Opioid Technical Expert Panel Web Meeting 5

Moderator: Kim Patterson
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Jeff Schiff: Hi there. This is Jeff.

Vaish Kosuri: Hi, Jeff. We're promoting you, so you should have access shortly. This is Vaish from NQF.

Hi everyone. This is Vaish from NQF. Welcome to Webinar 5 of the Opioid Technical Expert Panel. We're going to have a busy day today, so we'll get started.

We have Michael, Sam and myself, as well as Madison Jung who's joining our project. She's a project manager. And so you'll hear from her as well.

On our agenda, we have - we'll be going over introductions, the prioritization criteria, and the result of the survey that you guys submitted a couple of weeks back. We will also provide an overview of CMS federal programs, followed by a discussion regarding these programs, and then an opportunity for public comment, as well as next steps.

We'll get started on roll call now.

Jeff Schiff?

Jeff Schiff: Good afternoon.

Vaish Kosuri: Good afternoon, Jeff. Brandon Marshall?

Anika Alvanzo.

Anika Alvanzo: Here.

Vaish Kosuri: Michael Ashburn?

(Lindsay): This is Jonathan Gleason's assistant, (Lindsay). He'll be on in a few minutes. He was just running behind at another meeting.

Vaish Kosuri: No worries. Thank you.

(Lindsay): You're welcome.

Vaish Kosuri: Michael Ashburn?

Michael Ashburn: Here.

Vaish Kosuri: Hi, Michael.

Michael Ashburn: Hi.

Vaish Kosuri: Antje Barreveld?

Antje Barreveld: Here.

Vaish Kosuri: Patty Black?

Jeannine Brant?

Jeannine Brant: Here.

Vaish Kosuri: Caroline Carney?

Caroline Carney: Here.

Vaish Kosuri: Anthony Chiodo?

Jettie Eddleman?

Jettie Eddleman: Here. Hello everyone.

Vaish Kosuri: Hi. Maria Foy?

Maria Foy: Here.

Vaish Kosuri: Jonathan Gleason? As we know, his assistant said that he'll be here shortly.

Anita Gupta?

Mark Hurst?

Katie Jordan?

Katie Jordan: I'm here.

Vaish Kosuri: Navdeep Kang?

Navdeep Kang: Good afternoon.

Vaish Kosuri: Sarah Melton?

Sarah Melton: Here.

Vaish Kosuri: Gary Mendell?

Gary Mendell: Hi, I'm here.

Vaish Kosuri: Darlene Petersen?

Darlene Petersen: Here.

Vaish Kosuri: Laura Porter?

Laura Porter: I'm here.

Vaish Kosuri: Clay Rhodes?

Darshak Sanghavi?

Evan Schwarz?

Norris Turner?

Norris Turner: Here.

Vaish Kosuri: Sarah Wakeman?

Sarah Wattenberg?

Arthur Robin Williams?

And Bonnie Zickgraf?

Bonnie Zickgraf: Hello, I'm here.

Vaish Kosuri: Hi, Bonnie.

Bonnie Zickgraf: Hello.

Vaish Kosuri: Is there anyone that I mentioned or is there anyone who just dialed in that I missed their name?

Brandon Marshall: Hi there. This is Brandon Marshall.

Vaish Kosuri: Hi, Brandon.

Anthony Chiodo: This is Tony Chiodo.

Vaish Kosuri: Hi, Anthony.

SreyRam Kuy: Hi, this is SreyRam from the VA (unintelligible).

Vaish Kosuri: Of course. We'll get to the liaisons very soon.

Anyone else from the panel?

Okay, great. We will move on to the liaisons.

Robert Anthony?

Sarah Duffy?

Sarah Duffy: I'm here.

Vaish Kosuri: Elizabeth Kato?

Elizabeth Kato: Here.

Vaish Kosuri: SreyRam Kuy? I think you're here. I heard your comment.

Scott Smith?

Scott Smith: Hi, I'm here.

Vaish Kosuri: Judith Steinberg?

And Linda, we received an email from her that she will be out.

I will hand it off to Michael now to run through the prioritization criteria.

Michael Abrams: Very good. Thank you, Vaish. Hope everybody can hear me. Welcome. Thank you for joining. We're on meeting number five of seven, this joint Technical Expert Panel. So we're deep into our content now.

Just remind you all, the environmental scan is now officially published on the NQF Web site, you received a copy of that. That is a tool for you moving forward and that is also something that you should feel free to widely cite and use and share with others outside of this process. It's a fully public document. But ultimately intended to be, or explicitly intended to be a tool for you all in this process. And thank you all very much for helping inspire our staff to get that work completed.

So, Vaish described our agenda for today. I'm going to take just the next three slides and about 10 minutes to review for you your voting results on gaps, specific gaps that emerged from the environmental scan and the discourse that we've had to date.

And let me tell you explicitly what the purpose of this gap identification activity is and what we will do within the discourse that we'll have today, which will take maybe about the next 20 minutes at most, and then we'll pivot to a very rich content that we have for the next activity looking at CMS related - or CMS programs that we want you to think about.

But with regard to gaps, we're going to describe for you know how you voted on specific gaps that had the genesis of originally coming out of the environmental scan in our discussions so far. And then if you recall, staff dutifully recorded your responses and the discussions that we have. And just remind you, we winnowed down the list such as we could to 33 different measure concepts or specific measures.

And then we asked you to respond to a Survey Monkey or a survey that we put together to have you rate those on five criteria, pretty straightforward criteria, just to remind you -- morbidity and mortality was one, feasibility as a

measure was another. The apparent gaps that existed, the contemporary gaps that suggest there might be a room for improvement if the measure were deployed was a third criteria. A fourth criteria was that the measure - whether or not the measure was patient-centered or not, focused on patients and their families explicitly. And then the final criteria we asked you to consider, when you review it again, these 33 concepts we came up with through our process, the final criteria we asked you to think about was fairness and equity.

So with that, if you can direct your attention now to what is Slide Number 6, for those of you following along on the PDF entitled "Results of the Gap Survey." Here's just some brief heuristics or some brief touch stones for you to hold in mind as we look at the actual results.

First is, out of 28 of you, we got 20 response. Pretty good. Three partial responses, so, really 17 full responses. Still pretty good. A reminder for you that we ask that you just use the simple Likert Scale, 1 meant that it was a low priority rating on the criteria, and 3 meant that it was a high - it was the highest criteria, and then of course with 2 in the middle. So, very straightforward. We just wanted to remind you of that.

And then, the scores compiled in three ways. Staff compiled the voting that you did using three different schemes. Okay? And they're described - and let me tell you what I think you need to know in order to review the tabulations I'm going to show you in a moment.

One way to get it was just with a straight score. So there were five different criteria. We took the sum of the scores and divided by five. That means, if it got a perfect score, then it - a rating of 3 meant that you thought the particular measure was the highest priority it could achieve. Okay? Pretty straightforward. We're calling that simple sum.

The second thing, the bullet entitled Average Response, of just the first criteria, there we just looked at the initial criteria of morbidity and mortality, but again the range of the ratings that we might get would be from 1 being low to 3 being high, but we thought it would be useful to compare just that single criteria morbidity and mortality, anticipated impact on that, to (unintelligible).

And then the third way we did it is summarized at the bottom of the slide. And here we get just a little bit more nuanced, but not really that complicated, we just did a weighting, and it's a straightforward rating, if you look up at the slide there.

You see that we gave a bit more weight to morbidity and mortality, 2.5 times. Feasibility was rated right at (unity). And then we gave just a little bit, 1.5 times weighting to gaps, patient centeredness, and equity.

And so the sum there can go up to actually, if you go three times the total, which is 8, can go up to 24. And if you divide then - if you divide then by 5, then you get a much tighter range, but it is a range that goes above 3 in this case.

And in fact, in each case, there little, smallest bullets there give you the distribution. So the mean rating across all of the measures was 2.3 for the average sum of scores and 2.3 against the morbidity and mortality, and then a little bit higher, 3.74 for the response to the weighted.

And then the other thing that you should carry forward is the standard deviations. And generally speaking, if you just remember, about 10% of the average, that's one standard deviation. Okay?

So, for example, with regard to the sums, 2.3 was the mean, and the standard deviation was 0.2. So it'll give you some sense about whether or not if you see, say, a rating at, say, 2.0 for that particular coalescence of the criteria, then you know it's one standard deviation below the average. Just to give you some idea with how things are ranked.

Okay? Let's go to the next slide. And really I'm just going to show you two slides and maybe one exhibit, and then we're going to stop. And the question for you all is going to, if you think we did a reasonable job capturing, summarizing for you your priorities across these 33 different measure concepts, measurement areas, okay?

So this slide actually summarizes the top 12 priorities that you identified from your voting. And just to take a very specific example, the top row is pain management, which ended up rating at the very top based on the sum score, which was 2.71, so, pretty close to 3 overall. And that was pain management exclusively with regard to tapering measures and assessing whether or not tapering was completed or a plan was set up for that.

Compare it then to the weighted sums, and again it's validating there, it was one of the top scores at 4.4. But then in the very last column of this table, you see that it got a score of 2.3 on morbidity and mortality alone. And that was actually the 14th ranked item with morbidity and mortality alone. So what we have at the end of the day is pain management being ranked at the top for two of our three methods, but not for the third one.

And what's being displayed here then across the top, as I said, the top 12 items, is a ranked ordering that's (yoked) to that second column, the sum, just the simple sum scores.

And so, to take another explicit example, if you go to the very bottom row, you'll see that harm reduction ranked 12th using a simple sum. It ranks pretty close to that, 10th, using the ranked order sum. And it actually ranked considerably higher if you just consider morbidity and mortality in isolation. All right?

So, before we discuss this further, let's look at the next slide just for a second.

What the next slide is showing is the ranked ordering for the top 10, just for the morbidity and mortality rating. And there's actually a little n in the second column that highlights those measures that popped up when only this particular criterial was used, that is if we only consider morbidity and mortality.

And you can see that we arguably have added to the priority list with this particular sensitivity piece, criminal justice involvement and screening for that during intake for substance use treatment as a novel measurement concept, and also prenatal, neonatal (unintelligible) syndrome or prenatal screening for opioid use as well, and then two more down near the bottom, social risk factors, social support screening in particular, and criminal justice involvement specifically, down near the bottom.

So, one way you can think about this -- and I'll ask Vaish to go back to the previous slide -- is that, if you take the top 16, which is on the (path) of the ones we considered, okay, so it's a rich list, you are, including all the ones you see on this list and then the couple that I - that might be added if you think morbidity and mortality per se, is an important indicator of priority.

So now, let me point out just one other thing about this slide. At the very bottom you can see that we have, in the key, we've marked things as being

different, with a little d, or a big D being very different, and that refers to a footnote in the third column, actually the second and third column where we see the ranked ordering changes based on the method that we used in order to determine that ranked ordering.

So, generally speaking, the big D is the substantial differences occur, like again, for example, when we looked at - if you look at the very first measure, you see that tapering was the 14th ranked ordered measure for morbidity and mortality, even as it was number one when we use the more simple sums or the weighted sums.

So this is just a way for us to coalesce your rankings quasi-quantitatively, and to do a little bit of data reduction. Our intention is to use this to prioritize our writing, that is NQF staff writing, when we summarize the committee's attitude about what are the most important measure areas that CMS and that the - those stakeholders interested in measurement should be considering with regard to the problem of course that we're addressing.

So the question for you is (unintelligible) discourse, and I'll have it off to the chairs to conduct this conversation with you, is, do you think this kind of presentation and the types of things that came out of it, listed of course on the left-hand column there, do they reflect what you all believe are priority gap areas to address opioid use and opioid use disorder currently given the crisis that we're now faced?

So I'm going to suggest one other thing that we bring up, Vaish, if you could bring up the spreadsheet. You all received a spreadsheet from us with all 33 rank-ordered priorities, and Vaish is bringing it up now on your screen, you should see an Excel sheet, that looks somewhat like the slide I was just showing, with just a bit more detail, because right now you can see almost 20

or so of the measures that gives you the means and standard deviations on the right-hand side of the spreadsheet and also the criteria as a reminder of that.

But it shows you, and this is at the suggestion of Jeff Schiff, our co-chair, it shows you the full - a fuller listing of all of the rankings, you know, across most of the measures, we can scroll down as you like. But if for example you are curious to see - so, Vaish, scrolled, if you click on the cell D where the number 8 is right there? That's it. Perfect.

So, for example, if you were interested to see what was the eighth ranked measure using just the morbidity and mortality criteria, you can see that it's identifying social risk factors and social supports specifically there.

So if any of that, you wish to revisit that, you can of course do it on your own with your spreadsheet, but we can do it here during the discussion. But I think we'll leave this, unless anybody wishes to refer back to the slides, we'll leave this scrolled up to the top up as a place for us all to focus on as we discuss this.

So with that, I'll hand it to the chairs.

Jeff Schiff: Thanks, Michael. I think just a reminder, if you want to raise your hand…

Michael Abrams: So, Jeff, we're having - we're having some trouble hearing you. Can you speak up…

Jeff Schiff: Okay. Is this better?

Michael Abrams: Yes.

Jeff Schiff: Okay, thank you. Just a technical thing, are we - people can raise their hand if they want to make a comment as well as type a message in the chat, or just speak.

But to open the discussion of - I would ask Brandon if he wants to make any comments as well, but how do people feel about whether this (unintelligible) I guess I would say represents the need for further measure development around our world of opiate, you know, prevention of addiction and treatment and harm reduction?

Brandon Marshall: Thanks, Jeff. This is Brandon. I don't have anything to add at this point, so I might suggest we just dive in to the comments from the committee. I think we have one hand raised already. Anika, is that you? Would you like to launch us off?

Anika Alvanzo: Yes. Can you help me identify where among these measures, or maybe it's not among the measures, but where medication initiation falls among the measures? So, diagnosis of (unintelligible) initiation of medication, where does that fall?

Jeff Schiff: So, Michael, am I right, this is looking at the gaps and that that would be already in the environmental scan?

Michael Abrams: Yes. Thanks for the question, Anika. I am looking to see exactly where that might fall. Medication assisted treatment per se. And it may not be an explicit - I mean there are different OED treatments, so, number - row number 10 on the spreadsheet is OED treatment with comorbidities, but that's focused more on comorbidities.

I'm trying to recall exactly where that, specifically MAT, may not have made our gaps list simply because it's already an existing measure that is not typically forgotten or left out of measurement steps that currently exist. So it may not have hit our priority set in that form per se, Anika.

That's my sense. Anybody else want to comment about that?

Sam Stolpe: Hi, Michael. This is Sam. Yes, we did have a number of medication assisted therapy measures that emerged from the environmental scan. So it wouldn't fall under our gaps specifically for that reason.

So this would be measures that we didn't find anything on that we think should be prioritized. But measures where we identified them, obviously wouldn't call it a gap.

Brandon Marshall: I think for retention MAT, that's the same thing, is that right, Sam? Although there is long-term recovery-based outcomes that was identified as a gap right up at the top there, is that correct?

Sam Stolpe: Yes, that's my understanding.

Michael Abrams: Yes, I agree. And absolutely, the recovery, the long-term recovery measures have interest in MAT persistence.

Navdeep Kang: This is Nav Kang. As a clarifying question on that, I thought that this past meeting, that came up as the second item. So, to clarify, that, long-term recovery outcome section is kind of talking about the other diverse outcomes that could be generated from long-term recovery, is that correct?

Michael Abrams: Yes. So the wording, this is Michael, the wording is, that we used, is a change in (OUD) symptomology such as cravings, mood, work/social, extending out 12, 18 and 24 months long.

Navdeep Kang: Right.

Michael Abrams: So, any indication of a favorable outcome would be most desirable presumably. Medication adherence per se is not necessarily alluded to in this. It's more of the symptomology.

Navdeep Kang: Right. That's (unintelligible). Okay, got it. That's helpful. Thank you.

Michael Abrams: Yes. I agree with that characterization. The other recovery measure is also more about symptomology, and that may be well - may well be related to the attitude of the committee.

Again, as Sam said, the environmental scan had measures about medication use for (OUD) but, which are measures, but there are fewer measures certainly that look at more (distal) outcomes in terms of function and recovery. And that's more the emphasis of these two items that made fairly high rankings on our prioritization scheme.

Navdeep Kang: So what I'll say, this is Nav again, so, Anika's question is a good one because, while the measure concepts of time to (MOUD) initiation from diagnosis is like, you know, it's like a well-considered or well-dialogued concept, especially in the last year or so. I don't know that everybody is actually measuring it, so the gap is less around like the measure concept versus the actual visibility or insight into actually what the number is or what like the number in a given (unintelligible) would be or within a given provider or whatever.

So there is still a gap there but it's not a precise gap that we are looking to evaluate as part of this exercise, is my understanding. And so if that's the - if that's the exercise, then it's fine that it's not here, but there is still a "gap."

Separately, the fact that the (taper) came up first as the gap is fascinating because I think that's one that we get, at least within our health system, and from, anecdotally, from my experience with folks of most of the questions is around how do we set up and evaluate the progress in (such a taper). And so that (unintelligible) a very salient gap, for sure.

Brandon Marshall: Great, thank you. Sam and Michael, just one other thing as well, were 27 mentions referral to treatment initiation and retention OUD treatment, if you could just comment on what that gap represents, down almost at the bottom of the spreadsheet.

Sam Stolpe: Where is it?

Brandon Marshall: There we go.

Michael Abrams: Yes.

Brandon Marshall: That might interest some of the questions.

Michael Abrams: Yes. This is Michael actually. Let's see. Number of OUD treatments that show significant declines in OUD misuse at 6, 12, 18 and 24 months after treatment initiation. So this is really about, you know, one way you can do it of course would be to do lab screening. The other way would be to do a self-report of reduced use, reduced misuse specifically, of opioids.

So again, it's not MAT adherence per se. Instead it's the outcome you anticipate medications for opioid use disorder would affect, the emphasis of that. Does that answer your - does that clarify for you, Brandon?

Brandon Marshall: That does, thank you.

Michael Abrams: Sure.

Brandon Marshall: I see Norris Turner hand raised. Would you like to raise your point?

Norris Turner: Yes. No, thanks, Brandon. I just want to give my overall commentary. I want to first just commend the group, you know, the TEP and obviously the NQF team. I do, this resonates very strongly with me.

You know, I've been in the quality space, quality measurement space for a while and done work in behavioral health and criminal justice populations, and so from that standpoint, you know, kind of have an appreciation for where things really break down across different systems of care. And I think this, the gaps seem to reflect that quite well, whether it's special populations or, you know, different systems of care.

You know, and then also recognizing the complexity of this crisis, and we have the - you squeeze the balloon in one aspect of the crisis, and the other part expands around tapering, and the importance of getting pain management right given we're trying to also, you know, treat people, you know, with OUD.

And then the last part I would say around recovery, and, you know, I've just heard so many accounts of folks who have gotten to a place of stability and maintenance of their OUD but didn't fall out of recovery. And I think that

getting elevated at this higher level, it reflects that as well. So I would just say job well done. Excited about next steps.

Brandon Marshall: Fantastic, thank you.

Jeff, I don't see anyone else who's hand's raised at this point.

Jeff Schiff: I don't either. I think, Michael, I think we can probably move on. I want to say, take a prerogative to say one other thing. I was glad to see on this list as the pediatrician, or one of the pediatricians, the neonatal (unintelligible) because I think they're important to get better measurement around that. And we do have one more hand I see, from Jeannine Brant.

Jeannine Brant: Hi, thank you. I just wanted to reflect a little bit of feasibility. I didn't hear that mentioned a lot. You know, even as ranking measures, I'm really pleased with how things came out as well. I agree, I think it's a really nice reflection of where things are.

And as I was writing though, I thought about, okay, so, how feasible are some of the measures? So I don't know if we'll end up having discussion, you know, as we proceed. But, you know, how do we really recommend how you incorporate (unintelligible) care, and some of them might be very challenging.

Jeff Schiff: Jeannine, I'm curious about which ones you see as more potentially challenging in the feasibility space.

Jeannine Brant: I think the recovery and long-term outcomes, and maybe, was that you, Brandon, that talked about, you know, the relapse rate? And maybe that's, you know, not factored in there. So we're just looking at tracking that.

But even getting us the data, I think some of the data challenges with trying to track long-term outcomes because sometimes we lose track of people and we - it's very, you know, is a scientist, it's hard to look at patients longitudinally and follow them from setting to setting and see where they go. And so I just, you know, those types of data tracking challenges.

Brandon Marshall: And it seemed to me like in some sort of circumstances the converse is true as well, like looking now at the slide coverage for example, ranked 8th when we took into account some of those other metrics like feasibility, just looking at morbidity and mortality alone, it drops down to 26th.

So it suggests to me that it's something that might be more feasible perhaps, but the committee felt didn't - when we just look at impact on morbidity and mortality, doesn't pop out as a high priority as some other ones.

Jeannine Brant: Right. I think when we list it off, yes, there's definitely, you know, I guess we could just tease it out a little bit more and even, you know, really think about that, and I don't know, operationalize the quality indicators. You know, I'm - this is the second quality project I've been on so I wasn't sure how next steps are, but (unintelligible) guidance that's given to, you know, like I said, operationalize these.

Jeff Schiff: Thank you. I think the comment that Brandon made too is really interesting because, you know, the idea of coverage population rates or coverage reimbursement rates, it's interesting how we sort of have decoupled the insurance coverage, at least in these rankings, because they came so much lower from the impact on morbidity and mortality.

Jeannine Brant: Good observation.

Michael Abrams: Yes, this is Michael at NQF. These are good observations. We'll try to capture them in the scan.

And I think, if there's no objection, we'll move forward. And actually, Jeannine gave us kind of a segue because in a moment Sam Stolpe, my colleague, is going to be talking about different federal programs.

And during that activity, this point of feasibility may be in fact somewhat more prominent than it's been so far, although we appreciate the fact that you all gave it some consideration here in your weighting exercise so far. So if there's no objection, I think I'll ask Sam to overview the CMS federal programs for us.

Sam Stolpe: Very good. Thank you, Michael. Hello everyone on the committee. I'm delighted to be leading us into this next area for us, which is really a culmination of all the work that we've done thus far as a committee, as a Technical Expert Panel.

And what we're going to ask you to do is synthesize everything that you've learned so far and everything that you've - the wealth of experience that we have on this committee around opioids and opioid use disorder, to really provide a series of feedback points to CMS on five quality and performance programs currently administered by HHS.

So the thing that I'm going to be doing over the next hour and 15 minutes or so is providing a brief overview, just a very basic overview of program structure and content of the measures for these five programs.

And I will also just refer you to the end of the slide deck which has been sent to you, where we have the full list of measures inside of those programs, with

one exception, merit-based incentive payment system. There is a huge number of measures and we haven't listed them all, but we do have a list of all the opioid measures for those programs.

Now, at the end of each one of these descriptions that I'm going to offer, I'll turn it back over to our co-chairs for discussion, but because we're covering five programs and we have, you know, about, you know, an hour and 15 minutes to do so, that means we have 15 minutes total for each overview and discussion. So we need to keep this a little bit tight.

And I wanted to just clarify what we're asking you to comment on. What we're asking you to think about is, could these programs cover the nature of the programs overall, the sort of accountability that this level of analysis and care setting should have for opioids reduction, and what that nature of that should be for opioid treatment disorder?

So, how pain management works inside of these settings, how opioids should be used, and what sorts of processes need to be put into place can be used for accountability at the appropriate care level and care setting for each of these programs?

So we'll ask you to comment on what's missing from the measurement standpoint, and provide overall guidance or concrete recommendations to CMS on how to improve these programs in the future.

And of course, staff will be synthesizing the information that you provide us in this discussion and putting it into the final report, which we'll invite you to review and you'll have the opportunity to have additional comment then. But this really represents a strong opportunity for you to put forward the best recommendations for CMS.

Okay, with that being said, let me just give you a highlight of the five programs that we're going to be discussing over the next hour and 15 minutes. So we'll cover the Medicare shared savings program, the merit-based incentive payment system, alternative payment models, the hospital inpatient quality reporting program, and the hospital value-based purchasing program.

So let's start with SSP, shared savings program. The Medicare shared savings program is intended for accountable care organizations, which is a structure that program was introduced under the Affordable Care Act, and that the goal of it is to improve the quality of care for fee-for-service beneficiaries as well as to reduce the rate of growth and healthcare-related costs.

Now it's called the Shared Savings Program for a reason. ACOs can share in savings that they're able to demonstrate, if of course they demonstrate that savings, as well as perform on a set of quality measures, which, as I mentioned, are tucked away in Appendix A at the end of this slide deck that you've received attached with your meeting materials.

Now, one of the things we wanted to highlight, and this is courtesy of our federal partners, so, big thanks to them for helping us to prepare this presentation. In December of 2018, the Shared Savings Program underwent some policy changes, which include improving how information sharing occurs related to opioid use. And that aligns with a lot of what's going on in Medicare Part D, and I'll give you an idea of how this works in just a moment.

For each of these programs that we're going to be putting forward, we want you to consider the sort of requirements that CMS has around measure adoption, when they're putting new measures into it, there's a lot of considerations that go onto it. So we want you to understand what the

requirements are. So I've listed a few of them, key measure requirements out on this slide. And I'll just review them with you briefly.

So, measure requirements for the Shared Savings Program, outcome measures that address conditions that are high cost and affect a high volume of Medicare patients, measures that are targeted to the needs and gaps for fee-for-service patients that align with CMS quality reporting initiatives such as the Quality Payment Program, and that means MIPS and APMs, and we'll show you those in a moment.

Measures that support improved individual on population health, and measures addressing high-priority healthcare issues such as opioid use. You can see that's one of their key areas of focus for this particular time. The measures that align with recommendations with the core quality measures collaborative also fall onto these high-priority measure requirement areas.

One thing we wanted to note is that there are currently no measures related to opioids inside of the measure set for accountable care organizations, but that being said, there are a number of measures that they get reports on. I'll show you that in just a moment.

We had a little bit of a more, I won't say loose, but a broad approach to how we considered opioid measurement as we did our environmental scan as a Technical Expert Panel, to include measures like tobacco use, which is also included inside of the ACO measure set, and measures like screening for clinical depression, depression remission of 12 months, and access to specialists.

So we thought that those were tangentially associated with caring for patients that may have opioid use disorder, but not directly addressing opioid measurement per se.

Okay. So I mentioned these opioid utilization reports that the Shared Savings Program recently adopted. So, every quarter, Shared Savings Programs, accountable care organizations receive a quarterly series of reports that are separate from the scoring that they receive on the measures in their measure set.

So they contain information about how the opioid utilization has occurred across four opioid measures, which are aligned with opioid measures that are currently inside of the display ratings for Medicare Part D plans.

Now, three of those metrics were based on measures built by PQA, the Pharmacy Quality Alliance, and those align very closely with how we're thinking about how we pay for drugs through the drug benefit, sort of monitoring it on one side, on the population health level for health plans. We're also doing it inside of the Shared Savings Program for ACOs.

Those reports are - contain beneficiary accounts for each opioid metric and provide a series of analytics for the ACOs, both the mean and median number of assigned beneficiaries flagged for each of the measures, as well as a 10th to 90th percentile performances. The records also - or the reports, excuse me, also include the total number of opioid prescribing practitioners and the top six opioid prescribing practitioners for each beneficiary flagged in the report.

Now, the overall analysis by CMS has been that the ACOs in general have a very small number of assigned beneficiaries who are meeting any of those four measures.

Just to give you an idea of what this looks like, the overutilization monitoring system flags beneficiaries with an average daily morphine milligram equivalent greater than or equal to 90, who received opioids from either five or more prescribers, for a combination of three or more prescribers in three or more (unintelligible).

So this is patients who are using a fairly high dose of opioids in combination with seeking medication from a large number of providers and pharmacies, or just a high number of prescribers.

Okay. There's also the use of opioids at high dosage, which is strictly looking at greater than 90 milligram MMEs for 90 days or longer. And the use of opioids from multiple providers, which is beneficiaries receiving prescription for opioids from four or more prescribers and four or more pharmacies in 180 days. And the use of opioids at high dosage and from multiple providers, which is a combination of those two opioid measures listed above.

Okay. So this is - turn this over to our discussion, so I'm going to hand it over to our co-chairs now and invite you to think about what else should be measured inside of this program. So we're asking for recommendations directly to CMS on measures to be included, or general guidance related to opioids.

And what I'd just want to pause to remind you of, that this is not just the gaps that we just discussed. This is also all the measures that we've reviewed thus far, so, everything that went into our environmental scan that we've been discussing to date as far as measures for consideration and to recommend to CMS, would be considered fair game for you to suggest as well.

If the measure that you think belongs inside of this measure set hasn't been made yet, then certainly the gaps in priorities would be the place for us to look to for those.

And with that being said, I'll hand it over to Jeff and Brandon to lead our discussion.

Jeff Schiff: Sam, I just want a point of clarification here for everybody. The Shared Savings Program is for accountable care organizations, which are most often health systems that have a sort of this direct relationship to the Medicare program. Because, I think, one of the things I'm noticing here is that these are measures around prescribing behavior but not measures around treatment. Is that correct? That the ACOs are mostly these health systems that (unintelligible) may be newer in the realm of opioid use disorder treatment?

Sam Stolpe: Right. So it is health systems. They take accountability for patients for a fixed period of time, and that includes both inpatient and outpatient cares, comprehensive.

Jeff Schiff: Right.

Michael Abrams: Yes. Jeff, this is Michael. So an ACO doesn't have to be a health system per se, it could be a big payor as well, just to be clear about that. It's any accountability organization, you know, that's able to define itself as such.

And then I do agree, the measures that we're talking about here that Sam just described in this program are ones that relate to, you know, high prescription rates and looking for, you know, doctor shopping and that kind of phenomenon. That seems to be the emphasis so far in their portfolio, which is very thin. It doesn't really have any other opioid measures, as Sam described.

Jeff Schiff: Okay.

Kim Spalding Bush: Hey. This is Kim Spalding Bush from CMS. I'm sorry I don't know the protocol. I just wanted to mention that ACOs could be large, they could be a bunch of small groups. They have to have at least 500 - I mean, sorry, 5000 covered beneficiaries in order to participate, but many of them are made up of a number of small practices, so they do vary in their composition. And they've come together voluntarily to take accountability for cost and quality for that assigned patient population.

Jeff Schiff: Thanks. Anika, I think your hand has been raised.

Anika Alvanzo: Yes. So, in terms of what additional measures, I saw that there was a measure for tobacco use screening. I think it should be a comprehensive substance use disorder screening inclusive of tobacco, alcohol, opiates and other substances. For those patients who screen positive for tobacco, alcohol and opiates, was pharmacotherapy offered or initiated? And for those patients who are not doing well, was referral to specialty care initiated?

Jeff Schiff: Thanks. I think, Bonnie, we have you next.

Bonnie Zickgraf: All right, thank you. With regards to, I believe it was on Slide 16, bullet three, where it talked about the top prescribers and the top five or six I think it was, yes, top six opioid prescribing MPIs.

I'm just assuming, although I'm trying not to assume, as I'm sure all of us are, does the numbers, the aggregate numbers that we're looking at here -- with regard to the top prescribers -- are we also coinciding that or correlating that to the difference in the diagnoses? Because obviously your different

populations are going to have different usage rates. And I do see that this is addressing utilization.

So, something to consider there. I don't expect answers now, but - and I believe it may be, but again that's just an assumption on my part. Thank you.

Jeff Schiff: Thanks. Darlene?

Darlene Petersen: Yes. Where we're looking at the utilization and the greater than 90, you know, morphine equivalent, are we looking at also the co-prescribing of like benzodiazepines, sedatives, hypnotics? Might be a measure as well, because that sets a patient obviously at higher risks with that.

And then also, you can also look for quality measures as, yes, as when you have five or more prescribers involved, if there've ever been any drug testing or any kind of monitoring, what kind of monitoring has been done in that situation when those prescriptions are being given? So, some kind of - some kind of monitoring there, and that can be - that can be checked easily.

Jeff Schiff: Good. So, Norris is next. I think we had some comments on the measures that exist, I just want to make sure people, before we close up this thing on Shared Savings Program, if anybody has any comments on other measures that would be - that we would suggest get added to CMS, that get added to the quality measurement list for the Shared Savings Program.

Norris?

Norris Turner: Yes. No, thanks. So when - full disclosure, so I'm with Pharmacy Quality Alliance, so, other than the over-utilization monitoring system measure, you know, these are PQA measures, as Sam mentioned. It's interesting to see that

the rate - it doesn't sound like a lot of the patients thus far, or beneficiaries, have triggered, you know, (unintelligible) numerator.

I do think looking at other prescribing measures, so we've been partnering with CMS in supporting them in kind of getting this in place. One of the types of measures that we have that are very, very new, not many people know about, are initial opioid prescribing measures, one of which is related to duration of seven days or less, another one for, you know, initiated at less than 50 milligrams MME, and then another one is related to long duration (unintelligible).

So I'm just thinking, for the (unintelligible) population, it's possible that you may get more patients who are at risk of inappropriate initial opioid prescribing than having problematic opioid prescribing, you know, like sort of just a hypothesis.

Jeff Schiff: Good. Any other - I don't think we have any other hands raised. Any other comments on this section? Otherwise, I think this goes back to you, Sam.

Sam Stolpe: And just a note, we're getting some comments in the chat box, I'll just assume that the NQF staff has those recorded.

Woman: We'll be sure to review those as well.

Sam Stolpe: Okay.

Woman: Yes. I won't read them out for now.

((Crosstalk))

Sam Stolpe: Okay.

Michael Abrams: This is Michael at NQF. So, one guiding principle for discussion moving forward. It is fair game if you wish to say something like, you know, the gaps that we identified, the priority gaps that we identified, are applicable to this current program because or are not applicable, or you might want to talk about how they would be useful or otherwise for each program that we describe to you today. So, just consider using that as a touch stone for you to comment about each program.

Woman: Okay. I think, Sam, it's back to you for MIPS.

Sam Stolpe: All right, very good. Let's jump in to MIPS, everybody. So the merit-based payment system is a - came as a result of the 2015 Medicare Access and CHIP Reauthorization Act, which requires CMS to implement two of these programs for clinicians, so the two participation pathways, MIPS and APMs, which we'll be discussing next.

So, MIPS really combines these three Medicare legacy programs, this quality reporting system for physicians, value-based payment model program, and the Medicare EHR incentive program for eligible professionals, a.k.a. meaningful use, into one single program.

Now, the - under MIPS, there are four connected performance categories that impact how clinicians are paid. Each of these categories scored independently and has a weighting, those weights undergo changes with each of the proposed physician payment system rules, and currently, in the 2019 iteration, they're weighted as you see here on the slide, with quality and performance being 45% of the scoring, promoting interoperability at 25%, improvement activities at 15%, and costs at 15%.

So, MIPS has a couple of important quality focus priorities that are worth mentioning, looking at including more outcome measures, more patient reported outcomes measures, measures (that fill at popped-out) specialty area, and measures that are relevant for specialty providers.

Now of that (popped-out) scoring policy, the CMS has identified over 50 quality measures from the 2019 period, some of which are related to opioids, and you'll see listed here on the slide, from pain assessment and follow-up, opioid therapy follow-up evaluation, documentation of assigned opioid treatment agreement, and evaluation or interview for risk of opioid misuse.

Comparable to the other programs that we've discussed (unintelligible) savings, but there are key measure requirements for MIPS as well, so these measures must be fully developed and specified with testing results at the clinician level. Preference is given to measures that are endorsed by NQF. Measures could not duplicate other measures currently in MIPS. And we'll show you those measures that currently exist in a moment.

There's a total of 257 measures inside of MIPS. So there's quite a few that physicians can choose from. They're required to select (unintelligible) must be an outcomes measure. The total number of measures that we were able to identify was 13, and you'll see them here on this slide. And I'll go ahead and read them because some of them fit our opioid-specific criteria a little bit stronger than some of the tangential ones.

So we have - excuse me - continuity of pharmacotherapy for opioid use disorder, documentation of signed opioid treatment agreement, evaluation or interview for risk of opioid misuse, and opioid therapy follow-up evaluation. Now I won't read the remainder, but just note that some of them are related to

alcohol or anesthesiology, antidepressants, pain management, and tobacco use, are some of the more prominent themes that emerged from our look at the MIPS measures.

So, our question for you is, if we're going to be holding clinicians accountable, what sort of opioid measurement guidance would you give CMS related to this program?

I'll go ahead and hand it over to Jeff and Brandon who'll lead the discussion around MIPS.

Brandon Marshall: Excellent. Thanks, Sam. I don't see any hands raised yet, but please go ahead and do so if you have a comment.

Anika Alvanzo: So this is Anika. (Unintelligible) measure continuity pharmacotherapy, so, is that for somebody who comes to the clinician already on pharmacotherapy? Can you say a little bit more? Is there an initiation? I'm just trying to figure out what that measure actually means.

Michael Abrams: Yes, this is Michael here, Anika. It isn't necessarily somebody that's, you know, an existing case. It could be an incident case. It's either. But the point is it's not just about initiation, it is tracking somebody, and there are measures that exist in our portfolio now that I think go out at least six months if not 365 days. So it is explicitly about continuity here, but not exclusive of somebody who's starting, and tracking…

Sam Stolpe: Yes. So I'll go ahead and read the measure description, you might find it helpful. It's the percentage of adults, age 18 years and older, with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment.

Anika Alvanzo: Okay. Thank you.

Brandon Marshall: And I see someone with their hands raised, the username is a little funny. So, whomever raised their hand, go ahead and state your comment now.

SreyRam Kuy: That might be me. This is SreyRam. I don't know if it's too late to include this or somehow incorporate this, but one thing that hasn't been mentioned in these measures is utilization of the prescription drug monitoring program.

Across the country, many, many more states are passing laws requiring providers to document that they checked the prescription drug monitoring program before writing new prescriptions for opioids. And just thought that that'd be something useful to consider (unintelligible) measure.

Sam Stolpe: Hi, sorry, this is Sam. Could you tell me who made that comment please?

SreyRam Kuy: This is SreyRam Kuy from the VA.

Man: From the VA.

Sam Stolpe: Oh. Thanks very much.

Michael Abrams: Good. And SreyRam, it's Michael here at NQF, just a reminder to everybody, we did as part of the environmental scan review state laws and stuff, and I think almost all 50 states have prescription drug monitoring programs, and there's quite a bit of discourse.

And I would note, that didn't emerge -- comment appreciated -- but that didn't emerge as a priority area even in the top 33 that we did. That doesn't mean

that it isn't applicable to federal programs directly as a touch stone. As Sam said, you should consider, you know, sort of bread-and-butter measures, ones that are deployed, as well as gaps. But I just wanted to offer that clarification.

SreyRam Kuy: Thanks. That's helpful.

Brandon Marshall: There's a comment in the box that I think referred to the prior set that might be of interest here too, which is around Naloxone co-prescription for patients being prescribed opioids in a chronic therapy context. I thought that was interesting. I'm not sure if the person who recommended that wanted to say a little bit more, open that piece up for discussion on this.

Antje Barreveld: (Unintelligible) it's Antje Barreveld, that was me. I think that - I think this is wonderful and exciting. I think I'm feeling my reels are spinning and I feel quite pressured to be able to think of some of these things right now on the spot, so I'm wondering if these are things that we need to be saying are set in stone now in regards to our recommendations, but as a side note.

You know, I think Naloxone co-prescription is something I don't see here, and so that's why I mentioned that. And I think by principle at our institution, we recommend really any one prescribed daily opioids should be given this prescription. And we do look for that as a best practice in our institution.

I also was wondering, in regards to - we spoke a lot about pain assessment in the first few calls and the sort of functional scales that exist, and I think it would be really interesting to see if perhaps MIPS could be expanded to really anybody on opioids or even, you know, anyone with pain, so it's not just an osteoarthritis (instance).

I think those are my major comments, but I'd love to hear also sort of what - how quickly our comments need to come back in regards to these and perhaps other measures that we could (employ).

((Crosstalk))

Man: Go ahead, Sam.

Sam Stolpe: Go ahead - thanks. Okay. Antje, thanks for that. And sorry if we weren't clear. We'll continue accept comments in the committee as you think of them after the call. It's of course much better if we can generate discussion over the course of this dialogue that we're having for the next hour or so, so to the extent that we're able to do that, the better, the more we're able to, the better.

But of course, if you want to send us an email with more thoughts afterwards, we'll, as we're putting together the final report, which is our next step, you'll also have the opportunity to get feedback on what we write in the final report. So, keep that in mind.

Man: Great.

Anika Alvanzo: So this is Anika Alvanzo. So I guess Antje and I, we're on the same page, because I also typed in about Naloxone co-prescribing, and I didn't see that in any of these and I think that should be critical to include, I also think it's very important to include with this initiative.

Brandon Marshall: Excellent, thank you. And Katie Jordan, your hand is raised, go ahead.

Katie Jordan: Similar to the previous speaker, I see that pain assessment and follow-up and pain brought under control is listed, but when it comes to the combination of

function and pain, it's limited to osteoarthritis. So I was just curious as to why it's limited and if there's a way to expand on that.

Woman: …we're always coming together - right now we're on a little break and then we'll finish the call. She told me she got her.

Brandon Marshall: Oh. Sorry, just a reminder, to mute your line if you're not speaking.

Katie, can you maybe repeat that question? I missed it in the fracas.

Katie Jordan: Sure, no problem. So, pain assessment and follow-up and pain brought under control is clearly listed, but the combination of function and pain is limited to osteoarthritis, and I was just wondering why the limitation and is there a way to expand on that.

Michael Abrams: We don't. So, Michael here at NQF. I mean, if there's somebody from CMS, at MIPS, that knows the why with regard to that. But we do know that these are the extent of the measures. So, as a practical matter, we can certainly take your comment and talk about, you know, creating somewhat more of a composite or a functional approach, which certainly would be consistent with the values espoused by the committee so far.

Does that help? Does anybody from CMS who's - knows the MIPS program well, know why these particular pain measures were represented and there aren't sort of functional ones on the menu right now?

Jeannine Brant: I think -- this is Jeannine Brant -- I think I can answer that as somebody from CMS can. Right now…

Woman: He said he turned in his homework to Ms. (Rawhide), I guess. That's the little thing he did today.

Jeannine Brant: I think that's somebody in the background.

Woman: Or the thing he had on email.

Man: Hi, sorry. This is NQF. Whoever is speaking, the whole committee can hear you, could you please mute your line? Thank you.

Jeannine Brant: Okay. So, right now there's a set of quality measures under MIPS for palliative care. And so the pain brought under control within 48 hours is more of a palliative care and (unintelligible) pain measure, I believe, and so function was not as much of an issue with that one measure. So I think that could be. But I think your point on function is really well taken as well.

Brandon Marshall: Thank you, Jeannine.

Jeff Schiff: This is Jeff. I just want to ask some of the people who have more expertise in this, something that I have, we've been concerned about in Minnesota is, if we assess, are we assessing whether the pain assessment was done or are we assessing whether there's a decrease in the pain score? Because I feel like we've been on that clinicians have really struggled with, you know, how much pain medicine to prescribe to get the pain under control, and being rated on that has led to obviously some challenges in prescribing behavior.

So I'm looking at this as that the pain assessment was completed and not - and now we - and I think adding something functional was a little different than that. And then the pain under control is a palliative care measure, it's different from a measure out of the spectrum. Is that - are those correct assumptions?

Jeannine Brant: Yes, I believe - I would agree with that. This is Jeannine.

Man: Great. Thank you.

Man: I think…

Anita Gupta: This is Dr. Anita Gupta. I would like to just add to this like a comment. So, you know, I think what will really be helpful when think about functionality is that if perhaps we could just, you know, in some shape, add functional improvement, you know, just evaluating functionality in individuals who have pain in a chronic pain setting can be quite challenging.

And so the point that was just made about, you know, the issues regarding just assessing pain and determining, you know, whether it was a pain score, a physical exam, you know, sometimes that's a very important question. But if we could really assess whether or not there was a change in functionality, I think that could be of great value to the clinician and the patient.

So, you know, I would love to hear thoughts, but that's just an added point there.

Brandon Marshall: Excellent, thank you. And we have got two more hands, and then maybe we should move on. Katie, go ahead. Did you have something additional to add?

Katie Jordan: I was just going to echo the same point that was previously made. I think it - function as a qualifier, that is really important when it comes to assessing pain because it's not just what the pain score is but what the person can and can't do what their functional capacity is that really gives you a lot of information.

And so I'd like to see function included a little bit more consistently across the board.

Brandon Marshall: Great. Thank you, Katie. And it looks like we should move on, but if the folks that have their hands raised would like to type their comments into that chat, that can be recorded.

Go ahead, Sam.

Sam Stolpe: All right, very good. Thanks so much. Let's go ahead and move to our next area. We're going to be looking at alternative payment model, which as I mentioned is really the counterpart to MIPS.

So we're looking at measures that are at the clinician level of the dialysis. And the settings are really going to be largely outpatient driven for the most part. So, keep that in mind as you're thinking about measure considerations (unintelligible).

And I'll give a brief overview of APMs and then we'll follow up with a comparable discussion around APMs that they have with MIPS.

So, alternative payment models are value-based payment programs operated by CMS, which have a couple of requirements. So, the clinician is expected to be held accountable to measures comparable to MIPS. So we expect that you would have comparable recommendations around what sort of measures would be directed to clinicians in this setting, the ones that are in MIPS, since they are very comparable programs, but there may be differences.

The other requirements are use of certified EHR technology as well as a certain amount of financial risk that clinicians are expected to assume under

these value-based payment programs. Now, multiple model categories have been developed for APMs.

And something I wanted to point out is that advanced APMs, as they're called, they will receive an annual 5% increase in the Medicare Part B payments, as well as an exemption from the AmeriBase incentive payments.

I wanted to give you a couple of examples of alternative payment models. This isn't fully comprehensive, but to give you an idea of how CMS structures these programs. Under the list of advanced APMs, there's a series of options under which an entity can structure their own accountability and risk system for physicians inside of that organization.

So this is just an example, the Comprehensive Primary Care Plus program. ACOs with either track one plus or track two or three, as well as next-generation ACOs can create these sorts of alternative payment models for their clinicians.

There's also the Comprehensive ESRD Care and oncology care models. Some other ones to consider are other payor advanced APMs, which include Medicaid - Medicare Advantage, Medicare and Medicaid plans, PACE plans, the programs for all-inclusive care for the elderly, as well as commercial and private payor arrangements that can all fall under this category if they're covering entities that would typically receive the care or had their payments made through fee for service payment structures.

Now, for our discussion question related to alternative payment models, CMS has requested guidance on how measurement should be approached within this program. But what are the primary considerations for measurable -

measures comparable to MIPS to include related to opioids and opioid use disorder?

Now I'll hand it over to our co-chairs.

Jeff Schiff: Thanks, Sam. So I think for many of us who don't live in the details of some of these alternative payment models, it's - these are starting to blend together a little bit. But Sam, is it safe to say that the alternative payment models are sort of a 200-level class as opposed to an intra-level class (and to) value-based purchasing so that we expect a little more out of the folks who are in these models (then out) of MIPS or the MIPs program for example?

Sam Stolpe: I wouldn't say that empirically that's the case, that this is expected to be an alternative to MIPS. So the level of accountability is slightly different in that the APM is directed at a MIPS order popped - if you're looking at a nested series of structures where clinicians and groups of clinicians would fall under accountabilities for MIPS.

But if you have some sort of overarching structure of accountability imposed by another organization, that's not directly from CMS, they can structure a MIPS-like program where there's risks that's assumed, accountability to quality measures, and use of EHR by the clinicians underneath that organizational structure, then it can qualify or it can accept a physician from MIPS.

And it's really - really can seem quite complicated because there are so many different structures under which you can categorize clinicians, where they can qualify for a MIPS-like structure. But it just gives a lot of other options for clinicians instead of being directly accountable through the MIPS program. But the expectation at least from what I understand of the programs are

essentially very comparable between the two. I don't see the next level necessarily.

And I would leave it to my CMS colleagues to comment as well if they want to clarify.

Jeff Schiff: Thanks. I think we'll go into our discussion. And Norris, you're first.

Norris Turner: Yes. Yes, this is interesting. I do feel like the APM kind of category is useful, you know, for the category of type of programs you're talking about Sam under the quality payment program. But for the purposes of thinking about measurement, I'm not sure that the APM category is a very useful one. Because we - one of the - one of the APMs - programs that meets APM's criteria is what we already reviewed, right?

The Medicare Shared Savings Program, I think, Sam, you had it listed as track one, track two and three is ACOs. But then you also had on that slide like that could be four, Medicare and Medicaid duals, could be related to Medicaid, and for all of those different APM type programs, covering different populations, measurement needs are going to be very different.

So I just want to kind of throw that out there as a general comment. I'm not sure how helpful it is for us from a measurement framework standpoint, other than just globally (unintelligible) for all these different APMs, there's some common measures that are useful, and I don't know, I think that'd be hard to (unintelligible).

Jeff Schiff: Thanks. Any other comments specifically about this program?

Do you have a - sorry. Do you have a feeling that the measures of initial opioid use belong in this discussion as well? I think, Norris, you had brought them up initially, and then there's also the measures that - of the risk of ongoing opiate use, for example.

Norris Turner: Yes. No, I'll just comment a little bit further. I do think, I think what would be useful for the purposes of the APM was going like, okay, what are all the different types of APMs that we know of, I mean, maybe not every state-specific example, but, you know, the most common ones, and then going across those, like the measures that are currently in the (MSSP), you know, for problematic opioid prescribing.

Yes, some of those measures are going to be very relevant for some of those programs, and in some, the initial opioid prescribing measures are going to be more applicable across a lot of them.

So I do think it's a function of looking at the program and what population it covers and then going what are the risk factors associated with those populations. And that helps to lead you to the right kind of measures, I think.

Jeff Schiff: Thanks.

Michael Abrams: Yes, this is Michael at NQF. So I want to offer this suggestion for clarity here. It seems to me that one of the key ways to differentiate perhaps APMs from MIPS is that we're talking, with APMS, a lot about managed care and about bundled payments and that kind of thing.

So, perhaps one way that the committee could think about how to deploy measures in those different regimes is to think about, you know, under, say, a waiver with the Medicaid program, if you wanted to do managed care and

putting things together, there's more of sort of a coordination perhaps theme or there's more complexity with regard to attribution, you know, who's the responsible party, as opposed to on a fee-for-service regime, what is sort of a more straightforward.

So that might offer some clarity, one that, you know, as Norris suggested, what that means in terms of specific measures, is not completely evident. But as I say, I think it does have more to do with bundling and doing some things that are different than a straight, you know, point-to-point fee-for-service sort of thing.

Jeff Schiff: Okay.

Anika Alvanzo: This is Anika. And this question is coming from a healthcare financing novice. So, would this be somewhere where you would see a model like a behavioral health home model, would that fall under this type of financing?

Michael Abrams: Yes, this is Mike with NQF. I think that's actually an excellent example. Again, we're, you know, so what you've given a name to is a situation where somebody would say opioid use might have been wrapped around services that, for a certain amount per member per month, covers, there's Medicare and there behavioral health (unintelligible) and there medication for opioid use disorder treatment all-in-one package.

And that's an alternative payment to then just a straight fee-for-service or just paying for, say, methadone separately or buprenorphine separately, something like that. So, yes, I think that's a reasonable example.

Do the folks at CMS care to comment, if we're capturing the - and I think it's a reasonable question for the committee to have, what's the difference between

each of these programs, between MIPS and APM, is the way that I'd characterize - is it reasonable?

Kim Spalding Bush: Yes, so this is Kim Spalding Bush from CMS. And I actually work on Shared Savings Program quality. I'm not sure whether anyone from the (QPC) program is on the line, but if they are, they should feel free to interrupt me, and I will tell you what I know, which is that there are advanced APMs and then there's MIPS.

And so you can be in an APM and still be subject to the MIPS program, meaning you get, which a lot of the Shared Savings Program tracks are. So, our track one ACOs and our basic level A, B, C and D, are all alternative payment models, so we are APMs, but they're still subject to MIPS.

And the distinction there is you have to have assumed - there's a few things you have to do to be considered an advanced APM, I'm not going to profess to be able to quote the regulation on this. But you have to have taken on more than nominal financial risks. So, however that's defined, you have to get kind of over that comp to be considered an advanced APM. So you can lose money.

You know, you could get money or you could lose money. So if you take on more than nominal risk and you have a higher threshold of your eligible professionals using 2015 electronic health record technology, certified electronic health record technology, then you could - that particular model could qualify to be considered an advanced APM.

Advanced APMs are not subject to MIPS, so they don't report to MIPS. They're not paid - their payments aren't adjusted by MIPS, but they may well

still be, you know, paid under fee-for-service or they may get bundled payments.

So the advanced Shared Savings Program track, they're still fee-for-service, they still get paid fee-for-service, but they get a payment based on whether they shared in savings at the end of the year. So, a shared savings or a shared (lost) payment kind of on top of and outside of fee-for-service.

So, some of the models are still in fee-for-service and it really is model-specific, which I think is that something someone earlier, it would be difficult to understand, you know, the implications if we just sort of took advanced APMs as a cohort and say whether or not these things would be applicable.

I think it might really depend on the type of advanced APM that we're looking at, which I think someone else had also said. So there's a lot of nuance and complexity there, but sort of, generally speaking, those advanced ones have assumed some kind of additional financial risk and they've also invested in a higher percentage of their clinicians using the 2015 EHR technology. I don't know if that helps.

Jeff Schiff: Yes, thanks.

Michael Abrams: Very good. Thanks for that. I think we should probably move on shortly.

Jeff Schiff: Okay. We have a couple of really quick comments, Jeannine and Kim, if you want to very briefly state your comments.

Jeannine Brant: Sure. This is Jeannine. I think a lot of the measures would apply to comprehensive palliative care - or primary care, I'm sorry, because a lot of the things that we suggested are truly applicable there. I've also done a lot of

consulting with the OCM, the oncology care model. I know they're looking for some guidance.

They're using a lot of patient reported outcomes. But the measures that might be very helpful there are introducing opioids and then also discussion of tapering. Like, once patients (unintelligible) for so many opioids into the community and, you know, and to care through oncology, and yet we're not always mindful about how to taper and how to provide the best (plan) even like following surgery and treatment when pain really does lessen.

Jeff Schiff: Great. Jeannine, a really quick comment?

Hello? Jeannine?

Jeannine Brant: Oh yes. Did you hear me?

Jeff Schiff: Oh, I'm sorry. Yes, I did. I'm sorry.

Jeannine Brant: That was Jeannine. Sorry…

Jeff Schiff: I mistook you for somebody else. Let that go. Okay.

And Norris, do you have something new to add, there's your hand go up.

I think, Sam, we can keep going then.

Sam Stolpe: All right, very good. Thanks everybody. Appreciate the discussion.

We're next going to turn to the hospital inpatient quality reporting program. This is a program that's been around for quite a while. It's introduced under

the Medicare Modernization Act, and expanded by the Deficit Reduction Act of 2005.

The program requires hospitals that are paid under the inpatient prospective payment system to report on a series of measures inside of a public-facing reporting structure. Now, the failure for them to meet the requirements of the inpatient quality reporting program results in a reduction in payment by the hospital of a total of one-fourth of the hospital's fiscal year IPPS annual payment (update).

So, comparable to the other programs, there are some high-priority areas, so, strengthened person and family engagements, promotion of effective communication and coordination of care. Promotion of effective prevention and treatment of chronic disease, and making care safer by reducing harm caused in the delivery of care.

Also wanted you to note a couple of measure requirements. The measures that are required to be fully developed and tested, specifically for the acute inpatient setting. The measures are also required to be endorsed by NQF to the extent possible.

Measures need to address an area inside of the meaningful measure domains, with preference for measures addressing those high-priority domains. And last, the measures must promote alignment across HHS and CMS programs.

A couple of things to note. Currently inside of the hospital inpatient quality reporting program, there are no measures related to opioids or opioid use disorder. Previously, the CAHPS survey for inpatient hospitals had a number of measures that related to pain management.

Those were in turn changed to measures of pain communication. But those three items are slated to be removed next month from - excuse me - from IQR.

And now, in terms of the final rules for 2020 for IPPS, there's two measures that are worth noting. The first is safe use of opioids concurrent prescribing. This was finalized. And CMS requested comments for hospital arm opioid related adverse events. So those two measures, one slated for inclusion, the other currently seeking comments around it. So that's a very brief overview of IQR.

As you know, this is at the hospital level of analysis, facility level, and the discussion question remains the same. We'll hand it over to our two co-chairs to facilitate the discussion.

Brandon Marshall: Excellent. Thanks, Sam. I'm going to take this one. I don't see any hands raised yet. So please do so if you have a comment.

Jeannine, go ahead.

Jeannine Brant: Yes, thank you for this really hot topic, and I've watched this through the years evolve as I was really involved with some of the early measure developments.

I think, you know, trying to steer away from the focus on opioids, one helpful measure might be looking at whether patients were offered non-opioid options to manage their pain. So, really encouraging more use of (unintelligible) positioning (unintelligible) and we had a measure in our pain care quality in U.S. hospital survey, and it was the lowest score measure. But just to get organizations to start thinking about non-drug ways to manage pain might be helpful.

Brandon Marshall: Thank you. Other comments? Anika, go ahead.

Anika Alvanzo: Sorry, I was on mute. So, yes, I think, again, kind of the same thing, initiation of medication, what proportion of patients with opioid use disorder are given a prescription for either a given medication - or initiation of medication prior to discharge, what proportion are linked to ongoing care in the community.

If you want to do a, you know, a post (unintelligible) what proportion of patients treated for an overdose are in treatment 30 days later, what proportion of patients who came in with an overdose received Naloxone at discharge. I think there are a number of measures that could (be provisioned).

Brandon Marshall: Great, thank you. And I see a comment from the chat box also around post-discharge taper plan, and that actually has come up on some of these other payment systems as well, a call from the committee to consider patient-centered opioid tapering plans. So that may be relevant to the system as well for discharged patients being discharged.

Jeannine Brant: I have a question though, aren't all of these like patient-reported outcomes, so, patients are sent a survey and then - so these would be measures that patients would respond to, or is that correct or not?

Sam Stolpe: No. So they do have the CAHPS measures, has patient-reported outcomes, but the CAHPS measures don't encompass the entirety of the IQR system. So there's lots of measures that draw on very different data sources.

Jeannine Brant: Very good, thanks.

Brandon Marshall: And I have a note here to ask for any comments from our patient reps on the committee, if they have any suggestions or insights, comments, we would greatly appreciate them.

Laura Porter: This is Laura, and I don't have anything to add. I'm pleased with the - what's been happening. And also I agree that the -- as far as I'm concerned -- you know, pain management is important but also the tapering is also, you know, instead of just leaving people hanging without drugs, medications. So, thank you.

(Sarah): So this is Sarah from NIDA. I did have just a couple of comments.

One is, and it's not on this hospital inpatient one specifically, but one of the physician ones. The six months continuing care of opioid use disorder, of continuing care, that's kind of a maybe a little bit of a heavy lift. So, while it's a great thing to achieve and I think we should work for it, care will need to be taken on how that's specified, so that you don't scare them doctors away from wanting to provide the care.

And then the other thing on that tapering, I think tapering is a great idea. As far as I know, we have no evidence-based procedures for doing that yet. But I could be wrong on that. I know we have a number in process. Researchers looking at it. Thanks.

Brandon Marshall: Fantastic. Thank you, Sarah.

Anyone else? Otherwise, I think we can move on to the last program.

Sam Stolpe: All right, very good.

Brandon Marshall: Go ahead, Sam.

Sam Stolpe: Yes. Excellent. Thank you, Brandon.

So our last program that we'll be considering is the value-based purchasing program. Now, the value-based purchasing program is the same level of analysis as the previous program, but it's introduced a little bit later, so this (unintelligible) as a result of the Affordable Care Act, under which value-based incentive payments are made each year to hospitals that need performance standards established for the previous period.

Now, measures are eligible for adoption based on certain statutory requirements. So the first is that the - it needs to be specified under the hospital inpatient quality reporting program, with posting dates already established.

And statutory requirements are employed for public reporting of the measures for at least one year, instead of the inpatient quality reporting program, prior to use inside of the value-based payment - value-based purchasing program. So, something to keep on mind on that.

(Unintelligible) for inclusion inside of VBP, it has to have already been inside of IQR. So, keep that in mind.

So the CMS has also identified domains as high priority for inside of VBP. These two domains, you'll notice that they're drawn from a previous program as well, which had four total. This one has two. So, strengthening family - person and family engagement as partners in their care, and the promotion of effective treatment - excuse me - prevention and treatment of chronic disease.

So, a special note there, prevention and treatment of opioid and substance use disorder and risk-adjusted mortality fall directly under that last category.

So the key measure requirements, you'll notice there's a lot of these similar to the previous ones we've looked at. NQF endorsement is a priority. Measures that address conditions for which there's a strong evidence of performance gap on those measures. Measures are expected to fully developed and tested. Measures must address meaningful measure area and promote alignment across other CMS programs.

As noted, the value-based purchasing program measures are drawn from IQR, so that makes sense, if there are no measures related to opioid present in the previous one, that there'd be no measures related to opioid and this one as well. Noted again the CAHPS survey measures are going to be removed.

And so with that being said, we'd invite the group to consider what opioid measurement guidance they'd like to proffer to CMS regarding this program as well. And I'll hand it over to our co-chairs for discussion.

Jeff Schiff: Thanks, Sam. Is this then our discussion is a subset of the prior discussion because it's, well, I think our recommendations would be, well, I think would be as a continuation of the prior discussion, is that correct?

Sam Stolpe: It is. But the difference of course being that the accountability for value-based purchasing program is somewhat higher, that this reduction in payment associated with failure to perform, failure to submit for IQR, but it's a little bit different inside those value-based incentive payments that are structured under VBP.

Jeff Schiff: Okay. All right, any other specific comments here from the committee?

Jonathan?

Jonathan Gleason: Hello. As someone who manages VBP for hospitals, I think what makes the most sense to me is to have a strong process measure that'll reduce harm associated with opioids included in value-based purchasing. And so I think about several of the comments of my colleagues here around co-prescribing of risky medications, benzodiazepines, etcetera, or co-prescription with Naloxone at discharge.

I think value-based purchasing is a tremendous opportunity to drive practice in hospitals. And so I would really vote for a strong process measure around opioids that's very evidence-based and aligned with the interests of the patients to be included.

Jeff Schiff: I'm curious if you'd include a - some sort of a dosing or tapering recommendation in your consideration. You mentioned benzos and Narcan.

Jonathan Gleason: So, are you talking about tapering of opioids for inpatients during their inpatient stay or a prescription of taper at discharge? What are we talking about?

Jeff Schiff: I think I'm talking more about the latter, like how much gets prescribed at discharge, that could also be - I don't think we have measures like (this yet), but I know some systems are working on measures that look at specific opiate dosing by procedure as well.

Jonathan Gleason: I think that's aspirational and certainly would be terrific. I think that's a really complex area. The evidence around opioid prescribing is probably doubling every month, because everyone is publishing on opioids right now. So I think

that could be really tricky just operationally. But I think theoretically that makes a lot of sense.

Jeff Schiff: Thanks. Jeannine?

Jeannine Brant: Yes, I want to add to that. I think of course the evidence, you know, is starting to emerge as far as the different tapering recommendations and some guidelines by Mayo Clinic and such. But I think a measure at least recommending that there should be communication or conversation with patients that they need to start, you know, decreasing the amount of opioids are taking after surgery.

For example, we currently have an education packet, and it doesn't say how much or by how many days, but at least are talking about it (unintelligible) where you send the patient home with some sort of a plan that talks about that.

Jeff Schiff: Thanks. Laura, I think you're next.

Laura Porter: Yes. I think that it's basically, I'll tell you from personal experience of having multiple surgeries for cancer and multiple orthopedic surgeries and, you know, and being prescribed the opioids and then being told when, you know, to stop taking them, and that was it.

And I didn't have a problem until I was prescribed the OxyContin. And just being told to stop when I wasn't in pain anymore, I suffered severe withdrawal symptoms, and I could understand why people make a decision to not go through that.

And I feel like it's so important, if people are going to be prescribed opioids because they're necessary, and I'm talking about short term, not chronic cancer

pain type thing, that they're given a plan, at least what was mentioned, a communication. Something that says, you know, you're not going to have to go through this by yourself and we'll help you and guide you through it. Because I think that that's critically important, critically important, especially with opioids that had been prescribed by doctors.

I think that, unfortunately, the (Sentinel) and the things out on the street are a different beast, but, you know, but if it's prescribed by the doctor, then I believe that it needs to be managed also. Thank you.

Jeff Schiff: Thank you very much. I don't see any other hands raised here. Someone just specifically asked if any other patient advocates or folks from those communities have anything else to say about this topic or in general.

Okay, thank you.

Sam Stolpe: Thanks everybody. We can go ahead and turn it over to the public for any comments you may have (unintelligible) please feel free to either enter your comments directly into the chat and we could have NQF staff read them, or you're welcome to just make your comment directly over the telephone.

Okay. Hearing none, Vaish, I'll hand it over to you for next steps.

Vaish Kosuri: Okay. Thank you, Sam.

So our next steps, our next Web meeting will be October 10, 2019. We will then post our comment period for the report, from December 6th through January 6th. Our final Web meeting will be on January 21st. And our report will be out February 6, 2020.

We are, just a point to note, we will be working on a draft of the report, and so we will have something for you guys to react to in our Webinar 6. So please keep a look-out for that.

Once again, this is our contact information, if you guys have any, you know, additional measures ore recommendations, please note that our email is available. So please email at opioid@qualityforum.org.

And towards the end we sort of have the appendices, which include the measures found in the programs that we discussed today.

If anyone has any final comments, once again, the opioid inbox is free. And I'm handing off - handing it off to the co-chairs as well as Michael and Sam to provide any final remarks.

Michael Abrams: Very good. So this is Michael. Thanks to everybody for participation, both full TEP members and our liaisons, and the public as well. We've given you a lot of materials. Encourage you to have a look at it.

Following up this meeting, both the prioritization schema as we've described it, environmental scan of course is an ongoing tool for you, and now these nice descriptions that Sam provided of the different federal programs. And then let us know if you would like to add anything to inspire our drafting of recommendations to CMS from these products.

So, thanks again, and I'll hand it to Sam next.

Sam Stolpe: I would only echo Michael's comments and just say we always appreciate all the feedback we get, and just make sure also say thanks. And we can close it out from there. I don't know if there are any parting words from our co-chairs.

Brandon Marshall: Thank you, Sam. This is Brandon. I enjoyed the conversations. I learned a lot and just wanted to thank the committee members for their participation.

Jeff Schiff: And I'll just ditto that and have a good afternoon. Thanks.

Man: Very good. Thanks everybody. Bye now.

Woman: Bye.

Man: Thank you.

Man: Bye.

END