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

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

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

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

(Laughter.)

DR. CASSELL: But that is for your discussion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

contributing to.

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

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

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

So, at the end of this couple of

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

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

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

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

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

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

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

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

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

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

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

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

Association, sitting in for Rich Umbdenstock.

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

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

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

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

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

California and I am also on the MAP Clinician Council.

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

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

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

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

DR. TERRY: Can you hear me now?

COURT REPORTER: Yes.

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

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

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

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

the transition of patients who require post-acute care.

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

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

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

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

MS. MITCHELL: I'm Dolores

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

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

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

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

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

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

(Laughter.)

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

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

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

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

Workgroup and Coordinating Committee.

DR. ADAMS: Hi, good morning. Karen Adams, the Vice President of National Quality Partners. I know I have had the pleasure of working with many of you over the years but I really want to thank you for this work. And I know we have been talking about how in the context of portfolio and affordability in helping us pave the way through it. Thank you.

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

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

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

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

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

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

on.

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

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

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

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

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

So, that is what is in front of you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

workforce.

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

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

And so, based on that, the staff --

DR. SIRIO: I have a question.

MR. SAUNDERS: Sure.

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

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

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

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

DR. MC CLELLAN: They are not.

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

DR. MC CLELLAN: Yes.

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

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

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

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

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

also there.

So, this is --

DR. SIRIO: What page?

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

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

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

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

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

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

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

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

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

DR. MC CLELLAN: David and then Jeff.

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

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

I don't know exactly how you do

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

DR. MC CLELLAN: Beth?

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

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

DR. MC CLELLAN: Helen and then Sean.

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

were, what you mean by removing workforce, Rob.

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

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

MS. HASKELL: What measures are we talking about?

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

MS. HASKELL: Okay.

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

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

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

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

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

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

MR. SAUNDERS: Sean?

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

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

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

MR. SAUNDERS: Thanks. Sally?

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

DR. MC CLELLAN: Thank you. Ron?

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

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

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

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

Sound okay, David?

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

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

DR. MC CLELLAN: Okay, sounds good.

Moving on to the next question on

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

Do these look good, Carl?

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

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

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

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

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

DR. MC CLELLAN: Nancy?

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

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

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

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

DR. MC CLELLAN: Thank you. Joanne?

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

cost of care?

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

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

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

David?

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

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

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

DR. MC CLELLAN: Peg.

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

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

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

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

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

and affordability information together.

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

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

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

translates into patient affordability.

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

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

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

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

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

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

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

DR. MC CLELLAN: Yes.

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

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

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

a preliminary family.

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

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

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

(Laughter.)

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

DR. MC CLELLAN: Thanks. Aparna.

MS. HIGGINS: So, I have been

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

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

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

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

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

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

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

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

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

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

Okay, thanks, Aparna.

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

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

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

MS. MITCHELL: Just a quick question.

DR. MC CLELLAN: Yes.

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

own?

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

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

MR. NELSON: Mark, this is Gene Nelson.

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

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

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

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

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

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

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

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

David.

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

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

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

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

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

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

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

price.

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

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

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

about something that is really a semantics issue.

DR. MC CLELLAN: I would just --

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

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

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

Nancy?

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

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

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

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

Yes, Carl.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Laughter.)

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

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

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

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

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

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

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

MS. HASKELL: But you can have

lower valued healthcare.

DR. MC CLELLAN: That's right. Jim?

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

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

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

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

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

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

DR. MC CLELLAN: Thanks. Beth?

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

DR. MC CLELLAN: Jennifer.

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

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

Sean, is that still -- David.

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

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

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

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

DR. MC CLELLAN: Dolores and then Aparna.

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

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

take a blood and can report the results.

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

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

DR. MC CLELLAN: Aparna.

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

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

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

Gerri?

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

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

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

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

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

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

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

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

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

DR. MC CLELLAN: So, Peg.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay, Peg? Is that left over?

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

DR. MC CLELLAN: Okay, Nancy.

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

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

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

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

MS. FOSTER: Right.

DR. MC CLELLAN: Okay.

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

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

DR. MC CLELLAN: Beth?

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

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

staff level to make sure we have got some standing.

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

DR. MC CLELLAN: Aparna?

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

So, we should look at that.

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

MS. HIGGINS: National level, yes.

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

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

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

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

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

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

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

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

Ron?

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

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

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

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

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

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

MS. O'ROURKE: Yes, I think

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

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

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

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

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

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

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

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

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

DR. WALTERS: Yes.

DR. MC CLELLAN: Chris.

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

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

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

DR. MC CLELLAN: Thank you. Sean?

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

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

obviously, going to be really helpful for encouraging implementation.

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

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

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

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

MS. MITCHELL: This has been

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MC CLELLAN: Thanks.

MR. NELSON: I have a comment.

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

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

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

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

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

DR. MC CLELLAN: Thanks, Gene. Nancy?

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

and others were going.

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

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

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

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

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

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

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

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

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

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

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

really the --

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

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

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

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

DR. MC CLELLAN: Okay. And it

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

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

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

Aparna?

MS. HIGGINS: So, just to

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

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

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

MS. HIGGINS: Yes.

DR. MC CLELLAN: Ron?

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

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

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

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

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

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

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

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

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

the ability to capture those different perspectives.

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

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

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

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

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

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

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

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

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

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

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

clear how they fit in that framework we just described.

David?

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

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

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

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

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

Kevin?

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

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

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

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

MS. MITCHELL: You have got to pay.

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

DR. MC CLELLAN: Nancy.

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

DR. MC CLELLAN: The whole question of what?

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

DR. MC CLELLAN: I think it is a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And we were just talking about

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

Yes, please, jump in.

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

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

there.

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

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

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

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

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

MS. HIGGINS: What is the data source?

MS. O'ROURKE: The data source.

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

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

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

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

Okay, Sean?

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

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

It is pretty simple. It is pretty blunt.

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

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

DR. MC CLELLAN: That would be nice.

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

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

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

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

DR. MULDOON: Okay.

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

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

we just get this version?

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

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

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

DR. MC CLELLAN: Okay, I get that

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

Okay, --

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

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

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

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

Yes, Peg?

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

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

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

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

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

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

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

that would be helpful, too.

Kevin.

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

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

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

And do you want to say something

about the procedure or measures that you use?

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

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

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

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

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

DR. MC CLELLAN: Aparna?

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

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

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

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

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

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

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

I'm not sure what that means for

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

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

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

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

So, there is some level of

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

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

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

DR. MC CLELLAN: Great. Go ahead.

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

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

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

DR. MC CLELLAN: Thanks. David?

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

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

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

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

DR. MC CLELLAN: Thanks. Beth?

DR. AVERBECK: I think one way of

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

DR. MC CLELLAN: Thanks. Wei.

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

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

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

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

DR. MC CLELLAN: Thank you. Nancy?

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

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

DR. MC CLELLAN: Thank you. David?

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

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

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

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

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

DR. MC CLELLAN: Thank you. Dolores.

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

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

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

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

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

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

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

time and choose once they have a diagnosed disease.

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

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

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

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

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

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

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

Sally?

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

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

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

Sean?

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

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

Well, we have got the general problem.

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

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

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

DR. MC CLELLAN: Kevin?

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

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

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

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

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

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

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

DR. MC CLELLAN: Dolores?

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

DR. MC CLELLAN: Aparna?

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

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

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

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

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

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

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

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

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

Helen?

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

talked about creating another category of gaps.

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

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

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

David.

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

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

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

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

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

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

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

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

DR. MC CLELLAN: Thanks.

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

DR. MC CLELLAN: Yes, go ahead.

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

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

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

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

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

press * then the number 1.

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

OPERATOR: There are no comments from the phone.

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

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

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

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

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

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

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

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

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

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

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

(2:25 p.m.)

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

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

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

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

We are going to start with Group

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

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

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

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

We also want to ensure that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay, questions for our group?

DR. MC CLELLAN: Thanks, Kevin.

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

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

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

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

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

DR. MC CLELLAN: Jennifer?

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

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

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

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

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

Dolores?

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

(Laughter.)

DR. HOPKINS: Don't take it personally.

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

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

(Laughter.)

MS. MITCHELL: I think it is an

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

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

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

sorry, were you waiting?

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

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

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

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

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

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

DR. MC CLELLAN: Sean?

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

But the question for the group,

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

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

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

DR. HOPKINS: It got endorsed.

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

DR. HOPKINS: Yes.

DR. MULDOON: Thank you.

DR. MC CLELLAN: Nancy.

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

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

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

David?

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

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

DR. MC CLELLAN: There is a right rate?

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

(Laughter.)

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

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

DR. MC CLELLAN: Sean, did you

have another comment?

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

David.

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

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

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

outpatient overall.

DR. HOPKINS: Yes.

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

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

DR. YING: Right.

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

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

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

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

DR. HOPKINS: That was the point.

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

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

DR. SEIDENWURM: Yes.

DR. MC CLELLAN: Do you have a slide?

DR. SEIDENWURM: We have a slide.

Okay, so a lot of what we talked

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

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

And then there are also problems

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

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

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

goes through the endorsement process would be okay.

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

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

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

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

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

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

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

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

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

DR. MC CLELLAN: Jennifer?

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

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

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

DR. SEIDENWURM: Yes, right.

DR. MC CLELLAN: Appropriate asthma medications.

Comments, David?

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

DR. THOMAS: And we have obstetrics.

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

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

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

reviewed in the context of the overall measure set.

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

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

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

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

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

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

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

better handled elsewhere on the quality side?

Aparna.

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

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

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

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

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

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

You know we were looking at, for

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

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

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

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

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

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

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

pharyngitis, things like that.

MS. HIGGINS: Okay, thank you.

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

David?

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

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

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

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

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

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

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

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

on it as the utilization group discussed.

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

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

DR. MC CLELLAN: Good. Jim?

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

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

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

DR. HOPKINS: Yes.

MS. FOSTER: Yes.

DR. MC CLELLAN: Okay, so Wei.

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

(Laughter.)

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

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

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

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

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

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

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

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

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

Helen, did you want to comment on that?

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

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

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

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

DR. MC CLELLAN: David?

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

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

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

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

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

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

So, if we can really specify some of those things, then I think we would have

come a long way. And the principles, I think, are established. We just don't have the examples at each difficulty.

DR. MC CLELLAN: I see some head nodding along with that. So, I will ask my usual question. Are there any specific examples of this around now that we could highlight?

DR. SEIDENWURM: Well, as always, I am going to say mammography because that is the easiest one. That is our cardiovascular disease, you know our cardiovascular surgery. There is one disease. There is hard outcomes.

DR. MC CLELLAN: So, there is a measure --

DR. SEIDENWURM: Yes.

DR. MC CLELLAN: -- or something approaching a measure that captures this notion of --

DR. SEIDENWURM: Oh, no. No, there is not a measure but there are these decision tools. I guess the target group has

been very active in promoting these. I think that there are similar decision tools for low back pain and I don't know about other examples.

DR. MC CLELLAN: Yes, I don't know if Gene is still with us on the phone but maybe that is an area where --

MR. NELSON: Yes, I am.

DR. MC CLELLAN: Maybe we could follow upon some of the tools that are available in these areas of choosing wisely and potential overuse where pairing with a measure related to effective patient engagement in decision-making might be appropriate -- might be helpful.

MR. NELSON: Yes. A lot of the times a body of work for a long time and some new development shorter measures reflecting the ability for people that have good decisions for routine care.

So, we could follow up with that.

DR. MC CLELLAN: Carl -- I'm

sorry. Kevin.

DR. LARSEN: I have a couple of things. First, the choosing wisely. I had a contract with RAND to actually look at an analysis of the first 40 choosing wisely to build them into measures for federal programs and especially a systematic analysis of kind of their fit for use. And I can follow up with the RAND researchers but the plan is to get that published. It was Cheryl Damberg and Peter Hussey. The last I think was submitted to publications. We are kind of waiting to hear from them that they will actually pick it up.

But it is essentially the same things that we have been talking about here at the table. It is really appealing. We were very interested and a deep kind of systematic analysis showed the same kind of things you are hearing here that we came up with about five of them out of 40 that might be a minimal with enough discrete data to be ready for

measurement at scale.

The other thing that I would -- I am trying to wear multiple hats as consumers of this. And one of the hats that I am thinking of now is my state Medicaid director hat and thinking about where is the long-term care utilization and appropriateness and where it is for both the Medicaid elderly as well as behavioral health because I know those are really big buckets of spend for state Medicaid programs. And I think we have been pretty silent about making the measures about appropriate use of long-term care.

So, I am wondering if you guys thought all about that. I didn't think of this during our utilization time but it is something that either you get fair measures out there or if we can identify those as gap areas because I think it is really important.

We know that there is a lot of state-to-state variance and provider-to-provider variance about use of long-term post-

acute care.

DR. MC CLELLAN: Sorry. Just to be clear, post-acute and long-term.

DR. LARSEN: I think post-acute care and long-term care both of them. I think especially the long-term care is the one that the Medicaid programs are keenly interested in. The post-acute care Medicare is keenly --

DR. MC CLELLAN: Medicare is more involved. Thank you.

Carl?

DR. SIRIO: Yes, just briefly, in sort of a different direction. You know we have used in this conversation overuse and appropriateness as synonyms. Whatever preamble we have in this section of our report needs to acknowledge, I think that appropriateness could also deal with the issue of other tail on this and that is utilization.

DR. MC CLELLAN: Yes. Yes, that is a very good point.

MS. HIGGINS: I just want to echo

that because it talked about the Texas CAM and the work that we are doing. We actually looked at both commercial and Medicare. On the Medicare side, there is evidence to show that they need to be screened and there is underuse on the Medicare side.

DR. MC CLELLAN: Great. That is going to be a good one to discuss in this context. So, I appreciate that concrete example.

David?

DR. SEIDENWURM: Right and just to go on to echo what Carl said, also I think in many of the areas that we have been discussing, the gap in care is on the overuse side more than on the underuse side. And I think that is what led to the focus but I think you are quite correct. There are certainly are circumstances where the opposite is true, especially in dual eligible population and the other hard to treat groups.

DR. MC CLELLAN: Jennifer?

DR. THOMAS: And I would just again, the underutilization goes along with the proportion of days covered the issue of the use of medications appropriately for our large populations of diseased patients.

Obviously, we know if we don't take diabetes medications, our A1Cs and glucose is non-controlled. So, could those lead to those complications of the disease and use of services.

The other thing that I want to mention since we have brought this up for the long-term care, so many of these medication measures, obviously, were really targeted at I think the older adults, primarily the issue was high-risk medication. Certainly Part D is following that but they are looking at that need in the nursing home population as well.

So, while the measures are not perfect, as I think, Nancy had said, they are some way getting at a process to say are we looking at these high-risk medications and

persons that are vulnerable. So, we tended to lump that into one thing to try to improve one measure and make it -- you know that parsimony helps. Those are some of the areas that -- the reason that I think they are included here.

DR. MC CLELLAN: Okay, I am not going to try to do a detailed summary of this very rich discussion. But among the key points, choosing wisely we will have some discussion around the importance of the difficulty of turning those concepts into measures in many cases. And as a potential path forward in those cases, reporting on utilization rates and taking the approach of utilization plus incorporating some explosive measures related to the use of effective decision tools to engage patients, which Gene is going to help us with. It could be very helpful there. I will try to include a few concrete examples, too.

In terms of current measures, we

have had some discussion around parsimony good in that it could help focus consistent reporting and, thereby, hopefully get more focused action. Concern about not having too few measures on the other hand, though.

And then we have a number of specific measures that we went through around low back pain, around maternal care, C-section use, antibiotics, appropriate use of asthma medications and maybe some other medication adherence measures. So, the latest generation. The best one sort of is some real connection to actual care and outcomes and some variation in performance.

In terms of current measures, we had some discussion around complication-related measures. We illustrate the CABG re-op measure. Those really don't belong in this category, although they are important considerations for quality and had an impact cost as well.

And then future direction areas

include maternity, end of life, mental health, more on imaging, orthopedics, cancer treatment.

MR. NELSON: Mark, one more comment.

DR. MC CLELLAN: Yes, go ahead.

MR. NELSON: This is Gene. In the spirit of parsimony and measurement gaps, and especially those having to do with real waste and harm, I think there is a measurement gap in just us having total expenditures per capita clearly very high priority. One of the drivers is total harm caused by healthcare, having to do with safety, complications, et cetera. And there has been work in the past but that continues to be a real gap.

It would be very helpful to have a total harm measure for populations that are clearly more than waste. It is harmful waste.

DR. MC CLELLAN: Gene, in terms of directions to get there, is that a roll-up of some of the error measures or what is the

foundation that we describe in the report to happen?

MR. NELSON: Yes, I think conceptually it is a roll-up of measures, smaller metrics or a global trigger tool kind of approach that has been tested. 3M has developed a commercially-viable product around this idea as well.

So, I think maybe there are a couple of different conceptual approaches that people have taken to measure total harm.

DR. MC CLELLAN: Great thanks. All right, thank you all. Good discussion.

And we move on to is it Group B, unnecessary use of higher cost providers. And who is the lucky speaker?

MS. O'ROURKE: So, I somehow got elected as spokesperson.

(Laughter.)

DR. MC CLELLAN: The group did a good job.

MS. O'ROURKE: So, we had

consensus on three measures that we wanted to bring forth for including in the family. So, 0173 emergency use without hospitalization. We did want to mention a caveat with this measure, that this is only a home health measure at this point and that this needs to be expanded to address all providers, not just home health, but unnecessary hospitalizations go beyond just that care setting.

Then two measures about hospice care and patients not being appropriately referred to hospice. Again, this caveat is that we, to make a strong statement that hospice uses a societal issue and recognizing there are cultural issues, disparities and access and family resistance but that all stakeholders have a role to play in. You can see the uptake of hospice care.

So, the short-term measurement gaps, if you will. Also, we recommended aligning with the choosing wisely campaign to develop measure issues like unnecessary

consultations and referrals, recognizing that not all are unnecessary and it is very, very difficult to actually get to that type of granularity to see what could have been avoided.

Looking to the AHRQ ambulatory sensitive condition measure, start to address issues where care could have been better provided in a primary care setting not elevated to the hospital.

As I mentioned, expanding measures of unnecessary ED use and hospitalization for all providers, not just home health.

And our big changes that we wanted to increase the theme of our high-leverage opportunity for higher cost providers to higher cost services that it was a big gap that high cost drugs and devices were not mentioned. And while there are measures that there needs to be developing of using a higher cost treatment before an effective lower cost treatment.

Some longer term opportunities, increase the access to care, the lower levels of care that a lot of patients end up in the ED because they can't get a hold of their primary care physician or they don't have a primary care physician.

As I mentioned, increasing the acceptance of hospice care and end of life issues. Increasing health literacy that patients understand what is going on in that area and understand how to adhere to their treatments. Don't end up in an emergency department because they didn't understand how to take their medication and manage their condition as an outpatient.

And finally getting into levels of system or measures of system level accountability that they have there are not population measures or things addressing affordability and starting to look at whether there is a level beyond the space that we need to hold people accountable for for testing

these issues. That might not be feasible but an aspirational goal.

So, next slide. So, implementation barriers. We did want to mention a caveat about team-based care and that as we move to ACO models. A specialist may not cost more and may actually be the most efficient choice to manage a complex patient.

We wanted to pick up the orphaned mental health infrastructure issue that a lot of these patients might turn up in EDs for mental health and substance abuse issues that they could have probably handled at a lower level. But since there is no access, they bounce into hospitals.

Again, considering the issue of unnecessarily using higher cost drugs and devices and a way to balance increased patient empowerment and marketing to the patient with demand for services without a rationale. Again, looking to choosing wisely to provide guidance on what is an evidence-based reason

for service.

DR. MC CLELLAN: Thanks, Erin. Any additions from the group? Sean?

DR. MULDOON: A little clarification around the ER use without hospitalization. I know this is for home healthcare. But sort of ironically, the goal of home care and other post-acute care is not to have the person admitted to the hospital when they go to the ER. So, go to the ER; make the diagnosis very promptly; and then get them back to us.

So, this seems to run counter to that.

MS. HASKELL: Yes, I am a little puzzled if somebody goes to the ER for all sorts of things, a broken arm, they would be seen and not admitted. I am trying to look this measure up but I don't understand it.

DR. MC CLELLAN: Nancy?

MS. FOSTER: So, the concept behind this measure is really that there are

many times in which the patient could be better managed in the nursing home, which is to our expansion, in the other care setting where they are currently be cared for, we wouldn't expect -- I don't think we were talking expanding this to all patients showing up at the ER, just patient who are otherwise engaged in some sort of medical care who are ending up in the emergency department because they either failed to contact the home health nurse, the primary care provider says my slate is full, go to the ER. It is that sort of the patient could have been best managed by the care givers they are engaging already but it didn't happen and so, they ended up in the ER. That was the notion of this measure.

I can't swear to it that that is doesn't exactly right but that is why the measure exists, not because every visit to the ER by somebody who is in home health is wrong. They could fall and break their hip, knee, arm. But that was the thought.

DR. MC CLELLAN: Kevin.

DR. LARSEN: So, with your expansion of the scope of providers to services, I think there is some additional measures we should pull out for consideration.

So, I know there are some use of advanced imaging for certain conditions like headache that do have measures that either are in the pipeline or are endorsed. There is this MRI and a CT for a complicated headache and an MRI and CT for complicated back pain. Those are the kind of measures that are already out there. And those, I think, would fit in here under the new rubric of services, rather than providers.

Also, it was a little bit of a head-scratcher around things like inappropriate emergency department use. I put on my commercial business hat that is isn't about healthcare and I think would Walmart ever feel this is what they measure. Did people come into the high cost door versus the

low cost door. They would just figure out how to make their low cost door the door people wanted to come in.

And it seems as if some of this stuff is fundamentally finding our current business model. And so it is just a head-scratcher to figure out how measurement is going to help there when the business model still says my per unit margin is much higher in this door than that door.

DR. MC CLELLAN: That is a good point. Going back to your first point, Kevin, about -- it totally makes sense to shift the scope to high cost services, not just high-cost providers. We may need, as we are formulating the actual report to figure out where to draw the line from that overuse measures that we just discussed.

So, if there are any comments on that now that would be helpful, it would be good. I think are kind of heading in the same direction on all of this but we will find a

good way to write that out.

Beth, do you have -- did we already cover it? Okay, great. So, Nancy, then Aparna, and then Wei.

MS. FOSTER: So, just to address Kevin's question. While I won't comment on any specific measure here, when we were talking, we were talking about these measures as providing insights that could impact the policies, procedures, and actions of a wider group than just the providers. So, it may be that if we are seeing overuse in the emergency department because people don't have access to primary care, you are absolutely right. But this is not only in the hospital who keep that emergency room door wide open. The business model for everybody else should be how do we figure out how to get them to the right primary care provider.

So, it is how do we have those conversations? How do we bundle this measure?

DR. MC CLELLAN: Aparna?

MS. HIGGINS: So, I just wanted to comment on trying to draw a distinction between where this, like the imaging measures you suggested, Kevin, does it fit in overuse. Does it fit in this bucket? And my group can correct me but I think that the discussion we had around higher cost drugs and devices was more around are there alternatives available.

So just like would you want everybody to go to the ER when many of them could be seen in the primary care physician's office, that is a site of care kind of an issue. Similarly, there are alternative treatments available. Would you always want to go to the high cost drug when there might be equally effective other options available? I think that is where sort of we were sort of drawing the line between pure overuse and unnecessary use of high cost.

DR. MC CLELLAN: So availability of lower cost alternatives.

MS. HIGGINS: Yes.

DR. MC CLELLAN: So if there are any good examples of measures along those lines, like something like use of generic prescriptions.

MS. HIGGINS: Well, that would be one example, I guess, but I don't think there are any endorsed measures for generics, generic use.

DR. MC CLELLAN: We will do a little researching.

Gerri?

DR. LAMB: Was there any discussion about 0265? I just wondered why it wasn't on a list.

MS. O'ROURKE: Yes, we thought that might be better to the errors and complications. That measure didn't get at unnecessary hospitalization. It got to a safety issue. That measures is for the ACS setting and addresses when a patient had a complication during what should have been a routine procedure and ended up in a hospital.

So, we wanted to propose that during the errors and complications discussion.

DR. MC CLELLAN: Okay, Wei.

DR. YING: When we looked at unnecessary use of high costs service, we actually look at the site of service. So I think we catch up on here, we look at inpatient, we look at ED. But then sometimes it is not necessarily just that a lab test can be done in the hospital and it can't be done in the community just like let's say the Quest Lab. The cost is very different and imaging the same thing.

So, just looking at IPOPER will not necessarily get to the root cause of the cost differentiation. Sometimes it is really the cost site of service is not just the suite that we are talking about here.

DR. MC CLELLAN: And any examples of site of service measures?

DR. YING: That is when we look at

the lab and the imaging.

DR. MC CLELLAN: The lab and the imaging.

Nancy?

MS. FOSTER: I mean talking about, not that specific example but others, I think one of the caveats we offered up was the one that Kevin provided this morning, which is you may not be looking at the total burden of debt measure. Just sending somebody out for a lab is sometimes a big burden on them.

So, not that it shouldn't be used but we have got to figure out how to do it right.

DR. MC CLELLAN: Yes, it is the frame that costs the patients somehow. We need to make sure we don't lose sight of if I have to drive 50 miles to the low cost service, as a patient, the total cost is higher than if I do it next door and it is slightly more expensive.

Aparna?

MS. HIGGINS: So, if you are looking for more specific examples in relation to what Wei brought up, you know MedPAC has done work on this and issued a report. So, that might be worth looking at.

DR. MC CLELLAN: Any other comments on this area?

MR. NELSON: This is Gene. Again, I think it is perhaps this topic and the prior one that John Watson in How's Your Health and has been developing an item in several publications on health confidence is what he calls it. And if a single item measure of my ability to take care of myself and to follow my care plan. And that has been associated with lower costs, better health outcomes, higher satisfaction and varies widely across providers and can be improved by focusing on it.

And it goes really to the ability of self-care and self-management, enlightened and intelligent, and competent that produces

savings.

So, it may be something that we should be taking into consideration.

DR. MC CLELLAN: Thanks, Gene. Sean?

DR. MULDOON: On the three-day hospice measure, what behavior are you trying to drive? Don't send them or send them?

DR. MC CLELLAN: We not waiting until the last minute to send them.

DR. MULDOON: Okay. So, someone who is really sick isn't going to go and it is going to drive your hospice utilization rate where you don't want it.

DR. MC CLELLAN: Well I think ideally you get them in longer so that -- longer is higher

DR. MULDOON: So the idea is that people will come earlier.

DR. MC CLELLAN: Right.

MS. MITCHELL: The underlying with that is that those people are getting kicked

out of care.

DR. MULDOON: Oh, I understand. That part, again, I am trying to decide when you have got a patient and you have to decide whether to send them to hospice whether you are going to end up -- you are going to end up saying oh, this patient is really sick, could die this week. Let me just leave him in the ICU.

DR. MC CLELLAN: That would be an undesirable consequence.

DR. SEIDENWURM: So, is this an example of the over/under thing you were talking about before with respect to other benchmarks?

DR. MULDOON: There is a sweet spot instead of a lower is always better, higher is always better.

DR. MC CLELLAN: Dolores?

MS. MITCHELL: Well, we had a long discussion about this. It is difficult and it is loaded with family, integrational baggage.

I don't think we are talking about sending somebody to hospice but initiating the discussion between the patient, the patient's family, many of whom come loaded with guilt about not doing everything for dear old so-and-so. But rather trying to change the culture, both the medical culture and the culture at large about what is the most humane and decent way to ease people out of life, rather than us pouring dollars for -- and sometimes amounting to cruelty, when they aren't going to help.

So, I think that was the thrust of that discussion. But understanding that you talk about person and family in my inquiry of this morning, that is a classic case where it is not just the patient, it is the whole family and you have got a lot of different motivations and a lot of different threads at work.

So, the general idea that we know that people do that we underuse that very,

very good capability that we have developed and to no particular purpose or value to anybody.

So, that was the thrust of that discussion. But I did want to just underscore something that Erin said but I think we didn't pay any attention to it. I am proud leading dissenter -- not dissenter but nag might be a better word on this issue of the evasion of the central issue of price.

And all of these measures are interesting and they have an obvious effect on costs but I would like to think about -- and I said this before. So, if I have said it in front of any of you, I apologize for repeating myself but although it is always good to quote a good source. But it is sort of actuaries. It is my beef with actuaries. They can tell you what something costs but they can't and don't tell you what something could or should cost.

And I think we are always to

remember that cost and price are two different things and that we are trying to manage costs but we are trying to lower prices. And we don't have any good measures there. You want to talk about a gap, that is the Grand Canyon there.

DR. MC CLELLAN: Yes, I think we are talking about that tomorrow.

David, did you have a point on this issue?

DR. SEIDENWURM: Yes.

DR. MC CLELLAN: Then, I will get to Chris.

DR. SEIDENWURM: Well, I think that is an example of an area of where you can't get -- well, I don't imagine you could get an NQF-endorsed measure because we would all, I think, taking Dolores' point and saying wouldn't it be great if everybody had to put out a price list of their ten biggest services or whatever. But how do you show that that has an impact on the rank in disability score

or something that would give the type of data that would get you an NQF-endorsed measure when we think in common sense it would help us get at this issue of affordability.

DR. MC CLELLAN: Well, we did have some discussion of this earlier around the cost measures and the decomposition of the utilization and price. And we had some pretty positive comments from the group that will be reflected in the report about the potential value of efforts by plans, employers, others to promote transparency around price comparisons and the like. And it is hard to come up with one general measure of that because the price that matters to a particular patient depends on what plan they are in and so on.

But I think that we will include some of that in the report.

Chris?

MR. DEZII: Yes, is it safe to assume, and maybe we should write this in

there, the use of higher cost drugs and devices, I guess, perhaps tests and procedures with a non-differentiated evidence-base. Right? Is that a reasonable assumption. Should we write that?

DR. MC CLELLAN: We could. I was trying to push for to give the audience the general concept of some examples. And we did have kind of -- just kind of find where I wrote them down -- we did have a few earlier like brand versus generic drugs and some others along those lines for the non-NQF endorsed measures now but there could be.

DR. LARSEN: And it is sort of equivalent outcomes. Right? So, it is like conservative therapy versus spinal surgery. So, we know that for a whole pile of patients, there are equivalent outcomes in those two care pathways.

DR. MC CLELLAN: Joanne?

DR. CONROY: Yes, I'm sorry, I don't have the measure 0216 or 0215.

So, I just had a question about it. it the proportion of patients admitted to hospice from the inpatient care or is it regardless? Meaning, we are not looking at people that are in an outpatient setting, maybe at home, not in hospice. The only reason I am concerned about it is if we are really trying to get at overuse, it is really getting them out of an institution and acute care setting into hospice. I think we are crossing that funny line though for actually people are dying at home and we are insisting they actually be enrolled in hospice when that feels like more of a family decision then that may be doing the same thing.

DR. MC CLELLAN: Well, you can die at home and be covered by hospice. A lot of hospices go to the home.

DR. CONROY: Right. But my thought is if we are really focusing on overuse, it is getting them out of the acute care mindset and into hospice. I just wonder

does the measure mean any death?

DR. MC CLELLAN: Well, sure.

MR. SAUNDERS: Hospice will give you the measure set that helpful. And so for 0216, the proportion of in the hospice within three days. It is a percentage of patients who died from cancer and were admitted to hospice within less than three days.

So, the numerator is the patients who died from cancer who spent fewer than a two days in hospice. The denominator is patients who died from cancers who were admitted to hospice.

So, that is the population of what you are looking through. And there are no sort of major exclusions or risk adjustments to put in there.

DR. MC CLELLAN: You were saying, their being in a hospice is not equivalent to dying at home. And even if they are not dying at home, you can have -- most people get hospice care at home. And I think that is

meant to be captured by the measure.

DR. CONROY: We just have all cancer patients? Because hospices are far more than cancer patients. It is for aging --

DR. MC CLELLAN: In terms of future directions.

DR. CONROY: Yes, so but I think that is an important measure.

So, are we actually supporting a measure that is just cancer patients?

DR. MC CLELLAN: Well again, sort of our short-term measures are measures that are here and now. So, right now the answer would be yes. But that is the point of having this discussion. If it should stay that way. You would say yes and the measure should make sure that it doesn't lead to the disincentives to use hospice services that Sean mentioned and yes, it should really be about encouraging appropriate palliative and supportive care. And it should be extended to other conditions as well. But we are trying to start with some

concrete things.

Jim?

DR. SIRIO: Just, there are some rules in emergency medicine that we follow. If we are looking for other criteria, there is the nexus criteria. And other c-spine criteria for when we clear people clinically and don't x-ray their spine. There is the Ottawa ankle rules, there is an Ottawa knee rule. So there is a number of things in emergency departments that we use routinely to try to avoid an unnecessarily and consider to be well-validated in journal- style data.

DR. MC CLELLAN: Kevin?

DR. LARSEN: It seems like there are a lot of cases we go to high cost procedures and services. So things like all the news lately about the da Vinci surgery systems and how they might not be giving us any better outcomes but they are very high-cost. Place the values to practice with cardiologists in different kinds of cardiac

pacemaker choices that they exist. And we, for most patients, they get the Cadillac where the Chevy would actually serve all their needs. I think we have some similar issues with what orthopedic implants that are well-known that they have equivalent outcomes but they have vastly different costs.

So, there is a whole like suite of low-hanging fruit in this space that we many organizations know pretty well.

DR. MC CLELLAN: Well, we will try to include some of those examples. That goes along with the engineering and so forth.

Any other comments for this group? Okay, on to public comment. Operator, if you are with us, can you please open the lines for public comment?

OPERATOR: At this time, if you would like to make a comment, please press * then the number 1.

There are no further comments at this time.

DR. MC CLELLAN: Okay, we've covered everything. Good.

So, I should say we covered everything just for the first day. So, we are reconvening tomorrow. As you can see from the agenda, there are a number of other areas related to on these high opportunity affordability measurement areas that we haven't covered yet. We are going to cover them then. And also, we are going to have some discussion around how this work fits into other activities at NQF and more discussion around how we will get these high priority measures implemented.

Rob, any other comments with this go around?

MR. SAUNDERS: No, just a quick housekeeping. Tomorrow, we are going to start a little bit earlier. Because we have the meeting next door, we are pairing off. And so they became second. Tomorrow, we come first. So, you will note breakfast starts at 8:00 and

we will start promptly at 8:30.

DR. MC CLELLAN: But we end earlier, too. So start a half hour earlier and end an hour and a half earlier.

MR. SAUNDERS: But otherwise, concepts I think we have got a lot to do.

DR. MC CLELLAN: All right, thank you all very much and we will see you in the morning.

(Whereupon, at 3:45 p.m., the foregoing meeting was adjourned to reconvene at 8:30 a.m. on 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 my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter