went up to 12 because Medicare
13 gave us permission to go up to 14.

14 (Laughter.)

15 DR. SEIDENWURM: So, that is a
16 pretty concrete example of the challenges in
17 setting benchmarks.

18 And it is the same thing when they
19 change the rules with taxes. You know it
20 becomes accepted, the floor becomes the
21 ceiling.

22 DR. MC CLELLAN: Sean, did you

1 have another comment?

2 So, just before we wrap this part
3 up, could people talk a look at the measures
4 on the screen? This is what came out of the
5 group's analysis. I just want to make sure
6 there is not any additional specific comments
7 and then as the people might like to think, on
8 the specific measures.

9 David.

10 DR. HOPKINS: This is really minor
11 but I was worried about how -- what gets
12 written then outside the room for people who
13 weren't here gets interpreted.

14 Did we mean -- and Wei, this
15 question is for you. Did we mean to restrict
16 that utilization outpatient care for cancer,
17 orthopedics, OB? I don't know how outpatient
18 got in there.

19 DR. YING: It is sort of like two
20 different topics. What we found was the four
21 critical area of high cost, high prevalence.
22 So, we tried to do something with it, not just

1 outpatient overall.

2 DR. HOPKINS: Yes.

3 DR. YING: But then, in general,
4 on the outpatient. So here, we keep talking
5 about those patients are sick. But actually,
6 if you look at the driver of the majority of
7 the cost and it looks relatively healthy
8 people only use the outpatient. So, if we
9 were talking about the total cost of care to
10 the system, outpatient care is one of the key
11 drivers. They are not necessarily for the
12 patient that is sick.

13 DR. HOPKINS: You really mean that
14 is a totally separate point, then.

15 DR. YING: Right.

16 DR. HOPKINS: So, they need to be
17 separated in that bullet.

18 DR. LARSEN: Yes, so essentially
19 what we are saying is that to kind of --
20 actually what Wei was saying is they could get
21 some information on the inpatient care. What
22 they have had to struggle with at Blue Cross

1 Blue Shield was actually understanding the
2 outpatient utilization in those four areas,
3 which are high-utilizing areas for them. So,
4 kind of the measurement priority is to be able
5 to understand better the utilization in those
6 high priority areas.

7 So total cost would be fine as
8 long as there is really good ability to drill
9 down in that outpatient space and it is not
10 just lumped as outpatient.

11 DR. HOPKINS: That was the point.

12 DR. MC CLELLAN: Any other
13 comments on the specific measures?

14 Okay, Let's go the overuse and
15 appropriateness, which is a nice complement to
16 the utilization discussion we just had. And
17 David, you are going to lead that, right?

18 DR. SEIDENWURM: Yes.

19 DR. MC CLELLAN: Do you have a
20 slide?

21 DR. SEIDENWURM: We have a slide.

22 Okay, so a lot of what we talked

1 about in our group was also covered in the
2 utilization group because obviously there is
3 a big overlap between those topics. You know
4 we got a little granular here and we also
5 tried to talk about the general topic.

6 We thought that choosing wisely
7 was a potential source for new areas to
8 generate performance metrics around overuse
9 and appropriateness. We thought that there
10 might be challenges with operationalizing
11 these general topics into precise metrics. We
12 thought there were big challenges with data
13 availability because there simply aren't
14 randomized trials for most of the choosing
15 wisely metrics. There are other sorts of data
16 that often don't make it through the measure
17 development process, the measure endorsement
18 process. So, we looked at the concepts of the
19 tiered endorsement and endorsement with
20 testing and things like that as ways to go
21 forward.

22 And then there are also problems

1 with measure development and stewardship with
2 the transfer of responsibility to the
3 specialty societies.

4 The next big concept that we
5 talked about a lot was in parsimony and we
6 talked about how different competing measures
7 could interact in inappropriate ways. The
8 example that we dealt with was low back pain
9 in which there were metrics with four-week and
10 six-week rating periods but that other
11 criteria were adjusted to account for the
12 longer period. For example, if you wanted to
13 make sure you covered all of your bases, you
14 would set your parameters to the strictest one
15 in each category and wind up with a much more
16 narrow population than was originally
17 intended.

18 So, we wanted to make sure that in
19 each topic, teach domain area, that they would
20 be one metric so that we wouldn't run into it.
21 We happened to pick the one with the six-week
22 waiting period but we are not proud. Whatever

1 goes through the endorsement process would be
2 okay.

3 Similarly for medication review,
4 we thought it was important that we thought
5 polypharmacy was a problem. We though high
6 use medications was a problem. We thought
7 that there were lots of opportunities for
8 affordability and generics and other criteria.
9 Again, we wanted to pick possibly one metric.
10 The best one we could come up with in our
11 group was the 553 metric but we thought that
12 that was imperfect and could be just a
13 documentation type of checkbox. And so we
14 thought that in the next go-around, perhaps
15 discussion of specific criteria, such as
16 adverse drug reaction, polypharmacy, high-risk
17 medications could be incorporated within this
18 metric.

19 We had support for measure 309,
20 which was the epidural steroid injection
21 method which we thought was correct -- which
22 we thought was a good type of metric because

1 it included the correct indication, as well as
2 the correct techniques. So, radiculopathy,
3 not just back pain and image guidance, not
4 just whether you felt you were in the epidural
5 space, for example. And so, again, we support
6 that pending the endorsement.

7 We had a long discussion of the
8 number 115, which was CABG re-exploration.
9 And we thought it was a good idea because it
10 was obviously re-operation is something we
11 would be concerned about the potential for
12 perverse incentives in the context of the
13 larger cardiovascular measure set. But we
14 thought that that was a good place to include
15 it, provided it passed that next level of
16 review.

17 And I think we have one more
18 slide. Oh, and so opportunities for future
19 direction and performance measurement.
20 Beginning of life and end of life, the same as
21 the other group. Mental health, same as the
22 other group. Imaging, same as the other group

1 and orthopedics. So, I think it was pretty
2 consistent identification of priority areas.

3 And if other members of the group
4 want to chime in, if things I have
5 misrepresented or have forgotten entirely,
6 that would be great.

7 MS. HASKELL: Wasn't cancer
8 treatment on this list as well?

9 DR. SEIDENWURM: Yes, it was,
10 thank you. Thank you. It was, yes.

11 DR. MC CLELLAN: Jennifer?

12 DR. THOMAS: And I also thought we
13 had included the asthma, appropriate asthma
14 medications.

15 DR. SEIDENWURM: Oh, yes, we did.
16 Yes, we did. Yes, we did. Sorry about that.

17 DR. MC CLELLAN: That was on the
18 measure, the first measure list.

19 DR. SEIDENWURM: Yes, right.

20 DR. MC CLELLAN: Appropriate
21 asthma medications.

22 Comments, David?

1 DR. HOPKINS: Yes, on the measure
2 list could we add C-sections for first-time
3 mothers, low-risk?

4 DR. THOMAS: And we have
5 obstetrics.

6 DR. MC CLELLAN: Great. NQF staff
7 can confirm that. Aparna? Oh, sorry. Paul
8 and then Aparna.

9 DR. SIRIO: So, it sounds like you
10 folks chatted a bit about the CABG
11 explorational. Do you know what the default
12 process was? Because I am not a surgeon but
13 I practice with these guys and they don't want
14 to re-operate. I mean would you want to
15 reopen a chest for a bleed? I'm not even sure
16 it is available to them. But I guess at what
17 point are you talking about re-operations? I
18 am not familiar with the measure.

19 DR. SEIDENWURM: Sure. This isn't
20 my field and that is of course why our --
21 because it was nobody's field in particular
22 and that is why we thought it should be

1 reviewed in the context of the overall measure
2 set.

3 Our impression was that since
4 there were hard outcome metrics like mortality
5 at 30 days and things like that in the CABG
6 measure set, that this might be a measure of
7 the pathway through which the patient got to
8 their mortality or not that would be system
9 cost and also patient experience-related that
10 might be valuable in that context. And that
11 is why we put this with that it ought to be
12 reviewed in the larger context.

13 DR. SIRIO: So, I guess I wouldn't
14 quibble with fault process. I guess what I
15 was struggling with was why would you bucket
16 it with all the use and appropriateness. At
17 least the appropriateness. The overuse part
18 I would imagine is not part of the
19 conversation was the appropriateness piece.

20 I guess I would just ask that when
21 you look at it in a little more detail to see
22 if that actually fits here, as opposed to more

1 in quality bucket. Because I mean again if
2 you are going to bifurcate the issue is
3 unexpected bleeding and bleeding that is sort
4 of controlled in the operating room. The
5 second one, I am not so sure it is a quality
6 metric. The first one probably is.

7 So, my only point is that I don't
8 spend too much time in the weeds on a
9 particular disease or particular procedure.
10 I would just ask that some consideration be
11 given to how in fact that be placed it in a
12 portfolio that makes the most sense.

13 DR. MC CLELLAN: Yes, I think it
14 more that the group spent so much time on this
15 one is because it is potentially lesser than
16 a lot of measures and we are going to have
17 some discussion tomorrow around errors and the
18 like.

19 And I think the other question
20 back to NQF staff is the scope question. Is
21 this something that we should be considering
22 as a part of an affordability family or is it

1 better handled elsewhere on the quality side?

2 Aparna.

3 MS. HIGGINS: So I have a comment
4 and then a question. So I think I agree with
5 David that the challenges with the choosing
6 wisely measurement we are trying to do some
7 work right now.

8 DR. MC CLELLAN: Do you want to
9 say a little bit more about that? Because
10 this came up on our call in February. This
11 was an area where there was kind of an effort
12 underway trying to turn the concept into
13 measures. Given that there is a lot of
14 potential overuse, appropriate use in there,
15 the group wanted to make sure that we had as
16 clear of a statement as possible we could make
17 about how we could accelerate or support that
18 process data to outline some of the
19 challenges.

20 MS. HIGGINS: Yes, I think that
21 challenges to data. So, there are a number of
22 people working in this area and probably

1 offline would be worth it to have a
2 conversation with Dan Wilson because he is
3 trying to have his group meet regularly and
4 talk about the work that we are doing.

5 So, the work that I am involved
6 with is actually with the American College of
7 Physicians. So, we are doing a joint project
8 trying to get a look at what we use for
9 specific services. And you know while
10 choosing wisely campaign identifies specific
11 services, so for example it is the imaging for
12 low-risk cardiac patients, patients at low
13 risk for cardiovascular disease. How do you
14 define low risk? There is no one definition
15 for low risk. So you try to take that and try
16 to operationalize the data.

17 For example, Dartmouth is doing
18 work in that area and they have put together
19 a group of clinicians, an expert panel to kind
20 of tell them okay here is how we identify low
21 risk in administrative data.

22 You know we were looking at, for

1 example, under the under 65 population use of
2 excess scans in women. And there is overuse
3 in this area, a number of them probably should
4 be getting it. If you don't have a diagnosis
5 of osteoporosis or osteopenia, sure you could
6 identify those people but then looking at okay
7 what about women who are on steroids use. And
8 then how long should they be on the steroids
9 before they come up with bone loss.

10 So, there is like -- it is not
11 straightforward. So, I think I agree that
12 those are issues.

13 But the comment I had related to
14 that and I think it complicates the benchmark
15 issue, too, is how are we going to use these
16 measures. And I think that if you are trying
17 to how to get your hands around what the
18 magnitude of this problem is and where we
19 drive quality improvement, maybe we have
20 imperfect data and we can use that to help
21 inform the kinds of things that maybe
22 clinicians should be not doing.

1 I think when it obviously gets
2 tied to incentive payments and so forth and it
3 becomes a whole separate sort of issue.

4 So, I think maybe it is how this
5 report will -- we might want to think about
6 addressing this. You know, yes, measurement
7 is imperfect but there are ways in which we
8 can use this to help improve affordability.
9 So, that was kind of my comment.

10 My question to the group is around
11 the specific measures, which is I don't know
12 if you considered at all some of the other
13 appropriateness measures, such as appropriate
14 prescribing of antibiotics. Some of them are
15 endorsed. Some of the HEDIS measures that
16 look at appropriateness and why maybe they
17 weren't part of this list.

18 DR. SEIDENWURM: Yes, we did
19 discuss that and some of those are endorsed
20 and our thought as a group was for staff to
21 look into including some of those. I think we
22 had with for the childhood otitis and

1 pharyngitis, things like that.

2 MS. HIGGINS: Okay, thank you.

3 DR. MC CLELLAN: So, we do need
4 the NQF staff's help on that.

5 David?

6 DR. HOPKINS: You know this area
7 of overuse and appropriateness is such a tough
8 nut to crack. And it seems to me there is two
9 ways to go about it and they are not mutually
10 exclusive.

11 So, one way is for the profession
12 to engage in the kind of discussion that led
13 to choosing wisely. These are things that
14 just shouldn't be done. And that list, if I
15 understand it correctly, could be much longer.

16 Then we have to figure out how to
17 convert that into the measures, which I heard
18 the same things. It is very, very difficult,
19 the initial set.

20 The other way, it seems to me, is
21 to really focus ourselves a lot more on shared
22 decision-making. Because if any review by

1 expert clinicians says well, there is this
 2 small set of situations where you just
 3 shouldn't do it. And there is a set of
 4 situations where you absolutely should do it.
 5 And here in the middle is a lot of situations
 6 that maybe you should, maybe you shouldn't.
 7 It seems pretty critical that the patient be
 8 involved in deciding whether it is done.

9 And maybe we can do something
 10 about this patient-generated demand, if we
 11 develop more effective ways of dealing with
 12 that and then created measures around it.

13 So, that is a measure concept that
 14 I would like to see us include in terms of
 15 addressing overuse and appropriateness.

16 DR. MC CLELLAN: So I heard sort
 17 of two parts in addressing the challenge of
 18 turning the choosing wisely concept into
 19 measures. One is to make the utilization
 20 approach, which is find the appropriate,
 21 reasonably appropriate related utilization
 22 measure. We need to at least focus attention

1 on it as the utilization group discussed.

2 And second is to pair these with
3 some measures of patient engagement or shared
4 decision-making.

5 DR. HOPKINS: Yes, I was even
6 thinking at a higher level how to address the
7 problem of overuse and appropriateness. And
8 those were the two ways I see.

9 DR. MC CLELLAN: Good. Jim?

10 DR. DUNFORD: I was just going to
11 quickly recall on the last the 015, that, if
12 I read that right, because I read all 1500 of
13 these. But I had read this one and this is
14 return to the operating room for mediastinal
15 bleeding. You know, it is just an operative
16 complication that there is no electivity to
17 the procedure. So, this should just be more
18 like in a safety -- I see this as more of a
19 safety metric than appropriateness or overuse.

20 This is if they don't take you
21 back, you die. This you have got to fix
22 something.

1 DR. MC CLELLAN: Right. So, this
2 is the specific example. Is the group okay
3 with that general concept of that being a
4 complication measure, rather than an overuse
5 measure?

6 DR. HOPKINS: Yes.

7 MS. FOSTER: Yes.

8 DR. MC CLELLAN: Okay, so Wei.

9 DR. YING: So, overuse and
10 appropriateness is a topic. I guess if we
11 come up with a suggestion, basically we are
12 only saying one, two, three measure and there
13 is another asthma measure as the only one that
14 we can identify in this group. It is kind of
15 I don't believe that.

16 (Laughter.)

17 DR. YING: But I think, for
18 example, antibiotics use is definitely one
19 that are measured and antipsychotics.

20 So the drug utilization overuse, I
21 believe they are measures out there that are
22 endorsing overuse. I just feel hard to say

1 okay, if MAP only endorses four overuse and
2 appropriate use, or the other ones is more of
3 a concept. That is one comment.

4 The other is, on the lower back
5 pain imaging one, I understand the group right
6 and the six-week one, I think that is the one
7 that resulted in red flag, which is really
8 appropriate use. But if you think about it,
9 it is very hard to implement. For example,
10 for Health Net, we don't know where that red
11 flag, how is that coded. It is not coded. So
12 actually the other one, the four-weeks lower
13 back pain image and the one developed is more,
14 from usability point of view is more useable.-
15 - It has specific exclusions and the old
16 information, so we can implement it at a the
17 large scale. For this 0315, we can't even do
18 it. We don't have enough information.

19 And another comment, I think
20 someone mentioned the asthma measures being
21 supported also. The asthma measure, the one
22 that is included on the sheet was appropriate

1 use one. If you look at the nationwide data,
2 at least in the commercial population, there
3 is not much variation. Everyone is pretty
4 high for this one.

5 Actually there are two measures
6 that were developed as the second generation
7 of the asthma measures. It is more about
8 medication inhalers and what type of
9 medication is prescribed. I think there are
10 more variation in that set instead of this
11 one. It is sort of help out with this
12 measure.

13 DR. MC CLELLAN: I think -- I
14 don't want to over simplify things from the
15 group. But I think focusing on the measure
16 that is best in your examples around both
17 lower back pain, appropriate imaging, and
18 asthma seem like right on point with that.
19 There is the other issue you raised was about
20 the parsimony concern, though. So, behind the
21 group's push for parsimony is to get
22 consistent measures reported widely, rather

1 than have inconsistent measures, which are
2 related to the same topic that don't promote
3 the same kind of comparability and action on
4 addressing the problem. That was David's
5 point, if there any views about that specific
6 issue.

7 Helen, did you want to comment on
8 that?

9 MS. HASKELL: Well, I just wanted
10 to say in defense of being good measures when
11 you get them, --

12 DR. MC CLELLAN: Oh, we don't have
13 to stick with them, though.

14 MS. HASKELL: You know there are
15 so many measures, you are right, it is such a
16 huge topic, which is why we went with choosing
17 wisely because we would keep coming up with
18 things and they were all in choosing wisely.
19 So, we saw that as a source of getting at
20 overuse in perhaps a more systematic way.
21 That was my thought. And certainly there were
22 lots of measures on other things. So, this

1 list made me and, I think, others really
2 uneasy because it was so lengthy.

3 DR. MC CLELLAN: David?

4 DR. SEIDENWURM: Yes, I had a
5 couple of points to make. The first was with
6 respect to the challenges in getting overuse
7 measures across the finish line of NQF
8 endorsement. And that has been a real
9 challenge. And part of the challenge is that
10 it is very hard to generate the normative
11 data. When you do have it, it is not in the
12 form of sufficient rigor to meet the
13 challenges.

14 And then there is also the
15 interesting phenomenon that the pushback is
16 not from the radiology committee often but
17 from the clinical community. I don't want to
18 miss this. I don't have the time to explain
19 that. You know these data aren't good enough.
20 Where is the randomized trial?

21 So, it is a very hard nut to
22 crack. And it is surprising that we haven't

1 been able to do this but it is just the
2 reality of the world in which we live,
3 unfortunately.

4 The other thing about shared
5 decision-making is I think that if we can --
6 to elaborate on what David said, if we can
7 take, that in these patient preference
8 sensitive conditions, what are the criteria
9 for an informed consent? Do you have to --
10 can we put it in that regard? Do you have to
11 present parts of that as natural frequencies?
12 Do you have to present the absolute benefit
13 not relative benefit?

14 I mean superiority versus non-
15 superiority, conservative versus operative
16 approaches? I mean what really be the
17 criteria for this? And then are these
18 instruments validated? Can they be understood
19 by people with an 11th grade education? Can
20 they be actually used in the field?

21 So, if we can really specify some
22 of those things, then I think we would have

1 come a long way. And the principles, I think,
2 are established. We just don't have the
3 examples at each difficulty.

4 DR. MC CLELLAN: I see some head
5 nodding along with that. So, I will ask my
6 usual question. Are there any specific
7 examples of this around now that we could
8 highlight?

9 DR. SEIDENWURM: Well, as always,
10 I am going to say mammography because that is
11 the easiest one. That is our cardiovascular
12 disease, you know our cardiovascular surgery.
13 There is one disease. There is hard outcomes.

14 DR. MC CLELLAN: So, there is a
15 measure --

16 DR. SEIDENWURM: Yes.

17 DR. MC CLELLAN: -- or something
18 approaching a measure that captures this
19 notion of --

20 DR. SEIDENWURM: Oh, no. No,
21 there is not a measure but there are these
22 decision tools. I guess the target group has

1 been very active in promoting these. I think
2 that there are similar decision tools for low
3 back pain and I don't know about other
4 examples.

5 DR. MC CLELLAN: Yes, I don't know
6 if Gene is still with us on the phone but
7 maybe that is an area where --

8 MR. NELSON: Yes, I am.

9 DR. MC CLELLAN: Maybe we could
10 follow upon some of the tools that are
11 available in these areas of choosing wisely
12 and potential overuse where pairing with a
13 measure related to effective patient
14 engagement in decision-making might be
15 appropriate -- might be helpful.

16 MR. NELSON: Yes. A lot of the
17 times a body of work for a long time and some
18 new development shorter measures reflecting
19 the ability for people that have good
20 decisions for routine care.

21 So, we could follow up with that.

22 DR. MC CLELLAN: Carl -- I'm

1 sorry. Kevin.

2 DR. LARSEN: I have a couple of
3 things. First, the choosing wisely. I had a
4 contract with RAND to actually look at an
5 analysis of the first 40 choosing wisely to
6 build them into measures for federal programs
7 and especially a systematic analysis of kind
8 of their fit for use. And I can follow up
9 with the RAND researchers but the plan is to
10 get that published. It was Cheryl Damberg and
11 Peter Hussey. The last I think was submitted
12 to publications. We are kind of waiting to
13 hear from them that they will actually pick it
14 up.

15 But it is essentially the same
16 things that we have been talking about here at
17 the table. It is really appealing. We were
18 very interested and a deep kind of systematic
19 analysis showed the same kind of things you
20 are hearing here that we came up with about
21 five of them out of 40 that might be a minimal
22 with enough discrete data to be ready for

1 measurement at scale.

2 The other thing that I would -- I
3 am trying to wear multiple hats as consumers
4 of this. And one of the hats that I am
5 thinking of now is my state Medicaid director
6 hat and thinking about where is the long-term
7 care utilization and appropriateness and where
8 it is for both the Medicaid elderly as well as
9 behavioral health because I know those are
10 really big buckets of spend for state Medicaid
11 programs. And I think we have been pretty
12 silent about making the measures about
13 appropriate use of long-term care.

14 So, I am wondering if you guys
15 thought all about that. I didn't think of
16 this during our utilization time but it is
17 something that either you get fair measures
18 out there or if we can identify those as gap
19 areas because I think it is really important.

20 We know that there is a lot of
21 state-to-state variance and provider-to-
22 provider variance about use of long-term post-

1 acute care.

2 DR. MC CLELLAN: Sorry. Just to
3 be clear, post-acute and long-term.

4 DR. LARSEN: I think post-acute
5 care and long-term care both of them. I think
6 especially the long-term care is the one that
7 the Medicaid programs are keenly interested
8 in. The post-acute care Medicare is keenly --

9 DR. MC CLELLAN: Medicare is more
10 involved. Thank you.

11 Carl?

12 DR. SIRIO: Yes, just briefly, in
13 sort of a different direction. You know we
14 have used in this conversation overuse and
15 appropriateness as synonyms. Whatever
16 preamble we have in this section of our report
17 needs to acknowledge, I think that
18 appropriateness could also deal with the issue
19 of other tail on this and that is utilization.

20 DR. MC CLELLAN: Yes. Yes, that
21 is a very good point.

22 MS. HIGGINS: I just want to echo

1 that because it talked about the Texas CAM and
2 the work that we are doing. We actually
3 looked at both commercial and Medicare. On
4 the Medicare side, there is evidence to show
5 that they need to be screened and there is
6 underuse on the Medicare side.

7 DR. MC CLELLAN: Great. That is
8 going to be a good one to discuss in this
9 context. So, I appreciate that concrete
10 example.

11 David?

12 DR. SEIDENWURM: Right and just to
13 go on to echo what Carl said, also I think in
14 many of the areas that we have been
15 discussing, the gap in care is on the overuse
16 side more than on the underuse side. And I
17 think that is what led to the focus but I
18 think you are quite correct. There are
19 certainly are circumstances where the opposite
20 is true, especially in dual eligible
21 population and the other hard to treat groups.

22 DR. MC CLELLAN: Jennifer?

1 DR. THOMAS: And I would just
2 again, the underutilization goes along with
3 the proportion of days covered the issue of
4 the use of medications appropriately for our
5 large populations of diseased patients.

6 Obviously, we know if we don't
7 take diabetes medications, our A1Cs and
8 glucose is non-controlled. So, could those
9 lead to those complications of the disease and
10 use of services.

11 The other thing that I want to
12 mention since we have brought this up for the
13 long-term care, so many of these medication
14 measures, obviously, were really targeted at
15 I think the older adults, primarily the issue
16 was high-risk medication. Certainly Part D is
17 following that but they are looking at that
18 need in the nursing home population as well.

19 So, while the measures are not
20 perfect, as I think, Nancy had said, they are
21 some way getting at a process to say are we
22 looking at these high-risk medications and

1 persons that are vulnerable. So, we tended to
2 lump that into one thing to try to improve one
3 measure and make it -- you know that parsimony
4 helps. Those are some of the areas that --
5 the reason that I think they are included
6 here.

7 DR. MC CLELLAN: Okay, I am not
8 going to try to do a detailed summary of this
9 very rich discussion. But among the key
10 points, choosing wisely we will have some
11 discussion around the importance of the
12 difficulty of turning those concepts into
13 measures in many cases. And as a potential
14 path forward in those cases, reporting on
15 utilization rates and taking the approach of
16 utilization plus incorporating some explosive
17 measures related to the use of effective
18 decision tools to engage patients, which Gene
19 is going to help us with. It could be very
20 helpful there. I will try to include a few
21 concrete examples, too.

22 In terms of current measures, we

1 have had some discussion around parsimony good
2 in that it could help focus consistent
3 reporting and, thereby, hopefully get more
4 focused action. Concern about not having too
5 few measures on the other hand, though.

6 And then we have a number of
7 specific measures that we went through around
8 low back pain, around maternal care, C-section
9 use, antibiotics, appropriate use of asthma
10 medications and maybe some other medication
11 adherence measures. So, the latest
12 generation. The best one sort of is some real
13 connection to actual care and outcomes and
14 some variation in performance.

15 In terms of current measures, we
16 had some discussion around complication-
17 related measures. We illustrate the CABG re-
18 op measure. Those really don't belong in this
19 category, although they are important
20 considerations for quality and had an impact
21 cost as well.

22 And then future direction areas

1 include maternity, end of life, mental health,
2 more on imaging, orthopedics, cancer
3 treatment.

4 MR. NELSON: Mark, one more
5 comment.

6 DR. MC CLELLAN: Yes, go ahead.

7 MR. NELSON: This is Gene. In the
8 spirit of parsimony and measurement gaps, and
9 especially those having to do with real waste
10 and harm, I think there is a measurement gap
11 in just us having total expenditures per
12 capita clearly very high priority. One of the
13 drivers is total harm caused by healthcare,
14 having to do with safety, complications, et
15 cetera. And there has been work in the past
16 but that continues to be a real gap.

17 It would be very helpful to have a
18 total harm measure for populations that are
19 clearly more than waste. It is harmful waste.

20 DR. MC CLELLAN: Gene, in terms of
21 directions to get there, is that a roll-up of
22 some of the error measures or what is the

1 foundation that we describe in the report to
2 happen?

3 MR. NELSON: Yes, I think
4 conceptually it is a roll-up of measures,
5 smaller metrics or a global trigger tool kind
6 of approach that has been tested. 3M has
7 developed a commercially-viable product around
8 this idea as well.

9 So, I think maybe there are a
10 couple of different conceptual approaches that
11 people have taken to measure total harm.

12 DR. MC CLELLAN: Great thanks.
13 All right, thank you all. Good discussion.

14 And we move on to is it Group B,
15 unnecessary use of higher cost providers. And
16 who is the lucky speaker?

17 MS. O'ROURKE: So, I somehow got
18 elected as spokesperson.

19 (Laughter.)

20 DR. MC CLELLAN: The group did a
21 good job.

22 MS. O'ROURKE: So, we had

1 consensus on three measures that we wanted to
2 bring forth for including in the family. So,
3 0173 emergency use without hospitalization.
4 We did want to mention a caveat with this
5 measure, that this is only a home health
6 measure at this point and that this needs to
7 be expanded to address all providers, not just
8 home health, but unnecessary hospitalizations
9 go beyond just that care setting.

10 Then two measures about hospice
11 care and patients not being appropriately
12 referred to hospice. Again, this caveat is
13 that we, to make a strong statement that
14 hospice uses a societal issue and recognizing
15 there are cultural issues, disparities and
16 access and family resistance but that all
17 stakeholders have a role to play in. You can
18 see the uptake of hospice care.

19 So, the short-term measurement
20 gaps, if you will. Also, we recommended
21 aligning with the choosing wisely campaign to
22 develop measure issues like unnecessary

1 consultations and referrals, recognizing that
2 not all are unnecessary and it is very, very
3 difficult to actually get to that type of
4 granularity to see what could have been
5 avoided.

6 Looking to the AHRQ ambulatory
7 sensitive condition measure, start to address
8 issues where care could have been better
9 provided in a primary care setting not
10 elevated to the hospital.

11 As I mentioned, expanding measures
12 of unnecessary ED use and hospitalization for
13 all providers, not just home health.

14 And our big changes that we wanted
15 to increase the theme of our high-leverage
16 opportunity for higher cost providers to
17 higher cost services that it was a big gap
18 that high cost drugs and devices were not
19 mentioned. And while there are measures that
20 there needs to be developing of using a higher
21 cost treatment before an effective lower cost
22 treatment.

1 Some longer term opportunities,
2 increase the access to care, the lower levels
3 of care that a lot of patients end up in the
4 ED because they can't get a hold of their
5 primary care physician or they don't have a
6 primary care physician.

7 As I mentioned, increasing the
8 acceptance of hospice care and end of life
9 issues. Increasing health literacy that
10 patients understand what is going on in that
11 area and understand how to adhere to their
12 treatments. Don't end up in an emergency
13 department because they didn't understand how
14 to take their medication and manage their
15 condition as an outpatient.

16 And finally getting into levels of
17 system or measures of system level
18 accountability that they have there are not
19 population measures or things addressing
20 affordability and starting to look at whether
21 there is a level beyond the space that we need
22 to hold people accountable for for testing

1 these issues. That might not be feasible but
2 an aspirational goal.

3 So, next slide. So,
4 implementation barriers. We did want to
5 mention a caveat about team-based care and
6 that as we move to ACO models. A specialist
7 may not cost more and may actually be the most
8 efficient choice to manage a complex patient.

9 We wanted to pick up the orphaned
10 mental health infrastructure issue that a lot
11 of these patients might turn up in EDs for
12 mental health and substance abuse issues that
13 they could have probably handled at a lower
14 level. But since there is no access, they
15 bounce into hospitals.

16 Again, considering the issue of
17 unnecessarily using higher cost drugs and
18 devices and a way to balance increased patient
19 empowerment and marketing to the patient with
20 demand for services without a rationale.
21 Again, looking to choosing wisely to provide
22 guidance on what is an evidence-based reason

1 for service.

2 DR. MC CLELLAN: Thanks, Erin.

3 Any additions from the group? Sean?

4 DR. MULDOON: A little
5 clarification around the ER use without
6 hospitalization. I know this is for home
7 healthcare. But sort of ironically, the goal
8 of home care and other post-acute care is not
9 to have the person admitted to the hospital
10 when they go to the ER. So, go to the ER;
11 make the diagnosis very promptly; and then get
12 them back to us.

13 So, this seems to run counter to
14 that.

15 MS. HASKELL: Yes, I am a little
16 puzzled if somebody goes to the ER for all
17 sorts of things, a broken arm, they would be
18 seen and not admitted. I am trying to look
19 this measure up but I don't understand it.

20 DR. MC CLELLAN: Nancy?

21 MS. FOSTER: So, the concept
22 behind this measure is really that there are

1 many times in which the patient could be
2 better managed in the nursing home, which is
3 to our expansion, in the other care setting
4 where they are currently be cared for, we
5 wouldn't expect -- I don't think we were
6 talking expanding this to all patients showing
7 up at the ER, just patient who are otherwise
8 engaged in some sort of medical care who are
9 ending up in the emergency department because
10 they either failed to contact the home health
11 nurse, the primary care provider says my slate
12 is full, go to the ER. It is that sort of the
13 patient could have been best managed by the
14 care givers they are engaging already but it
15 didn't happen and so, they ended up in the ER.
16 That was the notion of this measure.

17 I can't swear to it that that is
18 doesn't exactly right but that is why the
19 measure exists, not because every visit to the
20 ER by somebody who is in home health is wrong.
21 They could fall and break their hip, knee,
22 arm. But that was the thought.

1 DR. MC CLELLAN: Kevin.

2 DR. LARSEN: So, with your
3 expansion of the scope of providers to
4 services, I think there is some additional
5 measures we should pull out for consideration.

6 So, I know there are some use of
7 advanced imaging for certain conditions like
8 headache that do have measures that either are
9 in the pipeline or are endorsed. There is
10 this MRI and a CT for a complicated headache
11 and an MRI and CT for complicated back pain.
12 Those are the kind of measures that are
13 already out there. And those, I think, would
14 fit in here under the new rubric of services,
15 rather than providers.

16 Also, it was a little bit of a
17 head-scratcher around things like
18 inappropriate emergency department use. I put
19 on my commercial business hat that is isn't
20 about healthcare and I think would Walmart
21 ever feel this is what they measure. Did
22 people come into the high cost door versus the

1 low cost door. They would just figure out how
2 to make their low cost door the door people
3 wanted to come in.

4 And it seems as if some of this
5 stuff is fundamentally finding our current
6 business model. And so it is just a head-
7 scratcher to figure out how measurement is
8 going to help there when the business model
9 still says my per unit margin is much higher
10 in this door than that door.

11 DR. MC CLELLAN: That is a good
12 point. Going back to your first point, Kevin,
13 about -- it totally makes sense to shift the
14 scope to high cost services, not just high-
15 cost providers. We may need, as we are
16 formulating the actual report to figure out
17 where to draw the line from that overuse
18 measures that we just discussed.

19 So, if there are any comments on
20 that now that would be helpful, it would be
21 good. I think are kind of heading in the same
22 direction on all of this but we will find a

1 good way to write that out.

2 Beth, do you have -- did we
3 already cover it? Okay, great. So, Nancy,
4 then Aparna, and then Wei.

5 MS. FOSTER: So, just to address
6 Kevin's question. While I won't comment on
7 any specific measure here, when we were
8 talking, we were talking about these measures
9 as providing insights that could impact the
10 policies, procedures, and actions of a wider
11 group than just the providers. So, it may be
12 that if we are seeing overuse in the emergency
13 department because people don't have access to
14 primary care, you are absolutely right. But
15 this is not only in the hospital who keep that
16 emergency room door wide open. The business
17 model for everybody else should be how do we
18 figure out how to get them to the right
19 primary care provider.

20 So, it is how do we have those
21 conversations? How do we bundle this measure?

22 DR. MC CLELLAN: Aparna?

1 MS. HIGGINS: So, I just wanted to
2 comment on trying to draw a distinction
3 between where this, like the imaging measures
4 you suggested, Kevin, does it fit in overuse.
5 Does it fit in this bucket? And my group can
6 correct me but I think that the discussion we
7 had around higher cost drugs and devices was
8 more around are there alternatives available.

9 So just like would you want
10 everybody to go to the ER when many of them
11 could be seen in the primary care physician's
12 office, that is a site of care kind of an
13 issue. Similarly, there are alternative
14 treatments available. Would you always want
15 to go to the high cost drug when there might
16 be equally effective other options available?
17 I think that is where sort of we were sort of
18 drawing the line between pure overuse and
19 unnecessary use of high cost.

20 DR. MC CLELLAN: So availability
21 of lower cost alternatives.

22 MS. HIGGINS: Yes.

1 DR. MC CLELLAN: So if there are
2 any good examples of measures along those
3 lines, like something like use of generic
4 prescriptions.

5 MS. HIGGINS: Well, that would be
6 one example, I guess, but I don't think there
7 are any endorsed measures for generics,
8 generic use.

9 DR. MC CLELLAN: We will do a
10 little researching.

11 Gerri?

12 DR. LAMB: Was there any
13 discussion about 0265? I just wondered why it
14 wasn't on a list.

15 MS. O'ROURKE: Yes, we thought
16 that might be better to the errors and
17 complications. That measure didn't get at
18 unnecessary hospitalization. It got to a
19 safety issue. That measures is for the ACS
20 setting and addresses when a patient had a
21 complication during what should have been a
22 routine procedure and ended up in a hospital.

1 So, we wanted to propose that
2 during the errors and complications
3 discussion.

4 DR. MC CLELLAN: Okay, Wei.

5 DR. YING: When we looked at
6 unnecessary use of high costs service, we
7 actually look at the site of service. So I
8 think we catch up on here, we look at
9 inpatient, we look at ED. But then sometimes
10 it is not necessarily just that a lab test can
11 be done in the hospital and it can't be done
12 in the community just like let's say the Quest
13 Lab. The cost is very different and imaging
14 the same thing.

15 So, just looking at IPOPER will
16 not necessarily get to the root cause of the
17 cost differentiation. Sometimes it is really
18 the cost site of service is not just the suite
19 that we are talking about here.

20 DR. MC CLELLAN: And any examples
21 of site of service measures?

22 DR. YING: That is when we look at

1 the lab and the imaging.

2 DR. MC CLELLAN: The lab and the
3 imaging.

4 Nancy?

5 MS. FOSTER: I mean talking about,
6 not that specific example but others, I think
7 one of the caveats we offered up was the one
8 that Kevin provided this morning, which is you
9 may not be looking at the total burden of debt
10 measure. Just sending somebody out for a lab
11 is sometimes a big burden on them.

12 So, not that it shouldn't be used
13 but we have got to figure out how to do it
14 right.

15 DR. MC CLELLAN: Yes, it is the
16 frame that costs the patients somehow. We
17 need to make sure we don't lose sight of if I
18 have to drive 50 miles to the low cost
19 service, as a patient, the total cost is
20 higher than if I do it next door and it is
21 slightly more expensive.

22 Aparna?

1 MS. HIGGINS: So, if you are
2 looking for more specific examples in relation
3 to what Wei brought up, you know MedPAC has
4 done work on this and issued a report. So,
5 that might be worth looking at.

6 DR. MC CLELLAN: Any other
7 comments on this area?

8 MR. NELSON: This is Gene. Again,
9 I think it is perhaps this topic and the prior
10 one that John Watson in How's Your Health and
11 has been developing an item in several
12 publications on health confidence is what he
13 calls it. And if a single item measure of my
14 ability to take care of myself and to follow
15 my care plan. And that has been associated
16 with lower costs, better health outcomes,
17 higher satisfaction and varies widely across
18 providers and can be improved by focusing on
19 it.

20 And it goes really to the ability
21 of self-care and self-management, enlightened
22 and intelligent, and competent that produces

1 savings.

2 So, it may be something that we
3 should be taking into consideration.

4 DR. MC CLELLAN: Thanks, Gene.
5 Sean?

6 DR. MULDOON: On the three-day
7 hospice measure, what behavior are you trying
8 to drive? Don't send them or send them?

9 DR. MC CLELLAN: We not waiting
10 until the last minute to send them.

11 DR. MULDOON: Okay. So, someone
12 who is really sick isn't going to go and it is
13 going to drive your hospice utilization rate
14 where you don't want it.

15 DR. MC CLELLAN: Well I think
16 ideally you get them in longer so that --
17 longer is higher

18 DR. MULDOON: So the idea is that
19 people will come earlier.

20 DR. MC CLELLAN: Right.

21 MS. MITCHELL: The underlying with
22 that is that those people are getting kicked

1 out of care.

2 DR. MULDOON: Oh, I understand.
3 That part, again, I am trying to decide when
4 you have got a patient and you have to decide
5 whether to send them to hospice whether you
6 are going to end up -- you are going to end up
7 saying oh, this patient is really sick, could
8 die this week. Let me just leave him in the
9 ICU.

10 DR. MC CLELLAN: That would be an
11 undesirable consequence.

12 DR. SEIDENWURM: So, is this an
13 example of the over/under thing you were
14 talking about before with respect to other
15 benchmarks?

16 DR. MULDOON: There is a sweet
17 spot instead of a lower is always better,
18 higher is always better.

19 DR. MC CLELLAN: Dolores?

20 MS. MITCHELL: Well, we had a long
21 discussion about this. It is difficult and it
22 is loaded with family, integrational baggage.

1 I don't think we are talking about sending
2 somebody to hospice but initiating the
3 discussion between the patient, the patient's
4 family, many of whom come loaded with guilt
5 about not doing everything for dear old so-
6 and-so. But rather trying to change the
7 culture, both the medical culture and the
8 culture at large about what is the most humane
9 and decent way to ease people out of life,
10 rather than us pouring dollars for -- and
11 sometimes amounting to cruelty, when they
12 aren't going to help.

13 So, I think that was the thrust of
14 that discussion. But understanding that you
15 talk about person and family in my inquiry of
16 this morning, that is a classic case where it
17 is not just the patient, it is the whole
18 family and you have got a lot of different
19 motivations and a lot of different threads at
20 work.

21 So, the general idea that we know
22 that people do that we underuse that very,

1 very good capability that we have developed
2 and to no particular purpose or value to
3 anybody.

4 So, that was the thrust of that
5 discussion. But I did want to just underscore
6 something that Erin said but I think we didn't
7 pay any attention to it. I am proud leading
8 dissenter -- not dissenter but nag might be a
9 better word on this issue of the evasion of
10 the central issue of price.

11 And all of these measures are
12 interesting and they have an obvious effect on
13 costs but I would like to think about -- and
14 I said this before. So, if I have said it in
15 front of any of you, I apologize for repeating
16 myself but although it is always good to quote
17 a good source. But it is sort of actuaries.
18 It is my beef with actuaries. They can tell
19 you what something costs but they can't and
20 don't tell you what something could or should
21 cost.

22 And I think we are always to

1 remember that cost and price are two different
2 things and that we are trying to manage costs
3 but we are trying to lower prices. And we
4 don't have any good measures there. You want
5 to talk about a gap, that is the Grand Canyon
6 there.

7 DR. MC CLELLAN: Yes, I think we
8 are talking about that tomorrow.

9 David, did you have a point on
10 this issue?

11 DR. SEIDENWURM: Yes.

12 DR. MC CLELLAN: Then, I will get
13 to Chris.

14 DR. SEIDENWURM: Well, I think
15 that is an example of an area of where you
16 can't get -- well, I don't imagine you could
17 get an NQF-endorsed measure because we would
18 all, I think, taking Dolores' point and saying
19 wouldn't it be great if everybody had to put
20 out a price list of their ten biggest services
21 or whatever. But how do you show that that
22 has an impact on the rank in disability score

1 or something that would give the type of data
2 that would get you an NQF-endorsed measure
3 when we think in common sense it would help us
4 get at this issue of affordability.

5 DR. MC CLELLAN: Well, we did have
6 some discussion of this earlier around the
7 cost measures and the decomposition of the
8 utilization and price. And we had some pretty
9 positive comments from the group that will be
10 reflected in the report about the potential
11 value of efforts by plans, employers, others
12 to promote transparency around price
13 comparisons and the like. And it is hard to
14 come up with one general measure of that
15 because the price that matters to a particular
16 patient depends on what plan they are in and
17 so on.

18 But I think that we will include
19 some of that in the report.

20 Chris?

21 MR. DEZII: Yes, is it safe to
22 assume, and maybe we should write this in

1 there, the use of higher cost drugs and
2 devices, I guess, perhaps tests and procedures
3 with a non-differentiated evidence-base.
4 Right? Is that a reasonable assumption.
5 Should we write that?

6 DR. MC CLELLAN: We could. I was
7 trying to push for to give the audience the
8 general concept of some examples. And we did
9 have kind of -- just kind of find where I
10 wrote them down -- we did have a few earlier
11 like brand versus generic drugs and some
12 others along those lines for the non-NQF
13 endorsed measures now but there could be.

14 DR. LARSEN: And it is sort of
15 equivalent outcomes. Right? So, it is like
16 conservative therapy versus spinal surgery.
17 So, we know that for a whole pile of patients,
18 there are equivalent outcomes in those two
19 care pathways.

20 DR. MC CLELLAN: Joanne?

21 DR. CONROY: Yes, I'm sorry, I
22 don't have the measure 0216 or 0215.

1 So, I just had a question about
2 it. it the proportion of patients admitted
3 to hospice from the inpatient care or is it
4 regardless? Meaning, we are not looking at
5 people that are in an outpatient setting,
6 maybe at home, not in hospice. The only
7 reason I am concerned about it is if we are
8 really trying to get at overuse, it is really
9 getting them out of an institution and acute
10 care setting into hospice. I think we are
11 crossing that funny line though for actually
12 people are dying at home and we are insisting
13 they actually be enrolled in hospice when that
14 feels like more of a family decision then that
15 may be doing the same thing.

16 DR. MC CLELLAN: Well, you can die
17 at home and be covered by hospice. A lot of
18 hospices go to the home.

19 DR. CONROY: Right. But my
20 thought is if we are really focusing on
21 overuse, it is getting them out of the acute
22 care mindset and into hospice. I just wonder

1 does the measure mean any death?

2 DR. MC CLELLAN: Well, sure.

3 MR. SAUNDERS: Hospice will give
4 you the measure set that helpful. And so for
5 0216, the proportion of in the hospice within
6 three days. It is a percentage of patients
7 who died from cancer and were admitted to
8 hospice within less than three days.

9 So, the numerator is the patients
10 who died from cancer who spent fewer than a
11 two days in hospice. The denominator is
12 patients who died from cancers who were
13 admitted to hospice.

14 So, that is the population of what
15 you are looking through. And there are no
16 sort of major exclusions or risk adjustments
17 to put in there.

18 DR. MC CLELLAN: You were saying,
19 their being in a hospice is not equivalent to
20 dying at home. And even if they are not dying
21 at home, you can have -- most people get
22 hospice care at home. And I think that is

1 meant to be captured by the measure.

2 DR. CONROY: We just have all
3 cancer patients? Because hospices are far
4 more than cancer patients. It is for aging --

5 DR. MC CLELLAN: In terms of
6 future directions.

7 DR. CONROY: Yes, so but I think
8 that is an important measure.

9 So, are we actually supporting a
10 measure that is just cancer patients?

11 DR. MC CLELLAN: Well again, sort
12 of our short-term measures are measures that
13 are here and now. So, right now the answer
14 would be yes. But that is the point of having
15 this discussion. If it should stay that way.
16 You would say yes and the measure should make
17 sure that it doesn't lead to the disincentives
18 to use hospice services that Sean mentioned
19 and yes, it should really be about encouraging
20 appropriate palliative and supportive care.
21 And it should be extended to other conditions
22 as well. But we are trying to start with some

1 concrete things.

2 Jim?

3 DR. SIRIO: Just, there are some
4 rules in emergency medicine that we follow.
5 If we are looking for other criteria, there is
6 the nexus criteria. And other c-spine
7 criteria for when we clear people clinically
8 and don't x-ray their spine. There is the
9 Ottawa ankle rules, there is an Ottawa knee
10 rule. So there is a number of things in
11 emergency departments that we use routinely to
12 try to avoid an unnecessarily and consider to
13 be well-validated in journal- style data.

14 DR. MC CLELLAN: Kevin?

15 DR. LARSEN: It seems like there
16 are a lot of cases we go to high cost
17 procedures and services. So things like all
18 the news lately about the da Vinci surgery
19 systems and how they might not be giving us
20 any better outcomes but they are very high-
21 cost. Place the values to practice with
22 cardiologists in different kinds of cardiac

1 pacemaker choices that they exist. And we,
2 for most patients, they get the Cadillac where
3 the Chevy would actually serve all their
4 needs. I think we have some similar issues
5 with what orthopedic implants that are well-
6 known that they have equivalent outcomes but
7 they have vastly different costs.

8 So, there is a whole like suite of
9 low-hanging fruit in this space that we many
10 organizations know pretty well.

11 DR. MC CLELLAN: Well, we will try
12 to include some of those examples. That goes
13 along with the engineering and so forth.

14 Any other comments for this group?
15 Okay, on to public comment. Operator, if you
16 are with us, can you please open the lines for
17 public comment?

18 OPERATOR: At this time, if you
19 would like to make a comment, please press *
20 then the number 1.

21 There are no further comments at
22 this time.

1 DR. MC CLELLAN: Okay, we've
2 covered everything. Good.

3 So, I should say we covered
4 everything just for the first day. So, we are
5 reconvening tomorrow. As you can see from the
6 agenda, there are a number of other areas
7 related to on these high opportunity
8 affordability measurement areas that we
9 haven't covered yet. We are going to cover
10 them then. And also, we are going to have
11 some discussion around how this work fits into
12 other activities at NQF and more discussion
13 around how we will get these high priority
14 measures implemented.

15 Rob, any other comments with this
16 go around?

17 MR. SAUNDERS: No, just a quick
18 housekeeping. Tomorrow, we are going to start
19 a little bit earlier. Because we have the
20 meeting next door, we are pairing off. And so
21 they became second. Tomorrow, we come first.
22 So, you will note breakfast starts at 8:00 and

1 we will start promptly at 8:30.

2 DR. MC CLELLAN: But we end
3 earlier, too. So start a half hour earlier
4 and end an hour and a half earlier.

5 MR. SAUNDERS: But otherwise,
6 concepts I think we have got a lot to do.

7 DR. MC CLELLAN: All right, thank
8 you all very much and we will see you in the
9 morning.

10 (Whereupon, at 3:45 p.m., the
11 foregoing meeting was adjourned to
12 reconvene at 8:30 a.m. on
13 Thursday, May 8, 2014.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Map Affordability Task Force Meeting

Before: Chair Mark McClellan

Date: Wednesday, May 7, 2014

Place: NQF

was duly recorded and accurately transcribed under
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