NATIONAL QUALITY FORUM

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MULTISTAKEHOLDER INPUT ON PERFORMANCE MEASUREMENT FOR RURAL SMALL-PRACTICE AND LOW-VOLUME PROVIDERS
RURAL HEALTH COMMITTEE

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THURSDAY
FEBRUARY 5, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Kelly Court and Ira Moscovice, Co-Chairs, presiding.

PRESENT:

KELLY COURT, MBA, Co-Chair
IRA MOSCOVICE, PhD, Co-Chair
ANN ABDELLA, Chautauqua County Health Network
MICHAEL BAER, MD, AmeriHealth Caritas Pennsylvania
TONYA BARTHOLOMEW, OTR, Platte Valley Medical Clinic
JOHN GALE, MS, Maine Rural Health Research Center, University of Southern Maine
AARON GARMAN, MD, Coal Country Community Health Center
GREGORY IRVINE, MD, St. Luke's McCall Orthopedics Clinic
JASON KESSLER, MD, Iowa Medicaid Enterprise
JASON LANDERS, MBA, Highmark West Virginia
BRUCE LANDON, MD, MBA, MSc, Harvard Medical School
JONATHAN MERRELL, RN, BSN, MBA, IA, Profound Knowledge Products, Inc.
GUY NUKI, MD, BlueWater Emergency Partners
KIMBERLY RASK, MD, PhD, Alliant Health Solutions

ROBERT RAUNER, MD, MPH, SERPA-ACO
SHEILA ROMAN, MD, MPH, Consultant
SUSAN SAUNDERS, MSN, CNM, WHNP-BC, Rush Health CNM, American College of Nurse-Midwives
STEPHEN SCHMALTZ, MS, MPH, PhD, The Joint Commission
TIM SIZE, BSE, MBA, Rural Wisconsin Health Cooperative
BROCK SLABACH, MPH, FACHE, National Rural Health Association

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
SEVERA CHAVEZ, Project Analyst
MITRA GHAZINOUR, Project Manager
ANN HAMMERSMITH, JD, General Counsel
KAREN JOHNSON, Senior Director
MARCIA WILSON, MBA, PhD, Senior Vice President, Quality Measurement

ALSO PRESENT:

GIRMA ALEMU, MD, MPH, Health Resources and Services Administration
MARTIN RICE, RN, MS, Health Resources and Services Administration

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

9:00 a.m.

MS. JOHNSON: So, good morning everybody and thank you and welcome to Washington, D.C. and NQF and the Rural Health Committee.

We appreciate very much your coming and being with us in these two days. I think we're going to have some interesting discussions, we're going to learn some stuff from each other and hopefully, we're going to enjoy ourselves as well.

So, that's one of my goals.

Let me very briefly introduce the NQF team. I'm Karen, I know we've corresponded back and forth several times. And then we have Mitra and Severa, I'll let them say hi. And then I'll also ask Helen and Marcia to say hello this morning.

Mitra?

MS. GHAZINOUR: Hello everyone. This is Mitra Ghazinour. I am a Project Manager at

NQF supporting the work of various projects including Rural Health and just wanted to welcome everyone to today's meeting.

Thank you.

MS. CHAVEZ: Good morning everyone. This is Severa, I'm the Project Analyst for this project. In addition to this Rural Health project, I also support our data project and Medicaid development.

Thank you.

DR. BURSTIN: I'll add my welcome as well. Helen Burstin, I'm the Chief Scientific Officer here at the National Quality Forum. I'm delighted you could join us.

It's really -- this was a very fun committee to actually assemble, as you might imagine, since you wanted a blend of those who are doing it, those who study it and those who live it.

So, I think hopefully we have succeeded and have a great mix of methodologists and those who live and breathe Rural Health. So,

we're really looking forward to your input.

DR. WILSON: Good morning. I'm Marcia Wilson. I'm the Senior Vice President for Quality Measurement and I'm delighted to have everyone here and very much looking forward to this discussion.

Thank you.

MS. JOHNSON: And I'll hand it over to Kelly and Ira to say hello and introduce themselves and take us into the meeting.

CO-CHAIR COURT: Good morning. I'm Kelly Court, I'm the Chief Quality Officer at the Hospital Association in Wisconsin.

CO-CHAIR MOSCOVICE: And Ira Moscovice, I'm a professor at the School of Public Health at the University of Minnesota and run the Rural Health Research Center and this is a topic of real interest to us. Welcome.

MS. JOHNSON: Okay, so the charge for the committee today, we have a really broad area of rural health issues and measurement. But our charge is really to try to make recommendations

to CMS for mitigating challenges in performance measurement for rural providers.

So, with that broad scope, we really want to narrow ourselves down a little bit and we want to consider these issues through the lens of engaging providers in CMS P4P programs, or pay-for-performance programs.

So, there's a lot of interesting things that we can talk about in terms of QI and we'll probably touch on those things, but we are really thinking as much as we can at that P4P accountability piece of things.

And we are going to very much talk about the low case-volume problem. It's a problem that we all know about. It's a problem that really was the top issue that everybody mentioned in all our pre-work and some of our earlier discussions.

So, we are going to start our major discussions early this afternoon about low case-volume and then we'll branch out from that to the other challenges.

And, Ira, would you like to go ahead and go through our meeting objectives for us and --

CO-CHAIR MOSCOVICE: Sure. We have four meeting objectives. The first is to finalize the consensus set of measurement challenges for discussion.

Then we want to make some recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians. So, we're looking at a broad range of providers.

We want to make recommendations to help mitigate measurement challenges including the low case-volume as was just mentioned.

And finally, what NQF does in these panels which is really important is to identify what are the measurement gaps for both in this case, rural hospitals and clinicians.

So, we have an important set of meeting objectives and we'll march through them in order today.

CO-CHAIR COURT: So, we'll go over the agenda quickly.

A couple of housekeeping items before we start. You all have a microphone in front of you and so there is a little button to press to speak so we'd ask that when you do speak, please press the speak button and it'll show up red on top here because it's being recorded, so we want to be able to hear.

And then when you stop speaking, turn that off because only a couple microphones can be on at a time.

The other thing we'll do to kind of control the conversation is if you have a comment or a question or input, if you put your table tent up like this, then we know -- Ira and I will do our best to try and make sure we get people's inputs in order.

The restrooms are past the desk where you came in and then to the right, and there's refreshments in the back.

And Karen and Mitra and the staff will

kind of help keep us on track today.

So, the first item we're going to talk today about today is kind of setting the stage, so putting some context to our work. Then we'll take a break mid-morning about 10:30.

Then we're going to jump right in to our work really talking about trying to get consensus on those overarching measurement challenges.

So, we have some pre-work that everybody did. There's some themes in there so we want to narrow those down.

And like Karen said, we want to make sure that we focus our discussion today on measurement and measurement as it relates to potential P4P.

So, there's a lot of challenges we all deal with every day, but we'll try to stay focused on the measurement issues.

And then after that, we're going to move into some discussion and possible solutions related to low case-volumes which is, I think,

probably going to be our number one challenge, obviously, bubbled up in the pre-work like Karen discussed.

And then there's going to be opportunity for public comment and then we'll take a lunch at 1:00.

And then this afternoon, we're going to talk about potential solutions and I think that's really what we're here to do is not just talk about what's wrong because I think we all know that, but what can we offer up as potential solutions.

We'll take a break about 3:00 and then this afternoon, we're going to break out into two different groups. One group really focusing on the physician practice side clinical kind of issues and then the other group will focus on hospital issues, again, related to --

The solutions may be different for the two different groups, we'll do that this afternoon.

Then we'll finish up with a report out

from those breakout groups. We'll have an opportunity for public comment again and then we will summarize and adjourn about 5:30.

MS. JOHNSON: Thank you, Kelly.

And right now, we're getting ready to do introductions and Ann, our General Counsel, is going to walk us through that.

But before, Ann, I hand it over to you, I would like to introduce Marty Rice. Some of you know him, maybe not everybody does, but Marty, would you like to say a welcome to everybody?

MR. RICE: I just wanted to thank everyone for coming today.

I'm with the Office of Rural Health Policy and we thought this was a topic when we proposed it that was really relevant to the rural community. And it seems for the last few days, it's been getting a lot of traction at the last conference that we were at.

I think Patrick Conway was made aware of the project and I've gotten a ton of emails

about briefing him now about it.

But, there's going to be somebody else taking over this project from me and we're going to make sure you have somebody who's really great from ORHP.

And I'm going to Medicaid in the next two weeks. So, I wish everybody the best of luck and I'm going to really thank you all for joining us. Not the best place to be in the wintertime sometimes, but I think we've got better than average weather.

MS. HAMMERSMITH: Good morning everyone. I'm Ann Hammersmith, I'm NQF's General Counsel. And as Karen said, I'm going to lead you through the introductions and the disclosures of interests.

We combine those because we find it saves a little time so that you can go ahead and do your work and get into the meat of the meeting.

I'm going to summarize for you what we're looking for and then we'll go around the

table and ask you to introduce yourselves and disclose.

You received a form from us, a fairly lengthy form, where we asked you about your professional activities. And what we'd like you to do is not summarize the form, not summarize your CV, but to disclose things to your fellow committee members and anyone listening on the phone if you are engaged in something that's directly related to the subject matter before the committee.

I realize that Rural Health is a very large issue. So, use your judgment in what you disclose. We're particularly interested in whether you have grants, you're doing consulting or research in an area that's directly related to what's before the committee.

Just because you disclose does not mean that you have a conflict. Part of the reason we do this is in the spirit of transparency and openness so that everyone knows where everyone else is coming from.

I also want to remind you that you sit on the committee as an individual. Sometimes people will say, I'm Susie Smith and I'm here representing the American Academy of Fill-In-The-Blank and actually, that's not the case.

You don't represent your employer, you don't represent any professional group that you're associated with. You don't represent any group or individual who may have nominated you to serve on the committee.

So, with that, let's go ahead and go around the table, introduce yourselves and tell us if you have anything to disclose.

We'll start with the Chairs.

CO-CHAIR COURT: So, again, Kelly Court and I don't have any conflicts or anything to disclose.

CO-CHAIR MOSCOVICE: Ira Moscovice and we have a substantial number of grants from the federal government dealing with Rural Health Quality which is presumably why we're here. So, anyhow, that would be it. But I don't think it's

a conflict of interest.

DR. IRVINE: I'm Greg Irvine, I am an orthopedic surgeon in McCall, Idaho. I have no conflicts except that I practice medicine in a rural community.

DR. NUKI: My name is Greg Nuki, I'm an emergency medicine physician and I also don't have any conflicts other than I'm the partner in a group that practices in rural emergency departments.

DR. LANDON: Bruce Landon, I'm a professor of Health Care Policy and an Internist up at Harvard Medical School. My conflict is that I don't practice in a rural area.

DR. GARMAN: My name's Aaron Garman. I'm a physician in Beulah, North Dakota in an FQHC. I serve on the Commission for Quality and Practice for the AAFP. Other than that, I have nothing to disclose.

DR. RAUNER: Bob Rauner, a physician from Lincoln, Nebraska and two hats, one is Medical Director of a rural physician-led ACO

with 12 clinics in Nebraska that, of course, uses NQF measures for our incentive programs.

Second, I sit on a legislative policy group that sets medical home standards and develops quality measure sets for the State of Nebraska.

DR. BAER: Good morning, Mike Baer from Pennsylvania. I am a family doc. I work with AmeriHealth Caritas. I'm a network medical director in Pennsylvania and we have a lot of rural areas there. I have no conflicts.

DR. ROMAN: Sheila Roman, I'm an endocrinologist and part-time attending at Johns Hopkins University. I have no conflict, but I did work until just about a year to date for the Centers for Medicare and Medicaid Services for 14 years and saw them transfer themselves from public reporting to pay-for-reporting to pay-for-performance.

And I just want to reiterate that I'm here representing myself and not the agency at all.

MR. LANDERS: Jason Landers, I'm Vice President of Medicaid Markets for Highmark West Virginia. I now manage a joint venture project between Highmark and 23 FQHCs in West Virginia which, obviously, derives a large percentage of their income from grants.

CO-CHAIR COURT: Could you turn on your mic, please? There you go.

MR. MERRELL: Is it on now? I guess I was holding it down.

Jonathan Merrell, President of Profound Knowledge Products, Incorporated out of Oklahoma.

I think my disclosures at this time are important. I'm also a faculty at the Institute for Healthcare Improvement.

Until six weeks ago, I was the Vice President of Performance Improvement at OCHIN, Incorporated in Portland, Oregon which is an organization, a health center controlled network by definition that provides Epic EMR to FQHCs, CHCs and others. We have about 4,500 physicians

using our customized Epic platform.

I'm also preparing to do quite a bit of work in the next few months with the Indian Health Service out of Portland Area Office.

And I'll just be clear at this point, again, that I won't be representing the agency of the Indian Health Service. So, thank you.

MS. BARTHOLOMEW: I'm Tonya Bartholomew from Saratoga, Wyoming and my husband is a physician and I am the practice administrator for a small rural clinic. We serve about 2,800 patients out in the middle of nowhere and I have nothing to disclose.

DR. RASK: Kimberly Rask, I'm an internist and I'm the Medical Director for the CMS-funded Quality Improvement Organization for Georgia and North Carolina.

And we do technical assistance to hospitals and physician practices for quality reporting and work with some more critical access hospitals on flex grants.

MR. SLABACH: My name is Brock

Slabach, I'm the Senior Vice President for the National Rural Health Association. Formerly, a critical access hospital administrator in Southwest Mississippi. We also ran four provider-based rural health clinics.

I work for the National Rural Health Association and we have some contracts with the Federal Office of Rural Health Policy and I will not be representing the association nor those grant programs.

MR. SIZE: Hi, I'm Tim Size, Executive Director of the Rural Wisconsin Health Co-Op and we're a collaborative of 39 rural hospitals, mostly CAHs, about six to eight tweeners.

About 90 plus percent of our budget is shared services but we're well known for advocacy which is a lot of what I do.

Programs, I think things I'd like you to be aware of kind of under disclosure, I don't think I have any conflicts, but under disclosure, we have a number of quality reporting programs, so obviously, decisions of this group eventually

could affect that work.

We also are involved in contract negotiations on behalf of our hospitals with payers and increasingly in pay-for-performance, so decisions here could affect that work.

And then I'm also on a quality committee of a local insurer which is very engaged with this type of metrics.

MR. GALE: John Gale, I'm from the University of Southern Maine and the Rural Health Research Center and we have some federal funding to develop quality measures, but there's no conflict.

DR. KESSLER: Jason Kessler, I'm a pediatrician and the Medical Director for the Iowa Medicaid Enterprise. I am contracted to the State, but I'm actually an employee of Telligen which is the Iowa Quality Improvement Organization, QIO. I think they've changed what they actually call it now.

But Telligen does some work with quality measurement and quality improvement in

rural practices and the Iowa Medicaid Enterprise has contracts and grants from CMS and the government for rural health programs and quality measurement programs.

MS. SAUNDERS: I'm Susan Saunders. I'm a Certified Nurse Midwife and Women's Health Nurse Practitioner in the rural Southeast. And I have no disclosures.

MS. ABDELLA: Good morning, I'm Ann Abdella from the Chautauqua County Health Network and the Chautauqua Region Associated Medical Partners. I don't think I have anything that's a conflict.

Through the network, we are a HRSA grantee. I sit on the Board of a local FQHC, so we get funding from there.

And also, I think part of my involvement in this committee has to do with the fact that I'm the Treasurer for the local Chamber of Commerce that works with the Manufacturers Association. So, they have no conflict, but they have a lot of interest in this topic.

DR. SCHMALTZ: Hi, I'm Steve Schmaltz. I'm a Senior Statistician for the Joint Commission in their Division of Health Quality Evaluation.

The Joint Commission is a subcontractor on a grant with CMS for performance measure development and a number of the measures that the Joint Commission has developed are used by critical access hospitals.

MS. HAMMERSMITH: Thank you for those disclosures.

Mr. Alemu, would you like to introduce yourself?

DR. ALEMU: My name is Girma Alemu. I am with HRSA and I work as a public health analyst.

MS. HAMMERSMITH: Thank you.

Before I leave you today, just want to remind you that if during the meeting you think you have a conflict, you think someone else has a conflict and they're not speaking up, or if you think someone's behaving in a biased manner, we

ask you to bring that to our attention.

Our conflict of interest process doesn't work without your participation and cooperation and we don't want you sitting there in silence if you think something is up.

So, if you think there's bias, you think there's conflict, you can always approach your Chairs, who will approach NQF staff, you can approach NQF staff, and of course, you are always welcome to bring it up openly in the meeting itself.

Do you have any questions of me or of anyone else based on the disclosures?

Okay, thank you.

MS. GHAZINOUR: So, I just would like to provide a brief overview of the project.

So, in September 2014, the Department of Health and Human Services contracted with the National Quality Forum to convene a multistakeholder committee to provide recommendations on how to address measurement challenges for rural providers, particularly in

the context of pay-for-performance.

The rural health providers of interest for this project include critical access hospitals, rural health clinics, community health centers, small hospitals, small practice offices as well as clinicians who serve in these settings.

So, as part of this effort, NQF conducted an environmental scan and to help inform the committee's deliberations and the primary goals of the environmental scan were to identify performance measures and quality measurement programs that are currently on their way and would apply to rural providers as well as to identify and describe both measurement challenges and solutions for rural health care providers for payment purposes and to identify key measurement of gap for rural health.

So, the committee could use this environmental scan as context to provide recommendations regarding how HHS can mitigate measurement challenges in payment incentive

programs for rural providers and also identifying the best -- the most appropriate measures to be included in these programs.

And lastly, to identity development resources that could be best directed toward filling those measurement gaps.

So, this is our time line. As mentioned earlier, the project started in September and we held a call for non-committee rural health nominations and we received many wonderful nominations and the committee was seated in mid-December.

And immediately after, we held our first web meeting which was to orient the committee members to the project and also to seek your input in terms of the priority areas that you would like to discuss during today's meeting.

So, after today's meeting, NQF will draft a report which will contain your recommendations and, again, in March -- March 19th, we're going to hold another web meeting for you to review the draft report and to provide

comments to us.

And on April 15th, we'll submit the draft report to HHS and in June/July, we will post the draft report for a 30-day public comment period and, again, we're going to convene the committee via a web meeting in July to review and respond to public comments.

And the final report will be submitted to HHS in September.

Now, I would like to turn it over to Karen.

MS. JOHNSON: Thank you, Mitra.

So, I know you guys heard that stuff before, but we wanted to make sure it's in front of your mind what you're up to here.

We wanted to give you a little bit of the insights that we found from our environmental scan and from the pre-work that you guys did as a committee.

I don't think any of this will be news to any of you. It was a little bit new to me and to NQF. We have not done a lot of work in the

rural health area.

My interest actually is because I am from the Central Appalachian Region. I grew up about 20 minutes from the Cumberland Gap. So, I understand what's going on. Our local hospital closed last year. The doctor that my parents visit actually quit the clinic that he worked in because he didn't like the EHRs and having to work with EHRs and he went out and started his own practice, but he does not take insurance. So, that's a very -- it's difficult.

So, I understand, at least from my own personal perspective, some of these issues.

But these are the ones that bubbled up from talking to you and from doing quite a bit of reading and looking at reports and such.

So, one of the biggest things is the limited availability of the health care providers, including the specialists as well as the post-acute care providers.

Along with that is the limited emergency response options that are a part of

life in rural America.

Also, very closely related is the geographic isolation. So, that really -- the first thing I think of is the transportation issues and I'm sure that there are other things as well that go with that isolation. But, I think it really has an impact on measurement.

There is limited hours of operation for many providers including ED docs and pharmacists. There is, and I know it well, the patient characteristics, SDS factors, health status and health behaviors.

Again, I'm from a part of the country that our health behaviors aren't so great and we have a very -- the cultural status for looking at health care provision is sometimes a little different than in other parts of the country, a very independent streak, so there's a lot of that out there.

I think the other thing that's really interesting and it's my bottom point there, it's heterogeneity. I know about my area, Rose Hill,

Virginia, but I know that's very different than Nebraska and Wyoming and these other places. So, that heterogeneity makes things difficult in terms of measurement.

We have the workforce capacity that many of you talked about a lot on our web meeting. And that really comes up in measurement because of the IT expertise that's needed as well as the QI expertise. And I think one of you mentioned in your pre-comments, the pre-work that you did that you're the doctor and the plumber and the IT guy and the QI guy. So, we get that.

The low patient volume, we've already talked about and we're going to talk about that a lot today.

And then finally, the lack of resources. So, it's resources, financial as well as workforce, et cetera.

So, part of our environmental scan was to dip our toes into some of the different QI programs that are out there. So, we were trying to look at measurements and QI programs, a very

large scope.

So, we didn't hit everything but we learned a little bit about the various CMS programs and Mitra's going to walk us through a couple of those later on today.

We know that CMS has the very successful QIO programs that have recently changed, so I'm not quite sure how they're going to morph given the recent changes.

Medicaid, there's a lot of work going on in Medicaid, particularly from the Medical Home Initiatives that Medicaid is doing.

We have a lot of work from HRSA in the MBQIP, is it QIP, is that how you say that? MBQIP? Okay. And that program for CAHs trying to help with measurement there.

Telehealth programs, we've pulled that out because that's very -- or at least I think it's important. It'll be you guys to talk about telehealth and importance for measurement there.

Private sector P4P programs, there's at least 40 throughout the country. So, lots of

employers, health plans, et cetera are doing P4P, so that is not new. CMS is not the only entity that's doing P4P.

And then finally, there are a lot of regional QI collaboratives that have bubbled up over the country. Probably more in urban areas, but they have their own ways of measuring things, their own measurement sets, that sort of thing.

So, we did get some specific feedback from folks. We talked just one on one with a few different people, some of you around the table and then a few that aren't around our table.

We learned that state regulations can actually impact which measures are used in programs and Pennsylvania I think is one and Minnesota are the two that come to mind. I'm sure there are others.

The low case-volume problem is known. Nobody's surprised about this. And different folks try to solve it in different ways, including I talked to someone from one of the large insurers and they don't worry too much

about, at least for their specialists where the low volume problem is really big and even more so in rural areas.

They look at a lot of structural measures as a way to assess quality of their physicians. So, a different way of thinking about it.

Even though the low case-volume problem is known and it definitely impacts reliability of measurement, particularly for P4P or other kinds of accountability programs, that really doesn't impact the ability to provide clinician-specific feedback.

So, what that means is, you know, you can still learn even if you only have three cases of whatever and different groups are providing that feedback.

And then finally, we have some indication that employers in rural areas may not be as focused on quality measurement as other purchasers.

So, we tried to do a scan for measures

and don't get too upset about this number, we found 1,265, way more than what there really is. We realize that there's a lot of duplicates in the list. And part of that is to some extent, it just shows how difficult it is to try to find lists of measures, especially if people change titles or tweak them just a little bit.

So, 1,265, we limited it down a little bit but still, our list is still a little bit too long, to a little over 200 hospital-specific measures and a little over 400 clinician-specific.

I've actually tweaked that a little bit more and narrowed it down a little bit more, but the take home from that is if we need it later on today and we want to look at some of these measures, we can pull up this spreadsheet. We may not need to get into the weeds of individual measures, we'll see how that goes.

The other thing that I learned and we have Ira and John who know very much about this and I'm sure you could talk about this more as

the day goes on, but they have through the work with HRSA, they've done some work on rural relevancy. So, they've actually looked at different measures that are being used pretty much in the CMS programs, I think.

And in various years, they've looked at those to see if those measures seem to be rural relevant or not. So, they started out looking at small hospitals back in 2004, updated their work in 2010/2012 somewhere in there and then John's work with RHCs is ongoing.

And we actually tagged measures with results of their work in our Excel spreadsheets of measures.

Based on their work mostly, but also just looking overall and thinking about the National Quality Strategy and some of those kind of things, some of the gaps and measurement that we found in the scan have to do with medication safety and reconciliation.

Surgical checklist, there actually are some surgical checklist measures out there, a

couple of them. But, more in the ambulatory surgical centers. So, we, you know, we might can talk about that if we need to later.

There's not much in advanced care planning.

Shared decision making is very much missing from all of those measures. And then, so far, I did not see measures around telehealth and telemedicine.

So, I'm sure you guys will know a lot more gaps. Again, these are the ones that I found as we were doing our environmental scan.

Now this, this was my attempt at trying to put some order around all of these issues. And you'll notice that all these boxes, you don't have to try to figure this out. This is, you know, me trying to mind map a little bit here.

Some of these are challenges, some of these are issues. I didn't put everything on the table. But what I was trying to do, and what I convinced myself of, and this is not really a

surprise, is that a whole bunch of these things are really intertwined.

So, as we go through the day, we're going to talk about low case-volume. Right? But as we talk about low case-volume, we may need to talk about risk adjustment because there are some methodologies, I believe, if I understand correctly, that can help in the low case-volume.

Measure selection also impacts the low case-volume problem. If you are only looking at measures of things that everybody does, for example, a screening measure, then you might not have a low case-volume problem.

So, again, this is just to illustrate probably to myself more than anybody else, that all of these things are very much intertwined and that we will be talking about different things, even though we're going to try to be systematic throughout the day, we'll be hitting a lot of these different points as well.

And then finally, I know everybody was just dying to know what the pre-meeting exercise

results were. So, I asked you to do two things for me.

The first time, I just asked you to give me your top five of different challenges and you did that and we combined those and we really abbreviated those to a large extent because many of you really gave me some meaty feedback on that.

But then, I collected those and pulled what seemed to be the big ones off of your list and then asked you to rank those.

So, not surprisingly, we have low case-volume was the one that was ranked highest on the scale of one to ten. And then you see across, and if you kind of squint your eyes, you can probably read some of that.

At the very end, you have the aggregation, the level of analysis piece and the attribution. So, that didn't seem to be from your perspective as big the problem or challenge as the other ones.

But I think interestingly, there's not

a lot of difference there in between the, you know, 7.6, 6.4, there's not a lot of difference.

A lot of people see these as a lot of problems. So, again, just a real quick feedback of what you were able to provide us for the pre-work that you did and I do thank you for sending all of those in.

Okay, with that, I'm going to hand it back to Mitra so that she can remind us one more time of the various CMS programs that we need to keep in mind.

MS. GHAZINOUR: Thanks, Karen.

So, I just would provide a brief overview of CMS Quality Improvement programs that are directed towards hospitals and clinicians and are also relevant to this project.

So, to drive improvement in health and health care, CMS has administered a variety of quality improvement programs for hospitals such as the programs that are listed on this slide.

And the first quality improvement programs that CMS has implemented are pay-for-

reporting programs. And on top of the list, we see Hospital Inpatient Quality Reporting Program and followed by Hospital Outpatient Quality Reporting Program which requires hospitals to provide quality data on a set of quality measures to CMS and failure to do so will result in reduction in their annual payment updates.

And also we have quality reporting programs for Ambulatory Surgical Centers.

And a subset of measures from the hospital IQR and hospital OQR programs are reported publically on the Hospital Compare website which is -- the Hospital Compare website provides information on how well hospitals provide the recommended care to their patients. And also informing patients or consumers choices in regard to their health care decisions.

And so, CMS has been shifting from pay-for-reporting to pay-for-performance and now we have Hospital Value-Based Purchasing program which provides incentives to hospitals that meet or exceed their performance standards.

And moving on to the next slide. So, here, we attempted to show the relationships among CMS hospital programs. And so, CMS in its effort to align programs, tries to include same measures across programs and we see here that measures for hospital-acquired conditions, reduction program and measures for hospital readmissions reduction program are from the IQR program as well as the measures for the value-based purchasing.

So, the measures for the value-based purchasing program are selected from IQR, however, they need to be reported on the Hospital Compare for one year in order to be included in the value-based purchasing program.

And moving on to the next slide. So, again, we see here CMS quality programs for clinicians and we see the Physician Quality Reporting System which is a pay-for-reporting program and it started as a voluntary program for clinicians to report measures from a menu of measures, a set of measures, and they would get

incentivized for reporting a selected number of measures.

However, that is changing now this year to -- the incentive is changing to payment adjustments or reductions.

And for some of the -- actually, all the measures in the PQRS also are going to be included in the Physician Compare for public reporting and also in the value-based payment modifier which is a pay-for-performance program, and it evaluates physicians both on the quality of care that they provide and the cost of care.

So, the next slide also shows the relationship across the clinician programs and the measures need to be valid and reliable in order to be reported on Physician Compare. And also similar to the relationship between IQR and VBPM measures need to be in PQRS for a year before they can be used in VBPM.

So, under critical access hospitals can report measures on a voluntary basis through the physician -- through the Hospital Compare

website. They are excluded from reporting though IQR and OQR because they're not paid under the hospital prospective payment system.

And some small hospitals also may not be able to report on some of the measures because of low case-volume. And the same situation is for the clinicians who serve in rural health clinics and critical community health centers.

And because they are not paid under the physician fee schedule, they're excluded from PQRS and other clinician programs. And also solo practitioners also and small practices, they also have issues regarding reporting on some of the measures because of low case-volume.

So I think that was the quick summary of federal programs. I'm just handing it back over to Karen.

MS. JOHNSON: Thank you, Mitra.

So, the next piece of our morning is really to get a little primer from several of you about some of these settings.

Now, I realize that many of you may

know all of this stuff already, but maybe not everybody knows some of the details of some of these different settings.

So, I've asked a few of you to give us maybe a five, seven, eight minute, whatever you need to do, primer on the settings.

So, we'll just go through, let's start with Susan, who's going to talk to us about Critical Access Hospitals.

MS. SAUNDERS: All right, Critical Access Hospitals, they are limited to 25 beds or less. They can designate like up to ten beds for other services such as rehab, swing beds, psychiatric. They are required to provide 24-hour emergency care.

Some states will designate as necessary provider. They need to be 35 miles from other hospitals, although some states waive that and it can be less.

The surgery aspect is minimal-type surgeries because admissions are 96 hours or less.

In regards to how they're paid in revenue, of course, they were left out, as was mentioned, they're left out of the Medicare prospective payment system. But they are reimbursed at 101 percent of Medicare reasonable charges or costs.

They are subject to Medicare A and B copays and deductibles. With telehealth, they're subject -- they receive 80 percent of the reimbursement. And then they can have HPSA incentive payments for the physicians or providers.

They also are able to participate in the Meaningful Use or, you know, EHR incentives.

They can have some other incentives as far as teaching incentives, things like that.

The current measurements that are going on, you know, as stated, they were excluded from IQR and OQR type measurements. They can report voluntarily to Hospital Compare. However, you know, the fact that the reporting is voluntary, it may not be consistent, you know, or

representative of all Critical Access Hospitals.

They did participate in the Medicare Beneficiary Quality Improvement under HRSA which looked at things like outpatient ED transfers, pneumonia, acute MI.

And then they have many of the private pay-for-performance measures as well as regional quality measures.

Some of the challenges in Critical Access Hospitals, you know, is the availability of staff, especially when you get to specialists looking at pharmacists, dieticians, that kind of mix, IT, you know, those people and individuals can be very hard to recruit and retain.

You also, in your general education experience staffing mixes can vary. Often times if they're geographically locked or secluded, you may, you know, the further you move away from that academic environment, you kind of lose that culture of knowledge acquisition and, you know, from that regard.

Also, just implementation, the

importance of quality measures, you know, the implementation, the tool kit in which to do that can be challenging.

Because they are secluded and, as Karen mentioned, the heterogeneity of rural areas, your patient demographics can vary, you know, and quite largely. You also have that low volume less predictable kind of population.

Some of the key details, the quality measurements, I think we've kind of now mentioned several times is that low case-volume, you know, across the board, the lack of data.

The measures that I think we look at for rural health, they need to address what rural health does, the triage, stabilization, transport, you know, the front line kind of measures.

And then, you know, some of the measures required mandatory reporting on items that are really not applicable to Critical Access.

MS. JOHNSON: Thank you.

And, I don't know if anybody has any questions for Susan. It looks like Tim does. So Tim?

MR. SIZE: More of a comment and the first one might be a bit of a quibble.

There is a very much a controversy around the 96 hours being an average or a cap. It for many years has been an average. CMS, and it's a long complicated story, recently reinterpreted their position to say it was a cap that is being very much pushed back on.

So, a lot of CAHs, in fact, do have significant amount of surgery because they work and have been working on an average. Just a small quibble.

And the second thing is, and I would have mentioned earlier, it fits anywhere in the conversation, but I'm very much a fan of what the National Quality Forum has done by raising up the SDS issue and its impact on compliance and outcomes.

And I think that affects all of our

provider categories and I hope that -- I'm not sure we have re-discuss everything that NQF's already doing, but I think we certainly had a couple of key points needed to cite that -- well, it's not a unique role, it has a disproportionate impact on small providers in any of these categories.

Thank you.

MS. JOHNSON: Thanks, Tim.

Anybody else have any questions about CAHs?

DR. LANDON: Can you put a little bit more meat on the bones about the 101 percent of sort of usual customary fees or whatever and how much that equates to?

MS. SAUNDERS: I'm not sure I know how to answer that because I'm not really an expert in Critical Access. It was just some of the data that I pulled.

I think there are individuals at the table that could probably better answer it.

MR. SLABACH: I'll do the short

version, I could probably talk all morning on reimbursement by costs.

I'll give a little bit of history that in 1966 when the Medicare program started, all hospitals were cost-based reimbursed. And then in 1983, we had the Prospective Payment System which reverted to that program for all hospital payment. And then in 1997, we went back to Critical Access costs. We went back to cost-based reimbursement for Critical Access Hospitals at 101 percent of costs.

I will point out that due to cost reporting methodologies, that's really never 101 percent of costs, it's really more like 94 or 95 percent of costs. When you start to exclude some of what's considered customary and reasonable in terms of Medicare's eyes for what constitutes costs.

So, the cost of care is what determines -- your payment is based on cost not on your diagnosis. So, there's no upper payment limit as it were in terms of how those costs

shake out. So, you could have low volumes that are basically your overhead is spread out over low volumes.

And in this case, it corrects for that because you're getting reimbursed on costs, not on a set fee for each diagnosis.

Now, if you have any questions to kind of go down further, I'd be happy to answer those.

DR. LANDON: Do you have any sense for an average diagnosis of what the payment for a typical Critical Access Hospital is versus what a payment under DRGs would be for, you know, a hospital in the nearest local city?

MR. SLABACH: The answer is yes, but it's variable based on region and parts of the country, as we know. But I would say that most of your Critical Access Hospitals -- well, all your Critical Access Hospitals are paid on a per diem and those run anywhere from $1,500.00 to $3,000.00 per day and that's how they're paid on an interim basis.

And you can compare that then with

your average DRG payments for basic diagnosis and you could come up, in some cases, it could be more and some less. So, it's really hard to generalize in terms of the relationship there.

MS. JOHNSON: Bob?

DR. RAUNER: General follow-up question for that, Brock.

So, for example, since your costs -- say your costs are stable for three years but your volume went from 90 to 110 to 100. Your reimbursement would be the same in the per diem essentially ratchets up and down based on your volume for the most part? Maybe that's over simplified.

MR. SLABACH: No, that's a very good way of saying it. And basically, the costs, I look at it like a tax return. At the end of the year, your costs are based on your audits, are adjusted according to various things.

So, another thing that will impact it is not only volume but case mix or patient mix in terms of the types of patients you have in your

facility.

So, if your Medicare volume declines from 60 percent to 40 percent, then your costs are going to go down accordingly.

And so, you could either have an underpayment or an overpayment each year to Medicare and, believe me, as a hospital administrator, you never want to have an overpayment that you have to pay back because Boards don't tend to understand that very well.

MS. JOHNSON: And I have one question for you guys who really understand CAHs. I want to make sure that I understand.

Do you guys do Part A claims? And then physicians who work there, do they do Part B claims for Medicare or not?

MR. SLABACH: Hospitals bill Part A for their -- CAHs bill Part A for their services and those claims are all based on hospital-based claims.

Physician claims, now this can start getting very complicated.

Yes, if they're not working -- they are Part B claims for physicians working in a Critical Access Hospital unless the Critical Access Hospital opts for Method II billing. And then if they do Method II billing, you get your fee plus 15 percent.

MS. JOHNSON: Okay, thank you.

And I wanted to know because some measures are claims-based and I was just trying to understand are those measures even applicable for CAHs?

MR. SLABACH: Well, part of the problem for a lot of our hospitals right now is that if you have -- if you're in a rural health clinic as a physician, you may have only a small portion of your claims that are Part B. And so, now we're understanding that they are going to be penalized on PQRS for that small sliver of claims that they have.

So, in a Part B arrangement, and it's really unfortunate, it's a problem of regulation and we're trying to work on this, but you could

get -- they're going to get dinged on the PQRS for not reporting based on the fact that they have those small number of claims.

MS. JOHNSON: Okay. And one thing, as you do your tag, can you -- there you go, thank you.

Michael? Thanks.

DR. BAER: This goes back to the telehealth comment, the 80 percent.

Telehealth is only paid by CMS in certain areas, the health physician shortage areas and it is my understanding that anybody who gets reimbursed by CMS only gets reimbursed at 80 percent.

So, it's not really discriminatory, is it? Is that -- I mean that comment about the 80 percent, because they don't pay 100 percent to anybody for telehealth.

For the E&M codes, because in an urban area, they don't even pay for telehealth. So, in effect, it's kind of reverse disparity meaning, you know, for those who are not in a shortage

area, they can't bill telehealth.

So, it's actually a benefit for rural areas, but CMS doesn't pay 100 percent to anybody, they just made a decision since it's telehealth, we'll give the, you know, the originating site X and we'll give the receiving site Y and that was 80 percent.

MR. SLABACH: So, if I could, I'll respond.

The facility -- there's what's called the facility fee that a Critical Access Hospital or rural health clinic can bill and then you combine that with the Part B fee that the physician gets and it basically is supposed to equal out so that 80 percent -- yes, so the 80 percent combined would come up with a total fee.

DR. BAER: Right, but there is no 100 percent for payment for the physician E&M portion of that, right.

MS. JOHNSON: Okay, Bruce? And then we're going to have to go on to our next setting.

DR. LANDON: Sorry, can I get back to

that question about the sort of hospital claims?

Are you doing a typical, you know, UB-92 and putting in the same diagnoses and all? And more importantly, since you're not really getting paid based on those, is the accuracy of the diagnostic coding at a Critical Access Hospital going to be the same as a hospital where it's actually determining which DRG you fall into?

MR. SLABACH: You've hit on a very important topic and very astute because one of my big passions over the years has been, as a hospital administrator, we had certified coders. I had very rigorous attention to detail in terms of coding our claims. And we had a case mix index in our facility that was close to one, a little over one.

But I have a lot of colleagues who don't pay attention to this at all and I'm not being disparaging, it's just that they -- since they're not paid based on their diagnosis and the accuracy of their coding, it's not a big deal.

And so, they'll have case mix indexes that are much, much lower than that.

And so often you'll find that the acuity in these facilities is higher, it's just that the coding isn't as robust and so you get the kind of a suppression of what they're actually doing versus what their codes suggest.

MS. JOHNSON: Thank you.

Let's go on to our next setting. We're going to do Rural Health Clinics and that's John.

MR. GALE: Thank you.

The Rural Health Clinic program is probably -- is one of the oldest if not the oldest rural support program for primary care providers. It dates back to 1997 -- 1977, excuse me.

And the program was designed specifically to address geographic access for Medicare beneficiaries and Medicaid enrollees.

It does that through the provision of more volume appropriate cost-based reimbursement

for Medicare services, originally Medicaid services and that has transitioned from straight cost-based reimbursement to originally cost-based Prospective Payment System from Medicaid, so it was designed to try to cap their costs.

There are probably -- there are over 4,000 Rural Health Clinics located in 45 states. And there are some challenges for their participation and some of them are -- some of it's an understanding issue because Rural Health Clinics are certified and designated by CMS and they have to be located in a non-urbanized area. They have to be located in a shortage area either HPSA, medically-underserved area or a Governor designated shortage area. They tend -- and they're paid on a cost-basis.

They tend to be confused with Federally-Qualified Health Centers which have somewhat similar designation criteria.

The challenge being that they're not alike. RHCs aren't eligible for 330 Funding for the uninsured and in they're not nearly

homogeneous in terms of their organizational structure as FQHCs.

They can be for-profit privately owned clinics. They can be privately owned clinics. They can be municipally and county government owned, state government owned. And they can be 501(c)(3)s.

And so, we tend to think of them -- it's harder to move the industry or that population because they're all very different. And in many ways, they act much more like small private physician practices than they do an organized delivery system. So, that's the challenge first off.

The second part is that they're -- RHCs are paid under the Medicare B Trust Fund, but they're paid using Part A methodology. So, they submit UB claims to Medicare A for their reimbursement and they go through the same reconciliation process at the end of the year. They get a Prevacid rate.

They are capped. They're paid for a

defined package of services which is generally the provider and the professional component of physician services, the evaluation and management codes for osteopaths, they get paid. That includes the manipulation codes, the R&T codes, some procedures.

And a basic component of laboratory services, there are six, hematocrits, urines, the sort of basics.

And so, they are paid and they submit it and they get a calculated Prevacid rate and that's settled at the end of the year.

And I think Brock was saying this, it is true that certain services fall outside of the defined package of Rural Health Clinic services are billed to Part B. So, some of the more extensive diagnostic services, if they're doing some procedural activities, services and even inpatient care. So, if they're providing inpatient services, that's not considered an RHC component.

So, they get -- those services get

billed on the 1500 to Part B, the rest of the services get billed to the parties but paid eventually and reconciled to Part B.

The big challenge in terms of reporting because of the UB issue, the bulk of their services aren't billed using CPT code, they use the revenue codes. They submit CPT codes primarily to commercial carriers, some Medicaid programs, depending on the state regulation process.

So, they are getting caught in this PQRS penalty because certain things are being billed but not the bulk of what they do. So, as a result, they have not been eligible to submit the lion's share of their work through PQRS and participate where that's claims-based.

They've been left, I don't know if I want to say left out, if that's the right term, some of the other programs like Meaningful Use, they are typically, which doesn't makes sense for them to consider Medicare Meaningful Use Incentives because of that issue.

But they can qualify for Medicaid if they have 30 percent or more of their volume attributable to what's considered needy patients, SCHIP, Medicaid and the uninsured.

And there's probably much like Critical Access Hospitals, they are struggling with staffing issues. They're struggling with resources. We're beginning to see that in terms of Electronic Health Record Adoption, they're increasing their utilization, VHRs and implementation.

Probably rural providers or family docs are increase -- they're probably the fastest increasing group in terms of adoption. They're not quite there with everyone else, but they've been moving along more rapidly from a lower baseline.

But we're seeing inconsistent quality, if you will. Some have old legacy systems and what we're finding from some of the providers that we talked to is that even though they may have a certified system, that doesn't necessarily

mean what we think it's going to. They're not able to get the codes out. So, if you have standard codes, standard quality measures, they may not all throw out the same information.

Questions?

MS. JOHNSON: That's Bob. Can you -- yes, do your tag over towards -- there you go, Bob.

DR. RAUNER: Actually, this was the perfect segue between these two things. Because I think this is critical understanding the incentive problems in rural because of this A/B hybrid billing system that has resulted.

So, I actually was working for a couple of years for our regional extension center. About half of the rural physicians in Nebraska were in effect written out of the Meaningful Use Incentive program because this Part A, Part B issue that John just talked about.

And it messes up everything from PQRS, it even messes up the Medicare Shared Savings Program, ACOs in rural areas that I have a direct

conflict with, of course, because it made it, I think made it impossible for us to make a bonus actually because of these -- all this mess up here.

And I think, and no offense to the folks who are Washington people, if Washington had a better understanding of this, we could fix a lot of these rural problems because this A/B distinction messes up most of the incentive programs whether it's PQRS, Meaningful Use, ACO. And until they get around this A/B division, it's fundamentally unsustainable.

And Aaron and I were talking about this before this meeting started because he's in that limbo world where he actually does the FQHC but even that is really messed up in rural because there's a 30 percent threshold and many people can't make the 30 percent Medicaid threshold in rural.

In Nebraska, it even got to the point where even the urban pediatricians couldn't make the 30 percent Medicaid and so even urban

pediatricians were written out of Meaningful Use because of these different limitations.

And so, this A/B thing is really, really, really important to solve.

MS. JOHNSON: Ira?

CO-CHAIR MOSCOVICE: So, I'll be speaking as a member of the committee now.

I think a couple of issues got raised by a couple of speakers that I'm hoping the committee can deal with as we go through the next day and a half.

And it's basically the exclusion of CAHs or Rural Health Clinics or other kinds of providers you'll hear from whether it's mandated reporting, differences in, you know, how they're going to get paid.

And, you know, my observation is that many providers think, well, if I don't have to report, that's good. You know, it's one less hassle.

But, from my perspective, when we exclude rural providers from the programs that

are coming, it's a huge issue. And so, I'm hoping that the discussion we have over the next couple of days can at least start to grapple with that and make some recommendations to CMS where we think it's appropriate to try to include rural providers in these programs.

MS. JOHNSON: And Bruce?

DR. LANDON: So, could you elaborate more on why the A/B issue is problematic for constructing budgets for ACOs?

You know, for instance, in urban areas, we now are able to get around that issue with our community health centers who have the same A/B issue. And, you know, at the end of the day, the budget's the budget whether it's a Part B or a Part A part of it.

Does it have something to do with how the growth rates are determined? Can you -- I'm a little confused on that.

DR. RAUNER: And I may not get this completely right because we are still struggling with this. I finally got to talk to Medicare

actuary recently about this, so with our ACO, and again, I have a direct conflict with this one, just disclosure again.

We've had a 15 percent reduction in our hospitalizations over the last two years but no reduction in our costs and we're trying to figure out why. Well, we think the reason is, back to this volume issue, is though the hospital's volume has been reduced, their costs were not reduced so their per diem just went up accordingly.

And then that, because no cost was no changed, us as an ACO, we got no credit for those reductions. Yes, that's that.

The Meaningful Use was the A/B issue because literally most -- so we have a Rural Health Clinic. For example, they do most of their stuff but it all goes through Part A. But your Meaningful Use Incentives are based on meeting a threshold of Part B.

No, this goes back to the actual individual Rural Health Clinic and why they could

not get Meaningful Use Incentives. Yes, but almost every program, there's a unique A/B thing that messes it up whether it be Meaningful Use, PQRS, ACOs.

And until the federal policy fully understand that, all these things, they work, say, in Philly but they don't work in, you know, Minot, North Dakota because of these issues.

MS. JOHNSON: Brock?

MR. SLABACH: This has been a great discussion. I will point out and add a little bit to John's commentary that there are free-standing Rural Health Clinics that are -- and then there's also provider-based Rural Health Clinics. So, there's two very distinctly different reimbursement structures for each.

In a free-standing, they are subject to an upper payment limit which is amended, hopefully, annually to some kind of economic index. This year, it was a whole one percent, so they went from 79 AD to AD 16 per visit.

And so, if your costs are more than

that, then that's all just down the cracks, as it were.

For provider-based, there is no upper payment limit. So, those are clinics that are owned and operated as departments of hospitals either Critical Access Hospital or a PPS hospital 50 beds or less.

And so, those have a different payment structure and sometimes that does have an impact on ACOs. And the problem for us in our rural settings is not withstanding the problem for the ACOs, these are all designed as safety net programs to ensure the access.

So, if you remove that -- in other words, if you remove the effects of no cost decreases, then they're not going to be able to have enough money to keep their overhead in place to be able to support those structures.

So, there's the rub between one level of payment policy in terms of incentives to the ACO and the safety net concerns that we have between rural and those payment programs.

And so, there's some conflicts as you start layering these programs up.

MS. JOHNSON: John?

MR. GALE: One small clarification on the provider-based caps, it's 50 beds and higher. Provider-based clinics owned by hospitals with 50 beds and higher are subject to a cap. It's anything under 50 beds, 49 and smaller.

My understanding is, and here is the challenge, is that most clinics and most MIS systems used to do billing, they are entered in based on the CPT codes. So, actually that information is extractable. It's just a matter fo the claims submissions.

So, and in some ways, I have to say to be honest, the political calculation has been made when PQRS is being developed, Medicaid meaning -- Medicare Meaningful Use.

Whether or not it's worth fighting to get them included in some ways because they're not eligible for the incentives, they're also on the downside not subject to the penalties down

the road.

And in looking at the two Medicare and Medicaid reimbursement incentive payments, as long as they're eligible -- as long as they meet the 30 percent threshold, the Medicaid incentive payment is actually more beneficial financially for claims.

So, I mean there are so many things that they can fight for and they make some decisions about what makes sense and what, in the long run, is best for them.

MS. JOHNSON: Okay, Tonya?

MS. BARTHOLOMEW: I just wanted to give you some hardcore data.

We were just this summer dropped our Rural Health Clinic status because my costs of taking care of a Medicare patient was around $132.00 and my reimbursement from Medicare was $79.00. You can't keep the lights on, and we're an independent -- we were an independent rural health.

MS. JOHNSON: Okay, great discussion.

You know, part of me thinks that this may be a little tangential but maybe not. I think we probably need to understand some of these reimbursement issues a little better.

And I'll be coming back to you later because some of what you said was over my head and we'll get the details before we publish anything.

But, let's go to CHCs and Aaron is going to talk about CHCs.

DR. GARMAN: Thank you all.

Well, the FQHC program has actually been around since 1965, so we're celebrating our 50th year of service.

FQHC is our nonprofit community-directed providers that have to have a Board of Directors, community Board of Directors that composes at least 50 percent of their Board.

As of 2013, there were 1,200 organizations with 9,170 delivery sites. FQHCs served almost 22 million patients in 2013.

So, when we all get together and talk,

we're the largest health care delivery system in the United States.

About 50 percent of FQHCs are rural. The origination is to provide access and affordable care to the underserved and uninsured.

There's a huge push currently for FQHCs to follow 19 program requirements, one of which is a robust CQI program. I've got the other 18 if you're interested, but I don't think you will be.

At FQHCs, obviously, there's a wide range of services that can be provided. In rural areas such as myself, we do prenatal care and primary care. We cover emergency rooms. We cover the hospital. We cover the nursing home. We provide hospice care.

So, we have many hats and are pulled in multiple directions. I think that's one of the big challenges for rural providers is that it's great to talk about being able to sit down and talk about quality measures if you have the time to do it.

But which quality measures do you talk about? Do you talk about those that you're providing at the CAH? Or do you talk about those that you're providing at the FQHC? Or do you talk about those that you're providing at the nursing home? Where do you give your time?

As an FQHC, we do a lot of reporting, but I'll go into funding first. We are funded with federal grant dollars. We have a noncompeting grant that we have to fill out an application for every year. And then every three years, we have a competitive grant.

Both Medicare and Medicaid are reimbursed as flat fees. Medicare is billed through Part A and lab and x-ray components are billed through Part B. Medicaid, again, is a flat fee.

Other insurance is typical fee-for-service. We also get other grant dollars if you provide other services such as behavioral health, you can write for other grants.

Some benefits for being an FQHC

include FTCA coverage. However, with FTCA, we also have gap insurance because we don't necessarily trust FTCA coverage. And also, we have a 340B drug plan which is a great product for our patients.

Measurement, we utilize -- every year, we have to fill out a UDS or Uniform Data Set of measures sponsored by the Bureau of Primary Health Care. That follows the National Quality Strategic Plan.

And that goes through demographics which are cross-linked for all unique patients. The quality measures include entry into prenatal care or early entry into prenatal care, childhood immunizations prior to the third birthday, cervical cancer, weight for adults and kids, tobacco use, pharmacological therapy for asthma, CAD and lipid-lowering therapy and ischemic vascular disease.

One of the other measures or other programs that we have is VFC, so vaccines for children and also commercial products provide

quality measurements that we have to comply with or should comply with.

But the problem gets to be that all of these measures have little different tweaks. So, our UDS, for instance, we have to report all of our A1Cs less than nine and for everything else, it's A1Cs less than eight.

For immunizations for UDS, it's all kids up to their -- prior to their third birthday. For everything else, it's kids up to their second birthday.

So now, when we do these measures, we have to duplicate them multiple times and run data on multiple different fields to be able to figure out where we're actually at.

Other challenges, and I am the plumber of the group, I am the one that fixes the toilets in my facility, and so, you know, I shingle the roof and fix the toilets and do what you have to do to make a go of it. But, weather is a challenge, trying to get patients into the clinic can be a very big challenge.

And staffing, you know, staffing is a huge issue, especially in rural North Dakota with the oil that's filtered into the western part of the state, we lose a lot of people to the oil fields. And so, trying to find quality people that can work in a clinic is very challenging.

The rural health institutions, the CAHs in our area, really have significant challenges with that. And it's very interesting that despite the increase in volume, pretty much all of the Critical Access Hospitals in the western half of North Dakota have lost money every year since the oil came into play. They're seeing a lot more volume, but they're not getting paid for it.

So, that is FQHC in a nutshell.

MS. JOHNSON: Thank you.

I have one question for you, Aaron. You talk about FQHCs, and I understand that there are different types of clinics that fall under those. There's the community health centers and then there's some migrant centers and some other

ones.

Do we need to make a distinction for our work here and talk solely about CHCs or is it once you understand rural FQHCs, it's --

DR. GARMAN: That's a very good question and I do think there are some distinctions.

As far as funding, I don't believe there are. As far as measurement, I don't believe there are. But, it's very challenging for our migrant centers and also our centers who have a large homeless population to be able to capture data.

I mean if somebody doesn't have a place to hang their hat, no home, how do you capture that? So, it is a big challenge.

MS. JOHNSON: So, the biggest challenge is the patient population and the difficulties there. Okay.

Marty?

MR. RICE: So, one thing that isn't brought up much is that we have an all voluntary

military and a lot of the military folks come from rural communities to seek a better opportunity.

A report that we did a couple of years ago, what we found was is that when someone, unfortunately, gets injured in war and has become disabled, the VA takes care of that injured person, the injured military person.

But the family is not covered under the VA health care. So, where does the family from, you know, go to seek medical health care, to seek hospital care, to seek dental care? If maybe their breadwinner is not able to work and usually, it's federally qualified heath centers, rural health centers, Critical Access Hospitals.

So, to put a face on some -- you know, when we talk about safety net, we also have to look at the people who are involved within the safety net. And some of them, unfortunately, are kind of stuck and they get great care at these facilities.

But I just wanted to bring out the

military, even though VA takes care of the military person, the families are taken care of in their communities.

Thank you.

MS. JOHNSON: Okay, Michael?

DR. BAER: Two questions. One, the FTCP, that's the Federal Court Claims Act, and so you actually have a -- so that's medical malpractice?

So, if you work in a FQHC, you don't need to have malpractice, but you say you cover -- you carry a gap coverage for that?

DR. GARMAN: Correct, because the issue with FTCA, Federal Tort Claims Act, is essentially, it's free malpractice insurance for those practitioners in a FQHC.

The problem gets to be when we fill out our scope of service which is a form that we have to fill out for the federal government, we list all of the services that we provide.

Well, on there, it doesn't say anything about me seeing a kid at a basketball

game for a sprained ankle.

It also gets really gray when I leave my center and I go to the hospital and provide care to a patient who's not a health center patient. Who covers that?

So, that's why I said I don't really trust it. It's a great program and it benefits me tremendously, but there are gaps in that and that's why we have to have gap insurance.

Thank you.

DR. BAER: The second question, can you compare and contrast, if you can in any quick way, what's the difference between an FQHC and an FQHC lookalike?

DR. GARMAN: FQHC lookalikes have to fulfill all the requirements of an FQHC that's practicing. The only difference is lack of grant funds.

DR. BAER: Say that again?

DR. GARMAN: They don't get the grant dollars. So, as an FQHC, we get grant funds every year and an FQHC lookalike does not.

They've applied, they go through all the motions, they have to do all the reporting, but they don't get grant dollars.

DR BAER: What's the advantage of doing that?

DR. GARMAN: Of being an FQHC lookalike?

DR. BAER: Yes.

DR. GARMAN: Increased reimbursement, perhaps, but not --

DR. BAER: What about the 840B pharmacy stuff?

DR. GARMAN: 340B?

DR. BAER: 340B.

DR. GARMAN: 340B pharmacies, essentially, what happens, and this gets a little bit complicated, but we, as an FQHC, are able to procure pharmaceuticals from a large company such as McKesson, for instance for a discounted rate compared to what anybody else could get them for.

In turn, when we use our local pharmacy, when our pharmacist goes to -- when we

prescribe those medicines and our patients go to pick those up, if they have insurance, that medication is sold at the usual customary rate, whatever that is across the nation, normal customary fees. So, we make a little bit more money on that, no our end.

And then, every patient coming to the health center fills out insurance or financial information. If they fall into the Federal Poverty Guidelines, they can qualify for discounted care either at our center, which is one of the benefits, or at the pharmacy. So, they can receive a 100 percent discount of their pharmaceuticals at the pharmacy based on the 340B drug program.

And the way that that money is made up is that small margin that we make up when we purchase those pharmaceuticals. So, it's really McKesson or the other large entities, the pharmaceutical companies, that are essentially taking that hit.

As an insured patient, you don't take

the hit, you pay what you'd pay no matter where you go. As an uninsured patient, you get the benefit but the money is made actually in the small margin that we make on the drugs.

MS. JOHNSON: Kelly?

CO-CHAIR COURT: Aaron, you talked about 19 program requirements that includes a robust quality program and you talked about UDS with quality measures.

So, who requires those? Where does that data go? And what do they do with it?

DR. GARMAN: The Bureau of Primary Health Care tracks the UDS form and it's done yearly. And it's a very robust form and it's a very robust amount of data.

This is just the quality measures. There's also financial measures that we have to gather, but that goes to HRSA and to the Bureau of Primary Health Care.

CO-CHAIR COURT: And then, what do they do with that data?

DR. GARMAN: They -- well, that's a

very good question.

Some of it is political, they use it to say, hey, look how good our health centers are doing. And I think that translates up on The Hill as far as funding for health centers because the quality metrics that we have obtained do show significant improvements in care and also lower costs for our patients.

But, it's also a measure of how the program is doing as far as accountability for the program. So, when somebody else in the federal government comes up and says, well, we don't like this program, how is it doing? You've got the data to support how well your program is doing.

CO-CHAIR COURT: And is that the same thing as your 19 program requirements?

DR. GARMAN: No, totally different.

CO-CHAIR COURT: Where does that come from and what happens to that data?

DR. GARMAN: That's really not so much data. The 19 program requirements are things like you have to have open access scheduling.

You have to have a CQI program. You have to have appropriate staff in place. You have to have a place for your patients to go if they don't -- if your center is closed. Those are the 19 program requirements.

CO-CHAIR COURT: Don't the FQHCs, though, submit other measures like diabetic measures, immunization measures, to a central repository somewhere?

DR. GARMAN: That's part of the UDS measures.

CO-CHAIR COURT: Oh, okay. Thanks.

DR. GARMAN: Yes. It's a huge process.

DR. LANDON: Those are not patient level, though, I think they're aggregate.

MS. JOHNSON: Okay, great.

Now, I know we're at our time for break, but I think we should go ahead and finish this setting.

So, Tonya's going to tell us a little bit about small practices. Yes, she didn't know

she was going to, sorry.

MS. BARTHOLOMEW: Let's see, what do you want to know?

Small practices, I think in our initial webinar it was mentioned that those are the practices that we're really trying not to leave behind through these quality measures.

And there are so many things that we need to empower these practices with in order to keep up with the times, to keep up with the quality reporting.

A lot of them, at least in our state, are being encouraged to Become Patient-Centered Medical Homes for quality measure reporting.

We just received our Level 3 recognition, so I'm really proud of that, especially with three providers and an occupational therapist filling out the application.

A lot of the small practices are in conjunction, Rural Health Clinics. Like I mentioned, the reimbursement rates aren't

supporting the costs of providing for these patients.

Currently, transportation is a huge ordeal, telehealth is a huge ordeal. I'm trying to get that -- the specialists to cooperate with these small clinics to get our patients that access to the rheumatologist or the infectious disease specialist. It is a real challenge, even though they can sit down at their desk and easily see the patient and charge an E&M code.

I think, as far as the quality measures, it's kind of a chicken and an egg scenario. In order to afford to pay that person to run the data reports, to contact the patients and to gather that quality reporting measurements, you have to have that financial background to support that person to do that.

But often times, that financial incentive or background does not come until after you do that quality reporting measurement.

So, I think small clinics often times rely on a lot of philanthropy, to be honest with

you, to keep the doors of the clinic open, to keep access available for patients and, in turn, report quality measures.

So, I think that is one of the biggest challenges then is to how do you recruit these small practices? It's been mentioned before here this morning, time. It's when the physician is, you know, fixing the toilet, going out to do an end of life care visit, cramming 20 patients in a day.

How do you find time to do this quality measure reporting and what is most important? What is going to be useful in helping these patients achieve better health? And that's what it comes down to.

So, I think there's just a ton of challenges within that.

And then, of course, we've already mentioned the staffing issues. Living in a small town of 1,700 people, to find someone who's competent and reliable and able to do this kind of stuff is very difficult.

MS. JOHNSON: So, thank you.

Kelly?

CO-CHAIR COURT: Thanks, Tonya.

I've struggled with trying to figure out what's the difference between a rural primary care -- as it relates to measurement -- a rural primary care practice with three providers from a nonrural primary care practice standalone with only three providers.

So, it would seem to me, and so help me understand, wouldn't they all have the same kind of resource constraints and, you know, clinical island, if you will? So, what makes it different in rural?

MS. BARTHOLOMEW: Well, you're not operating under an umbrella of administrators as a standalone clinic. If I'm understanding your question correctly, we are not -- we don't belong to -- we're not owned by a hospital, we're not owned by an umbrella of entities where maybe they do have a practice administrator to provide me or they do have an IT person to provide me.

But truly, a standalone, you are out in the middle of nowhere, 40 miles away from the nearest other health care provider, you're it. You've got to figure it out and you don't have someone to go to to do those things and solve those problems for you.

MS. JOHNSON: Okay, I wasn't paying attention to who got their flag up first.

DR. BAER: Oh, it was a quick question.

So, a town of 1,700, you have 2,800 patients in your practice, so is everybody in your town in your practice? And what's the radiance from which they come?

MS. BARTHOLOMEW: Pretty much everybody in our town is in our practice. They come from at least a 40 mile radius on a regular basis. So, in Wyoming, you've got weather conditions to contend with, so that, again, that telemedicine is a huge component of what we need to do for our patients.

MS. JOHNSON: Aaron? Oh, sorry, Bob?

Whichever.

DR. RAUNER: Well, one, I credit Tonya to get to Level 3 NCQA, the paperwork slug of that in your size practice is huge. So, kudos to you for that.

My group is essentially almost 12 versions of Tonya's and that's partly literally, we formed the ACO not because we wanted to the ACO, because we want to do all of that and we have no way to pay for it.

The way to pay for it was to get an advance payment to basically fund myself and an IT person to help the clinics do that because that's the critical problem in rural areas.

It's not a sample size because I would bet her husband sees more patients and has a bigger panel than most urban people. So, it's not a sample size at the clinic level issue, it's a capabilities, having someone who has the time to pull quality measures out of a really badly designed EHR which most of them are for this type of thing.

And so, it's really what they need more than anything else, I think and correct me on this, is they need people who can do this stuff because they don't live in Saratoga probably.

And then having somebody who has the time to do that stuff. So, that our IT person, she actually goes to one of our smallest clinics and literally can dial in from her basement in her bunny slippers to the Broken Bow Clinic and pull this stuff for the clinic so, Tess, who's our version of you, doesn't have to do it. That's literally the biggest issue.

So, the quality from a small practice is not the sample size, it's the staff, the time and the payment because fee-for-service doesn't -- if actually a Patient-Centered Medical Home may hurt them financially on fee-for-service unless they get per member home out there or something like that and you may clarify some times.

But I know you guys well, because I used -- I grew up about 150 miles from you.

MS. BARTHOLOMEW: Yes, currently, the Patient-Centered Medical Home is killing us financially because of the time it has taken to fill out the application, the time it takes to negotiate with the payers, but then it still comes down to those quality measures and how are we going to use those quality measures.

However, my patient care coordinator, she answers the phone, she runs telehealth and that's the key thing with the rural clinics is that nobody has just one job, it is just so much multitasking and those staff are really hard to find.

MS. JOHNSON: Aaron?

DR. GARMAN: I would like to speak a little bit to your question, Kelly, as far as what's the difference? Why three docs in an urban environment versus three docs in a rural environment?

Well, right now, today, there's nobody seeing my patients because I'm here. And my partners are busy.

The other thing is, when I am there, I'm there seeing patients but also I have to go over to the hospital to see an ER patient. I have to cover my patients in the hospital. I have to cover the patients in the nursing home, might have to go make nursing home rounds. I might have to go for a hospice meeting. There's nobody else to do that.

So, it's not like a larger city where you have hospitalists, you have people to do those jobs. We are those people that do those jobs. There's nobody else.

So that, I think is the biggest difference is we're pulled in 15 different directions all the time. And if one of those things is reporting, which one do you think? Is Bob's heart attack going to take precedence over PQRS measures? Yes, it is.

And I've got to still fix the toilet.

MS. JOHNSON: Guy?

DR. NUKI: I was actually going to say exactly what Aaron said, so I almost turned my

sign down.

But I just wanted to add one thing, that does make for a low volume issue, though, because if you are acting as the hospitalist, delivering babies and seeing diabetics in your clinic, the number of diabetics is going to be a little bit less even though you're probably seeing more patients, you're the obstetrician, you're the hospitalist, you're everything else.

So, it does actually end up causing a problem with numbers.

MS. JOHNSON: Ira?

CO-CHAIR MOSCOVICE: So, just a couple of responses to Kelly.

The first is, I'll speak for the Twin Cities. There are very few three physician practices. Now, maybe on Park Avenue in New York, you have concierge doctors who are solo, don't take insurance. But, there's been such consolidation in the system that there's very few small practices in major metropolitan areas.

But I think the points that have been

raised really point out that we have states and Wisconsin's one, our state, Minnesota, and there are other states where it's a network that you're a part of and that's where you get the support. Or it's a QIO and the rep that they have that's providing the kind of support needs.

These practices can't do it on their own and what we, I think, need to figure out is, you know, what are the vehicles? What are the strategies so that every state has the ability to help, you know, practices like that. And then, how that feeds into the quality issue is the larger issue.

But, they can't do it alone. We're not going to be able to figure out a government program that's going to help every small practice. We need to figure out strategies that allow others to network with those facilities.

And, you know, you hear this and it's just, you're sitting here, you know, beyond belief saying, if you don't live in those small towns. I mean, they're saying what it really is.

Tonya's writing grant proposals, doing OT and God knows whatever else.

And we need to figure out a way so that the kinds of services that a good network, the good QIO, a good hospital association, how we get that available in every state so that small practices can survive.

MS. JOHNSON: Marty?

MR. RICE: Health care isn't my first profession. My first profession was accounting and one of the interesting things about going into becoming an Advanced Practice Nurse as an adult, if you kind of look at the business process of it.

And I think that one of the things that we need to look at as health care professionals and people in public health is that even though the practice of medicine is the same, we all give good care, we hope.

But the workflow is going to be different in every setting and I don't think we always look at the workflow. And you can't, even

though the medicine is practiced the same, we have to look at how it's actually practiced in that setting to make judgments and to set measures of how those outcomes come about.

MS. JOHNSON: Brock?

MR. SLABACH: Just a couple of quick comments.

First of all, I think that the statistics are noting at least in rural communities around the country that about between 75 and 80 percent of physicians are now becoming employed by hospitals or health systems.

So, the market, I think, has kind of taking -- having an impact in the very problem that you're talking about because those system resources are necessary to do the very things that we're talking about here.

Secondly, for recruitment, by definition, most of all of these places that we're talking about are in what's known as Health Professional Shortage Areas, or HPSAs. And by definition, there's not enough providers for the

population served.

And I have physicians in my hospital, in our clinics that say 70 patients a day.

I will point out that also in that context, most rural emergency rooms see over 50 percent of their volume as primary care visits.

So, you have access being received through the emergency department in these communities, which we all know isn't the best source of care, but it is, of course, if it's the only source for many of these folks, that's another backstop, if you will.

And so, that's why we're particularly distressed over 47 rural hospitals that have closed in the last four years, we're projecting another 283 probably over the next couple of years that are in very similar situations.

So, as we start to project here, I think, and again, it's important to understand, that sometimes the market works, sometimes it may not work so efficiently in these issues and we have to be conscious of the fact that there are

stresses in these local communities that do produce those kinds of reactions that we're seeing.

MS. JOHNSON: Jason?

MR. LANDERS: This is kind of a question and kind of a question to you in general and maybe a bigger question to the group.

But, I've been on the practice administration side and on the payer side establishing PCMHs and now I'm on the Medicaid side paying for all the Medicaid care.

But, one of the common things that come up, especially when I was establishing PCMHs was the time to mine out data from their EMR.

Someone talked about poorly constructed EMRs, and not only the time, but the expense because often you have to have custom reporting to draw the right reports out.

And in deference to my neighbor here who was on the epic side, it seems that the big winners in the Meaningful Use money were the EMRs themselves because they had federal dollars

coming in to pay for those.

And yet, they've established a system where there's no commonality in reporting and there's additional fees to develop reports. I would think that bringing more -- putting more emphasis on the reporting from the EMRs and kind of creating a very common and some method of you write one report for PCMH or UDS measures or PQRS and it works across platforms.

I mean as I talk to people like you, that's really the one thing is I go to them and I'm wanting my five measures for Medicaid, West Virginia Medicaid reported out and I've got, you know, 300 providers in West Virginia that are small providers and the one or two docs and you're in OT. But I mean it could be an MA or whoever that is kind of charged with getting us that information.

They don't have time, they don't have the money and that's really the barrier for getting good data back.

So, am I kind of on to the problem or?

MS. BARTHOLOMEW: Absolutely, and it goes back to what Aaron was saying is that he reports on the same measures but they're tweaked a little bit. The hemoglobin A1C is eight for one place and it's nine for another place. And that's the problem that we're running into is all of these little entities have their own little programs but these providers have to almost develop these fingers that, you know, specifically report on this program and specifically report on that program.

And again, it comes back to time and resources and money and I've actually been working with the Wyoming State Medicaid Program, this is probably -- I should probably say this, should have so this is the disclaimer, to design the Patient-Centered Medical Home attestation form and their big push is we want practices to participate.

So, we need to make these measures the same as what other people are asking for because otherwise, then you do lose money and you don't

want to do the quality reporting if you're having to report on the same things in different ways. It's a huge problem.

MS. JOHNSON: I want to have Tim then Kim and then Jonathan and we need to look at the clock, unfortunately. And Helen, I'm going to get you in here, too. We need to stop, have a hard stop at 11:00 so we can have a short break and we still have to talk about small hospitals.

MR. SIZE: I'll try to be quick and it's just an observation and, Karen, I compliment you on so quickly helping us bring out all the complexity of this topic.

And I'm just going to make it a little worse, I think, by reinforcing a couple of threads.

I think Brock may have been the first person to mention the word market and a lot of the conversation that I've heard before underneath it had more of a frontier tinge or maybe I misheard.

Most rural population is adjacent

rural and easily within driving distance of aggressive urban outreach and health plan or system.

I've got three meetings with insurers coming up in the next three weeks that we've invited in terms of pay-for-performance measures because we desperately want to have a mechanism to show our people can do the work and are doing the work.

So, this conversation isn't just about Medicare. In our state actually, and I think we're somewhat of an outlier, I think we're beyond 50 percent of our Medicare population is in Medicare Advantage. And not withstanding all the complexity we can get into around ACO development, Medicare Advantage is not going away in my mind.

So, the commercial side of this conversation is very important to some of us and that we not be left behind because I think if we're left behind the metrics, our practice sites will be left behind as more and more people

migrate away from them.

So, I just wanted to make our complex conversation just a bit more complex.

MS. JOHNSON: Tim?

MR. SIZE: You're welcome.

DR. RASK: Tonya, I have a quick question.

When we were talking about the rural health clinics, we talked about some of the billing issues and that made it around the Part A versus Part B which is a problem for reporting for PQRS.

Now that you're a small off practice and not an RHC, does that problem go away?

MS. BARTHOLOMEW: We report for Meaningful Use and PQRS and Patient-Centered Medical Homes.

But, I do want to say I think we're the exception to small clinics. Most small clinics are still using paper charts. Most small clinics are not reporting quality data.

So, I think our challenge here today

is how do we reach out to those clinics and make it feasible for them to do this? Because their quality measures, they're going to make a difference in the cost-effectiveness of health care.

MS. JOHNSON: And Jonathan and then Helen?

MR. MERRELL: Yes, I just wanted to first give rebuttal to Jason about his comments toward Epic, but --

Actually, I wanted to really go into talk about a little bit more about the history of Health Center Controlled Networks and the commonality of many of the programs that we've talked about through HRSA.

And the history behind the Health Center Controlled Network was in about 2002/2003, HRSA issued a series of grants to start the HCCN, the Health Center Controlled Networks, which were essentially small organizations that would provide electronic medical record, data aggregation and reporting and quality improvement

services for FQHCs and CHCs and RHCs.

Has anybody heard of these programs? The HCCNs? Is anybody a part of one or use one? I'm kind of surprised, again, there's, you know, pushing 5,000 docs now on OCHIN's version of Epic, in almost 22 states now, in 22 states by the end of 2015, several million outpatient visits. So, we can see the number of the percentage.

I think 50 percent of FQHC visits go through OCHIN Epic. I think that's the size and the scope of OCHIN's Epic.

Now, you know, Epic is not Epic is not Epic from one organization to another. So, all 5,000 of these physicians are using one customized instance of Epic.

So, whenever I get that power of data that's comparing apples to apples to apples, and as the Vice President of Performance Improvement, I would work with our FQHCs and so I know 22 state Medicaid programs. I know hundreds, maybe thousands of payer organizations that can turn a

definition of hemoglobin A1C as many possible ways as possible.

And it was my obligation at that Health Center Controlled Network at OCHIN to get that reporting out the door for that organization so that they can get reimbursed or that they can participate in local quality improvement efforts, HRSA, state, local or federal quality improvement efforts.

So, I think whenever we talk about those resources and identifying those resources, if you're an FQHC, a CHC, an RHC and you are not participating or partnering with the Health Center Controlled Network, you need to really look at that.

And I'm not selling OCHIN and I no longer work for OCHIN, but there's 60 other Health Center Controlled Networks across the country. They're great resources and that's why HRSA's fond of funding to get the HCCNs off the ground.

MS. JOHNSON: Thanks. And Helen?

DR. BURSTIN: Just to make a brief comment about some work we've been doing with CMS and all the medical directors of the large health plans through AHIP on alignment.

And so, it's actually really interesting to hear that that is a particular issue in the rural areas as well.

And it'd be helpful to try to get a sense of, are the unique issues in contracting in the rural areas with health plans, that might actually color our discussions between CMS and the health plans around alignment.

Are there specific kind of programs that are more likely to be part of the health plan, private health plan, environment or even, you know, for example, some of the public programs as well?

We've done some work as well as part of the initiative called Buying Value. We've looked, for example, at the state measure sets across 26 states, an analysis that Mike Bailey and Associates did for us we'd be happy to share,

that overwhelmingly showed, you know, I think it was about 1,300 measures used across 26 states just internally within states.

Huge disagreement within states across programs as well as between states and a lot of what they called tweaking of measures. They say they were using the NQF endorsed measure but they'd lop off the second weight or they would change the population.

So, we've really been interested in this issue of both comparability but also this issue of alignment.

So, if there are ways we could really learn about specific issues in the rural community, make sure that they're part of those discussions ongoing, it'd be really valuable and I hope valuable for you as well.

MS. JOHNSON: And we have five minutes before I'm going call a hard stop and let us take a bathroom break here.

But, Greg, you were going to tell us about small hospitals, so let's talk about that

and I'm sure we can come back and do some of these additional questions when we come back.

DR. IRVINE: I'll try to keep it brief so everybody can get to the bathroom.

I'm going to talk about this from a very personal point of view. I'm a surgeon that works at a Critical Access Hospital. I'm so naive, I don't even know when Karen asked me to do this what the difference between a Critical Access Hospital and a small hospital is. We are a small Critical Access Hospital.

I work in small rural hospital in the mountains of Idaho. We are 150 miles from any other hospital. I have patients that come to see me on snow machines.

We are the main health care provider for West Central Idaho, the only health care provider as a community access hospital.

I came there four years ago, allegedly to semi-retire. I came from Portland, Oregon where I was in a large group practice and got burned out and thought I was coming to nirvana.

I found I just stepped in to a much different set of problems and that's partly why I'm here because rural hospitals are floundering.

My hospital has 12 beds, two operating rooms, emergency room, we do obstetrics, we have lab and imaging, we have no ICU. We do infusion services. We're staffed entirely by primary care providers except for one general surgeon and one orthopedist, family practitioners and internists in mid-levels.

We have some part-time traveling specialists that come to visit us, mostly to go skiing from time to time.

And we have unique challenges in our Critical Access Hospital and I'm not an expert on reimbursement. I'm not an expert on acronyms and I don't pretend to be. I fix bones and joints.

The unique challenges that I have in my hospital are recruiting and training providers, especially nurses. Fully half of our nurses now are doing reporting functions and the other half are doing patient care. That's

untenable, it can't last, but we're pulling nurses constantly to do reporting functions to try to stay up with our reporting.

We have a widely disbursed patient population. I have farmers and ranchers that drive two and three hours to see me. I get patients from East Oregon, Eastern Washington, the mountains of Idaho and so on.

That patient population is very challenging to manage. If I operate on somebody from one of those ranches out in the middle of nowhere, I frequently never see them back again. I think they take a set of needle-nose pliers and take their staples out and then they're done.

These are independent, self-reliant patients. They are not people who are interested in follow-up. They're not interested in A1Cs. They're interested in getting back to their ranch and getting on their tractor and doing their job.

We have very small numbers, low denominators. My nurses are collecting data for quality measures for six patients a year that's

sent somewhere that we don't know what's done with that data and if you look at that data, it's meaningless. It has absolutely no impact on patient care. It's siphoning resources. It's creating problems.

This critical access designation in our hospital does allow us, having come from an urban center, I discovered when I came to a Critical Access Hospital, that I wasn't subject to PQRS or DRGs or Joint Commission and I have in-house rehab where I can rehabilitate my patients in the house. Those are definite advantages for me as a practitioner. It's a world of difference.

But there are a new set of problems that we just outlined.

I thought I'd use one quick example and then you can get to the bathroom, of sort of my very close in look at quality measurement.

We discovered after I came to Idaho four years ago that we have a zero percent surgical site infection rate and we wanted to

know why. In fact, the system that we work with wanted to know why we have a zero percent.

Was it that we were using antibiotics within an hour? I did that in Portland and I had a very average surgical site infection rate in Portland.

Was it because I use clippers rather than a razor to prep the patient? Another SCHIP measure. Well, I did that in Portland, too.

Was it because I was such a great surgeon? I'm pretty much the same surgeon I was in Portland.

Was it because we avoided hypothermia? No.

Was it because we had tight diabetic control? Probably not.

We discovered that the reason that our surgical site infection rate is zero is that we have a comorbidity index and we're operating on patients who are healthy and have a BMI of under 35 and are great candidates for surgery. And that's the main determinate as to the surgical

site infection rate. That's how you pick your patients.

Well, all the other folks that don't meet our comorbidity index go elsewhere. They have to, I don't have an ICU. I don't have specialists. I don't have ID guys, so I send them to Boise and they get operated there and they get their SSIs down there.

So, we have to look a little bit at what we're measuring, what we're doing and that's what I hope we can accomplish this next couple of days.

MS. JOHNSON: Great, any burning questions for Greg?

Okay. If not, let's come back, I'll give you a quick break. Let's come back at 10 after 11:00 by this clock.

(Whereupon, the above-entitled matter went off the record at 10:58 a.m. and resumed at 11:11 a.m.)

CO-CHAIR COURT: Okay. So our next book of business, if you will, is we're going to

spend -- we're going to take about a half an hour here. So, we're just a little bit behind. We're going to try and catch up.

What we want to do here is reach consensus on the four or five main issues that we are going to want to focus the rest of our time together in the next two days trying to create some possible solutions to.

So, there's great discussion about the challenges and there's some themes here. And many of the themes match what we all submitted in our pre-work. So now we need to kind of narrow down the list, and that will be the focus of our solution creation. And if we get to others, that would be great.

One thing that I want to -- had kind of a personal observation and maybe challenge us to think about is, all of our discussion today was relative to the challenge from a provider perspective.

So, as we do our work, we should also be thinking about what patients want, need,

deserve so that we don't become so provider-focused that we lose track of the patients. That's why we all do what we do every day.

So, I think that's an important perspective to keep and I think it's designed for us to be provider-focused because that's what we all do, but let's not forget our patients.

And we know we're going to talk about low-case volume next and possible solutions to that. So we've got the work from the homework. So, alignment, data collection. And it sounds like there was a lot of theme around resources, lack of systems related to data collection, use of this, you know.

So we've got all this data, but so what? What are we, you know, the measures might not be meaningful. How do they get used? And if it's just collect data for data's sake, that's an interesting administrative exercise that takes us away from doing what we all want to do every day. And then there is issues related to how the data gets used.

One issue that I thought is not really on this list that came out in many of the discussions this morning was challenges related to how rural providers bill. So the whole Part A/Part B, that was -- I had never thought about it like that, you know. CPT codes, not CPT codes and I get lost in some of that, but, you know, the current national federal programs are based on billing systems that don't support that. So, to me, that was a new issue.

So I'm going to open it up here. I think Karen is going to help us take notes or -- let's try and figure out which are the additional four or five things that we really want to say, yep, these are the things that we think are most important to work on first.

Go ahead, Bob.

DR. RAUNER: Okay. I'm still trying to think through this in my own head, too. So, and maybe this may be a little jumbled, but one of the things I see as an issue is that the measures that a health system insurance plan

looks at are different than the measures that a real hospital wants to look at, and, yet, are different than the measures that a clinic wants to look at.

I think that's part of our challenge here is that we're -- we've got three different groups in the room who have three different perspectives.

So do we want to try and solve each person's, or do we want to find at least some measures that unite all three?

One I would posit out there actually is a medication reconciliation, since that's literally our number one quality focus area because we have so many problems in that world, you know.

I'll finish with an anecdote. One of our newest clinics started -- we were trying to get the buy-in on the whole medical foam, care coordinator thing and the way that we have it now because in the first two weeks they ran into three med errors, two of which were potential

readmissions.

One was a patient who was on Coreg 6.25, got mistranscribed in the ER at admit to 25 -- so quadruple their beta-blocker dose -- and went home with that, because nobody ever bothered to reconcile that with the home meds.

They -- their first -- that was Day 2 of the care coordinator starting her job doing transitional care work. And that was the, you know, Day 2 ran into that one. So, wow, maybe this is a good thing to do.

Second, the next week ran into two issues. One was a Lisinopril Thiazide that got mistranscribed to just Lisinopril. So, didn't get her Thiazide. Maybe not as big a deal. But when they brought her back in, her weight was up six pounds.

Maybe that's minor, but several days later, again, similar issue where it was the patient didn't restart her on Lasix. And that patient was up 10 pounds and symptomatic.

And so, within two weeks, we have

absolute buy-in from those two care coordinators because they found it that quick. So, med reconciliation is such a huge issue that I think can unite to hospitals and clinics because they have decent sample size for that.

They may not have surgical size because they may not have enough surgical sites, but they have a lot of admissions and med rec applies to almost all. So, hopefully that makes sense.

CO-CHAIR COURT: So, let me help trying to put some framework around that as it relates to measurement for P4P.

Is it the lack of alignment of measures between the ambulatory side and the hospital side, or that the people or organizations are using the same measure with a different definition for different purposes?

How do we frame that issue as it relates to measurement for P4P?

DR. RAUNER: Yeah. Well, in the hospital I'm not sure if that actually is an

incentive measure at this time.

However, in Medicare Shared Savings Program, I think it's the first of the 22, is med rec. In the first two years it was med rec, but only post-discharge. But this year they have changed it to just every single visit, which we like because that's what we started doing.

You've just got to do this every single time, not just post-discharge, because it's such a common problem.

So, I think it should be added to a lot of hospitals' incentive measure because it's so important. Because if we both have financial incentives for it, we'll both focus on it.

And to do it well, there needs to be better interchange between the hospital and the clinic because so frequently people get admitted, especially when it's a rural patient who goes to the urban hospital. They just never bother to even talk to us to find out whether that med list was right or wrong or not.

And that's probably the most common

errors I've seen in things, and I can give you lots of stories on that of falls from excess beta-blockerage because there just is not that communication from the urban center back to the small-town family doc to make sure those meds are right, which leads to people being on two beta-blockers at the same time and whatever formulary switches and all that.

So, I think med rec needs to be like -- if you're a quality chasm, I think that is the number one source of medical errors in the country.

So, does that answer? Sorry.

CO-CHAIR COURT: So, Greg, you're shaking your head. So, help us.

DR. IRVINE: Well, and I think one of the real problems here is that we are -- a lot of us are caught in the no-man's land between EMR and paper charts.

A lot of rural hospitals are still using paper charts, including mine, but our clinics are using the EMR.

And a lot of these med rec issues and so on relate to inability to transfer data in a seamless fashion from one setting to another. And things get missed when you do that.

And until we can have a seamless integrated EMR that truly can communicate with other hospitals, other systems, I'm beginning to think that might be a pipedream. But until we have that, we're going to have that problem.

CO-CHAIR COURT: Brock.

MR. SLABACH: Oh, thank you. Just a quick comment and follow-up. 83 percent of critical access hospitals have attested to meaningful use Stage 1. So, a lot of them are on information systems and they do the medical reconciliation process.

CO-CHAIR COURT: Is it Michael?

DR. BAER: Yeah, Mike. So, our job right now is to maybe look at this and look at the categories in which -- so, I'm thinking I'm hearing what this discussion is about is use to improve care.

So, I would agree that, in addition to low volume, you know, the measures should be that we agree upon should be in the use-to-improve-care category.

Is that what we're doing? Is that the --

CO-CHAIR COURT: Right.

DR. BAER: -- the goal?

CO-CHAIR COURT: Right.

DR. BAER: So, that -- I'm voting for that. And I think this is -- kind of speaks to that category.

CO-CHAIR COURT: And so, is that better summarized in that -- do we think if the measures are meaningful to the practices that we have in the rural setting, they would be used, or do we not have the resources and infrastructure in place to use them as well?

DR. BAER: My statement for that is what I'm hearing is if there is good medication reconciliation whether it's EMR or paper or whatever, you know, the category of use to

improve care, we would improve care. It's not necessarily that they have to have an EMR. So -- or does it have to have, you know, alignment.

I don't see this as an alignment issue; I see it more as this is patient outcome. We don't want to have these readmissions for, you know, quadruple the Coreg dose, which could cause a fall.

So, I would just say that that's one category that we might want to consider for our final list.

CO-CHAIR COURT: So, let me restate it though. Is the problem that we don't use the measures, or that the measures that we have don't matter?

Ann, or if you guys got an answer to that question?

DR. NUKI: So, I want to find out what altitude we're flying at, at the moment. From a 30,000 foot point of view, to answer your question, clearly if you ask your doc to spend four hours a day doing data extraction and they

see no meaning, you're never going to get it; it's not going to happen. And it's bad for patients, because that's four hours they're not taking care of patients.

So, if you want to focus on patients, which is what I think we all want to do, it's the whole purpose of doing this, the measures have to mean something.

If they don't or if it becomes just a game, then it's not going to help anybody. It's not going to help the patients.

And the physicians or the providers, all the providers in the rural areas are going to see that and say, we're just doing this to get dollars, it's just a game, it's not helping our patients. So, clearly they have to mean something.

You have a great story where somebody in three days found out that doing this is, you know, with the med reconciliation was meaningful, but are we sitting here now trying to come up with measures and the details of those measures,

or are we trying to look at a system by which we build those measures upon?

CO-CHAIR COURT: I think it's the latter, right, Karen? So, we're trying to create categories of major problem that then there can be activity.

We can start it, but there will probably have to be a lot of follow-up activity to start to find solutions to those problems then which will, you know, I guess we get to nirvana.

MR. RICE: So, the genesis for this project was simply to look at measures that are valuable in rural health settings.

I think it's a different issue that if it's -- there's different concepts for measures. But we looked at the measures and how the numbers that those measures were counting, the denominators, and they weren't representative of the care.

We all know that rural health settings provide great care, but the measures don't -- aren't -- the measures that were developed, in a

lot of ways, were made for high-volume urban settings.

So, I think the project pretty much surrounds how does it apply to a rural setting? What are the gaps for measures?

I would leave out -- the IT issues are the IT issues. We all know this. EHRs are what they are. We've made a lot of progress and -- but there's still some things that aren't working great.

But if we can look at the actual concepts of the measures, what do we want to measure in a rural community?

One thing we know is there's a lot of transfers from critical access hospitals to larger facilities, you know. Is that an applicable measure? We use that in MBQIP, but it's not being used in Hospital Compare.

So, I'll throw that out to try to center it a little bit.

CO-CHAIR COURT: I think Ann was next.

MS. ABDELLA: Yes, I've been leaping

up and down in my seat.

In the spirit of full disclosure, I forgot to mention that I run a small rural accountable care organization that's part of the Medicare Shared Savings Program, but we don't get any money. We've been doing this all on our own time.

And I think Bob's my new best friend because we have a lot in common, but I think there is -- I think it's an issue of alignment. I would vote for that one.

In the spirit of looking at total patient care and putting the patient in the center of all of this madness, there -- we have wrestled for years trying to move toward clinical integration and trying to figure out how do we come up with common performance measures with payers that get the physician activity lined up with what the hospital is doing.

And the one piece in this that I think we could -- we should be talking about, and there are probably others, is we're not mentioning

skilled nursing at all and you all have measures related to that.

And I get frustrated in these conversations because it's so hospital-driven than physician-driven, and it's as though that care is delivered in that vacuum, and it's not.

There are a number of community services and resources that have got to come into play in order to make sure that we're delivering good quality care. And that's a whole other conversation. And that's this version like 4.0 down the road when we get to the broader population health measures.

But I think that alignment between the ways that we can make sure that we link something that physicians are doing and specialists are doing, that hospitalists are doing and then hopefully we can bring skilled nursing into this, that makes sure that we've all got the oars going in the same direction.

And med rec is -- that's the big one that we obviously have an opportunity to tangle

with. But when you're dealing with CVD, you know, you've got people who've got chronic heart disease in the primary setting, in the cardiology setting, in the hospital setting and in the rehab setting. I just think there's some opportunity for alignment there.

CO-CHAIR COURT: I don't know who's next. So, Tim.

MR. SIZE: Two things. One, I just wanted to reinforce what Marty said. I mean, this isn't about what might be a good idea for us to do in our home court. It's actually we're here to make recommendations to Department of Health, Human Services, CMS about what we think is reasonable for them to use as metrics.

And maybe that sounds like the same thing, but to me it isn't. I think, so it's focusing on what we think is a credible set of behaviors for the federal government to kind of model where they haven't been doing it to date.

So, I come at this in a sense of having been left out of a very rapidly moving

train that's trying to document the care that's being done.

And I think increasingly we're going into a time where if you can't show you're not doing good, unless you have zero zero choices, you're 500 miles from whatever, you'll be getting more and more to choose to go elsewhere. So that's how I frame the issue.

I'm not a quality guru. I'm more of a rural system co-op guy. So, I did ask people back home kind of the answer to the question I think you're making.

Definitely in the first four columns make good sense to me and I think the way we said it back home was four filters we're looking for, for this conversation.

The first is metric obviously evidence-based in support to achieving the triple aim. And maybe all metrics claim to do that, but I think some have a claim that's more valid.

Second, the data is already likely being collected or not onerous to begin

collecting. So, I think it's the collection issue.

Third is germane to low-volume clinics, hospitals, nursing homes, what have you. And the fourth, the likelihood it is or could be publicly reported and uses part of a value-based purchasing scheme.

I mean, so that's four key filters I think for anything we do going forward, hopefully.

CO-CHAIR COURT: Bob.

DR. RAUNER: You kept asking questions and I kept wanting to say yes because it's so broad.

So, I think one way of looking -- if you can find measures that solve -- that address multiple bars on the graph -- so, you know, in addition to like med rec, for example, flu vaccination. That crosses so many different things.

One of the problems with quality measures is every focus group wants their

measure. Well, if you have a heart failure measure, an asthma measure and blah, blah, blah, that works for a health system. It doesn't work for the small hospital, because they only have two of this and four of that.

Well, if you can blend it altogether, that works better for us and that's why we -- internally, that's why we use them that way.

So, a flu vaccination gets around low-case volume because it applies to everybody above six months.

Alignment, just like the med rec being such a disparate problem because there's no common med list because of all kinds of reasons, similar problems with flu shots.

It sounds simple. Either you got it or you didn't, but flu shots are given everywhere and nobody talks to any, you know, Wal-mart is the worst right now, you know.

So, the hospital will tell us when they get a flu shot, but Wal-mart won't tell us. So, how do you track that well, which leads to

the data collection problems.

You have to have things work, things combine somehow. Both obviously are huge for improving care. They apply, they address gaps, they're risk adjustment irrelevant because they apply to everybody.

So, if we can find measures that work for everybody, that might be one of the solutions to the either is it this or that.

Well, if we can find measures that cut across and address the low-case volume, fix the alignment so we work more together and so impede that kind of stuff.

CHAIR COUNT: Yeah, I had thought about that, too, that -- I think part of the problem right now is measures tend to be disease-specific. And in a rural setting, you only have a few of those.

And so, then you get to that quickly where there needs to be more cross-cutting measures, you know. And PQRS has started to address that with those measure groups.

Tim, did you still -- we're going to have to coach Tim at lunch. Marty, did you --

MR. RICE: So, think about, you know, we're worrying about what the measures are out there.

I'm pretty basic. Don't worry about the measures that are out there now. Tell us how you do business. We'll find the measures.

What are the concepts that you work on within your hospitals? How do you actually practice medicine?

And then let's come up with the measures from there, because you're not -- the measures that are already created may or may not work for you, but the way you practice medicine is what's important right now and how it's practiced in a rural community.

CO-CHAIR COURT: Ira, you've got to poke me because I don't see you there.

CO-CHAIR MOSCOVICE: All right.

CO-CHAIR COURT: Thank you.

CO-CHAIR MOSCOVICE: So, Marty sort of

stole a little bit of my thunder. But what we should be doing, I believe, is exactly what Marty says. Basically, if we can give CMS a list with bullets that basically say here are the 10, 12 core principles behind a set of measures.

And I think, you know, responding to Guy, if we had some examples, that would help, but obviously you're not going to develop a list of 82 or 200 measures. That's down the road, hopefully.

But if we can hone in, and I think we have started honing in on some of the key principles, and if we can give any specific example, it would really, really help.

CO-CHAIR COURT: Greg.

DR. IRVINE: I'm going to say something fairly radical. And in the next couple days you may learn that that's kind of my MO, but instead of us talking about a top-down approach from CMS, why not a bottom-up?

Why don't we empower hospitals, clinics in small towns to develop their own

quality measures, submit them to CMS, get them approved and then do something that's meaningful for that site?

We are such a diverse group. We have so many conflicting needs. Why can't that be the case?

Medicare came up with some fairly radical exceptions for critical access hospitals, for example, in the Medicare area exempting us from DRGs and things like that.

Why can't we have a bottom-up approach where we design our own quality improvement?

CO-CHAIR COURT: I think there's been some attempt, a start at that with the QCDRs -- so, we get all these acronyms -- which is a way for an organization that's already collecting measures to get measures approved for PQRS so that the clinical specialty registries have done that. So, there's a little bit of start of that on the ambulatory side.

Jason.

DR. KESSLER: In the spirit of

discussion here, I'm going to disagree with a couple of statements that were just recently made in that, in particularly looking at the issue of alignment if we start inventing a lot of new measures, doesn't that complicate the whole issue a lot more?

Doesn't that -- doesn't it, you know, doesn't it defeat the purpose of trying to, you know, trying to have -- trying to have people not digging out new things to measure and to be able to report the same things just once or twice instead of having to, you know, well, we've got, you know, A1C, seven here and eight here and nine here or whatever.

Isn't there some logic to, you know, using existing measures, looking at measures that are being used already for other purposes and seeing how they apply or how they don't apply rather than, you know, just kind of looking at high-level means and saying, well, let's make up a new measure for what we're seeing here?

CO-CHAIR COURT: Guy.

DR. NUKI: Well, I'll actually answer your question first, Jason. I think the problem with that is, is that we've shown that it hasn't worked.

All these measures have been out there and rural hospitals, rural clinics and providers have basically said these measures aren't going to work for us.

Now, we could tweak them and then that would be, you know, Tweak 8.3 and -- but I'm not sure that's really the way to go.

I think it sounds like we're here to kind of take a step back and look at the bigger picture and how do we frame -- how do we frame this.

I was sitting here and, you know, one of the things that I do is we do a pay-for-performance for our company with the hospitals that we contract with.

And so, we pick, you know, goals for the year, we go through it with the CO, they get approved. And then if we meet those, we make

more money. And in a private group, that's a good thing, and there's different ways to break that out.

One of the ways, you know, that we've done is through ACGME's core competencies. You can use that. We use that sometimes as a framework.

I was just sitting here and there's -- I look at it and there's -- if we want to -- what we're trying to do is improve the care, because that's what the patients want. We'll be a little paternalistic. I think patients want better care.

And so, if we're trying to improve the care, I would break that into two areas. One is areas of risk, and areas for improvement. And, you know, the example of the med rec is an area of risk, clearly.

Any time you have transitions of care, all of that whole around transitions of care is a huge area of risk.

Someone had mentioned about

transports, you know, transfers out. Well, is that a good thing, or a bad thing? Because, personally, I'm trying to decrease our transfers out of our hospital.

Because every time I put someone in an ambulance and send them, their family is driving two hours through the woods in snowstorms to go visit their family.

And I had a patient -- I'll just -- I think stories -- this is a very meaningful story to me. A woman with twins who decided she was going to go and get her OB care not with me at our hospital, but at the big medical center and, you know, she had some complications and all that was fine.

And the babies were born early. And the dad was driving and was killed in an accident. I mean, it was a two-hour drive through the woods, through a snowstorm. And now, these babies don't have a dad.

Well, that wouldn't have happened if they had been delivered at our hospital. So,

we've got to really think is that good, or bad? I mean, is decreasing what we can do at critical access hospitals good, or should we increase it? I don't know the answer, but we need to think about that.

Areas of improvement, overuse of services, really looking at outcomes. Hemoglobin A1C is not an outcome. Renal failure is an outcome from diabetes. Access to care, that's huge.

If you said to a community hospital, if you can provide more primary care providers, we'll give you more money, that gives more money to actually improve the care.

They'll be able to pay those doctors more, because they're getting more money for having better access.

Community as an entire system, I spent a lot of time trying to get our mental health service people to talk to us in the emergency department. And they're like, really? You want to meet with us? Of course we do. We interact

with you all the time.

And then coordination of care within the hospital. So, those are just some of them. Those are just the first five minutes.

There's got to be ways that we can look at how we can mitigate risk, how we can improve things and put -- and make the measures real so that -- and meaningful for rural areas.

However, I think what Greg said is a really good point. They've got orthopedics at his hospital. Another hospital might nave no orthopedics, but two urologists.

So, you can't put something -- surgical wound site infection for a urologist is going to be really low. They're doing everything through the urethra.

So, you can't -- how would you compare? I don't know how to do that.

CO-CHAIR COURT: Bob.

DR. RAUNER: I got to follow up on a couple of things. One was Jason's thing. I actually think that part of our problem isn't

that we don't have enough measures. I think our problem is we have too many measures.

So, for example, we have 22 through the Medicare Shared Savings Program. We really only focus on five of them, because we think those are the ones that are important. And then some of them, I think, are, frankly, stupid.

I don't -- we're not going to waste my doc's time on doing a stupid measure because -- I won't go into that, which that might make people mad, but -- so, one, I think we need to constrain on what's really important. It's a prioritization issue as much as anything.

Now, I use the example of Peter Pronovost's central line bundle. It wasn't incredibly complicated. It was five measures, and one of them was wash your hands. It's not rocket science.

If you do a couple things really well, the other things will take care of themselves. So, I think part of the problem with Medicare Shared Savings program and, frankly, most federal

programs, there's too many measures.

So, if we could prioritize because every -- they're all given equal weight. Blood pressure control I think is one of the most important measures, but it's no more important than any others, some of which I think are wasteful and a waste of our time.

If I were going to add anything, it actually would go away from quality measures to what Guy just said. Things like measuring continuity of care, access to care and coordination of care.

I think those are the three most understudied things in healthcare right now and there's not financial incentives for them. If anything, there's financial disincentives for most of them.

CO-CHAIR COURT: Ira.

CO-CHAIR MOSCOVICE: These have been some really good comments. I think we're getting to where we need to be.

In response to Jason, I think you

raise a good issue, but the challenges -- and I think, you know, I'll point this out for CMS and for NQF. The other -- the pushback has been, well, you can't start new measures that are really different, because we have a limited amount of resources and we want people to have the same set of measures that they're looking at.

What we've done in the work we've done in the past, is to say, here's a core set that we can all agree everybody wants. And now, there's extra modules.

You're doing surgery, you got a surgical module that we can -- you're doing urology, it -- you're doing orthopedics, so you have the modules that are specific to the individual environment.

And I think if we have a small core set, and then say let's really individualize to some extent at least in some broad areas -- if you're doing obstetrics, you know, fine, we'll have that kind of -- that's one way of looking at it.

I think the important thing is for us to come up with these -- we've had some good ideas, some basic concepts. And if we can break through to CMS that it really is a different environment, an alignment doesn't mean every measure is going to be exactly the same for all institutions and providers.

If we can get them over that hump, then I think we can start trying to individualize, but it can't be one set of measures for every, you know, all 1,300 critical access hospitals.

And the problem, by the way, when you don't have comparable measures is people start raising -- it's two-tiered, you know. We have two tiers of medicine now and rural is not as good, and that's just simply not true.

Different doesn't mean not as good, and we need to be able to figure out a way to get that point across to CMS.

CO-CHAIR COURT: Okay. I think Karen and I kind of conversed here. Let's get the last

three comments here and then we're going to wrap this up. And then we're going to move more into our problem-solving, because it sounds like we have consensus around kind of the big key bucket.

So, John.

MR. GALE: I was going to make a similar point in that we know the rural health clinics that we have worked with, they have a different -- part of their practice patterns are such that they may not be able to refer patients as easily to other services.

So, they hold onto folks with behavioral health issues and treat them longer in the clinic. They hold onto other patients they can't get out for other services.

Unfortunately, you can't capture everything that they're doing that's that different. So, we in working with our group defaulted on really trying to target what was the most important benefit. And also obviously up front, the lowest hanging fruit.

At some point, clinics haven't been

reporting consistently to any sort of external quality measurement system. So, we have to bring them along relatively gently.

In the beginning, we wanted five measures as a core set that we were asking any of our demonstrations to test. And then we gave them a set of optional measures that may have been more reflective of their practices. So, for us, it was really about the importance, how important it is to measure it.

We've got two patients that you're holding onto for behavioral health service. We really want to do a good job for them, but does it make sense to measure them? No.

You've got diabetes. You've got a variety of very common chronic illnesses in these practices. How useable can they do something about it?

At the end of the day, we want them to make a difference in their practice. So, they really have to have something that is much more actionable.

Can they collect it and does it pass the straight-face test if you want to compare rural health clinics to the performance of primary care providers in an FQHC or a small physician practice or hospital clinic?

So, for us, it was really a matter of trying to find measures that -- who have captured the essential, most common services and look at some of the process of care measures.

For me, meaningful use was sort of an interesting process. It was a lot less about technology in some cases, but actually making a statement about the things that providers should do.

A provider should be reconciling medications from a new patient coming in or going elsewhere regardless of whether they have an electronic health record, but put it in one place. And so that was the type of thing that we looked at.

CO-CHAIR COURT: Tim.

MR. SIZE: Yeah, I very strongly agree

with what Ira said and John just said. I'd go back to what you said earlier, Kelly, about let's remember the patient perspective and I would reference a meeting I was at here in town next door Monday with an accountable care organization.

And one of the strong themes I heard from a lot of the people who spoke is ACO gives them an opportunity to begin to address a serious problem for many of them, out migration.

And out migration is about people making choices where they can. And I, you know, as now a senior citizen and lots of friends more and more using the medical system, and then as a parent and a grandparent, I can tell you, I mean, what they're interested in is show me you are as good as my alternatives.

That's the fundamental question and that's why I'm kind of libertarian, we all do our own thing, but that's not going to cut it for what I think the market need is.

And I think Ira -- and Ira and I go

back a long way. And for me to say I totally agree with Ira is almost unprecedented, but I did agree with his summary, you know.

If we think about a core, then we can build around that. And for those who can only do the core, they do the core, but at least that would give me as a patient or my family the ability to compare.

CO-CHAIR COURT: And Brock.

MR. SLABACH: I guess a couple of important questions maybe more than an answer in terms of a statement.

I think are we going to be agreeing on the significant population or portion of our providers that are exempted from any reporting requirements?

In other words, are we going to address the issue of voluntary versus mandatory in terms of recommendation to CMS?

Secondly, I think that another important thing or a question is the process under which these measures down the road are

selected and how is that going to be established.

And I think one of the suggestions I would make, just to answer my own question now, is the Measures Application Partnership, there is a MAP for about every single category of providers.

And I'm wondering if we would recommend a MAP for small-volume providers, or however we want to style that, to then begin the selection process through a multi-disciplinary group of people to be able to select the specific measures that we would then start using down the road.

Because I think we're starting to talk about a lot of individual measures and we're getting into the weeds, if you want to call it that, in terms of discussion. And from a bigger picture level, I think we have some policy issues that are going to be more valuable or more important, I think, in terms of whether it's going to be successful. And that is 1,332 critical access hospitals that don't report

mandatory and rural health clinics that are exempted from all of these PQRS and other programs.

CO-CHAIR COURT: And Helen.

DR. BURSTIN: I just want to quickly respond to the suggestion, Brock. I think it's a really interesting one.

So, for those of you who don't know, NQF convenes something called the MAP, the Measures Application Partnership, where we review over 20 different federal programs to make recommendations to CMS about which measures to use for which program. So, for example, we do that across all the hospital programs.

We don't currently do it for these programs, because they're not part of the puzzle of what gets reviewed. I think it's a really interesting idea.

We would have to think carefully about who is on that work group, obviously, because you'd want to make sure you have the right kind of input into that.

Part of that process is not just that CMS puts forward measures, but usually there's a process, to go back to Dr. Irvine's point earlier, where people can suggest the measures potentially as part of this process of what should be considered under the measures under consideration.

So, there might be an interesting angle for us to follow up with what CMS said on a particular and maybe Marty going back to CMS could be very useful here.

DR. IRVINE: I just want to quickly respond to Tim. I agree a hundred percent that patients should be empowered to make decisions about where they get their healthcare based on data, but you have to be very careful about the data they're getting.

In this era of the connected Internet, patients in the State of Idaho have discovered that our little critical access hospital of 12 beds and an emergency room has a zero percent surgical site infection rate.

And we have actually had medical tourists coming to our hospital because they say, well, that's where I want my surgery then.

And I, you know, and they come in with a BMI of 40 and I send them away because they don't meet our comorbidity index.

So, you have to be very, very -- and that's just an example of how you have to be cautious about how data is reported, because sometimes what creates an affect isn't what you think created the affect.

DR. RAUNER: Totally agree.

CO-CHAIR COURT: Okay, Ira. This is the last comment.

CO-CHAIR MOSCOVICE: I think it's essential, in response to Brock, that we do deal with the voluntary versus a mandatory issue.

If you aren't collecting data and participating in these programs, then you can't measure quality. And so, I think it's the first -- I'm hoping one of the first bullets is we think, however we feel as a group, that either we

should remain voluntary or should be mandatory.

If we make it mandatory, we're going to have some people who aren't going to be so happy with us, obviously. But, to me, if you don't measure, the rest of this is not going to happen. So, I think that that's essential.

CO-CHAIR COURT: Yes, go ahead.

DR. ALEMU: I, too, totally agree with what Ira said. As Karen mentioned this morning, we know that there are a lot of measures out there for different programs.

In some cases, some people complain that there are too many measures out there. And when we listen to some other people doing different, you know, committee meetings, they say there are some areas where we don't find measures.

So, when we look at now the project, what we need to do is to look at using measures which are out there. I think Karen has already mentioned that there have been a voluntary scan of the measures which are out there.

We have talked about the challenge the rural population is facing, rural providers are facing in reporting, in collecting data for quality improvement. All these issues we have discussed now to some extent.

And what we would like to see is which measures are, from those which are out there, which ones are the most relevant ones which could resolve the problem or the challenge which we are facing in the rural area.

And another point which hasn't been mentioned is if we think there are areas where there is no measure available, but that could be available to us, the Committee is charged to come up with recommendation, you know, the concept areas.

We lack some measures in some specific concept areas which are relevant to the rural providers or to the rural settings. So, that is one of really the recommendations which we need to think about.

And after having a collective search

concept, we can recommend CMS to develop measures. That is really the most important outcome of, you know, this group. So, identifying core measures, identifying gaps and making recommendations.

So, I think I just want to highlight that we can also recommend areas which are really not covered until now, which we think there are gaps. So, I just want to highlight that point.

CO-CHAIR COURT: Okay, Sheila.

DR. ROMAN: I agree with a lot of the comments that have been made that I think where we should be focusing is from a patient perspective and on patient safety and ways to improve the care of patients so that they stay healthy and we meet really the three pillars of the chair.

And I'm going to, I guess, be tangential a little bit here, but I think that providers want to be compared to providers that they see are like them rather than like the mass.

And I wonder if we should be thinking

of a critical access hospital compare and thinking about it from that perspective as we think about measures in core groups and modules, which I also agree with.

CO-CHAIR COURT: Okay. I'm going to, I guess, I am chairing this, so I get the last word. Sorry, Tim.

(Laughter.)

CO-CHAIR COURT: So, two thoughts. I agree with Ira. I think patients deserve that we move into an eventual mandatory system, but it has to be done in a way that doesn't create unintended consequences and deteriorate the safety net that's been set up because rural access is really important. And a lot of patients get rural care, but they deserve good care. And so, I think we need to move into a meaningful system.

I think there is a lack of measures that are meaningful and reflect what really happens in the rural setting.

And so, I would hate to see us just

trying to choose from the measures that are already there.

And so, I think there are -- we need different measures. Otherwise, we wouldn't have these problems that we're already in.

So -- and I'm not sure if that's the work of this group or to think about how -- what would be the guidelines to create meaningful measures like a MAP or whatever. Perhaps that is where we would better spend our time.

Because I think if we start talking about individual measures, we will be here until Christmas, and I have to go home.

DR. BURSTIN: Just one quick comment on that. I think that's a great point. You're obviously not going to develop measures at this table.

I do think there is very much a need to identify the core measure gaps of what you think. If there is a need for a measure to be developed, what it could be with some level of specificity like don't say care coordination and

continuity. Those sound wonderful. We have lists of gaps that say that.

Something perhaps more specific that really gets into what's unique and special about the rural community space, I think, would be really important.

And then lastly it is also really, I think, an opportunity to do something we've been affectionately referring to as "prospecting for measures". I guess that's kind of a rural term.

What's out there in your communities that people are using for internal QI that have really worked? That clinicians and patients and others have actually found valuable. That perhaps we could try to bring some of those up and bring some of those into measures that -- rather than it being top-down, some of it really bringing in the ideas of what's been effective on the ground and bringing that forward to try to get those developed into national standards that could be part of these kind of programs.

CO-CHAIR COURT: Okay. So, time

check. We're going to move into the next section. And, Karen, do you have --

MS. JOHNSON: Yeah, and let me interject. We have a pretty good list now. What we want to do with that list is just make sure that when we leave tomorrow at 2:00, that we have addressed at least those things on that list.

If we end up having extra time, we can certainly talk about other challenges, but the idea of trying to come up with at least the top few things that we want to do is just to make sure that we don't talk all day and not end up with some recommendations. So, never fear.

And we also have -- we didn't point these out earlier, but we do have these big -- I call them big post-it notes back here. We can have that as a parking lot issue.

If there's something that you just feel like is burning and you don't want us to lose it, put it on those notes. We won't lose it. And we'll come back to it.

I think now I don't know if anybody

wants to just stand up and stretch your legs for a minute, but we have about an hour or so before lunch and we want to start talking about potential solutions for the low-volume problem.

And I'm going to tell you guys what we found in our environmental scan just to get us started. And I think our methodologists, who have been pretty quiet so far, will probably have a lot to say in this session particularly.

But what we know is it's not a new problem. Programs are excluded, oftentimes because of a threshold or maybe because of reliability.

So, reliability measures is very important when you talk about accountability applications.

So, there's been lots of solutions identified, you know. We can talk about all of these things, and I don't know how you want to best do it. Maybe talking about pros and cons. Maybe -- I'm sure there's things that you'll come up with that aren't on this list, but we've

already addressed the broadly applicable measures.

That's one way to get around that problem is, you know, look at things that, you know, that everybody is seeing.

Thinking about indicators that don't have a typical denominator just in terms of how do you construct measures.

Pulling your data, there's lots of ways across years, across providers. That's, you know, using networks or some other conglomeration of providers, perhaps, or even across settings.

We saw the idea -- and I think Bob has addressed it a little bit, but maybe not in this way -- grouping across settings. There's some things that you, you know, some things are outpatient measures versus inpatient measures. And that's almost an artifact almost at the, you know, how you -- the claims are created, but it's the same stuff.

Composite measures, that's a little weedy, but that is one way that you can increase

your denominator size if you create composite measures in particular ways.

There's statistical approaches. This starts really getting in the weeds, but there are approaches where you can do this hierarchical modeling and be able to pull in some information from the average. And that kind of helps out the small numbers problem.

And then obviously in reporting, there are things like, okay, we know we have a small volume problem. Let's be sure that we include additional information so that people understand what's going on. Let's show those CIs, which we don't usually see. That sort of thing.

And then finally stratification, comparing like to like, would be potentially another way to think about small volume problems.

So, again, I just wanted to put this out as stuff that as we were going through our readings, these aren't new. You may have new ones in addition.

And with that, I'm going to hand it

over Ira to facilitate this session.

CO-CHAIR MOSCOVICE: So, this is a simple problem. We'll figure it out in 5 or 10 minutes and be able to go to lunch early.

Obviously, it's a complex problem. I'll just offer a couple comments, and then we'll open it up for suggestions. And particularly, as we say, some of the methodologists who are here can offer their comments.

When we offer our thoughts, remember one of the objectives of the meeting was to make recommendations regarding measures appropriate for use in CMS pay-for-performance programs.

So, it's a little bit more complicated when you say, okay, let's look at the low-volume issue, but not just with respect to the quality measure, but we're linking it to a pay-for-performance or reimbursement system and just think about that as you go through these.

Because the notion of, for instance, pulling data across years, well, maybe I can get enough sample size in three years, but guess

what? Payment systems aren't set up to not pay anybody for three years. You got to figure out on an annual basis how you're going to do that.

So, I would just, you know, that's one thought about how it -- in the back of our minds we need to take that into account.

There are obviously a whole host of other approaches, and I would just say we've tried in our work to use some of these statistical approaches. I mean, we did a couple papers on using article modeling, invasion modeling, and came up with suggestions about how you could actually do that.

And what is involved is saying we're going to use your hospital's data, but then we're going to look at all the other hospitals that are sort of similar to you doing similar stuff. We're going to use their data, we're going to pull it together, and we'll come up with a more reliable estimate.

Practically what happens is you do ten out of ten cases perfectly and then say, you

know, it's not really 100 percent in your hospital, it's really 88 percent.

If you do five out of ten, you know, perfectly and have five that you don't, and then say, you know what? It's not 50 percent; it's really 75 percent -- yeah, that looks much better. So, there's those kinds of issues that really underlie all this.

So, it's a complicated issue, but we're trying to look at, and I doubt that we're going to come up with the solution, because smarter people than all of us have been trying to deal with this for decades.

But if we can once again come up with a series of bullets that underlie recommendations for where CMS is, how they should move forward, I think that would be really helpful.

So, we'll open it up for discussion and just put your signs up as you feel fit. So, we'll start with Greg.

DR. IRVINE: Yeah, the problem as you point out, Ira, is that with the low denominator

issue is it can make you look worse than you are, but also it can make you look a lot better than you are, as we've proved.

And, you know, I'm not sure how to solve that problem; I'm not a statistician. I'm sure there's statistical ways to deal with that, but we're going to keep bumping into this issue of trying to use small numbers to make big decisions, including how you're going to pay people for what they do.

And I think we're going to have to think much, much more radically about, you know, what do we do about PFP? Because if you pay people to perform, they will perform. They will give you a performance. They'll do what you ask them to do, but you may not get what you want.

CO-CHAIR MOSCOVICE: Any thoughts about how you would define "radically"?

DR. IRVINE: Going back to my bottom-up, I think that paying people, perhaps small hospitals, to design quality systems that makes sense in their setting looking at various metrics

within that system that makes sense. Offering that as a project for a year and saying if you meet your own defined goals, you can do that, you'll get paid for that.

I don't know any other way.

CO-CHAIR MOSCOVICE: How does that get you around the small number issue, though?

DR. IRVINE: Well, what we're looking at is not necessarily making a project that doesn't use numbers, it looks at processes. It looks like -- at access to care it looks at more perhaps fuzzy and esoteric goals, but goals that are very important to the community.

We've recently at St. Luke's McCall begun trying to augment -- we realized as an organization that our behavioral health services were horrible. And we tried to augment behavioral health by recruiting practitioners, by setting up clinics, by dealing with that as a problem in the community.

If we had set that up as a CMS goal saying we want to improve behavioral health in

this community because Valley County, Adams County, Idaho County, which are the three counties we deal with, have no competent mental health providers and we want to work on that, finding funding, doing what's necessary to get community buy-in and so on, we can do a better job of that.

And if then we can show CMS that we've done that, then that makes some sense.

CO-CHAIR MOSCOVICE: And so Greg has raised the issue of focusing perhaps more on population health measures rather than specific individual health measures.

I'm just wondering if people -- how people feel about the utility of that and whether it's an area that we can move down.

Yeah, Bob -- oh, Steve.

DR. SCHMALTZ: Well, I guess the problem with population measures is the attribution question.

So, if you have a good population-type measure, how much of that is due to the

particular critical access hospital or rural health center?

And if you're reimbursing the rural health center for a good community measure, are you giving enough credit, or not enough credit, where it's due?

CO-CHAIR MOSCOVICE: One of my reactions is in some ways in rural environments we can deal with that a little bit better than in urban environments where there's all sorts of different programs.

We've been hearing about the isolation and sort of -- particularly looking at smaller practices. And so, in some sense particularly if they're certified as a primary care medical home, you would think we might feel a little bit more comfortable. There are some advantages to doing stuff in rural environments.

Okay. I have Bob, and then I have Sheila and then Marty. So, Bob.

DR. RAUNER: Okay. Two comments. One is on the question of pay-for-performance. The

pay sometimes leads to bad, unintended consequences, unfortunately.

I'm actually coming to the point where I think we don't need the pay-for-performance. All we need is public reporting.

I'm too close. Whoops. Sorry. Because it turns out physicians and nurses are so competitive they hate to not look good publicly and that that actually is enough to drive performance.

So, maybe if you don't have the pay so tightly connected you avoid some unintended consequences.

Kind of like Cleveland Clinic puts all its stuff out to the world partly because it drives their own people to do a good job because they know the whole world is going to see how they do. That actually turns out to be more than enough incentive.

The second, back to the population and some of these issues. I'll just -- because we've been on -- this has been an issue for us the last

two years. That's why we drilled down to five measures.

And that's why we focused on five at the ACO level; med rec, influenza, pneumonia vaccination, blood pressure control and diabetes control, because they're broad enough, the sample size is big enough and I'm pretty convinced that if you do well in those five, you do pretty well in most of the others as well.

There's enough cross-correlation that the processes those fix pretty much fix many other issues, too.

And in terms of prospecting for something new, the only other thing we add to that actually right now is percentage of our patients who have had an annual wellness visit.

It's real easy to track and I think it's also again reflective of the process and the prevention and mentality of the docs. So, that's kind of what we've got around some of those things.

CO-CHAIR MOSCOVICE: Sheila.

DR. ROMAN: I'm just thinking about how the methodologies in the pay-for-performance programs have been set up. And generally they have been set up by domains and percentages on domains and come up with a performance score by a variety of methodologies in all of the pay-for-performance projects -- programs that are up and running.

And I'm just wondering if we can put our heads together and think of domains that would be applicable to the rural environment and address the low-case volume issue, one of them being patient experience with care, perhaps, or population health measures and then maybe those process of care measures that are broad enough to actually have sufficient case volume.

CO-CHAIR COURT: So, I think the domains idea is the right idea, but in the current pay-for-performance programs there's a serious flaw in if you don't have enough measures in one domain, then the other domains get weighted more heavily. And so, it becomes very

perverted.

And so, if we want to recommend something about domains, we have to have something to guarantee that we don't get the situation there is now where no measures here, then all your weight is on two measures over here. So, the domain process is not designed well.

CO-CHAIR MOSCOVICE: And so, what we can do as a recommendation is be as specific as possible to how we change that.

The other action I would say is -- you mentioned patient experience with care. And this is where the voluntary versus mandatory comes in.

We know, on average, rural looks better than urban any way you look at it usually for patient experience with care. So, you'd have to be foolish not to report.

Yet, there are still so many rural providers that don't for all the reasons earlier, you know, how difficult it is just to do this, but that's one area where you know you're going

to look better. On average, we know that across the U.S. and still it's not -- and so, that notion of mandatory versus voluntary is important.

I'll come back to this side. I want to go to this side of the table for a while. And so, I had Kimberly first and -- I forget your name, Wyoming, but -- Tonya.

MS. BARTHOLOMEW: That's all right.

CO-CHAIR MOSCOVICE: And then Tim and then we'll come back to this side. So, why don't we start with Kimberly.

CO-CHAIR COURT: Use your microphone, please.

DR. RASK: Two thoughts. I really like the idea of focusing on pay-for-reporting. If we think we have measures that have significant analytic issues with them because of the low-volume piece, there is a benefit exactly as you mentioned to reporting to competition to drive that keep you from some of the perverse incentives of tying payment to it.

The second piece is that as I hear a lot about, you know, what makes rural providers different and especially some of the rural health clinics and critical access hospitals in terms of their payment strategies, they are being paid and supported in a way to provide a necessary community function which is accessibility to care.

So, that's the social good of what they do. It would make a lot of sense to have measures then that capture that.

Are they meeting the community good for which they are being treated in this special way for doing that?

At the same time, it's problematic to add -- to then put things like coordination of care measures on them if they are not being paid in such a way to be able to support the actual delivery of coordination of care services that are particularly needed in their setting.

And as an example that does not apply to the rural health, but I've been involved with

two states' Medicaid Waiver DSRIP programs where they're really trying to broaden some of what their Medicaid providers who are taking care of low-income, very challenged communities.

And so, they held back their DSRIP payments and asked them to be working with other community providers and improving coordination. And then tied their payment as to whether or not they were able to achieve certain improvements in patient outcomes that were dependent upon kind of a voluntary building of things.

And so, there was such a big disconnect over time in terms of when the data was collected and in terms of reality as to whether they could deliver services that they were not being paid to deliver, that it just kind of makes the whole thing an exercise.

Now three years into it, what they're basically doing is falling away from most of the measures and coming into can you write a good plan about what you were going to do. And if it checks off everything on the planning list, then

we'll say, yes, you implemented a program.

So, you know, I think it's just that issue of coming up with the alignment between measures. And if it's going to be for payment, being sure that the payment system is actually paying people to do the things that your measure wants them to do.

CO-CHAIR MOSCOVICE: And that might be one of the -- outside the core, one of the modules that really is much more specific, perhaps, to rural than urban that we push in terms of getting CMS to change the way they perhaps think about things.

So, why don't we -- we'll go to Tim, and then we'll go to Tonya.

MR. SIZE: Maybe at the risk of saying the obvious, but I haven't heard it said and just to get on the record, and I'm not a metrics guru, but there's a distinction, I think, very relevant to low volume between outcome and process measures.

And obviously you got to have higher

volume to have validity on the outcome side, I think. Whereas I think on the process measures if it's the right thing to do, it's the right thing to do with one patient, two patients or three patients.

And while I understand the attraction to outcome measures and I understand why the field is going that way, I think we need to make a statement that one way we need to think about addressing process measures is a belief that the research is there to say that people who do this kind of process, they have good outcomes.

And we don't burden in a crazy way low volume and say, well, you got to redo the research every time you do an outcome report.

And then I do think that is something that's rural-specific and low volume is the way to do it.

And I think where we -- that's not to say we shouldn't give up looking for those things where we can show good outcomes, but I think process measures will retain -- will be longer --

are still relevant in the rural areas and we need to be clear and unapologetic about that.

CO-CHAIR MOSCOVICE: Tonya.

MS. BARTHOLOMEW: What I'm hearing is everything that's a component of a patient-centered medical home model of care, it captures patient experience, it captures access to care, it captures quality measures.

And going back to what Greg said, it captures quality measures that are designed by the entity as, you know, for example, for my patient-centered medical home, I got to choose what I wanted to define as a high-risk patient. And I wrote a process, how am I going to define this patient? How am I going to measure outcomes on this patient and am I going to do it, and then report on those quality measures.

That would really encourage us to take a look at that model of care, because I think it encompasses every single thing that we're talking about today in a realistic and useable way.

And that's what all of these data and

these metrics are about is how can we use this to improve our patient care.

CO-CHAIR MOSCOVICE: I want to come back to this side. I have Guy and Aaron and Jonathan at the end. I think Jonathan actually had his sign up the longest. Why don't we start and we'll work back this way.

MR. MERRELL: Yeah, I just wanted to be explicit. I think we've kind of tiptoed around some of the metrics on the population side of the house, but I want to be explicit in considering social determinants of health metric selection.

The National Quality Strategy that HHS has set forward and the work that the National Association of Community Health Centers has done in the last two years in conjunction with HRSA in selecting social determinants of health metrics, I think, is important for consideration of this group.

We all know that zip code has a lot more impact to outcome of morbidity and mortality

than genetic code does in our current setting. So, I think being explicit with social determinants of health and considering that for selection is going to be important especially for alignment, because those things are going to be added to us in the future. Thank you.

CO-CHAIR MOSCOVICE: I don't know, Helen, if you have any comments in terms of the work NQF is currently doing in that area. How do you see it intersect, I mean, the rural folks feel that that's an important issue. But other than stating that, is there -- the work that NQF is currently doing, is there a way for this to fit into that?

DR. BURSTIN: I think so. I mean, I think the more we get some clarity as to what's unique that we can build into the current work I think it would make sense, yeah.

CO-CHAIR MOSCOVICE: Okay. We have Aaron and then Guy.

DR. GARMAN: Well, I think there is already some standard out there for a model that

utilizes some of this fluffier stuff to develop guidelines for a program to go forward.

And that's -- again, I'll refer back to these 19 program requirements for a community health center. And I'll read them and not all of them, obviously, are applicable, but the first one is a needs assessment.

So, in my center we had to go through with all of the surrounding communities, all the players, sit down and come up with what does our community actually need? Well, there's a good measure, I think, determining what your community needs.

Required additional services. So, preventative services, enabling health services, behavioral health services, do you have those items in place for your community?

Staffing requirements, are you appropriately staffed? Accessible hours of operations and locations. After hours coverage. Hospital admitting privileges and continuum of care.

For us, we have sliding fee discounts. A quality improvement assurance plan and that -- basically there are several guidelines regarding that, but it requires us to report that on a continuous basis to our project officer of items that we actually measure that are important for us and for our patients.

Key management staff. Contractual affiliations and agreements. Collaborative relationships. Financial management and control policies; billings, collections, budgets. Program data reporting systems. So, can you manage your data?

The scope of our project and then board issues like board authority and board composition.

There's also conflict of interest policy as well, but at least those first few I think would be very applicable to what we're trying to do here today.

CO-CHAIR MOSCOVICE: Guy.

DR. NUKI: I think most of what I said

was -- but just to try to reiterate and also to address something that Bob said and Tim, I actually think we could -- I know just enough statistics to understand that it's actually a bunch of voodoo to try to take bad data and try to make it look good using statistical analysis. So, I think we should give up. I don't think that you are going to solve that problem.

So, what you're hearing and what I'm hearing is that what we really need to do is have measures that don't have -- we don't have to worry about the low-volume issue.

The other thing is, is that when it comes to pay-for-performance, I mean, there's a huge amount of data out there that shows individuals are not going to change their behavior based upon giving them money. As a matter of fact, you may have the exact opposite.

If you ever listen to Daniel Pink or, you know, the whole daycare scenario, all of that sort of stuff, using -- telling individual physicians that you're going to get paid

differently to perform on a statistical grid definitely isn't going to work, but systems will.

If you go to a CEO and say you're going to get more money if you implement these systems, that works.

So, I think, you know, I'm just reiterating, I think, what everybody has said which is we need to look at pay-for-performance not in the traditional sense that all of these other measures have been, but really more like things that Aaron had just talked about.

CO-CHAIR MOSCOVICE: Okay. We'll come back. My co-chair here has a comment.

CO-CHAIR COURT: So, a couple potential solutions. I think we need more measures that are cross-cutting, you know, that apply to here's things every patient should get.

And I -- other than the immunizations, there's not very many of those because then, I mean, it's things every patient should get.

And then I think we need to get on the record that there has to be a system where you

have to have, you know, pick -- you've got to do eight measures. I don't know what the number is.

And then the hospital or the clinic is free to choose the measures that most apply to them. They're more likely to use them and it is meaningful to the patients they serve.

The other thing I think CMS needs to think about is I think the reason that many rural providers don't do CAHPS, either HCAHPS or CG CAHPS, is because right now it's mandated that you do it through a vendor. And those vendors are very expensive.

And so, on the hospital side they developed the cart tool which is a free tool for submitting your process measures.

And I think the CAHPS need something similar so that the cost to these vendors isn't prohibitive to collecting patient experience, because I think it's really important. And it's the measures the patients really understand.

CO-CHAIR MOSCOVICE: Okay. I've got John and Jason.

MR. GALE: I do want to sort of pick up on one point that was mentioned earlier about the idea of creating program-specific compare subgroupings, you know, CAH or Rural Health Clinic and I have to say I am not a fan of that idea for the express reason we've got two sets of issues.

First, it sort of creates a secondary tier issue, you know. A different reporting category.

And the second is that critical access hospital status, rural health clinic status, federally-qualified health center status and all of these support programs are designed to stabilize the facilities. They don't really change the way medicine is practiced.

So, if I am sitting in a rural community and the idea is transparency and I can either make a difference -- I want to choose a provider -- I want to see a primary care provider at some level. I could care less if they're an FQHC or an RHC or anyplace else.

And the second is we want to make sure at least for purposes of value-based reporting there is some consistency across the delivery of services regardless of the site.

CO-CHAIR MOSCOVICE: Okay. I have Jason, then Brock.

DR. KESSLER: I have somewhat of an outside-the-box, but perhaps half-formed idea that I want to kind of throw out for discussion of the group.

But before I do that, I want to just take a step back and kind of think, you know, thinking about these measures from the perspective of patients.

What matters and what's important to patients is maybe a good way to focus on things, but, you know, it's fair to say patients will find information out there and they really don't know what it means.

I know from, you know, what I know about looking at data, that a good data person can take data and make data mean just about

anything they want it to.

So, I tend to be very skeptical about looking at data just in terms of making decisions about, well, how good is the healthcare, or how good is this institution, this community, this provider.

Looking at the different types of measures that are out there currently, most measures have a numerator and a denominator and crank out a rate.

And then we have P4P programs that based on where this rate is, you know, you might stand to get such and such amount of money for that. And I almost think that's overthinking a little bit for a lot of these types of things.

If rather than rate measures we started looking at just, for lack of a better term, pass-fail measures where, you know, there's not so much data behind it, but it's a question that you can answer yes or no, that may actually produce some meaningful information for people, you know, whether it be consumers, patients or

payers of P4P types of programs that they can use to judge -- I guess that's what we're really looking at is judging the quality of care that's delivered.

I don't necessarily know how to do that. I don't have specific ideas of yes or no, pass or fail types of measures, but that might be one way we could look at it.

So, I just throw that out for discussion if anyone wants to comment on it.

CO-CHAIR MOSCOVICE: Okay. We have Brock and then Marty.

MR. SLABACH: A couple of things. And, Kelly, I like the discussion on some of the specifics around, for example, HCAHPS.

One of the things that I think would be appropriate to address is the issue of exclusion of patient populations from those surveys.

So, for example, patients discharged to nursing homes are not eligible. Well, this just decreases your population of patients that

can answer the questionnaire.

So, rural-specific -- or rural-sensitive processes at least would, I think, maybe help providers to become more alert to using those systems.

And the reason they don't use it is not necessarily only because it's so expensive. It's because they get poor responses or response rates and it's not as meaningful.

So, for example, in my institution we had two systems. We had the HCAHPS system and then we had our internal system that we used for patients that were discharged and we gave them the survey before they left the building. And that was far more effective for us than what we got back from the HCAHPS vendor a month or two months later.

Second, I'm thinking back in terms of issues in my hospital and our clinics that probably produced the best performance improvement. And it's not -- and we did all of the quality reporting. We were Joint Commission

accredited. We did all of that and that all helped and it was all part of the processes that we did to improve care.

But when we did AHRQ's culture patient safety survey and used that tool within our facility, and we did it, I think, every two years if I'm not mistaken, this was an incredibly powerful tool to improve the safety culture of our institution and making us, as leaders, aware of our vulnerabilities and gaps that we have within our system of our caregivers.

I'm seeing the same evidence now with TeamSTEPPS through AHRQ and the processes that that includes in terms of problem-solving.

And I think that goes back to the point that was made just a second ago in terms of pass-fail. So, that could be some of the programmatic things I think that they pass so that if they do this and they're engaging in that process, it could be helpful.

The last thing I'll make a comment on is stretching ourselves to thinking ahead. And I

like the conversation about population health because we can sit and comment about all of the existing metrics like whether or not we, you know, get the correct antibiotic within four hours of a patient arriving to the emergency room and diagnosed with, you know, respiratory disease.

Those are important and I'm not going to reduce those, but we need to be looking ahead at where -- what's going to be important ten years from now for populations and for how -- where do we see medicine going? And the ACO model, I think, is a good example.

And how do we prepare the future of our rural providers and incenting them into systems that are going to get us to where we're going and not just looking behind and asking them to continue in kind of performing on things that they should have hopefully done a long time ago, but we need to be stretching them forward. So, I guess I'll stop there.

CO-CHAIR MOSCOVICE: Yeah, I think the

latter point is a good point. And rather than just looking at existing, where are we heading, my bias has always been if you're looking at population health as a concept, we should be able to do that better in rural starting with we can define the population better and also hopefully could develop programs that would be not having to fight against lots of other programs. So, I think that's an important comment.

We had Marty and then Bob.

MR. RICE: So, I think Jason made a good point. Maybe we're looking at these measures so broadly that you can't really break it down.

We look at attribution. We look at, you know, can you take attribution out of a measure? I don't know whether you can or you can't, but maybe there's different types of measures we need to look under different categories like measures for consumerism that we should just look at and separate it from everything else.

Process of care, population health, they're all kind of subcategories. And when you lump them altogether it gets so confusing. To tell you the truth, I start getting confused. I don't know whether there's an answer to it because when you put everything together, you really can't build a measure for these large topics. It's hard to wrap your arms around it.

My arms are short. So, I can't wrap my arms around anything. So, but it's tough concepts. How do you, you know, how are you going to look at this?

And then when you add attribution into the mix, it just gets to the point where it's almost hopeless.

So, is there subtopics -- and this is probably more for Kelly and Ira, you know. Would it be better to break this down into subtopics and just look at the specific areas? And then look at the practice of care within those areas.

I don't know. I'm just kind of throwing that out there.

CO-CHAIR MOSCOVICE: I like the idea of -- I don't think we can avoid all the work that's going on. We have to address is that relevant for rural or not.

And if many of us are concluding that certainly all of it's not relevant and there are alternatives for how we might look at this in rural and we need to discuss those alternatives and proposing that to CMS, hopefully they could opt into saying one or two of those areas, let's really demonstrate and see if it really works.

So, the concept of not just being boxed in with where we are, I think, is what I'm hearing time and time again. And hopefully we can get some more details as we go along.

So, I have Bob and then Stephen.

DR. RAUNER: Actually, I'm going to go back to Brock's comment about HCAHPS and CCAHPS. And it's really a question I'm hoping one of you guys in the room can answer for me.

I was thrilled that that was part of the ACO measures and that we would be judged on

customer service. I think that is really, really important.

And I was real excited about it and then I started looking into what the CCAHPS includes and how it was actually administered.

Had some suspicions, and the suspicions were confirmed when I actually saw the ACO results of both us and everybody else in the country in that our numbers are all within one or two points of the mean.

We're essentially statistically equivalent to just about everybody, and so is almost everybody else, which, to me, says is this a fundamentally flawed survey?

And my suspicion is that it is because what happens is they ask the entire, I don't know, 70 some questions and they're calling, you know, 85-year-old Aunt Tilly on the phone at random. And by the time she gets to Question Number 7, I think she's answering four all the time.

And so, I guess does anybody know

enough about the CCAHPS to know whether this is the explanation for why almost all the ACOs are statistically equivalent to each other on patient experience?

And of course they're actually dinging us all because you have to get 90th percentile to get full credit.

Is this a fundamentally flawed problem, unfortunately, where it's like a perfectly sampled worthless data problem?

Can anybody answer that?

CO-CHAIR MOSCOVICE: Bruce, are you responding to that?

DR. LANDON: I mean, so there's always been certainly problems with CAHPS surveys and the power of the CAHPS surveys to discriminate among different institutions and whatnot. It's not completely strong, but --

CO-CHAIR COURT: Can you talk closer to your microphone?

DR. LANDON: It's not all that strong, but this is very sort of scientifically valid,

well-developed.

And we've actually published a paper looking at just the pioneer ACO program looking at first-year results and actually found improvements in two domains of CAHPS that were pretty relevant in -- to ACOs just among those 33 organizations that were -- 32 organizations that were participating for that year. So, there is some power there.

DR. RAUNER: I think it's something that's probably valid on the multiple system level, but I think it may lose its power on the individual ACO level because it's so much regression of the mean and so much -- I think there's probably -- so, I don't know if maybe I'm getting too weedy.

DR. LANDON: I guess I don't know in detail the sample sizes that they specified for each one of the ACOs, but I assume that they're using similar sample size requirements that they use for MA plans and the like which are, you know, reasonably adequately powered.

You know, clearly, you know, pioneer ACOs are larger than MSSP ACOs, but the MSSPs still have to have 5,000 patients if they're sampling. If 600 of them and get 50 percent, it should be adequate power.

CO-CHAIR MOSCOVICE: Stephen, so we want you now to defend statistics and explain --

(Laughter.)

CO-CHAIR MOSCOVICE: -- that it is valuable and can be useful.

DR. SCHMALTZ: Well, Jason mentioned pass-fail measures and we actually have those. They're called structural measures. And they tend to be less useful than other types of measures, but I think what you need to look at is the information content of the measures you have.

So, the larger the sample size, the better for proportion-type measures, and -- but proportion-type measures have less information than continuous-type measures.

So, if you could find a good continuous-type measure, I think that would be

the ideal because you'd need smaller sample sizes to show meaningful differences.

But for proportion-type measures which are most of our process measures, you do want a larger sample size and you can't really get around it statistically.

You just have -- if you have poor information from a measure, it's not going to help you to try to move everybody toward the middle.

You're not going to detect meaningful differences. And what you want to do is improve care by detecting meaningful differences and acting on those.

MR. MERRELL: So, with the continuous measures, so why has it been a challenge in general to come up with those kinds of measures?

Are they more difficult to collect, or do you have any examples maybe that might be relevant for rural that could be used?

DR. SCHMALTZ: Well, the emergency room measures, I think, is an example.

MR. MERRELL: The time measure. The timing measures.

DR. SCHMALTZ: The timing measures. The problem with timing measures is you can have these big outliers that really skew your results, but here is a case where statistics can help as far as giving more meaningful comparison values.

MR. MERRELL: And we sort of know that timing issues in emergency departments in rural areas in general are not the same as they are in urban areas.

DR. BURSTIN: I think also it would be helpful if you could give an example of a proportion measure versus a continuous measure. I'm not sure everybody is on the same measurement page.

DR. SCHMALTZ: Okay. A proportion measure, an example of that would be given aspirin at arrival for AMI patients.

CO-CHAIR MOSCOVICE: So, the percent of patients who would get that as compared to the emergency department, how long did it take a

patient to see -- to be served or how long did they wait to get transferred out or whatever?

DR. SCHMALTZ: Which is a more precise measure.

CO-CHAIR MOSCOVICE: Right. I have Bruce -- okay. Marty, is yours still up? Okay. Bob, though, definitely has a --

DR. RAUNER: Just this goes right back to that. So, for example, the -- all these, and actually I have our ACO with a whole bunch of other ACOs. They're all percentage measures.

And if I calculate the confidence intervals right, they're all plus or minus five percent just like your typical political poll.

All of these are within that plus or minus five percent because they're those proportion measures. And that's why I think unfortunately they are discriminatorily helpful for an ACO, because they're all within that plus/minus four, five percent like any --

DR. LANDON: But don't forget --

CO-CHAIR COURT: Microphone, please,

Bruce.

DR. LANDON: It's just pay-for-reporting.

DR. RAUNER: Yeah.

DR. LANDON: So, no one is actually trying to --

DR. RAUNER: But they're going to be, though.

DR. LANDON: I understand, but, I mean, so we've done a bunch of analyses of sort of the most prominent early commercial ACO contract, which is the Blue Cross and Blue Shield of Massachusetts Alternative Quality Contract.

CO-CHAIR COURT: I'm sorry, Bruce. We can barely hear you. Can you get closer?

DR. LANDON: We've done a bunch of papers on the first sort of large commercial ACO-like contract which is the Blue Cross and Blue Shield of Massachusetts Alternative Quality Contract.

And in a paper what we just published a couple of months ago, Zirui Song is the first

author, control comparing to national benchmarks. We actually showed substantial improvement particularly in the outcomes-type measures like control of diabetes, control of cholesterol, control of blood pressure, which I've actually never seen those measures that responsive to anything before.

CO-CHAIR MOSCOVICE: My colleague Kelly.

CO-CHAIR COURT: So, two thoughts. I think there is a nugget in what Brock said before about current measures that might need to be repurposed. And it's probably through the denominator definitions, because there is exclusions in defining the population that might not fit with rural.

And so, that's excluding patients that maybe don't need to be excluded. So, that might be a way to repurpose existing measures.

And then just a question. Maybe this is a really dumb question, but has anybody studied what these different providers do a lot

of? I mean, because that's the high volume stuff, you know.

So, when I used to be a hospital quality director, when you chose measures it was high volume, high risk, problem prone.

And so, it seems like there should be data that says this is what these organizations do a lot of. And then that would maybe be a place to naturally look.

And then I think from a patient's perspective, these programs should be aligned in measuring the same things because they don't know if they're in an ACO or a FQHC or what all those other letters are.

And so, you know, hopefully it should be aligned to things that matter to patients and it shouldn't be different for the different programs.

Now, perhaps the payment incentive needs to, you know, needs to be better aligned. I don't know, but seems like the measure should be converging on something similar.

CHAIR MOSCOVICE: So, we -- and I actually have the data. I had our folks just get the latest numbers we had at least in terms of critical access hospitals and the volume. And there's about 1300 plus critical access hospitals.

And if you say how many have -- meet the definition of, say, having 25 patients over a year, there's maybe 10 measures totally that have a couple -- there's two to three -- at least 200 of the critical access hospitals have it. So, most of the measures you just simply don't have the volume. So, we have that.

I don't know on the physician side or clinic side if you have any data like that, but --

CO-CHAIR COURT: But that starts from the -- let's look at the existing measures versus --

CO-CHAIR MOSCOVICE: Yeah.

CO-CHAIR COURT: -- what do they all have in common. Or if we had cross-cutting

measures, again, things that every patient should have. Like medication reconciliation would be a good example.

CO-CHAIR MOSCOVICE: Yes, fair enough. Guy.

MR. NUKI: I just want to caution you about the repurposing of the measures. Because if you make a little -- that's making a little tweak. It's another complexity. People will then try to compare -- you can't compare it to the untweaked measure and I think that that's the wrong direction to go in.

I think it's, you know, your volume through the emergency department, yeah, I mean, that happens to every patient. Med reconciliation happens to every patient.

But when you try to bring it down to disease, a specific disease process, I don't think -- I think it's going to be almost impossible to get enough volume on any single disease process and certainly not across enough of the hospitals to really compare.

CO-CHAIR COURT: Yes, I totally agree. And I think that's part of the flaw is that approach to measure selection has been a disease process, but what if you said these are things every orthopedic patient, surgical patient should get, or patients with chronic disease should have this, patients, you know, with well, you know, well patients in the clinic setting should get this.

When you get to disease-specific, the numbers get small so quickly.

CO-CHAIR MOSCOVICE: Bruce, you sound like you want to respond directly or --

DR. LANDON: Well, I'm jumping in a little bit. I mean, I don't think -- the potential solutions aren't rocket science. They're sort of, you know, you can collect measures over a longer period of time, you can create bundles of measures that, you know, are sort of combined together, or you can create bundles of institutions that are combined together to increase sample size.

And I think those are the sort of issues that we should debate in this room in our recommendations.

And as I thought about it, I mean, the extent to which we can potentially encourage, you know, small hospitals and small practices to come together in their quality improvement and reporting activities might be a reasonable solution in that, you know, they can share best practices, try to sort of all pull for each other and whatnot.

That might be more effective than, for instance, saying, all right, we're just going to get together all of your measures in completely disparate areas, or we're going to measure your care over the last three years which doesn't capture any sort of improvement. So, just want to get that on the table.

CO-CHAIR COURT: So, just back -- I'm not a fan of big time frames, because the measures drive improvement and that's what we want to happen.

And if you -- yeah, and so if you're -- and value-based purchase is a really good example. Now with the hospitals, they're getting penalized on something that happened three years ago and that's wrong.

CO-CHAIR MOSCOVICE: Greg had a comment.

DR. IRVINE: Pulling data between small hospitals, I think, is probably not going to work because of the issue that we've talked about, the providers have talked about so much today, and that is time and expense.

We just don't have time and we don't have the money to be able to do those things, period. So, pooling data is extraordinarily time consuming and difficult and expensive.

I had -- I asked my -- one of my nurses who does nothing but extract data for these kinds of things, to extract me some data to bring to this meeting.

This is actually data for the Federal Office of Rural Health Policy for Marty.

CO-CHAIR MOSCOVICE: Marty is leaving.

DR. IRVINE: These were part of the Medicare Beneficiary Quality Improvement Project, the MBQIP which I had never heard of, but it's something that our hospital spent a lot of time doing.

We looked at Phase 1 measures for small hospitals. We're looking at discharge instruction lists for congestive heart failure patients. And then later on evaluation of left ventricular function. And also getting blood cultures in the emergency room for patients that were admitted with pneumonia prior to receiving antibiotics. For fiscal year 14 we had six cases.

One of the problems with that was that in the pneumonia cases we actually had 14, but several of them were -- had other diagnoses. So, they were excluded. So, that's that exclusion issue.

Then Phase 2 came along looking at acute MI. For fiscal year 14 we had eight cases.

For antibiotic timing in the operating room which is also a SCIP measure, we had lots and lots of cases, but it's also a SCIP measure and something we do all the time. Every time really doesn't need to be measured.

Phase 3 was the pharmacist verification of the med rec which was within 24 hours of admission and ER department transfer communication which had seven elements. And she said the data extraction out of the paper record which we still have because there were subset elements within those seven elements that had to be measured, took a total of 153 hours of nurse time to extract that data.

Hugely time consuming, hugely expensive. The data that was derived from that, I dare to say, was probably relatively meaningless and that's what we're struggling with.

CO-CHAIR MOSCOVICE: Other comments. Tim.

MR. SIZE: Yeah, in all respect I

don't think -- let me try to say it more positively.

(Laughter.)

MR. SIZE: We are in a point of transition away from paper to electronics. I don't think we leave here with a report that assumes it's got to work for paper.

I think it's got to as we -- I thought as a society, have been doing to try to create a glide path for us all to get from paper to electronic, but, I mean, I feel your pain. But, I mean, you've got to become electronic.

DR. IRVINE: It ain't going well in small hospitals, I'll say that.

MR. SIZE: Well, I actually work for 39 small hospitals --

DR. IRVINE: Well --

MR. SIZE: -- and they are either all there or about to be there.

DR. IRVINE: I'll amend that. It's better for primary care. I'm coming at it from another perspective where we're struggling and

it's very difficult.

MR. SIZE: And I don't want to be disrespectful about that struggle. I just think, and it's the complexity of this conversation --

DR. IRVINE: Right.

MR. SIZE: -- we need to address where most people are likely to be, but also address with needed care sites that are much further -- have a much further journey yet to go.

CO-CHAIR COURT: I'm just going to jump in here. Some of those same issues, doesn't matter if it's paper, electronic, I mean, those MBQIP ED transfer measures are way labor intensive whether it's electronic or paper. So, I think the design of the measures is critical when we think about the resources needed to collect it.

And I'm not sure there's input from providers about what's it going to take to collect measures in a system that don't have a lot of resources to -- because your nurses collecting the measure is not working on

improving it.

DR. IRVINE: Well, they're also not at the bedside taking care of the patients, which is where they need to be.

CO-CHAIR MOSCOVICE: So, I must reflect on the fact that the measure developer is sitting right next to you. And so, we don't have enough time to talk about it now, but I sort of -- where we're heading is electronic and it should work electronic a lot better than paper.

We have 10 minutes left. I'd say let's look at the screen here. And if people have some specific thoughts, we can wheel through these pretty quickly.

But in terms of, you know, we have talked about broadly applicable measures, the screening measures and so forth.

Are there other examples, specific examples you can think that would help staff in terms of giving some information, providing some information on the kinds of measures that would be useful or broadly applicable so we're not

looking at a specific condition now, but everybody who comes in, for instance, would be looked at. So, you'd have a larger denominator.

Any thoughts on that or --

MS. ABDELLA: Well, I think that what I wanted to say before was we have an opportunity here to look at some measures that really get at the root of some of the health issues that we have in rural communities.

We know that we have tremendous burden of heart disease, obesity, diabetes. And so, looking at measure sets that get us potentially working as communities in front of the care.

So, I guess some screening measures for things like BMI, referrals to services, you know. Maybe there's composite scores that come for certain patients.

But I think looking at definitely having some component of screening that moves our whole rural set, I mean, everything that we're talking about is all about treatment. It's after the horse is out of the barn.

And that's never going to get us anywhere in rural if we don't start measuring performance based on getting in front of that and keeping the barn door locked.

CO-CHAIR MOSCOVICE: Okay. Stephen.

DR. SCHMALTZ: Right now measurement is pretty much a separate process as far as collecting the data. But I think as we go forward in the future, think about measures that can be obtained as a byproduct of care.

Now, moving to the EHR, I think we're kind of moving in that direction although we're a long way of getting there, because you still have to look at the workflow of the physicians entering in the data, but I think working with that might --

CO-CHAIR MOSCOVICE: Any example that comes to mind?

DR. SCHMALTZ: None that come to mind.

CO-CHAIR MOSCOVICE: Okay. Brock.

MR. SLABACH: As a hospital administrator, I can't believe I'm actually going

to say this, but this -- when the hospital readmission reduction rate program went into effect several years ago, I was highly suspicious of it and its impact and what it was going to do to our hospitals.

And I'll have to say that I was pleasantly surprised about the reaction in the hospital industry and the improvement that has been made on that.

And if you look at the statistics since 2010 or 2011, the number of patients readmitted has just plummeted within a 30-day period.

It did incent hospitals then to begin to look outside of their own four walls to discover ways that they can keep patients from becoming a readmit statistic. And they've developed partnerships and all kinds of collaborations to be able to make that happen. And it was all because of that one simple program that was implemented on the payment system that provided those incentives.

So, I think we do respond to incentives. I think those incentives if they're structured correctly work and if they have policy outcomes.

And so, I guess that's a measurement that I think that does work and it can be applied fairly universally.

CO-CHAIR MOSCOVICE: I have Bob and then Bruce.

DR. RAUNER: I'm going to say I'm a big fan of the population health measures provided they're done correctly.

So, for example, we have picked child obesity screening counseling as one of our measures across the ACO regardless of plan, actually.

The downside though, again, I think, Kelly, you said make sure that they're clinically useful meaning one of my big frustrations with the MSSP is what they've selected you're supposed to do for obesity screening and counseling and also for blood pressure screening and counseling

makes no clinical sense to me.

So, for example, every time someone has an elevated blood pressure, you're supposed to counsel them and arrange follow-up. But what if they showed up on December 30th with a back spasm and their blood pressure is 140 over 90? I'm not surprised at that and I'm not going to arrange screening and counseling at that time, but they're holding us accountable for what I think is really an asinine way to measure it.

So, I really like population health measures as long as they're implemented correctly.

CO-CHAIR MOSCOVICE: Okay. Kelly.

CO-CHAIR COURT: So, things that should happen for every patient. They should have a timely assessment, you know. So, they should leave the hospital with a discharge appointment.

So, if we looked at the Medicare conditions of participation which regulate hospitals, there is, you know, specific

categories in there, but what happens now is the measures are like way over here and then hospitals are regulated on a whole different set.

So, I mean, could there be thought of looking through the -- the areas of the COPs and saying, okay, you know, it's an area for thinking about measures.

There's things that you have to do for surgical patients, but that's not what we're measuring in surgery. So, it's just a thought about creating some kind of framework.

CO-CHAIR MOSCOVICE: And so, I think the balance we're going to need to think about over the next day plus is, so, there is an awful lot of focus on non-outcome measures that I'm hearing. And I think that's valuable.

It can't be, I think, at the exclusion about, you know, sort of that balance how we do that and make it relevant for rural, I think, is certainly important.

So, we have at least one minute before lunch, but why don't we give that minute back to

our chair here.

Karen.

MS. JOHNSON: Okay. So, thank you very much. We're going to be thinking about what you said. We may come back and tweak it just a little bit more if not later on today or tomorrow, maybe in the next few weeks.

I definitely didn't hear as much as I would have liked to have from our health plan partners. Curious as to what you guys do to take care of this low-volume problem. Is it the structural measures that we've heard about? Is it the broadly applicable measures? So, we'll come back.

In the meantime, looks like lunch is served. So, we have a 30-minute lunch break. We'll start back up at 1:30. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:57 p.m. and resumed at 1:35 p.m.)

CO-CHAIR COURT: Okay. We're going to reconvene here. So, our next big agenda item here

is Discussion of Potential Solutions for Overarching Challenges. So, if we go back to our objectives, and I keep touching base with Karen here, Ira and I do, to make sure that we get done what we're here to get done. So, we're going to really try and really focus now on solutions, because I think we have a pretty good common understanding of what our challenges are.

And then we're going to -- after we have this initial discussion, then we're going to break out into -- we think it still makes sense to break out into the two groups, so group focusing on physician issues, and another group focusing on hospital issues. And we're going to try and focus that breakout session on the measurement gaps, or areas that we really need measures for that we don't have. And probably not specific measures, but areas of measures, so we'll get to that.

So what we want -- the things that kind of bubbled up that we think make sense to do some problem-solving around, we'll try and do

them in order here, is the -- so be thinking about your thoughts. So, level of analysis. Okay. So, for the physician practices is that -- should a P4P program be at the physician level, at the clinic level, at a system level, at a network level, at some other new creative thing we haven't thought about yet, or you maybe thought about.

We also want to talk about -- spend a little time talking about solutions related to alignment. I think we had a lot of comments about the cacophony of measures, and different programs, different organizations using same or similar measures for same or different things, so we want to spend time on that.

I want to spend a little time talking about peer groups, so if CMS is going to create P4P for the groups we're interested in, and I assume they are eventually, and if we can inform them so it's done better, I think that's our goal. So, what would we suggest related to peer groups?

And then we also want to spend some time talking about if there's a -- or not if, when there's a P4P program I'll assume for rural providers, how would we want that program to be designed? So, what are the attributes of a good program design? So, we'll spend some time on that, as well.

And I think that's going to be maybe the harder one, and maybe the other things we talk about will lead us to that, so then if there's anything else we haven't covered, we'll get there.

So, let's talk first about level of analysis. So, if there's P4P for rural physicians, rural hospitals, at what level -- what level of analysis do we think makes the most sense? Please.

DR. RAUNER: Surprise, surprise. Actually, one thing that actually Tonya and I were talking about on break, that actually patient-centered medical home, a lot of these leads back to that, so if you don't have enough,

for example, measures for X, focusing on being that is just as useful, I think, sometimes.

Another thing that I think is a potential solution is if you're doing this, if they can exempt you from what I might consider a legacy CMS program. A few years ago we had ERX, Meaningful Use, PQRS, none of which aligned with each other, but if you're doing Meaningful Use, you're pretty much doing most of the other two, so why couldn't one exempt it from another? And it took them a while to get to that point. Actually, I think we're there now again where Meaningful Use Stage 2 went off the rails, and what we're doing with ACO and medical home is way more meaningful than what Stage 2 Meaningful Use is. So, if we could get out from underneath Stage 2 and not have to worry about that ball and chain and focus on ACO and medical home, we could do a lot more, but now we've got this extra bit of overhead stuck here. So, if we want to talk about process, I think focusing on being a value-based entity like a patient-centered medical home is

one of the big buckets that could help.

And then back to measures, you know, I think going back to the population level measures like flu shots, med rec, the BC screening which apply to most of your population, you're good.

CO-CHAIR COURT: Within that value-based entity?

DR. RAUNER: Yes.

CO-CHAIR COURT: Okay. Other thoughts about how a provider -- so, the ambulatory side, what that unit should be?

DR. LANDON: I think this gets back to sort of the issue we were talking about before. Again, there's sort of relatively limited options for doing these things. And to the extent that whatever system that comes into play provides a path or incentives toward, you know, aggregating across providers and sites probably makes the most sense. I think we were actually talking a little bit before how, I guess, he knows two different markets, and in one of them, even

though there's still a lot of practice sites that have solo or two-person places, they've kind of affiliated with either community access hospital, critical access hospital, or a system or whatnot that helps them a little bit with sort of having some common infrastructure and whatnot that can be used. And to the extent that whatever system that we develop or recommend on the ambulatory side is aligned with moving in that direction, that will probably be helpful for these places.

CO-CHAIR COURT: So, Bruce, how would that get implemented? I mean, what would -- so, clinics, I'll just call them clinics, would self-define some kind of network if they didn't belong to a --

DR. LANDON: I think --

CO-CHAIR COURT: You know, Wisconsin is so different because they're integrated systems and everybody is in a network, so if you're not in Wisconsin, how would you do that?

DR. LANDON: So, there's -- I mean, I think -- and I'm just thinking out loud here, so

someone who knows more please correct me. So, there's probably --

CO-CHAIR COURT: Into your mic, too, so we can hear.

DR. LANDON: So, there's probably two options. So one is, you know, we need to -- for stability we need to have, you know, 5,000 accountable patients, or 10,000, whatever it is. And there's an average of X patients for clinics, so we need five or ten of your sites to aggregate together and you can report together. And you choose it yourself, or we'll choose it for you. And I imagine that places will want to choose it themselves, so there's, you know -- relatively locally, so there's a big patient-centered medical home demonstration program being run by CareFirst, which is the Blue's plan in Maryland, D.C., and Northern Virginia. Obviously, those are places that are not particularly rural, although there are some rural areas in Maryland that they cover. And for their smaller practice sites they actually -- they impose -- they put them together

themselves. But, you know, my own feeling is that places would rather choose their partners than be told who their partners are. But, you know, again, implementation can be difficult.

CO-CHAIR MOSCOVICE: So, how does that play into pay for performance? So, in other words, you join a group of other clinics. I would join the highest performing group, obviously, if I'm going to be part of that. The whole group gets a payment increase, decrease, whatever. Is that how that works?

DR. LANDON: Yes. So, again, so this isn't like, you know, you've got this really high performing 15-member group, and you're aligning your single practice with that. It's that, you know, there's these 10 practice sites that aren't big enough on their own to become -- you know, to report, but we'll put them together so there's not -- it would be hard to know that, but you certainly can say, you know, I'm choosing to align with this guy because I think he has good systems in place and does things well, and

everyone thinks he or she is a good doc. So, in terms of sort what they're actually getting -- this program is actually a very interesting program, but they have these patient-centered medical homes which, again, are either single sites within larger sites. They have different, you know, groupings. And then the smaller sites, they put them together, and they're actually responsible for TME, in addition to quality measures. So, they're doing, you know, very -- sort of very serious kind of consequences for what they're doing.

CO-CHAIR COURT: So, would you see that -- those sites that would come together to have geographic -- some geographic proximity, or could you have a practice in Florida, and a practice in California, and somebody in Wyoming?

DR. LANDON: Well, you know, from a program perspective, to me it doesn't make sense to do this unless you can actually create, you know, working on the ground synergies. And I don't see that happening if you are putting your

practice in Florida with one in Kentucky.

CO-CHAIR COURT: Go ahead, Ann.

MS. ABDELLA: She saw me jumping again. And idea that we've been wrestling with to that point, and I think it's supported by some work that the National Rural Health Association had been working on, and maybe HRSA around the idea of virtual patient-centered medical homes, so the idea of the patient-centered medical home, I think there's a lot of kumbaya in the room about -- from a primary care perspective for those of us who are doing this work. We think this is as good as it's probably going to get for our lifetime. So, the virtual patient-centered medical home would be that opportunity for providing some of those data collection supports and, you know, helping get their care management pieces together and reporting in some kind of aggregated way. And I think there is potentially a rare opportunity right now in this window of time with the TCPI Initiative that CMS is funding through CMMI across the country to look at

bringing along small and solo practitioners. And they're trying to build that infrastructure now to get them up to speed.

There's also a huge press on -- certainly in my state, in New York, and I know others to bring primary care up to advanced primary care as part of Medicaid redesign. So, there's a lot of stuff going on right now that's kind of desperate to figure out how do we bring along these solos. Honestly, is that a rural-specific issue? I can't speak to it because the world I live in is only rural, but just some thoughts.

CO-CHAIR COURT: Great. Jason.

DR. KESSLER: I don't know that this is, you know, an ideal situation, but it's at least an example of something I'm aware of that has worked. This began in the State of Colorado. We don't have anybody from Colorado here? Okay, so no one is going to correct me if I completely screw this up. And I believe there's one other state that's doing it, and Iowa has been looking

at it, but what they did is they divided the state up into regions based on population. And, you know, there some process of putting somebody in charge of each region which was, you know, some sort of contract procurement thing. But, basically, each region became its own level for measuring the data so that each -- and it's based on population that they divided up the regions. But each region, even competing organizations within a region, the idea was that each region is measured. It's just an example of a way of leveling the field for measurement across the --

MS. MOORE: Do you think that would work, though, for pay for performance? So, if I'm a high performing primary care, and I know there's a not so great practice down the road, and I get grouped with them, and my pay is based on their -- driven by their -- I'm not sure providers -- how would that work?

DR. KESSLER: Well, I don't know for sure. I know that, you know, they kind of -- with the procurement that went along with it, there

was one organization per region that was sort of in charge of coordinating the effort, and then, you know, distributing the pay for performance results of what they did. So, whether those, you know, master organizations subdivided out different things in their regions, or how they managed that, I don't know.

CO-CHAIR COURT: Okay. We're going to come back over here and then go back across. I think Guy was next.

DR. NUKI: I have a little bit of concern about putting these clinics together, and it's around two reasons, one of which is if you're going to look at geographical similar areas, a lot of rural areas aren't going to have any choices. It's going to be the clinic that's 45 minutes away, and then the solo practice guy who's 85-years old and should have retired at the age of 30. That, you know, like well, they're the only people that I can work with, and so that's one problem.

The other thing is, I think it's just

going to end up being regression to the mean. I mean, if I'm a really good provider, and I'm not getting rewarded for that because the other providers aren't, I'm going to stop trying. And if I'm a bad provider, and I'm getting rewarded some because the other people are really good, so why should I change? I like the way I practice. So, I don't think that it's going to change the behavior. I mean, it's just -- it's going to move money around, but I don't think it's going to give us an improved quality of care. I don't think it's going to help our patients any, unless those disparate clinics all decide okay, we're just going to join an organization, Kaiser. We're going to all be employed by the hospital or something like that, and I think that most rural providers, some of them are there because they don't want to be part of a massive organization. So, I think putting this together like that is - I mean, it statistically makes sense, but I don't think it's going to work.

CO-CHAIR COURT: So, Guy, would you be

a proponent then of the level of analysis and being a penalty incentive is at the provider level, individual provider?

DR. NUKI: Actually, I'm not. I think that the level of analysis should be at the provider level so that you can -- but you've got to create, obviously, measures that are meaningful, you know, with a low volume, everything. I think the pay for performance should be at a different level.

I think tying all of the quality measures to money is not necessarily going to change behavior. And, as a matter of fact, I mean, there's science out there looking at this, lots of it, and it says this is a bad idea. I don't know why U.S. businesses and U.S. -- you know, why we keep looking to try to do this, but it doesn't work.

Does everybody know the day care situation that I referred to? Okay. Well, assume somebody doesn't. Very quickly, they had a day care, parents were showing up late to pick their

kids up. They decided okay, the day care said this is a problem, we need to prevent this from happening, so we're going to charge parents an extra $25 if they pick their kids up late. So, they said this should solve the problem. Parents don't want to have to pay that. So, they did it, and actually the rate went up. Okay, and then they said oh, geez, that didn't work. Let's get rid of it, and the rate went up even higher. And if you look at it, basically parents were saying you know what 25 bucks for an extra hour at work, it's worth it. I'm going to stay. And then when they took the penalty away parents were like hey, you know what, now I don't have to pay the $25. I might as well just make it two hours.

So, I think -- that's a real world situation. I think that we really need to think, really think are we just going to try to use money to change behavior? And I don't think you're going to do that with physicians. It's kind of what I do, I try to change behavior of physicians. Money doesn't work. I think it does

work in systems, as I said before. So, anyway, that's my two cents.

CO-CHAIR COURT: Okay. I think Bob was next.

DR. RAUNER: I'm actually going to go back to Bruce's question here, because that essentially is how we formed. Although it says ACO on my business card, we're not really an ACO, if you consider ACO to be a big, vertically integrated system. What we really are is a loose federation of patient-centered medical homes with a support structure that does IT and quality, and other stuff. And it helps us band together and negotiate as a group so we can get people like Ken to listen to us. But that's essentially how we formed. And we're not -- we're geographic -- along the I-80 corridor north and south, but we hopscotch around because sometimes there's a practice, frankly, I wouldn't want them part of us because I think they suck. They're practicing run up the bill medicine, and I don't want them with us.

And then from a level of analysis, we do need that pool because now as 12 we have, you know, 14,000 Medicare patients. That's enough to be a risk pool, actually. And then internally we actually don't -- I -- we don't -- from my level discriminate between the physicians. We leave that up to the practice. They're a team. If they ever got a bad actor in their shop, it's their job to fix it. It's not our role to go in and say you need to fire Dr. So and So. Because, frankly, we don't -- I don't think -- like you said, I don't think we need to give them money. If Dr. So and So sucks compared to his peers, he's going to fix it, or eventually he's going to get booted off the island. I don't think we have to throw dollars around to make him do that. If everybody agrees that controlling blood pressure is a good thing, and some guy has 70 percent, the other has 30, they're going to fix it, or eventually they're going to kick him out, or -- I don't think you have to pay him $10 more than the other guy.

Now, eventually, what's going to get awkward in our ACO is we do have written in so that if we do get a bonus and it gets distributed, there will be some quality criteria. And that's when the rubber is going to -- things can get ugly, you know, if this clinic misses out on 100 grand and so and so drug them down. It's not my problem, it's the clinic's problem. And it's going to be funny to see -- not funny, but it will be weird to see how that happens. But I'm actually totally for this loose affiliation of medical homes approach because it's working well for us, at least so far, anyway.

CO-CHAIR COURT: It sounds, though, that --

DR. RAUNER: And it ends that way, too, I think.

CO-CHAIR COURT: -- an important part of that design would be it's the provider's choice to either do that or not do it with the groups they're interested in being affiliated with. Is that --

DR. RAUNER: That's good, because if some people don't want to change, fine. But they're going to make less, if they're okay with that. And if patients want to keep going to those guys or gals who have crummy results, well, that's their choice. It's a free country.

CO-CHAIR COURT: So, we're going to do Mike, and then Greg, and then come over to John.

DR. BAER: Yes, you answered some --

DR. RAUNER: Sorry, I didn't mean to --

DR. BAER: No, no, not you. I think --

DR. RAUNER: The comment about getting you to listen.

DR. BAER: Oh, no, I wasn't listening to you. What did he say? No, what I wanted to say, I really like Bruce's idea of affiliations. I wouldn't -- but I would couch it in the sense that, you know, if those practices who otherwise would not qualify would only be in the pool to affiliate, meaning, you know, you have an ACO here. They're already affiliated. They don't need

to be in that pool, but as a payer right now -- and just to let you know, we're a small payer in a large pool of payers in Pennsylvania.

But one of the things that we struggle with are those practices -- let's just say, in Pennsylvania, you know, we have a big pot of members who qualify for Medicaid, and they're cut up amongst nine different managed care organizations. I am one of those managed care organizations, so we have practices who are -- whether they're a PCMH, or whether they're just a solo practitioner in rural Pennsylvania, they don't want to affiliate with an ACO, or Geisinger, or UPMC, some of the gorillas in Pennsylvania. They want to stay local, and they want to stay independent, so this would really be good for them.

And I agree -- your comment about what do you do after you get the money? I think it would have to be an aggregate analysis, but then have the ability to have group level or provider level results so it can be distributed, however

that loose affiliation would like to do it.

CO-CHAIR COURT: Okay, Greg.

DR. IRVINE: I want to agree with what Guy said, number one, is that physicians are poorly motivated by financial reward. They'll take an hour of free time over 200 bucks any time. And we've had great trouble in our organization motivating people with money, but they're very easily motivated with extra time. If they can have time with their family, that's extremely valuable.

CO-CHAIR COURT: So, how would you build that into a P4P program?

DR. IRVINE: I don't know, give them hours. I honestly don't know. I think it's very difficult to do P4P. I'm part of a big vertically integrated group at what I would call an evolving ACO. We're not really an ACO either, but we're trying to be, that is dominated by the largest health care system in the State of Idaho, and with delusions of grandeur. But they don't get rural health care, and I think that's where I got

into it with Tim earlier, was the one reason we don't have electronic medical records on our inpatient side is the hospital -- you know, we're kind of out there somewhere and they'll get it to us eventually, but not right now. Whereas, your cooperative clearly, you know, takes care of the rural health care. We're kind of -- we're at the back of the pig, as they say in Nebraska.

And I think we have to be careful if you look at large vertically integrated groups that happen to have sort of tag along rural health care providers incenting the big groups thinking you're going to get everybody because the rural providers are, as I said, often left at the back of the pig.

CO-CHAIR COURT: Okay, John, and then Tim, and Jason. Your microphone.

MR. GALE: Thank you. I tend to be a little nervous about the collaborations, not because they're bad things, but because I think we have to understand what we're trying to accomplish with pay for performance. If one

appropriate goal is to have enough transparency that an individual and a patient can make a decision about where they're going to go for their health care, aggregating up to a bigger unit doesn't really allow you to do that well.

And the second is that how a practice or a hospital decides how to award its money internally, that its own decision, but it's not really, I think, the point of pay for performance. I tend to default towards sort of the smallest unit of analysis that allows the entity that's under study to be treated as a team. So, to what extent does the practice allow -- does monitoring the performance, rewarding payment affect the direct delivery of care? So, I do understand the value of the collaborations because you can develop resources to monitor and track performance. You can set some established policies, but it sort of blurs things for me.

CO-CHAIR COURT: Tim.

MR. SIZE: I want to go back to Guy and Greg who have been disagreeing a lot because I

want to strongly agree with 90 percent of what they said. Where I disagree, if they're right about this economic incentive doesn't matter to physicians, we're overpaying an awful lot of orthopedists and other doctors, so I would need more conversation around that hypothesis.

Having said that, the rest of what they said I think they understated it. I think using -- solving the low volume problem by requiring aggregation would be a disaster in every sense of the word. I can't think of a worse idea.

I think where we're seeing some really good growth with the rural ACOs because it's a voluntary coming together. But if we solved the problem -- well, you guys are going to have to pick somebody or we're going to force you into a clump because that's the only way we can deal with low volume. I mean, that would -- I wouldn't want to imagine how nasty that would get. And I don't think we get the best out of people when we force them into unnatural relationships.

Having said that, one more point. I'm not speaking for -- I'm not speaking against mandating participation, because at my University of Chicago Business School, I believe in buyers and sellers. And if the buyers these days, whether they be CMS, or Anthem, whatever saying look, as part of this deal you're going to show me you're doing X; well, the only appropriate response is to exit the market, or to do a deal. So, I'm not arguing against mandatory, but I'm arguing it would be a disaster to the whole outcome metrics process metrics movement that we're all part of to use it as a way to other means of consolidation. There would be a rebellion.

CO-CHAIR COURT: Okay. Jason over here, and then I think Bruce is next.

MR. LANDERS: I'm a payer, too. So preface by saying that up front. But one of the things that we deal with, and we have a PCMH project, as well. Up until recently that was really my main function in life.

CO-CHAIR COURT: Bruce, can you speak more into your microphone?

MR. LANDERS: Yes, I'm sorry.

CO-CHAIR COURT: Thank you.

MR. LANDERS: I had a -- we -- Highmark had a PCMH project that we were -- that I was largely responsible for until very recently. But one of the things that is curious about West Virginia is that there are only a few large groups, and even fewer systems, so it is a collection of these I'll call them onesie-twosies, momsie-popsies. So, we were kind of confronted with how do we report data out?

We came to two conclusions, and one is that it -- looking at cost and utilization reporting only works if you aggregate. There is no other way around it. Now, how do you aggregate? Exactly what you guys have been saying, you'll either come together, or we'll force you together. And I can tell you that, as you said, people don't like that. It never works, and it doesn't work for a variety of reasons.

One, if you force people together, that doesn't mean they collaborate. And really that's what you need, is to be able to collaborate.

So, one way that we found that actually works to help them learn to collaborate is to, in that forced union of practices to create a data sharing or transparency among that group. And even if they are somewhat different in their practice styles, and the way they do it, they actually have to see it. They have to see how the other guy does it, and then it essentially is up to them how they allocate their group's resources in terms of incentives or whatever based on their outcomes of their group. So, they tend to learn to collaborate almost in that sense. It works only marginally better than not.

Now, on the quality side, we tend to report out at the lowest common level. I believe you should always report at the lowest common level, and then group those on the lowest common grouping; meaning, if it's a practice of five

doctors, well, they can affect each other in terms of their quality outcome, so you would report to them, but providing them with the individual data.

And that was kind of a question I had. When you say is the lowest level in the provider level, are you talking a person or an entity? I think of a provider as a person, as opposed to an entity, but in many cases entity reporting makes a lot of sense if they're integrated.

I think I'm echoing what was said, is that you -- what we've seen on the payer side is that there is this -- some things you can't do without aggregation. It makes no sense in the other situation, you have to have 5,000 members or 25 -- whatever the magic number is, depending on who your actuary is. But in other things like certain quality aspects, you can have a much lower standard because really you're measuring the direction of the practice, as opposed to kind of that larger system entity. So, I'm not sure I said anything new, but I was kind of echoing.

CO-CHAIR COURT: Okay. So, we'll do Bruce, and then Jason.

DR. LANDON: So, I want to push back on a couple of points, but really by making --

CO-CHAIR COURT: Up to your mic, please.

DR. LANDON: I want to push back on a couple of points, but really by making sort of more of an overall argument. So, the first question is, it's -- so, we can throw our hands up and say, you know, the volumes are too small, they're too disaggregated, they don't have their systems. Let's just exclude them from everything. I actually don't think that that's in our mandate. So, if that's not in our mandate, then as I said before, we have a relatively limited number of options that we can choose from; actually, do measurement. That's sort of statistically meaningful, you know, valid and rigorous. And for me, choosing the -- you know, what I'm sort of starting to advocate for, which is aggregating across provider groups, to me just

seems like a better solution than measuring over three or five years, or taking very disparate quality measures and just adding them all up. And we can talk about some of the statistical issues involved in that, and Steven can probably do a better job than I can do, but I know having done this in a lot of recerts that I don't think it works very well. So, again, so we have to remember we're not debating throwing our hands up versus one of these choices. We sort of have to make a reasonable choice. That's issue number one.

Issue number two is, I think when we think about sort of quality measurement, reporting pay for performance, just sort of like what I think of as low impact and high impact uses. So, a high impact use would be pay for performance where you've got money on the line, would be public reporting. And I think that it's paramount that we recommend that measures do have statistically valid, defensible, adequate sample sizes and all that, if you're going to do that

sort of high impact stuff.

Now, if you're doing internal data sharing and using it for quality improvement purposes, i.e., within, you know, an aggregated unit, I am all for disseminating those data at the smallest unit possible. And even if, you know, your sample was only three, but you didn't do it on two, there's some actionable information there.

And then some made the argument, you know, when you put people together all that's going to happen is you're going to regress to the mean because no one is going to work together. And I think, you know, that's a concern but, you know, if you sort of build the incentives the right way, the other thing that could actually happen is that, in fact, they start working together. So, the aggregate data come back, and people look at it, and then they actually look at the individualized data. And they say, you know, this practice over here -- and, also, we need to start, you know, don't speak, this guy is bad.

They just don't have good systems, you know. This practice over here isn't doing well. Let's see if we can have him spend a day with our best guy over here and learn what they're doing, or let's see if we can have our central infrastructure help them with developing their EMR better, doing a better job on the registry, or developing a system. And, you know, when you start putting a little financial incentives in the pot, and if they're groups that want to work together, you could see some of that cross site sharing.

Now, I think I also heard a lot of objections to say, you know, if we randomly just throw people together, they're going to completely object, and that won't work. So, potentially, you know -- so, there's two potential solutions to that. One is sort of, you know, choose your own. The second one is, you know, if you don't want to aggregate with anyone and you want to be out, then you're just out. But then they don't -- but that out has a penalty on it, which is that if you're putting part of your

pay in pay for performance or part of it in some sort of, you know, aggregate level thing, they don't get to participate in it. And if there is enough of a carrot there, then they'll work to find their partners.

So, I think those are some of the things that we need to be thinking about because, again, you know, we don't have a huge menu of options that we have to choose from. And if we have to choose something, those are sort of the three things I think that we need to sort of be talking about. And, you know, we need to sort of advocate for one of them at some point.

CO-CHAIR COURT: Jason, and then Kimberly.

DR. KESSLER: To make what perhaps is a sort of obvious statement, in looking for solutions there is no one solution. And we're not going to, you know, come to a consensus on one brilliant idea that is going to, you know, uniformly make fair, just, and accurate measurement of rural health care. Wouldn't that

be nice? But to look at the problem, think if a couple of things.

You know, Guy said a couple of times that giving money to individuals for better performance is not really a mechanism that works very well. And he went on to say that it might work more at a larger organizational level. And don't know whether that's true or not. I haven't seen any data, or have any experience on that, but the first part of -- you know, that giving money to individuals probably doesn't work very well, I would definitely agree with.

I mean, I have my doubts about the effectiveness of pay for performance as a concept, anyway, in a health care that so desperately needs to drive down the cost of providing care to people. But that's not really, I guess, our scope here, what we're charged with trying to determine.

So, to address, I guess, the question of the sort of levels of how we look at data to -- and measure data to analyze performance, you

know, we've noticed that doctors, and nurses, and providers tend to have some level of competitiveness to them. That's the nature of the profession, the types of people that take on medical careers. So, to look at people at an individual provider level may actually have some wisdom to it, just for the sake of looking at that.

The caveat to that is you have to have -you know, if I'm going to say that you're in the top 75th percentile of providers, it has to be a valid comparison. You know, I have to compare you to, you know, percentiles that are actually relevant to you. But I guess my thought then is that that would make sense than trying to do a population measurement to respond to that question.

CO-CHAIR COURT: Kimberly.

DR. RASK: I would really -- I just want to sort of, I think, reiterate the point that I think there would be a lot of value to recommending mandatory reporting. I think in, you

know, all the years I've had working with our critical access hospitals, as people have pointed out, all rural areas are different. A lot of our rural areas -- a lot of our critical access hospitals, many of them, some of them are probably going to end up being converted fairly soon. And they are going from never having been asked to do anything, never been required to do it, and then now facing the IPPS expectations. And I think there are real concerns about how that transition is going to go well for them or not.

You know, I see so much energy expended by our hospital associations and by the offices of rural health to get critical access hospitals to voluntarily report something for the activity of doing it. What if we -- I think it would be a vast improvement to take that off the table and say it's going to be mandatory reporting. Let's figure out some core measures, some optional measures, and it's pay for reporting, just report. And then let the

competition, and then let the ongoing market changes that are going on sort out. I bet, you know, again, we're in a little bit different area in North Carolina and Georgia. More of our critical access hospitals, rural hospitals will have the opportunity to become part of far flung networks that will probably drive a lot of the other change and integration, in which case they may end up reporting under some of these other entities. But simply mandatory reporting on some measures for all critical access hospitals, all rural providers I think could really jump the whole field forward.

CO-CHAIR COURT: So, let's just -- let's segue then to -- so, we've been talking about physician practices. Let's talk about level of analysis for rural or critical access hospitals. It seems obvious to me it's at the hospital level. I mean, are there other options that we should think about or suggest? Yes, Marty.

MR. RICE: One of the things that we

haven't really discussed here, and as a nurse I feel a little obligated to bring it up, is that the true consumer of health care is a patient. They purchase insurance, whether it's from Medicare or whomever else, and what we're seeing is -- and it's not going to happen in remote areas where it's 200 miles to another health care facility, but there's a tremendous amount of bypass. And how do we meet -- you know, we -- I'm hearing a lot about reimbursement of clinicians. What do the patients need to know to make clear decisions about their health care? And I think that was the true reason why quality measurement was put in place to begin with. So, you know, what do the patients need to make a decision where to go? I hate to kind of throw it in that direction, but --

CO-CHAIR COURT: Well, I'll just have some thoughts about that, because we deal with this with the purchasers in our local community. So, you know, some of them are moving towards this pay for value, you know, high quality-low

cost. But two internists can't take care of the entire city of Madison, so there's access issues, you know. So, I think it's a great concept, but being able to implement that in a way that -- and those two internists already have a full practice, they're not taking new patients. So, I think the concept is right but fundamentally very difficult to implement.

MR. RICE: But the patient has to be in the mix. That's all I'm saying.

CO-CHAIR COURT: Yes. No, I agree. It seems to me like -- I'm a big proponent of individual physician public reporting because I work with physicians a long time, and they're competitive, and they will try and change a result. And if the results are transparent, they'll self-correct. I think once you get to these penalty payment incentive, and I think we should all be honest, it's going to be penalties. You know, maybe that can be at the group level, but physicians -- patients want physician-specific results. And we've got research in

Wisconsin that proves that.

MR. RICE: But it's not just physician level results, it's hospital level results.

CO-CHAIR COURT: Yes. No, exactly.

MR. RICE: It's how communities take care -- because it's not just -- health care is more than just medical care. It's joint care between a community and the resources, and things like that. So, I just throw it out there as kind of -- to look at.

CO-CHAIR COURT: Other thoughts before we move on? Bob, or Mike, sorry.

DR. BAER: The comment about physician -- reporting data at the physician level, it's a great idea, but I'm really concerned about physician level attribution because one of the concerns that -- one of the things that happens in a claims-based reporting would be that who is that patient really attributed -- all I care about is I see a claim with a diagnosis code or, you know, a CPT code with a patient's name on it, and it meets the criteria for whatever, but it

doesn't mean that Dr. X took care of that patient.

CO-CHAIR COURT: No, it has to be done correctly.

DR. BAER: Okay.

CO-CHAIR COURT: Yes. And we've got a system in Wisconsin that attributes patients to primary care providers, and the providers do not complain that those aren't my patients. So, it can be done correctly, much better than how HEDIS does it, where one CPT with one doc, it's your patient. But there's ways to do it.

DR. BAER: We may need to talk because I need to know how to do that.

CO-CHAIR COURT: Okay. I think Guy is next.

DR. NUKI: So, I think I'm hearing that there's three different levels. One of reporting, the top is pay for performance where there's money behind it. The next is public reporting, and then the third is the individual provider. And I'm talking about individuals, I think when I

say that, gets the data. So, if you do something three times and get it wrong twice, to publicly report that is stupid, but it's still information that that provider can use, because it was really interesting hearing what Marty said, because it made me realize that we approach things from different ways.

I wasn't thinking about the patients making decisions about where to go to get their care. I was thinking we do this so that the system and the providers improve what they do. I think both are important, but that was kind of eye opening for me. So, I think, though, that it's -- we can have non-statistically significant data that goes to providers, and then we need really good statistically important data that is publicly reported, and then the pay for performance. I still don't think individuals are going to respond to the money, but I --

CO-CHAIR COURT: Okay. I think, I don't know, Tonya. I'm not sure where we're at.

MS. BARTHOLOMEW: Thank you. Two quick

points. When we're talking about attribution of patients, I'm going to say patient-centered medical home one more time. There's a factor in there that says that you attest to letting patients choose their primary care provider, and that you have agreements with specialists in outlying hospitals and other facilities to collaborate and provide that care coordination. The model is already built. I think we're reinventing the wheel here.

The second thing is, if we're going to do away with pay for performance, I still have to pay someone in my clinic to collect and report data. How am I going to do that? My patient -- I just said earlier on today my cost to take care of a patient is $132, and for Medicare under our rural health clinic I was reimbursed $78. I cannot pay someone to collect and report data if I don't have some sort of financial incentive to do so. That's, you know -- I think what we're going to come to is that, you know, small individual independent practices are going to

have to be absorbed into some sort of an ACO model.

CO-CHAIR COURT: Okay, Brock.

MR. SLABACH: Where to start? This -- first of all, when we talk about critical access hospitals, I'll start on that first. I think we need to broaden the discussion to make sure that we include and make our report specific to small PPS hospitals, as well, because a small volume issue affects PPS hospitals just as much as it does the critical access hospitals. So, I guess I just want to have -- okay, Karen is shaking her head, so that's good.

And I think a facility, whether CAH or PPS should be able to select for -- if we come up with an option, a menu option for small volume measurement, that they should be able to select that, at least the PPS hospitals.

Secondly, I do agree. I think the -- I find myself agreeing with a number of points, and some of them might be quite contradictory. And that may, again, noting the complexity, but I

think that -- I know that there was a lot of information I had on my clinics, and in my hospital that I would never dream of putting out public because, first of all, you have to have an understanding of the information that you're looking at. And, clearly, the issue is now how do you use this internally for performance improvement?

I think if there is some kind of them rolling up, if you will, of the data into something that could be meaningfully reported to the public, I think that's incredibly powerful because I think patients do need to know, to Marty's point, what their providers -- how they compare, how they're performing.

And then I'm less enamored with the pay for performance because I think that there's a lot of problems that could be held there. And everybody -- all of my colleagues will find every single flaw that will be problematic for their reimbursement. And we'd be spending more time talking about why they didn't get that extra bump

in this reimbursement than actually looking at the reasons for why they should improve their performance. I mean, it's -- so it becomes more of an excuse making exercise than it is actually a performance improvement exercise, just possible.

And, thirdly, I will -- or fourthly, I will point out that every state, all rural states, 45 of them, have State Offices of Rural Health. They have associated with them flex programs, their Medicare Flexibility Program. Those programs are set up to provide assistance to critical access hospitals, and their related clinics, and communities to be able to improve performance. That's one of the important characteristics of that.

I do know that the flex coordinators get a certain set of data from the Federal Office of Rural Health Policy through these MBQIP, as we've used that before. And they actually target resources, and they can use that data to target resources to these facilities to help them

improve and initiate activities to make improvement in certain areas.

And I think that if we did mandatory reporting and we recommended coupling with that targeting of assistance to those that need. In other words, we're making this a robust set of mandatory -- we have the mandatory, but they're also recommending process issues, i.e., a MAP process, or small volume providers, and technical assistance for those that -- in terms of this transition and adaptation to this new reporting environment.

CO-CHAIR COURT: Ann, and then Tim.

MS. ABDELLA: I'm not sure where this all fits into the conversation, but the idea that we're going to have to make sure that people are getting what they need, and managing them to process an outcome. And if we're going to be so data driven with all of this, I'm thinking to myself what are the data sources that these hospitals and these doctors are using? And it's only the information that they have in front of

them from their electronic medical record, or their paper charts, or whatever.

And I think in the new world order, and the thing that is so helpful from a rural perspective is having access to claims information, because we deal with people here, and we send them out into the world. And we don't know what happens to them. So, if we're really supposed to be managing them in a patient-centered medical home environment, I think we need to include something, if we're going to make data so doggoned important and process and outcome, then we have to be equipped with all of the data to be able to do the job.

CO-CHAIR COURT: Okay. Tim, and then Ira, but let's start thinking about appropriate peer groups, too, as we suggest solutions. So, Tim.

MR. SIZE: Yes. This is actually a comment on context of our conversation, and I apologize, I think it probably makes it more complicated, but I wanted people to have the idea

in their head. And it started with Guy talking about this hierarchy thing with pay for performance on the top. There's actually a fourth level above pay for performance. In that horizon you understand what we're doing. Well, we are concretely literally making recommendations into CMS. Those recommendations have an impact far beyond that, i.e., the commercial marketplace. And we're already seeing in the commercial marketplace in Wisconsin, I think we're far -- harbinger of a lot to come, that metrics being used for purposes of steerage are simply not contracting with a provider, which is more than a percent or two that doesn't incentivize anybody. It's either you're in the health plan or you're out of the health plan. So, the metrics we're talking about -- because I think we have to anticipate whatever we recommend to Medicare, and particularly if they actually read the report we give them, will be eventually picked up by the wider marketplace. So, the issues of the metrics we're talking about being used for steerage

and/or simply not contracting is extremely powerful, and I think will get people's attention. It gives our work, I think, even more responsibility.

CO-CHAIR MOSCOVICE: So, believe it or not, I think we agree on most everything, but there's one large issue we don't agree on. Call it what you want, external use, generalizability, external validity, but everything else in terms of the value of the data for internal use, I think a lot of people are saying the importance of mandatory reporting, transparency, and so forth. I think there's a lot of agreement here.

The one thing I don't think we're agreeing on is sort of okay -- and let me add one other comment before I move on, which is our charge is what do we do about rural in the context of pay for performance? So, that's not going to go away. And I don't think -- I guess one option to say well, rural shouldn't be in pay for performance, but I think we'd have to think real carefully about that before we went down

that path.

So, you know, maybe the best we're going to be able to do in the generalizability issue, or the external use, is to say there's a couple of options here. And here are the pros and cons. And in some ways Bruce is right, it's not great but it's better than other options. In other ways, though, what you're getting push back from is saying it doesn't really fit in small rural practices to start grouping them in any old way.

And I think maybe that's the best we could do, or maybe we can get some consensus as we move through to tomorrow about how do we grapple with the external use when you have a low volume? But I think that's the main issue we're not agreeing on. Most everything else I think we really -- there's a lot of overlap in terms of what people are saying, so I'd say stay positive and just keep -- we'll be thinking about the generalizability issue, or the external use issue some more, but I think it's probably time to move

forward to one of the other areas in terms of discussion.

CO-CHAIR COURT: Yes. So, let's talk about peer groups. That was something that was a theme in kind of our homework, and it's kind of bubbled around without real explicit discussion about it this morning. So, how would we suggest peer groups get defined? Bob?

DR. RAUNER: I think I might be able to segue into this one. Starting with the fact, I agree 100 percent that we need public reporting provided it's valid and agreed upon. So, I think Brock could come up with good measures for his folks, and if CMS would agree with him and pick measures that Brock agrees with, because the problem is, frankly, is that CMS picks what it wants and they don't listen to us a lot of times. And they judge us on the stuff that I think are frankly stupid. So, like these 33 measures, it's publicly out there. It shows how we did it, it shows how Ann did it. I think it's great that it's out there, except that some of these are

stupid measures. So, they should pick measures we all agree on that are good measures, like blood pressure control or med rec, for example. We agree on that, that should be out there, and I think it should be public, and down to the level that's statistically valid. So, on the ACO level it might be good, great, put it out there. If it's on the clinic level and it's valid, great, put it out. If it's on the physician level and it's statistically valid, put it out there. I think it will drive a lot of great change provided the measure is appropriate and statistically valid.

And the peers should be somewhat self-defined. Like, Tim, I'm more of a free market guy. Let them freely associate and the ones who don't want to associate, if they can't provide good results, they should get paid less over time so that the market will weed them out, and the money should flow to people who do a good job. That's the way it should work, so I really am against, like Guy has been saying -- I think read

Dan Pink's book about motivation. It's like a mindset changing book.

That granular level of pay for performance I think does provide bad things, but in a group, larger level it's good, frankly, just so it weeds out the people that aren't any good.

CO-CHAIR COURT: So, Bob, how should we counsel CMS that -- how would we get to a set of measures that we agree to? I mean, what process should be used?

DR. RAUNER: I think it's going to --

CO-CHAIR COURT: It, obviously, can't be --

DR. RAUNER: -- be a collaborative approach where -- what often happens is it gets defined for the most common group, which tends to be urban large systems and everything is designed around urban large systems. And it then doesn't apply to Brock's group or my group because they defined it to what works where they are in D.C., which doesn't fit in Montana, or Idaho, or Nebraska. So, again, it has to be collaborative.

Just like actually go back to Tonya, the attribution is a huge problem. Well, why don't we develop a system where patients self-attribute? Then all the problems get solved, actually. We actually have a problem in Nebraska where none of our plans can capture that, so what they're using is claims-based attributions which are all fundamentally flawed for the most -- many reasons. If they would just let Tonya Bartholomew say that Dr. Jim Miller is my doctor, and that's how attribution works, it fixes a lot of these attributions. But, literally, the plans, many of them can't do that right now, so we get stuck with these either prospective or retroactive attribution models which are really screwy. So, what you lead to is what I consider the poster child of bad public reporting, that's United Health Care's Physician Designation right now. It's invalid because sometimes a sample size is 10, sometimes the attribution is who knows what, because we would get these reports, and I actually talked to a doctor who was really upset.

She's a new OB/GYN who got "bad doctor" award. She's the new doc in town, so none of these people -- they're all brand new to her so, of course, they look bad. The attribution is based on like 10 patients, some of which she's never seen. It's horrible, and she's getting stuck and told she's a bad doctor out of this really crappy designation. So, there's a lot of push back to public reporting because it's been so -- done so badly in certain cases. But I think we have the way to go.

I think Brock can tell you what -- he could probably write on the back of an envelope 10 measures that are good, and if CMS would use them and he'd okay it with his buddy, Tim, and everybody else, there we go. We don't need -- sorry, I don't know. Maybe I'm going too far off on this, but --

(Off microphone comment)

DR. RAUNER: I haven't had any beer yet.

CO-CHAIR COURT: I don't think we can

remedy that here, but maybe later. What about peer groups for hospitals? So, there was some discussion about there's critical access, but there's low volume PPS hospitals that have the exact same challenge, the exact same environment, but they've got more than 25 beds. So, should we encourage CMS to look at a peer group of small hospitals? We've got to define what that would be, and what would that be? Tim, I knew you'd have a comment here.

MR. SIZE: I mean, yes. I mean, in the co-op, and we have a bunch of both. I mean, I just don't think -- we're going to work on quality issues together as we do then with the hospital association. I mean, the tweeners and the CAHs, I mean, they both have low volume.

I just wanted to introduce actually a second concept I hadn't heard yet. It's peer groups for what purpose? I mean, I think people really like to benchmark off people who are in similar situations, so I think certainly in the quality improvement world that you really need

that. But if you're talking about from the patient's perspective, if people don't go to a critical access hospital in Sauk County, or Iowa County, or whatever, they don't go to the next critical access. They go into Madison, and the same for LaCrosse. So, in fact, I think we are talking about multiple care groups for different purposes.

CO-CHAIR COURT: Ira.

CO-CHAIR MOSCOVICE: Yes, just in response to what you were just saying. I assume we're talking about peer grouping for quality improvement. That's been our main focus. We can go in that other area if we want to.

MR. SIZE: But let me just -- I'm going to -- I thought we're making recommendations --

CO-CHAIR MOSCOVICE: No, we are.

MR. SIZE: -- to Medicare that go well beyond quality improvement.

CO-CHAIR MOSCOVICE: Absolutely. But I think the way at least it's been laid out up to now, thinking about it in that context. If we

want to move to others, that's fine. But now you can think about your friends, the DRGs, I mean, the way they came up with peer groupings was statistically to look at what kinds of conditions are coming in, and what are the other factors, whether it's comorbidities or other things that we can say we can clump patients together and say that's a grouping.

You know, what we've done on something called the Flex Monitoring Team, my counterparts on the financial side have basically, they work with an expert group, but what they found were CAHs with attached nursing homes and above or below a certain revenue level, i.e., scale, guess what? Those were more similar peer groups to be looking at.

And I think on the quality side, we're about -- it's not a trivial thing just for us to come up and say what other peer groupings. We could probably talk about what factors we think influence them, but we're about to start a project which is going to try to do that on the

quality side. But I think it's really important because not all -- when we get down to critical access hospitals at a small level, not all critical access hospitals are the same. So, it would be good discussions, so what do we think are the key factors that distinguish one subgroup from another subgroup, or on the clinic side, same kind of thing.

CO-CHAIR COURT: Okay, and that creates some good framework. The way I'd like to see peer groups used is -- because, I mean, P4P is going to come, so when you're compared to a group to decide if you're statistically the same, better, or worse, it's a group that's similar to you. So, you could think about do you do surgery, do you do births? And case mix I'm not a big fan of, but what other attributes of what would make one critical access hospital different from another one or small volume? I mean, what are the things they do that make them different? Yeah?

MR. SLABACH: Well, I think you hit the nail on the head. I mean, it's basically by

service lines is how I would define it. And I think it's already been said, so I'll just repeat it, that you have core services, and then you have menu of options based on your service offerings beyond that. And I think that would be easily achieved. I mean, to Bob's point, I mean, it wouldn't take a long time, but I think that over time I think we have several issues. One, if we had a MAP process say for small volume providers of all types, then you would have a system for retiring measures because that's another huge issue, is making sure that we're making them relevant so that we're not topping out, and everybody is measuring things that everybody has done well on.

Secondly, introducing new measures that are going to keep us current. And then thirdly, importantly, looking forward to what are the things that we should be projecting? And I think population health sorts of considerations are where I put in that, as well. So, those three areas is what I would emphasize through a

process.

CO-CHAIR COURT: Other thoughts on peer groups? Yes, John.

MR. GALE: One of the issues I think is important to look at, and I agree with all that's been said about the characteristics of the service lines. But in the absence of mandatory reporting comparisons, we do have to be somewhat sensitive to bringing people along, I think, somewhat more gradually. So, for rural health clinics I really don't believe there's any difference in primary care if you're an FQHC, an RAC, private practice. To say otherwise, it just ain't so.

But if you're going to get the clinics to participate, and there are roughly 4,000 of them, they're nervous enough about it. They don't have to do it, so to the extent that you maybe phase that reporting initially doing peer grouping among real health stratified by size, service line, number of providers, and then maybe move toward a more transparent reporting across

provider types so that people can actually make that decision about where to go.

CO-CHAIR COURT: So, is that an important principle that we want to put forward, that mandatory reporting and all of this isn't one step. It's got to be a phased approach. I mean, the hospitals went through that. Yes? I think, Jason, you're next.

MR. LANDERS: I have a question. Service line is important, but what about like a catchment, a filtering up group, because service line is important, but that tertiary or quaternary facility is also part of that maybe non-formal, but a real system. And it -- I would think that in some ways a real catchment feeder system is probably a good peer group to report on because they're funneling in the same direction maybe. And I'm asking that as a question, is catchment worthwhile to think about?

MR. SLABACH: Let me translate that so I can maybe understand in my vernacular what you're saying. Are you talking about transitions

of care?

MR. LANDERS: Yes.

MR. SLABACH: Yes, okay. So, I agree, I think hand-offs are hugely important in this, and the measurements of how well those were done are very important. And not just on the transferring side, but also on the receiving side. So, yes, I'd like to see that included in our discussion here as far as measurement.

CO-CHAIR COURT: So, how would that play out -- so, I think about we've got the University of Wisconsin Tertiary Medical, Academic Medical Center, and 30 miles away I've got a critical access hospital, so that -- how would you see that play out, Jason?

MR. LANDERS: Well, I'm assuming that your University Tertiary is really the -- they're receiving the non-critical access type of care from that critical access. And I don't know that there -- there's probably an industry term for that; it escapes me. So, I'm making that assumption that that's what you're talking about,

but what I'm talking about is all of the patients in that -- catchment is probably an outdated term.

CO-CHAIR COURT: Do you mean like a geographic region, sort of?

MR. LANDERS: I mean, sort of. It's more of a handoff referral transition of care. It goes from me or that FQHC into a critical access hospital, and then up to some parent facility. That natural patient flow that kind of catches all of the patient care in a region. It may not necessarily be geographical in the traditional sense, but I would think that they're all peers and would have influence on the type of care that each delivers at the next level below and the next level up. So, that peer grouping of those feeder systems, both up and down, is important, and in my mind just as important as service line. And I get service line. If you don't have a CT, and that's not a good example, but --

(Off microphone comment)

MR. LANDERS: Right.

MR. SLABACH: So they have to then deal with the contingencies of what would happen. And I think that an evaluation of how effectively they are transitioning care and making sure that safety is paramount through the hand-offs and measuring that is a very critical part of the process.

MR. LANDERS: Right. And in terms of quality, that's a big piece of that, that transition of care both up and down, because it flows back into the clinics.

MR. SLABACH: Right.

MR. LANDERS: And some systems are really good at that.

CO-CHAIR COURT: Okay. Guy, and then Bruce.

DR. NUKI: So, first off, if a critical access hospital doesn't have a CT scanner, they should get one. They're not that expensive. They should go buy one. It's not okay in 2015 --

(Simultaneous speaking)

DR. NUKI: -- to not have one. So, as

I was thinking about it, I think service line is very good, but there's also -- there's a very big difference between a critical access hospital that's located on the -- right next to the entrance to a national park that's 35.1 miles from a big tertiary care facility, and one that is two hours away from a tertiary care facility with no resources, and half the population lives on the Passamaquoddy Indian Reservation. So, those become very different, and so I'm wondering -- and I don't know how to do this. Steven, help. How do you look at the socioeconomic or demographic to create peer groups, because I do think that there's a difference there. I mean, that's going to change the resources, and the abilities, and the capability. You can't -- it's easy to recruit to that hospital that's next to a national park. It's not so easy to be in the middle of nowhere.

CO-CHAIR COURT: So, that's a good point, Guy. What -- when it comes to qualify measures, what kinds of quality measures would

differ between those two critical access situations?

DR. NUKI: I wouldn't change the measures.

CO-CHAIR COURT: Okay.

DR. NUKI: But I think that the peer group is what you're comparing yourself with. Right? And I think that you should be able to say look, against my peer group this is how I compare, but you could also -- I mean, I don't think it's wrong to compare against the larger group, but I think you should have access to that, you know, more specific peer group.

CO-CHAIR COURT: Okay.

DR. NUKI: Maybe. But once again, we then start to water things down, so we have to be careful. I mean, do we say OB, we have an obstetrician, OB being delivered by family practice? I mean, once -- if you make it too micro, I think it will fall apart, but I don't know exactly where you draw the line.

CO-CHAIR COURT: Bruce.

DR. LANDON: So, initially, one -- I'm going to make two comments. The first one relates to something that I heard like an hour ago, but I'm not even sure there's -- so, it's very clear that, you know, we need to have reporting at the hospital level. And I think several people said, you know, every hospital has to report.

I strongly believe that we cannot have consequence -- when I say reporting, you know, giving the data. I strongly believe that we cannot have pay for performance or public reporting at the individual hospital level across the board because I think the statistical properties just fall apart. I mean, if you've got a 10-bed hospital that's seeing, you know, I don't know, five patients with pneumonia over a year, you just can't -- you know, you can't report at the level of a hospital for that. I mean, we -- that's just the reality.

And then a second issue related to peer groups; so, the service line issue, that's sort of -- I don't want to call it a cop-out, but

that's sort of like easy, like, you know, if you're doing OB measures and a hospital doesn't do any OB, then they get excluded from that. You know, that doesn't seem like it's really rocket science to me.

I think what is harder, though, is this issue of capabilities within sort of a service area or a service line. So, you know, so maybe speaking to what Guy was just talking about; so, not only are those two hospitals very different in terms of their proximity to sort of more tertiary medical care and the ability of their patients to get there but, you know, some are going to have MRIs, and some aren't. Maybe all of them have CTs now, I don't know, but maybe some have CTs and some don't. If you have an OR versus if you don't, that's a big deal. If you have an ICU versus not, so we might want to be considering some of these sort of capabilities, because certainly, you know, if you have someone with a serious MI presenting to a hospital that has no ICU, and no ORs, and no cardiologist,

that's very different than if you have somebody presenting to a hospital that might be also similarly kind of small, but much closer to a tertiary center, or has some capabilities to do some things. So, I think -- I just want to put that on the table, and I don't know the answers to any of that, but I think it's important.

CO-CHAIR COURT: I think, is it Susan?

MS. SAUNDERS: I think I just want to kind of echo what Guy said. You know, when you look at peer groups, and I think you have to consider the service lines, but you also have to consider some regionalization.

Jonathan mentioned earlier one of the, you know, major health determinates is going to be an individual zip code. And, you know, if you -- as a clinician, I'm in Central Mississippi. If you are comparing my outcomes to, you know, the individual provider that's in, you know, the northwest, and everyone -- you know, in my perception, everyone out there is healthier than what my population is, but you have to have some

generalizations, you know, towards the region in order to keep these valid to where providers are actually looking at them, and acting on them, and they become meaningful.

The other thing kind of goes back to a discussion we had earlier, but when we were talking about pay for performance, you know, providers, the clinicians, are the ones that are driving the improvement, whether they're doing it or not. There was a lot of discussion about, you know, the fact that more money is not going to change their behavior.

The other thing that I think we have to consider is that more and more clinicians are hospital-employed, so we're actually paying money back into the hospital system, you know, and then asking the provider to make changes in their practice. I mean, the two are not meeting in the middle at all.

CO-CHAIR COURT: Aaron.

DR. GARMAN: I guess this is somewhat of a point of confusion, but my critical access

hospital doesn't have a surgical program, but we have surgeons that come and provide that service. So, what's our peer group, because we have two hospitals, two tertiary care centers that bring up surgeons to provide that service on different days, with different staff. So, how are -- we've got a surgical program kind of, but it's not our program, so how do we report that? What peer group are we in? Are we lumped in with the tertiary centers because it's their program, or are we lumped in with who?

UNIDENTIFIED: I think it's you and other hospitals with surgery.

CO-CHAIR COURT: Yes, I was thinking other small volume hospitals that do surgery.

DR. GARMAN: That have their own surgeons, even though we don't control the program?

CO-CHAIR COURT: Well, I'd say if you let them do surgery there, you do somewhat control the program, or you have influence over it, or the outcomes of those patients.

DR. GARMAN: But I don't have any of the surgical staff. They bring up their staff.

CO-CHAIR COURT: Oh, and are the patients being covered there?

DR. GARMAN: We have a room they provide to them.

(Off microphone comment)

DR. GARMAN: Yes, that's what we do.

MR. SLABACH: Well, to clarify, these are all outpatient procedures, I'm sure. Correct?

DR. GARMAN: No, because we will follow those surgical cases. As a primary care doc, we'll follow their -- like a gall bladder, those kind of things, as an inpatient. I don't do the surgery, but the surgeon will do that, and then we'll follow them the next day.

DR. NUKI: He does the re-operation when they have a complication --

CO-CHAIR COURT: And he gets dinged for the readmission, too. Mike?

DR. BAER: I really don't know much about critical access hospitals, but I was

wondering as a part of, you know, the peer group, is there anything in the critical access or small hospitals like a case mix? And could that be put into the equation for peer group? I just don't know that answer.

MR. SLABACH: The short answer is yes, but as I think I mentioned this morning, because of the poor coding in the critical access hospitals, often it's understated, and so I guess if it's all understated then it would be equivalent, but you could get some potential problems there. And as I think Kelly said, case mix isn't really a good indicator for complexity.

CO-CHAIR COURT: Well, case mix might be very different than the capabilities or services. You know, I think we were closer -- at least I liked, you know, talking about do you have an OR, do you have an ICU, do you have a CT? What's your access to specialists? So, perhaps it would be some kind of survey that, you know, they catalogued your capabilities, and then you are -- for the purposes of deciding are you, you know,

bad or good, are compared to other hospitals that have similar capabilities. Steve?

DR. SCHMALTZ: One approach to looking at this is, I'm hearing there's a lot of characteristics you can use to define a critical access hospital, is to use all those characteristics and maybe some characteristics of the population like percent Medicare, or percent Medicaid. And you kind of come up with a group of hospitals that are closest to the hospital that you're comparing with. So, we might define maybe the 20-25 CAHs that are closest to the one, and that would be the peer group based on all those characteristics you're interested in looking at.

CO-CHAIR COURT: Ann?

MS. ABDELLA: One thing that occurs to me as we're sitting here is the dynamic nature in many respects of our communities and the level of service, and the affiliations that people have. So, how would it work if I've got a hospital that is maybe distressed right now, is on the brink of closure or affiliation, and it's reinventing

itself, you know, adding services, deleting services, or a year from now it may affiliate with someone and have a completely different book of business. How are we handling that currently in the system, and how will we look to be able to do honest measurement going forward?

CO-CHAIR COURT: Well, I think if we had some kind of -- create a peer group based on your attributes, that can't be a one-time where, you know, what are my attributes? That would have to be refreshed on a regular basis, because you're right, it changes regularly, which is good. I mean, because then they're meeting the needs of the community. Tim?

MR. SIZE: Yes. I mean, I'll be honest, and I don't really understand the conversation. Now, maybe that -- you all have known that I haven't understood the conversation, but I just figured out that I don't understand.

CO-CHAIR COURT: Well, it wasn't by design.

MR. SIZE: I just -- if we're supposed

to include a patient-centered approach, I'm having real trouble having a very long list of metrics that I would say that it would be legitimate to look at the results by peer group.

The one actual exception is the one which, I'm assuming is from our earlier discussion this morning, has to do with peer groups related to those serving a similar population socio-demographically. Because I think other than some of the pure procedures, I think the ability of the patient population to comply and participate in the treatment does affect outcomes. And while not adjusting, it's a good way to understand where there may be more need for more intervention. If we're actually comparing provider to provider, I think we need to control for that. And I think that's at the heart of the new National Quality Forum direction.

So, I guess other than the socio-demographic thing which is obvious to me that we need to create peer groups around that, it's not

obvious to me why we're talking about peer groups.

CO-CHAIR COURT: Well, I'll jump in there because I'm also on a technical expert panel with CMS that's looking at developing a Five-Star rating for hospitals. So, all the measures are going to be boiled up into one Five-Star composite rating. And I have real concern about that, and I think if you take all of the measures for a UW tertiary medical center and compare them to all the measures for Ashland Medical Center, which is on a -- you know, a Native American tribe in northern Wisconsin on Lake Superior, it's not apples to apples.

MR. SIZE: Okay. So, then you're -- if I understand what you just said, you say in the context of having a conversation about aggregate measures and you get into mix issue, then we have peer groups. But for lots of other measures where we're not talking about aggregation, I'm not so -- you're not saying we need peer groups.

CO-CHAIR COURT: I don't know.

MR. SIZE: Okay. So, I mean, I think -- I mean, we start off this conversation saying what do we want our peer groups to be? And I think well, it depends in good measure on what metric you're talking about. And in some metrics I don't think there should be a peer group.

CO-CHAIR MOSCOVICE: But there are other factors. We've heard throughout the day, for instance, the scale of an organization affects the ability --

MR. SIZE: For what?

CO-CHAIR MOSCOVICE: -- of that organization to do certain things, and to perform in certain ways. And so I think --

MR. SIZE: But if they --

CO-CHAIR MOSCOVICE: -- considering taking scale into account, something we should do.

MR. SIZE: So, it's okay people get bad care and --

CO-CHAIR MOSCOVICE: I didn't say that. We're talking about peer -- it's -- you may be

better off and it might make more sense to compare smaller CAHs with smaller CAHs, and larger CAHs with larger CAHs, because the smaller ones are saying they don't have the same capacity.

CO-CHAIR COURT: And I think it's more true, Tim, of the outcome measures than the process measures, because they tend to be -- well, they're just different. But should a patient get an aspirin in the ED, that should be the same regardless of your size.

MR. SIZE: But it's okay that smaller facilities have worse outcomes than larger facilities?

CO-CHAIR COURT: No, didn't say that.

MR. SIZE: Then how do we justify having peer groups that --

CO-CHAIR COURT: Well, actually, CDC -- the infection measures are created by peer groups, and so they're adjusted. Greg?

DR. IRVINE: I have patients tell me on a regular basis they'd rather die than go to

Boise. That's the ultimate bad outcome. And that's the honest to God truth. I'm told that almost weekly.

(Off microphone comment)

DR. IRVINE: Well, that's other people, yes. There's a song about that, actually, rather die than go to Boise. But these are folks when - I think, you know, rural hospitals near Madison, Wisconsin, 30 miles down the road are very different than rural hospitals in the mountains of Central Idaho, where we can't even fly people out half the time because the weather has got us socked in, or the roads are closed, or whatever. We have to give care, and sometimes it's not the same care they would get at the University of Wisconsin. It's what we can give, and we do the best with what we have and what we can do until we can get them to a higher level of care sometimes.

So, the answer is, we need to be compared to our peers, because if you take raw data and compare us with the University of

Wisconsin, we're going to flunk every time, I guarantee it.

MR. SIZE: And there are hospitals all over the state. And (b), I think we said earlier, and I think it's important to remember, some of this conversation we just haven't had time to break it down, differs significantly if we're talking a frontier application where -- versus Wisconsin, which is pretty typically average in terms of adjacent urbaness where people do have choices, and it is a decision about can I get care locally, or is worth my time to drive the hour to get it somewhere else?

CO-CHAIR MOSCOVICE: Maybe that's one of the characteristics of the peer group, geographic isolation versus -- however we want to characterize it. That's --

DR. IRVINE: Yes, and some of the things that are being foisted on the small hospitals in Wyoming and whatnot are creating tremendous hardship for -- financially for the hospital to survive. And if the hospital, which

was on the verge of shutting down four years ago when I came there simply because they could not generate the resources to keep it afloat. If they shut down, I assure you that's not going -- you know, somebody comes in with chest pain, they may stop at the Rite-Aid and get aspirin but they're not going to get an aspirin in the emergency room because it's not there.

CO-CHAIR COURT: Okay. I'm going to segue us into a slightly different -- make sure we cover all the big areas. So, we talked about alignment, and so FQHCs have their measures and their program, and rural health clinics have theirs, and the ACOs have theirs, and critical access doesn't really have anything. PPS hospitals have theirs, so if we were going to advise CMS about alignment, what do we want to tell them? I mean, how can -- what do we want to see? Brock?

MR. SLABACH: If I understand the concept correctly in terms of what we're wanting to achieve, the biggest frustration that I have,

and I heard it throughout the conversation of our members, is 30 or 40 different places that data is reported for different things and for different purposes. If there's any chance that CMS would have influence on standardizing the reporting process for a small facility, I think they would have no trouble reporting if it was one time in terms of the data collection is once, and it's for multiple purposes.

CO-CHAIR COURT: Okay, that's a good one. Ann? I think we're done.

MS. ABDELLA: To the point that I made earlier, I think if there's the opportunity to make them somehow complementary from the primary care surgical and hospital measure, I think that to the point of the -- you know, there's a core measure, if there's a way to do some alignment there. And then if there are optional measures within a geography that seem to make sense, then primary care should be complementary to what the hospital is doing.

CO-CHAIR COURT: Yes, I would add what

we see is the hospitals are -- so you've got the readmission focus, but there's nothing in the ambulatory side to -- you know, so if you don't employ the physicians, there's nothing on the ambulatory side to get the physicians to be paying attention to the readmissions. In fact, sometimes it's easier for them if the patient gets readmitted, so I think alignment across the sectors. I think, also, there have been a lot of projects, so there's been the Partnership for Patients Project CMS, the big CMMI project, there's the TCPI project, there's the QIOs have their thing, the Office of Rural Health has their thing, and they're not aligned. And they're not necessarily aligned to improving the measures. The PPS hospitals have gotten better, so infections, readmissions are part of value-based purchasing. Now, that was, you know, a big focus in the Partnership for Patients, so the improvement resources have to align to the measures or you just start sending people in multiple directions. Guy?

DR. NUKI: You said about 70 percent of what I was going to say just then, but it's about simplification. With all of these different organizations, and abbreviations, and choices it becomes almost impossible to figure out how -- what you really need to do. I spend half my time arguing with the Quality Nurse Director about, you know, whether the case is a fallout or not. I mean, and these are supposed to be relatively simple things, and sometimes things on the surface appear simple, but when you put them into practice they don't. So, we -- I think that creating -- it's a little bit like what I think the CIOs have been doing in trying to help some of these rural hospitals, because there's not someone who full time really understands this. So, it's got to be -- that alignment needs to also be easy to understand, and easy to process through.

CO-CHAIR COURT: So, the support resources have to align to the measurement requirements. Is that how we would say that?

DR. NUKI: Yes. I think that there needs to be support from CMS, or from all of these different organizations that want data. They all need to get together, agree, and be able to put a -- you know, put it -- limit it to 10 pages. All of the recommendations need to be written in 10 pages and given to the hospital, something. I mean, it's a little ridiculous, but I think you get my point about just needs to be manageable by people who don't just do quality measures.

CO-CHAIR COURT: I think -- and I'll -- you can tell I've got an opinion about this. It doesn't seem to me like the different places this is coming from within CMS talk to each other, you know, so CMMI is over here giving money to do things, and then there's the group that's mandating measures, and not always even sure how that all fits with the MAP and everything. So, it doesn't feel like everybody is talking to each other and knows what they're doing, so I think there's got to be better coordination in

Washington of what all of this is, and understanding the burden, the collective burden that it creates, and it could be simplified.

DR. IRVINE: Where does HIPAA come in with all of this? Because we've had some issues at our facility with HIPAA investigations related to transfers. CMS regulates HIPAA. Correct?

CO-CHAIR COURT: Are you talking about EMTALA?

DR. IRVINE: Or, excuse me, EMTALA.

CO-CHAIR COURT: Yes, that's a totally separate thing.

DR. IRVINE: That's totally separate.

CO-CHAIR COURT: And we're not talking about conditions of participation. That's -- I'm talking about measurement and improvement.

DR. IRVINE: That's it.

CO-CHAIR COURT: That's a different thing.

DR. IRVINE: Okay, got it.

DR. NUKI: Did you just say coordination in Washington?

CO-CHAIR COURT: I'll probably be struck down at the airport tomorrow. Bruce?

DR. LANDON: So, I think there's no one in this room that's not going to agree that alignment isn't desirable. And this is something we've been saying for, you know, 20 years of quality data collection. From the hospital side, you know, we can certainly -- and the other thing about that is, you know, we can -- the government -- at least we can suggest that they cooperate together but, you know, the government actually -- and we can't tell private plans what to do. We can maybe make suggestions, and unfortunately a lot of private plans, they distinguish themselves by their quality problems, and they don't want to align among themselves because that takes away one of the reasons for them to be in existence. But certainly, at the hospital side, you know, we can ask all of the government agencies to get together and actually have a core set because, you know, I don't want it to differ from IHS, and for HRSA, and certainly I would imagine that

Stephen's organization works pretty closely with the CMS, so there's a good amount of overlap there. And I think it might be easier to attain more alignment on the hospital side.

I'm concerned about the physician side because of this issue with sort of the competing health plans on the market who end up not wanting to collaborate sometimes.

CO-CHAIR COURT: So, we probably don't have much influence over the commercial side, but at least the things that CMS is funding, regulating, could those be aligned? I think that's what we have influence over. Stephen, and then Sheila.

DR. SCHMALTZ: Bruce talked about alignment efforts with CMS, and there's really different types of alignment. If we're talking about alignment of how the measure is defined, we work closely with CMS. And I can tell you the weekly meetings, the hours, and hours, and hours, it's a very painful process, but when it comes down to it, it's probably about one of the most

popular things we did with hospitals, being able to align.

CO-CHAIR COURT: And we thank you. Sheila?

DR. ROMAN: I was actually going to make a similar comment that Steve just made, having been involved in alignment. And I don't -- I think the committee may want to go so far as to say, and I'll be curious if others agree with me, that I don't think you can progress further from pay for reporting to pay for performance if your measures are not aligned.

CO-CHAIR COURT: Yes, well said. Brock, and then Tonya. Oh, Tonya, then a break.

MS. BARTHOLOMEW: Just real quick, I really want to reiterate what Guy said about the support resources available. When I asked my husband, who is a family physician, you know, what from a clinician point of view do I need to represent here at this meeting, and he said one of the challenges that clinicians have, and I think this would be from clinics clear to

hospitals, are the evidence-based guidelines. And when those change, it changes your clinical metrics. So, we need to take that into consideration, I think, when -- for example, you know, hypertension, that's a --

(Off microphone comment)

MS. BARTHOLOMEW: Yes, so how do we keep up with the evidence-based guidelines, and how do we use that in a longitudinal way to measure improvement? Because what I was measuring for hypertension is really kind of null and void now because the guidelines have changed. So, I'm not sure where that fits into the conversation, but I think it's important.

CO-CHAIR COURT: So, maybe a principle is that the measures have to keep up with the clinical evidence. And then I think they have to be cautious about trending over time when the measure changes significantly, because then when you've got the baseline from two years ago, and it was a different measure, that doesn't work. Okay, Bob?

DR. RAUNER: Kind of dovetailing off of that, because the good thing at least in the Medicare Shared Savings Program, they actually did retire a couple of measures because of recommendations around cholesterol, for example. So, they did a good job there, but I don't think they did it for all the other programs, too. So, part of the challenge is Medicare's approval cycle doesn't fit -- doesn't keep up with the practice of medicine, which I think is what drives some of the physicians, and nurses, and everybody else crazy, is that it may take three years to dump that thing off of there that's not relevant any more.

And the other thing which I alluded to earlier is that sometimes they take a measure and totally apply it out of context, which is when I said -- maybe I shouldn't have said stupid, maybe, but there are some of these that are not fit in the clinical context. They make sense from a cubicle, but they don't make sense in real life. So, partly evidence-based, but also that it

actually is clinically appropriate to use that measure in that context.

CO-CHAIR COURT: So, how would we advise them to improve?

DR. RAUNER: So, like when the lipid panel one comes up, for example, if it changes, everything gets changed, Meaningful Use, Medicare Shared Savings, patients, they update them all because once it's not valid it just has to be dropped, and it can't take two to three years to drop that one off of there. Or the blood pressure where we now have two different levels based on age, you've either got to adjust it pretty quickly, or make it null for a year or two until you can adapt it. And, of course, with the BMI, they actually jumped from a very loose screening tool, assuming it was diagnosis, then telling you to counsel when you actually missed the middle step, which is that literally you can have a BMI of 31 and not be obese, so why should you be counseling that person? So, I think -- I don't know. Sheila, maybe you know in that regulatory

environment, it is hard to update things fast enough to meet with the practice of medicine. And then some it's just the eternal problem of policy being too separated from practice, and that's I think what happened with the BMI measure, for example.

DR. ROMAN: I mean, I think it is difficult because schedules are set so far in advance. But I think that one can -- particularly for pay for performance hold measures back. And, you know, I think as you go from public reporting, to pay for reporting, to pay for performance, you know, you up the ante. And as you up the ante, your measures have to be more solid. And I think that's why you've seen requirements for the value-based programs that the measures be in use for a number of years, and that doesn't address the issue of guideline changes, which I think is a real issue that we should make some comment on, and ask them to be held back from pay for performance.

CO-CHAIR COURT: So, Karen, can you

help us understand how the measures get updated when the guidelines change?

MS. JOHNSON: I can give you the NQF perspective of it, and we might be able to get Helen back a little bit later to talk a little bit more about the CMS side, perhaps. But what we do at NQF, at least for NQF-endorsed measures, so part of it is schedule. Right?

The problem with developing measures and changing measures is it takes a long time to do. It's not something that people can do on a dime. So, when the lipid guidelines changed and the high blood pressure guidelines changed, we knew that we would need to re-look at those measures. Right? But we also knew that there's controversy on the -- which ones? On the lipid ones, so we wanted that to kind of settle out a little bit before we asked the developers to come in and bring in new measures. So, we purposely, actually at NQF, pushed back consideration of the lipid and high blood pressure measures about a year to give the developers time to do what they

needed to do.

We just got through a couple of new diabetes measures with different statin guidelines, so those are working their way through, but the CV ones are still a little bit out. So, that doesn't talk about things going off the P4P list. That's something else, and I imagine it has to do with rules and stuff. But that's at least from the NQF endorsement side of things, it just -- it can't be done on a dime.

CO-CHAIR COURT: Okay. Ira, and then let's do a break.

CO-CHAIR MOSCOVICE: I'll try to talk real quick so we can get to the break. I would just say the other side of the retirement issue is CMS just with Hospital Compare continues to retire measures, but quite frankly, in urban areas there may not be, for instance, for some measures that much room for improvement, but in rural there still is. So, that takes -- and then they introduce new measures that are not relevant to rural, and you get a more modest set. So,

that's something we need to take care of.

I would just say, I hope the report can say something like the quid pro quo for mandatory reporting is that we get one set of measures from the federal government. And just as with the DRGs, if the feds really push in that direction, guess what? The commercial side will, also. So, I think that, hopefully, can be one important bullet point, that really all -- the feds -- CMS can only control federal programs, but it is just not acceptable to have more than one set of measures period.

And, quite frankly, what would be good about that, if they actually moved in that direction, is that maybe the urbans could be learning from the rurals, because we'd be starting this. And it's -- I think it would be a terrific accomplishment if we can get them to move in that direction, even if they go from -- we won't say this out in public, but if they go from 20 measures to two measures, that's still a terrific accomplishment. I say we go for one

measure, but you can't have multiple -- you can't really have multiple sets. It's just -- it's not going to work.

DR. BAER: Can I make one comment? I know you want -- really fast. When we say the feds and CMS, CMS governs directly Medicare, Medicaid State plan, you know, it's a partnership between states and the feds, so I would strongly, as Bruce was mentioning, that it's not just Medicare, but it needs to be Medicaid, too. Okay.

CO-CHAIR COURT: Okay, 10-minute break? Yes. Okay. So, back at 3:30.

(Whereupon, the above-entitled matter went off the record at 3:16 p.m. and resumed at 3:33 p.m.)

CO-CHAIR MOSCOVICE: So, we're going to get going, and we're going to spend the next hour, instead of having breakout groups, we think it might be better if we had the conversation together, and particularly if we're looking at crosscutting overtures, or opportunities between

the hospital and physician, and other context. It would be good to have everybody hearing discussion.

So, we've done a bit on potential solutions. And one area that NQF is really interested in is measurement gaps -- what are the areas that we really don't have included up to now, we don't know much about, that we've had some suggestions, people have complained about the existing ones. We can talk about ideas we have for existing areas that haven't been used up to now, but specifically where are the holes? What are the areas that in the quality sphere that we haven't really -- we're at least not aware that there's much more work in. That would really help.

There's going to be a section in the report on that, and that would really help NQF in terms of posturing for additional resources if we feel these areas are important. So, why don't we start with the hospital side, and we'll take notes. And what's being passed around is about to

be passed around are -- not that you need to memorize these -- but it's just lists of some of the areas that are currently being used or looked at in measurements, et cetera. So, it gives a little bit of context.

But we're open for business on the hospital side for measurement gaps, areas that aren't currently being considered that we really think NQF and others should be taking a look at. Maybe you want a minute or two to look at the sheet that went around so you can --

MS. JOHNSON: And just to orient you to these papers that I sent out, these are just to give you examples of some measures that we have in different domains, if you like that term. So, don't get caught in the weeds here. This is just to give you an idea that -- and at least some conditions. And in some cross-setting kinds of ways, and some topics areas we do have measures. Possibly one of the things to pay attention to more is the domains, that first column there, and what's missing there. And then maybe is there

things missing within? But, again, this is not everything, this is just -- I just pulled a few to give you the flavor of what's out there.

CO-CHAIR MOSCOVICE: Bob?

DR. RAUNER: Actually, I like this hospital one because it's personally relevant to us, and it's something that's really all over the map right now, and that's timely transition of transition record, that we have such a huge problem, because some -- and, frankly, this is actually you have more problem with the urban folks. The urban folks don't send us anything when our patients are there, and so we -- it's hard to intervene and prevent a readmission if they never tell us that the patient was ever admitted, or even discharged or anything. So, this is one of those integration crosscutting things that it's really a big problem right now. And there's places that are great about it, and there's places that are horrible about it. It affects a lot of problems, actually.

CO-CHAIR MOSCOVICE: Other comments?

Yes, Tonya.

MS. BARTHOLOMEW: Just piggybacking off of Bob with that care coordination issue. Maybe a solution we want to look at, which we use in our clinic to find out, number one, if our patients are at the hospital instead of on Facebook or at the grocery store. And then also to get that information back to us to use for follow-up, is that we have made just a little simple one-page contract with the facilities that we send to the facility. It's more of an agreement, I guess. You know, if my patient comes and declares me -- going back to attribution, as their primary care provider, will you please forward these records. You know, first of all, call me and have your care coordinator call the clinic, and then also to send those records once the patient is going to be discharged.

It's been pretty useful. I'm a little bit surprised. I was a little bit doubtful at first. Actually, the hospitals in our area were really responsive to it, and it's worked out

really well for us. Something like that a PCMH. Yes, it's in the patient's new medical home model.

DR. NUKI: This is more of just a concept that we haven't brought up, but like the thrombolytic therapy for stroke. I'm sorry, it's controversial. I hate to tell the American Heart Association, but there's still more studies that show that it kills. It got stopped because it was so negative than there are positive studies. But one organization, the American Heart Association, has managed to convince people that it's actually the standard of care, when it really shouldn't be. So, it's very difficult to see something like this on a -- as a measure when it's really controversial -- thrombolytic therapy in strokes.

(Off microphone comment)

DR. NUKI: So, the neurologist thinks it's a great idea, and the emergency physicians aren't convinced.

CO-CHAIR MOSCOVICE: Other comments? Oh, Kelly has a comment.

CO-CHAIR COURT: And maybe this is too broad, but I don't think we have enough -- there are not enough measures on the hand-offs, so I think someone said earlier, maybe Ann, triage. I know there was like three things, and then transfer was --

(Off microphone comment)

CO-CHAIR COURT: Yes. But I don't -- I think we need measures of those hand-offs. So, medication reconciliation is one. You know, I think the -- Ira, your work on the ED transfers, those measures are a lot of them and hard to collect. But if the critical access hospitals are, you know, doing the good work locally and then transferring the patient to the tertiary/secondary center, when appropriate, how do we know that that goes smoothly, and that everybody's got the information they need?

CO-CHAIR MOSCOVICE: There's a three-item catch transition measure that Eric Coleman developed from Colorado. Are people aware or using any of that, which is a lot easier version

of --

(Off microphone comment)

CO-CHAIR MOSCOVICE: So, there's three items that I -- Helen said they were incorporated into HCAHPS, and I don't have the specific --

CO-CHAIR COURT: Yes, so that's the CTM3. So, that's -- there's three questions on the HCAHPS survey, was I involved in creating my care plan? Did I understand what I need to do when I went home? And then I can't remember the third one. And then those get rolled up into one composite measure. But I think that's from the patient perspective, which is really --

CO-CHAIR MOSCOVICE: Exactly.

CO-CHAIR COURT: -- important.

(Off microphone comment)

CO-CHAIR MOSCOVICE: Are there other areas related to care coordination hand-offs, et cetera, et cetera, that we want to think about? Guy, are you back up, or did you not take your -

(Off microphone comment)

CO-CHAIR MOSCOVICE: Okay. Bob, and

then I have Ann.

DR. RAUNER: This is just more of an additional comment. I actually think of -- this is one of the areas where there could be the most good with the least number of measures, frankly, because a lot of things that go wrong in medicine happen during a hand-off, so whether it's med rec, transfer note. And it applies to everybody, clinic, rural, tertiary, nursing home SNF that I think this could be one of the big things that could come out of this group, is -- because it does apply to all of us really, and that's where a lot of the bad things happen in health care.

CO-CHAIR COURT: In the care transitions work that's happened in the Partnership for Patients, a common measure is did the patient leave the hospital with a scheduled appointment? That would apply to every single patient. Nobody should leave the hospital without a scheduled follow-up appointment. And ideally within -- you know, not three weeks from now, but -- because then you know that there's a follow-up

plan, and the follow-up plan at least is initially, you know, hopefully in play. It doesn't mean everybody is going to follow through, but the first step has been taken.

DR. RAUNER: Sorry. A lot of those readmissions happen, the follow-up appointment is often made far beyond when all those bad things happen, and so there's some timeliness factor that probably needs to be added in there, because our goal, we try to contact them within 48 hours of discharge, but again we may not hear for three weeks that they even were there. But there need -- I think one of the things our clinics learn most of all that our docs didn't even know at first, is sometimes they themselves were making follow-up appointments a month later when they really needed to be one week or in four days. So, we've learned over time to make that follow-up a lot sooner than we used to just because of having learned. So, I think part of that might be not only that it's made but, of course, it's not appropriate for everybody. Some people maybe a

month is good, but some people maybe it should have been two days.

CO-CHAIR MOSCOVICE: Okay. I have Greg, then Ann, then Tim.

DR. IRVINE: Yes, I think that mandating time of a follow-up appointment is, quite frankly, overly burdensome. And if I discharge a hip fracture patient and they have home health services, they have a nurse coming to the house, they're getting physical therapy, I may set that follow-up visit for a month later. It depends on whether they're on anticoagulants. There are a million things that go into my decision as to when to see them back, and there's no set, you know, time that they should necessarily come back. So, mandating that is -- you know, interferes with my judgment as a physician.

CO-CHAIR MOSCOVICE: Ann.

DR. IRVINE: You haven't heard that before. Right?

CO-CHAIR COURT: No.

CO-CHAIR MOSCOVICE: The issue is timing, obviously. I mean, saying you need one is one thing, but what's the right time? Ann.

MS. ABDELLA: Well, so kind of counter to that, our Clinical Integration Committee, which is made up of specialists, MDs, SNF Medical Directors, primary care physicians all came to the conclusion that, from a claims-based perspective, the measure to use was the seven to fourteen day follow-up post-discharge. So, that's a performance measure that we've chosen for ourselves, and it can be pulled from the claims when that's activated.

(Off microphone comment)

MS. ABDELLA: At this point in time. I mean, we're just starting to operationalize it. We'll shake it out later, but yes. Trying to push the point of we need to know where these people are and complete a loop of care.

CO-CHAIR MOSCOVICE: Tim.

MR. SIZE: Two issues. One is, I guess, I need some clarification what the cost resource

use metric is, how does that work?

CO-CHAIR MOSCOVICE: Karen?

MS. JOHNSON: This is where I wish my colleague, Tareem, was in the room.

MR. SIZE: And my concern is, obviously, all things being equal, a rural clinic, or a hospital is going to have higher standby cost. And if this is supposed to be comparing urban to rural, it wouldn't work for me.

MS. JOHNSON: Right. So --

(Off microphone comment)

MR. SIZE: Standby cost. Like --

CO-CHAIR MOSCOVICE: Fixed cost.

MR. SIZE: Fixed cost. If you're an emergency room in a typical rural hospital, it's going to have less throughput, and it's probably going to cost more on average because --

CO-CHAIR COURT: Yes, I think this measure -- and jump in. So, this is totally from memory, is a certain number of days before admission up to I think 30 days after admission,

which the hospitals have some heartburn with because they can't really control the cost once the patient's left. So, whatever claims, you know, accrue, I think it's Part A and B.

UNIDENTIFIED: Yes, it is. So, if somebody has taken --

MR. SIZE: Not to contradict my previous discussion on peer groups -- this is certainly an area where peer groups makes sense to me.

MS. JOHNSON: So, this one is risk-adjusted, so just some of the controversy with this measure, not everybody loves it, of course, is questions about the risk-adjustment methodology. And I cannot remember if SDS is actually included in the models or not. And then also there is, of course, problems with attribution.

MR. SIZE: I may have missed -- I mean, specifically saying if we're comparing an isolated community of 2,000 versus one of 5,000 and just the scale, the size, okay. And then,

yes, you anticipated my other concern was we're not being very explicit. And I hate to be a broken record, but the whole SDS adjustment, when we're having this conversation like for the 3-day readmission, as presented it's not indicating SDS adjustment, and we're not doing that yet. So, I vote yes or no, depending on whether we're assuming it's going to be with or without that adjustment.

And maybe, it might be helpful just 10 minutes tomorrow morning you all could give us where NQF is on that issue.

MS. JOHNSON: Yes, I'd be happy to.

MR. SIZE: Thank you.

CO-CHAIR MOSCOVICE: Do people think that cost resource use is a quality measure? Okay.

DR. NUKI: You really think it's not a quality -- I mean, if I'm doing CT scans on every headache that shows up in the emergency department, that's cost resourcing, that's also quality.

(Off microphone comment)

DR. LANDON: The issue with that, you know -- so, for most quality measures we really try to pristinely define an appropriate denominator population and enumerator population. And while most CTs and MRIs for headaches and back pain are low value and inappropriate, that might not be the case if we suspect someone is having, you know, a subarachnoid, or if someone has fever and back pain, or if someone has a history of breast cancer and whatnot so, you know, you can look at rates over time which we've done in our work and be pretty comfortable that, you know, changes are probably changes in levels of appropriateness as opposed to clinical indications. But in any one particular thing, as we do with most quality measures, it's hard to say definitively this is actually high or low quality.

CO-CHAIR MOSCOVICE: Other comments, Steve?

DR. SCHMALTZ: They had a tobacco use

screening measure, I think they should have a substance abuse and an alcohol screening measure, as well.

CO-CHAIR MOSCOVICE: I have Michael, then Bob.

DR. BAER: I just wanted to support what Greg said in terms of, you know, the post-discharge appointment. I think it just needs to be created in an appropriate way because there may be risk groups, you know, that do require the seven to fourteen day visit versus other groups, so it just needs to be looked at.

CO-CHAIR MOSCOVICE: Bob?

DR. RAUNER: And actually I'm going to throw more into that, that I think as Greg -- Greg is right, maybe that's overly broad. However, most of what we see as bad outcomes that were avoidable, the frequent scenario is they had a surgical procedure in a hospital and the follow-up for the hip may not be necessary for four to six weeks, but the other things that happened were necessary, and it was never

scheduled. So, one of our first anecdotes we used forever was the urologic procedure where they held the diabetic meds because they were controlling it in the hospital, and they failed to restart those diabetic meds when the patient went home. And, obviously, that didn't go well. So, now not all this needs a visit, though, because that's actually the transitional care codes, or that's part of the -- if it isn't a visit face-to-face, it may be a phone call, for example. So, I guess we're breaking this into multiple things, but literally it is the most common cause of our errors, is this transition here. So, maybe they don't all need a visit, but everybody at least needs a transitional -- an opportunity do a transitional care code, or maybe there's a threshold where, you know, if I have no meds, I probably don't need to be seen. But if I've got eight meds, that person does need to be seen within a couple of days because a lot of those fluid shifts around surgery may not show up. So, I think this is more complicated, but

definitely does need to be fleshed out because this is where we see a lot of our issues happening.

DR. IRVINE: Yes, and the point is not that some patients don't need to be seen very soon afterwards by their internist, by their family doc, or by me. That's not the issue. The issue is, if I've got an ASA 1 patient on no meds and has got everything all lined up and so on, it's a waste of resources for them to come back and see me, or many times they're coming back, you know, 80 miles to see me. I'm not going to drag them back to say hey, you're looking great. We actually think about when we're going to have them come back, and that's what we put in the discharge order. So, I just think penning us in with prescribed times, then suddenly we're out of compliance because we didn't see the patient back two weeks after surgery. There are certainly many patients -- I mean, a hip fracture patient is a medical patient with a hip fracture, and they've got lots of comorbidities, lots of problems. And,

you know, it's an opportunity to actually get on top of a lot of the problems that they have that might have even led to the fracture. And that's a very different animal than other cases. And that's -- you know, we need to be allowed to use our discretion when we're admitting and discharging patients.

CO-CHAIR MOSCOVICE: Michael.

DR. BAER: One thing that's not on here, and I don't know if there are any measures related to telehealth, but that is something that might be considered. I don't know what a good telehealth measure might be to measure quality but, you know, as we're thinking forward with critical access hospitals and folks out in nowhere where there's transportation issues, maybe telehealth -- maybe a measure related to telehealth would be good to think about.

CO-CHAIR MOSCOVICE: Any telehealth experts out there who might have some areas we might hone in on vis a vis developing a quality measure for telehealth? Bruce.

DR. LANDON: I'm not an expert but I'm not aware of any. And we're doing a paper on this, the use in the Medicare population. We have data through 2012. The graph looks like this, but starting out at like 10, so it's -- even though it's going like that, even at the end of the period in 2012, I want to say the total number of visits is like 100,000 in a 20 percent sample, something along those lines. And, obviously, getting higher and higher, and Medicare keeps relaxing the rules and expanding indications.

CO-CHAIR MOSCOVICE: So maybe not ready for prime time?

DR. LANDON: Probably.

CO-CHAIR MOSCOVICE: John.

MR. GALE: Actually, I spent some time looking at this issue recently in response to a question. The only measures I could find were utilization measures that folks were reporting. But as I think about telehealth and the area that I work most closely with is behavioral health, it's really only -- I don't think I know, or I

can clearly understand what would be different about doing it through the telehealth technology. You'd still have a face-to-face psychotherapy interaction designed to change behavior, so I don't know in my mind that the use of the technology at least in behavioral health changes a measure that you would use for normal behavioral health encounter.

MR. GALE: Well, it's the most common because it's the easiest, again, because it translates well to that --

CO-CHAIR MOSCOVICE: Okay. I assume, though, that the timeliness issue would come into play with telehealth. Presumably, we're using telehealth because there aren't providers available, and that somehow this would facilitate access to providers. So, I would think there would be some timeliness aspects.

DR. BAER: And I'm really talking about, there's two different -- I mean, there's a couple of different things. If you're using telehealth in a hospital versus using in a clinic

setting. So like in the ER is you're using telehealth, and I'll give an example sort of like Greg was talking about, he's socked in behind mountains and can't even drive over the mountain to get to the airport to get the patient to another tertiary hospital. We had a case like that in Pennsylvania where in northern Pennsylvania, you know, up in Coudersport, they have to go over a mountain just to get to an airport, but they were able to use telehealth in the ER for that pediatric patient to have a visit with a cardiac specialist from Pittsburgh to obviate the requirement to drive the patient in an ambulance over the mountain to get on a fixed wing to get to Pittsburgh. So, I see it kind of differently, and so as we're thinking about it, maybe it's not ready for prime time, but maybe at some time in the future it might be something that we could use.

CO-CHAIR MOSCOVICE: So, Tonya, you were shaking your head.

MS. BARTHOLOMEW: Sorry, I have a lot

to say about telehealth. Being in a rural area in a rural state, it all comes back to what you said, Ira, is access and quality of care for our patients.

We do not have access in most of our state. I think Cheyenne might be the only -- let's say it's one of the biggest communities in our state with 55,000 people in it, small state, that has access to behavioral health. And that is our most utilized telehealth service, because we have so many kiddos, we have so many elderly people who need those services, and they can't get them unless they drive at least 150 miles. So, it becomes an access issue, it becomes a quality of care issue, because if we are not providing those services for our patients, then they are going to the ER. It also trickles down into a utilization issue.

We had a very small clinic that had no providers that was several hundred miles away from us who only had a nurse, and they called us up on telehealth and they said we have this

patient here who has a UTI. Can you please see them over telehealth and we can get the medications? It's huge in rural areas, and I think it's vital. That's my two cents.

CO-CHAIR MOSCOVICE: I had Kimberly, and then Guy.

DR. RASK: The two -- when I look at some of this list of measures here, I think two areas that are particularly pertinent to our rural sort of essential community providers that I don't see here are the accessibility/timeliness measures, something to say the reason that we support these institutions and are willing to pay a little higher cost for them is for accessibility to the community that otherwise would not have a provider to go to.

I don't know whether there might be some measures that are being used by FQHCs, or maybe some of the accessibility measures that are used by NCQA for managed care plans. If there's something that could be kind of adapted for measuring are you serving your community and are

people being able to access care in a timely manner?

And then the second area would be that notion of trying to capture the sense that sometimes what these rural providers have to do is to provide services that may be beyond -- either beyond their general scope or beyond a typical scope because they're in an area where there is not an appropriate next level of care that can be given in a timely manner. So, are there some measures around the scope of practice that's being provided, and timely transfer to the next appropriate level of care, and how that communication process goes so that a -- assuming a high quality provider is able to manage the triage and stabilization in their setting, and appropriately transmit the information to a next site of care, if that's what's required, or manage it entirely in their scope if that is, in fact, accessible. But those kinds of things I don't think it captured very well by a lot of the measures that have been developed currently that

really talk about what happens within this specific scope -- I'm sorry, this specific physical planned.

CO-CHAIR MOSCOVICE: Okay, I have Guy, then I have Jason.

DR. NUKI: I never get my name up fast enough. I was going to say basically what Kim said, but let me just reiterate, I think, how important it is. If I had to judge a CEO's performance at a hospital in a rural area, one of the major things that I would want to judge them by is how able they are to provide the services that their community needs. So, access to care is huge. It's very easy for a -- it's very easy to just say you know what, we're only going to do orthopedics and invasive radiology, and everything else gets sent out. You'll make lots of money that way, but you're not really servicing the community's needs. So, there's not a category here about access to care.

I almost think that that's probably one of the most important categories we could

have, but once again like the telehealth, it's probably nothing that I know that's necessarily already developed. And developing that and making it ready for prime time would be difficult, but I think it would probably be worth it.

CO-CHAIR MOSCOVICE: Jason.

DR. KESSLER: I'm just going to make a comment on that before I say what I actually wanted to say here. There are some measures out there for accessibility. I've never been totally happy with them, because they basically take a population and say what percentage of this population had a service, which I don't know if that's a useful measure or not, but just to add on to that, that there's a few measures like that that exist. I believe they're in the pediatric for specific age ranges.

So, what I was actually going to say was at the risk of kind of taking a few steps back in the conversation, I wanted to add on a couple of things in defense of measures around cost of care. You know, it's arguable whether you

really apply the term quality measures to those things, but I think they're, nonetheless, important. To use a health care cliche, you know, the triple aim of reducing cost, improving health care, and improving the health of the population, and all three of those things really do need to go together.

One of my colleagues described them as three different legs of a stool, and if they don't balance out, you can't sit on that stool. You can't rest the weight of our health care system on that uneven stool. So, I do really like the idea of having measures that do look at the cost of care.

I personally don't think that one that bases it strictly on Medicare spending is such a good measure, unless you are a Medicare program and looking at -- specifically at that population, particularly in a rural setting where Medicare is one population, and it's an older population, plus a few really sick people. But you'd be better off looking at the cost of care

over an entire population, which is something that at least in some data that I have seen, rural systems do fairly well on in comparison to their urban peers.

CO-CHAIR MOSCOVICE: I got Brock, and then Tim. John, is yours still up? Okay, so Brock and Tim.

MR. SIZE: I wasn't prepared. I was going to use you for my prep time. Jason reminded me of something I've been meaning to say, but I'm hesitant to because, again, we have enough work, but it would probably be inappropriate if it's not at least in as a placeholder for a little further down the lane.

Going back to triple aim, and it references one of the legs of the stool as population health. That very rapidly has been, I think, almost misinterpreted or overly narrowly interpreted to something I would call the medicalization of population health. And it's come to be a narrower interpretation than I think was in the original thinking around the triple

aim. It's come to mean my population of patients who are diabetics, versus those metrics that we are increasing looking at in terms of the health of the community. And I'm not sure we're ready to make a recommendation that we should be doing the pay for performance on hospitals to the degree that they're making their community more healthier than it would otherwise be. But, clearly, the responsibility, and our ability to measure the responsibility of clinics and hospitals to helping their community improve is certainly -- for us to be silent on that is probably a mistake, so just kind of putting that into the hopper. And the minutes should show that Brock said that, and not me, because I'm not sure my hospitals are ready for that.

MR. SLABACH: Thank you.

MR. SIZE: You're welcome.

CO-CHAIR MOSCOVICE: Kelly.

CO-CHAIR COURT: So what I hear from our members is they do lots of outpatient stuff, but there's really no measures of the outpatient

stuff they do. So, you know, if they're doing procedures there's no measures really of the therapies that they do. So oftentimes they're the only PT/OT, whatever diagnostic imaging center, and that's a lot of what they do. So, that's a gap, I think.

The other thing, and it's maybe not a rural issue, but I think it's a huge issue, is we don't have enough appropriateness measures. So, for orthopedic surgery, to pick on Greg and the surgeons, there's good measures about, did the wound heal? Did we do the procedure right? But we don't have measures about did we even need to do the procedure? So, you know, once the patient got to the hospital, did we do the right things, but did they even need to be here to begin with? And I think that's a big part of the cost issue is not using the right setting at the right time, or didn't even need the service, or could be done later. And that's -- I'm not sure what the answer to that is, but I think it's a big measurement gap.

DR. IRVINE: Trying to deal with that through looking at appropriateness, and looking at procedures, and when they actually make sense and when they don't, things like laminectomy for low back pain, and the viscosupplements for chronic knee osteoarthritis, and so on. So, I think a lot of that is going to be driven at the specialty level, and should be since we're the ones that are doing those things. But I agree that that's where the cost savings are going to occur a lot, is by not doing procedures that have no benefit.

CO-CHAIR MOSCOVICE: Other comments? Bob.

DR. RAUNER: Dovetailing on Greg's, I think that's one of the biggest missing gaps, actually, is that we've got great primary care measures, we've got great hospital measures, but what we're really lacking across the board is in specialty measures. I have a colleague who's an orthopedic spine surgeon, we've been talking a lot about this, is that some specialties have

great measures, like cardiology and oncology, but a lot of other specialties don't really have good appropriateness, other measures like the other fields, and those really need to be developed. I think it's way out of the scope of this for the most part, although Greg's situation, even rural ortho is an issue. What are those appropriate measures? I don't know.

CO-CHAIR MOSCOVICE: Can you give an example of -- just an idea of what might be a way to measure appropriateness for something that you do, Greg?

DR. IRVINE: Well, I think looking at Academy guidelines, looking at the specialty societies in terms of -- I mean, one small tiny thing that's kind of come to the fore is the whole issue of the appropriateness of viscosupplements, which are used heavily in the outpatient setting both by primary care physicians, internists, and orthopedists, and others. They're extremely expensive, and have never been shown to significantly alter the

outcome of treatment for osteoarthritis of the knee. But the industry is fighting back tooth and nail to keep those from being implemented. There could be huge cost savings just from that, looking at that guideline alone. The Academy recently came out with a position that they could not recommend the use of viscosupplements in osteoarthritis of the knee, and those Academy guidelines are, I think, helpful both for that and surgical procedures of various sorts.

CO-CHAIR MOSCOVICE: Bob. Ann.

MS. ABDELLA: Have you looked at the Choosing Wisely work that's been done, because there have been huge debates within the colleges and academies in specialty to identify those very debates.

DR. RAUNER: Actually, that's what I was going to say, is Choosing Wisely is like the right place to start because they're already aligned with the specialty societies, so always leave -- I have a wife and three daughters, I know I'm supposed to yield.

CO-CHAIR MOSCOVICE: Bruce.

DR. LANDON: Just related to Choosing Wisely, we've actually done a lot of work in trying to actually translate Choosing Wisely recommendations into quality -- or measures, you could call them quality measures, use measures, whatever you want to call them. And, you know, they've been submitted by like 51 societies. Each one of them has like five. We've been able to code up a total of 31 using administrative claims, and many of them are sort of low value, but also low cost. And others are really hard to get your hands around, like a really good example, hopefully you're not a spine surgeon mostly. So, I'm one of those people that's not a big believer in spine surgery. Let's say if you counted spine surgery procedures done in the United States, many of them are inappropriate, but just like I was saying before, you really can't tell the few that might be appropriate from claims in any way.

CO-CHAIR MOSCOVICE: That issue of

being able to use claims data is a big issue, and when we had some technical panels together in the past, when we looked at the appropriateness of imaging services, and the committee basically came to the conclusion you just can't do it using claims data. It's just impossible to do.

DR. LANDON: Yes, we call this issue sort of -- it turns out that there is practically no things on the Choosing Wisely list that either don't have some caveat like after trying appropriate physical therapy and this and that, or whatever, that are things that you can actually identify in claims, or more importantly have what we sort of refer to as clinical heterogeneity. So, yes, it turns out that for most applications this is a low value service, but for this little group over here, very high value service. And when you can't distinguish those, it's really hard to get them in one fell swoop.

Now, when you look at things sort of like trends over time and whatnot, and papers

like that looking at back pain imaging, for instance, you know, those trends over time, that all probably nets out. But, again, when you're looking at sort of an individual case or comparing people, it's hard to do that netting out.

DR. IRVINE: But another thing is relevant on your list here, is all the issue -- or all the guidelines referable to osteoporosis screening, the Academy of Orthopedic Surgery has actually begun to question the advisability of Fosamax in most therapies for osteoporosis, and it's changing the way we're thinking about osteoporosis screening in terms of what we advise and so on. There are definite complications, problems. Today's dogma is tomorrow's dog poop, as is often the case in medicine. And that may be going away, so that's one of those things that you may want to watch closely. There may be different recommendations. Not that we shouldn't be counseling our patients about osteoporosis and proper conservative management, but we may lose

one bullet in our holster on that treatment that's been used fairly heavily. And, quite frankly, I think was largely industry-driven, also.

CO-CHAIR MOSCOVICE: Bob.

DR. RAUNER: Just comment on that, because I'm really happy to hear you say that, because I always wish there would have been a randomized controlled trial of Fosamax versus going for a walk.

CO-CHAIR MOSCOVICE: Any other issues with respect to measurement gaps? We distinguish it between hospital and physician, clinic side, but we've had some discussion of both. But any -- on the physician, clinic side, other stuff you'd like to talk about? Ann.

MS. ABDELLA: Just a question. Are we suggesting that we're endorsing these measures?

CO-CHAIR MOSCOVICE: No, we're identifying areas that are gaps that we really are recommending that NQF and CMS take serious -- a serious look at are these areas we want to try

to develop measures in.

MS. ABDELLA: Okay.

CO-CHAIR MOSCOVICE: So, these are the areas where we don't have appropriate measures at this point.

MS. ABDELLA: Can I tell you how much my doctors hate the diabetic eye exam? Unless you're going to give us the claims, we can't do it, because the patient doesn't know the difference between a refracted exam and a clinical eye exam. And if you don't get the report back which Walmart just isn't willing to do, we won't be able to report on that.

CO-CHAIR COURT: So, maybe a gap would be being held accountable to a measure that you don't have the data for. So, another example in the hospital setting, but it got suspended, maybe permanently, I hope, was the patient that's had cataract surgery, did they have an improvement in their vision? You know, how does the hospital know that? So, that's an example of the data lives in a different setting, and you don't have

access to it. So, I think maybe a principle we would want to endorse is if you're held accountable to the measure, you have access to the data to show how you're performing, because then you can improve it.

CO-CHAIR MOSCOVICE: Any other final comments on measurement gaps?

DR. KESSLER: I just had kind of a follow-up, I guess question about that. Because those two situations I think would be the same in a rural hospital that they would be in an urban hospital, or anywhere else. Are there some areas where rural hospitals are more likely to have specific gaps in their ability to collect data than would another hospital in a larger setting? And I don't know the answer to that. I just throw it out as a question.

CO-CHAIR COURT: Well, I think -- I mean, the cost measures get to that, you know, so if you've initiated the care and end up transferring the patient, and you're held accountable for the cost that happens outside

your walls, you know, that doesn't make sense. And maybe we're kind of jumping to principles, but it seems like if you're going to -- if it's going to be reported on publicly and used in some kind of incentive or penalty program, you have to be able to control, you know, the result. I mean, wholly control the result. You can't be dependent on someone else further down the line, or shouldn't be held accountable for someone else's performance that's not part of your system.

CO-CHAIR MOSCOVICE: I think Jason has raised an important issue, though, which is this is supposed to be about rural environment and these issues. And I think as we write the report and look through this, and if you have observations now about other issues we've talked about that really are sort of rural-centric or at least much more important to a rural environment as compared to an urban environment, or most of the stuff we talked about, do you feel that the same issue exists out in urban environments? Just interested if you have any thoughts on the rural

centrality of these kinds of issues. Guy.

DR. NUKI: So, I'm going to go completely against what you just said, and I apologize, but -- so one of the things you're hearing, and it's not just rural, is that, you know, kind of the data behind some of these measures just isn't really there. And the one I brought up was TPA, the osteoporosis screening. I don't know if this is something that we can use this forum for, but to say, you know, to really use data to drive the measures, but to leave industry out of the room. The process that we went through where we disclosed was fine, and I'm going to bet you that when you sit there and do the thrombolytic therapy measure there's somebody from the makers of TPA in the room and they just disclosed, but they're allowed to be there. Europe doesn't let them show up at the table, and they end up with much better measures. So, my vote would be that if we can we use this to say in reviewing measures there's some that clearly don't match the data that's out there. They're

controversial, and they seem to be driven by various industries that have -- for-profit industries. And that our recommendation is that these are made with -- by excluding all those people who have for-profit industry connections.

CO-CHAIR MOSCOVICE: Michael.

DR. BAER: Two things related to diabetes. One on here is missing, the nephropathy screening. I don't know, this is just a list here but, were we going to look at other ones that maybe include -- if we're not, I would consider including nephropathy screening for diabetics.

CO-CHAIR MOSCOVICE: I believe it's just -- these are examples.

DR. BAER: Okay.

MS. JOHNSON: Yes, these are just examples. Yes, so just to give you a --

DR. BAER: And coming back to the retinal screening for diabetics, and I'm a family doctor, but my exam doesn't meet the HEDIS criteria for retinopathy screening in diabetics. When I look in eyes and I can see cotton wool

spots and hemorrhages, I think I -- not that -- I'm not saying the optometrists and ophthalmologists shouldn't be doing it, but the question is, you know, the family doc wants to do his due diligence and has to get the patient to Walmart to get the optometry exam, but then he never finds out, or she never finds out that it was done. So, this is maybe just a comment on further future work on the actual measures themselves for the retinal screening.

CO-CHAIR MOSCOVICE: Okay. Any other final comments on measurement gaps before we turn it back to Kelly? You want to talk about a few other overarching issues? Tim.

MR. SIZE: I'm not sure what measures -- what the screen was to get measures on or off this sheet. I just had a question. I know in our state there's a huge, huge push around advance directives. Should there be a metric in here somehow about that? And I'm not sure if that's hospital, or clinical, or both.

CO-CHAIR COURT: Maybe we can expand

that to end of life, I mean, as a broader category.

MR. SIZE: Yes. Well, except actually, you know, I mean, honoring choices in our state is a lot more than end of life. It gets closer to a measure for the patient being brought into the decision making process, and giving that patient the support to be able to in advance at various stages in the person's life and disease, whatever, to speak up.

CO-CHAIR MOSCOVICE: Jason.

DR. KESSLER: Well, my bias is that, you know, I work for a program Medicaid that is, you know, if you look at the numbers, 25 percent of the population is in the 50 or older age range. The majority of the population are healthy kids, so if we start looking at metrics in rural settings where volume is a limiting factor to measuring, I just -- I have some wondering if things like advance directives that, you know, are only going to apply to the older population, is that you're going to have more problems with

numbers, things like diabetics. Diabetes is 10 percent of the population which is huge, but if you already have issues of low volume, does it make sense to be throwing in lots of measures around any one specific condition at all? And that's just kind of rhetorical question, I'm not trying to pooh-pooh the idea.

MR. SIZE: Well, no, this is an open discussion. No, advance directives a) aren't just for old folks. B) Since we're going to Medicare that by definition is kind of about older or late middle, I prefer the term late middle, actually, that's all.

(Off microphone comments)

MR. SIZE: No, we're not, but it's (a) we sort of said advance directives is well -- at least in our state we're promoting it well below Medicare age. And there's -- you know, most rural is serving Medicare so I don't think that's actually a small number issue.

CO-CHAIR MOSCOVICE: Bob.

DR. RAUNER: Yes, kind of jumping onto

that. Although it may not be relevant for Medicaid, it's relevant for everybody else in the room, family medicine, rural, CAH, everybody. Almost every state now has a state-recognized version of the POLST form that started in Oregon. Nebraska, as usual, is probably going to be one of the last, but we're working on it right now. Using something like the state-recognized POLST form, it's equivalent I think actually will be hugely beneficial for lots of reasons. And I'll put a plug in for a book, read Atul Gawande's Being Mortal. It's a great book, but a lot of it goes along with some of this stuff, so I really would be a huge fan of having a POLST-like measure, probably the state-designated, because there's variation from state to state what's actually in that POLST form, or even what the acronym is. But most states now do have a state-recognized form like this. In Wisconsin, I know they've got some great programs. I think La Crosse has a really nice one, for example.

CO-CHAIR MOSCOVICE: Ann.

MS. ABDELLA: And just to hitchhike on that, if we think that these measures can change behavior that would be huge, because we have most in New York State and doctors and hospitals are just reticent to put those forms into place. And we've been working on it for five years, and until something more -- with more oomph comes behind that in a pay for performance type of environment, I don't think it's going to happen.

CO-CHAIR MOSCOVICE: I have Jason back there, and then Bob.

MR. LANDERS: A question, is -- and I'm cautious to ask this with so many primary care physicians in the room. There's an obvious lack of appropriate use of antibiotics on this list. is that -- is there a reason for that, or was that just in the sense of not including every important measure?

CO-CHAIR MOSCOVICE: This was almost a random list put together by NQF staff. And really as Karen said earlier, it's the topics that in many sense -- in no way, shape, or form is this -

- should this be viewed as a measurement list and that works for them.

MR. LANDERS: That's an important measure that I want to talk about --

MS. JOHNSON: I will -- Helen remembers things much better than I do. My memory is not so good, but the antibiotic measures that I can think of are really surgery measures, so are there other ones, as well, Helen?

MR. LANDERS: Yes, appropriate --

DR. BURSTIN: Yes, there was a whole series of --

(Simultaneous speaking)

DR. BURSTIN: -- bronchitis, et cetera, overuse measures.

(Off microphone comment)

DR. BURSTIN: No, there's actually -- we actually have a couple of dozen overuse measures now, including imaging, cardiac imaging, things like that.

MR. LANDERS: Pharyngitis testing, which is essentially --

DR. BURSTIN: Yes, we've got all those. Yes, and the question would be, you know, particularly in areas where under-use may be more of an issue than overuse, is that the right logical approach for rural when access may be a bigger issue? So, those are questions I would pose to you.

CO-CHAIR MOSCOVICE: So, Helen has raised the issue of under-use as compared -- you know, often we worry about over-utilization of resources, so in an environment where we don't have a large -- as many resources as other environments, any concern about under-use?

DR. BURSTIN: I'll just follow-up and say, I mean, many of the measures could still be about appropriateness, but it may not always be appropriateness towards the eye of saying it shouldn't have been done. My guess is Greg probably has a whole lot more patients in his area who need total knees and hips who don't come forward, who probably are appropriate. So, you know, who don't have access.

CO-CHAIR COURT: I think the challenge with that is where -- so, it's easy to measure what happened that wasn't supposed to happen, but how do you measure something that didn't happen that was supposed to?

DR. BURSTIN: That was a contorted sentence, that was good. You know, there are measures of appropriateness.

(Off microphone comment)

DR. BURSTIN: Yes, and there also are measures of patient reported outcomes of symptoms. I mean, that's the other piece of this, is do you begin assessing sort of physical function and mental function as a starting point, and being able to see those difference might be profound, as well.

CO-CHAIR MOSCOVICE: Brock.

MR. SLABACH: Yes, going back to the advance directives. My memory is not as good as it used to be, so Helen or someone at the MAP work -- the hospital work group back in December, did we -- we did not approve the advance

directives to be recommended to CMS for hospital inclusion, did we?

DR. BURSTIN: I think there was -- I think you're right. I think it was a whole issue of where should it be done. I think everybody agreed it was an important topical area, but it's a question of is it an outpatient issue, an inpatient issue, should it be done repeatedly? There are already HEDIS measures that look at advance directives for older folks in the outpatient arena.

MR. SLABACH: Yes, I just wanted to clarify because, again, that goes back to where you do the -- where does accountability rest for that particular function. And I think that's an important question as we move through this.

CO-CHAIR MOSCOVICE: Hearing the sirens and no further cards, I think we'll move to the, I believe, last session. And we're not going to have reports out from the breakout groups because we didn't have breakout groups, but we have a few other issues we want to get some conversation on.

And Kelly is going to lead that discussion.

CO-CHAIR COURT: So, we have a little more time today, and we've kind of circled around many issues, but let's kind of nail them down related to program design, for lack of a better term.

So, assuming that P4P is coming, what kind of things do we not want the design of that program to have, or things we want it to have? So, for example, right now in the HAC penalty program that applies to the PPS hospitals, there's two domains.

And if you don't have measures in the one domain, all your weight goes into the second domain. I think that's flawed, so if there's going to be domains around this, the weighting of those domains has to be done in such a way that it guarantees there's measures, or enough measures in each of the domains, or the way the domains get re-weighted based on absence of measures in one or more, doesn't put all the weight in the other ones. And I don't know what

the answer to that is, but it seems -- you know, you could have your whole program based on two measures, because the domains tend to not have a lot of measures in them, so if you don't perform well on one or two measures, that could be your whole incentive or penalty.

So, what other things as measures would get applied in an incentive or penalty program, do we think need to be considered? Ann.

MS. ABDELLA: Straight from the lips of four small PPS hospitals, the return on investment of their time and energy just isn't there. They do it because it's the right thing to do, but that's -- the money is not sufficient. So, if they're putting all their money in a bucket to do this, and they generally perform pretty well, it's just -- it is what it is.

CO-CHAIR COURT: So, would we want more money to be at risk? I mean, what's the solution to that?

MS. ABDELLA: I don't have the answer --

CO-CHAIR COURT: I don't want to go on the record saying that as a hospital association. I'm sorry. Guy.

DR. NUKI: That's where it's going anyway. Right?

CO-CHAIR COURT: Yes.

DR. NUKI: I mean, the whole way we get paid is going to completely change.

CO-CHAIR COURT: Tim.

MR. SIZE: Yes. I think what's unique about this conversation then is what's the ethical and effective approach, pay for performance for cost-based providers who are cost-based for a particular reason. So you take those who are struggling, maybe not all that successfully to do the right thing, and so if they don't achieve it, you take more resources away from them. I think that's kind of counterintuitive. And I think that's a position for some of us who were at the ACO meeting Monday that Lynn Barr certainly spoke about, that her experience was telling her it's about providing

opportunities for a little bit additional on top of the cost.

And again, you know, going back, cost doesn't mean 100 percent of cost, or 101, or 98 doesn't mean a full cost, it means you really get around 93. So, if all they have is what they're getting from Medicare on their costs, they're not going to survive. So, it's not like we're giving them money to go to Vegas or something.

I think -- I had one more thought. I think I forgot it. I'll come back to it.

CO-CHAIR COURT: We'll turn to Brock, and then maybe you'll remember.

MR. SLABACH: Well, Tim said what I was going to say, so I'll probably finish the thought that he lost.

(Off microphone comment)

MR. SLABACH: No, I may do that here. I think, again, we go back to this balance between our obligation in terms of a safety net and access, and a lot of the facilities -- I mean, if you look at the statistics of the

financial status of critical access hospitals as a group, you're looking at about 70 percent that are now losing money on an annual basis on operations. So, I think I would agree with Tim, if it was an additional amount of money that you could stand to gain if your performance is good, would be a much better direction than to do a discount based on not performing. And I -- so, I would agree with that, and I'll stop there.

MR. SIZE: Back to what I forgot?

CO-CHAIR COURT: No way. Okay, go.

MR. SIZE: Yes. I just was going to make the point is, you know, the most recent iVantage data that was just released Monday, I mean, they're basically making the point that Medicare's expenditure per beneficiary in rural areas is on average 2.5 percent less than urban. So, it's not like there's not a little bit of money that's in the trust fund that they could spend for incentives and still have the investment to rural beneficiaries being below the national average. I think the money is there, and

the case could be made for it.

CO-CHAIR COURT: Greg.

DR. IRVINE: I would concur with that completely, what was said, that we don't want to take away because there's nothing to be taken away, and you're going to kill hospitals if you do that. Critical access hospitals are going to go down, especially in the west, I think. Places that are truly critical access, and that there's just nothing else. There's no other option.

I would also plead for -- when it comes to pay for performance, looking at the measures that you are going to be using as your marker, that hospitals be given at least some flexibility, if not allowed to design their own program, at least be given a menu of quality measures to look at and say this one doesn't make sense for us, but this one does. Kind of like a Chinese menu, one from Column A, one from Column B.

Don't force them to necessarily live with everything, and if you give them enough

choices, they'll find things that make sense for their environment.

CO-CHAIR COURT: I'd like to see the dates of the measures closer to -- a faster cycle time, because in the hospitals there's a -- I mean, you've got to get your measures in fairly quickly, but it seems like the time that then those measures are applied to the program is so far after the fact that it's really hard to get too excited about something that happened two years ago. So, if there would be a way to speed up the cycle time between the performance and whatever they're used for. Tonya.

MS. BARTHOLOMEW: If I could choose one thing that this program would have it would be going back to the alignment, and reporting the same data to the same place for multiple entities. I think that you'll do a better job of recruiting people to do that to participate in the quality measures, and I think it would really ease the burden of the cost of creating the data used in the reporting mechanisms.

CO-CHAIR COURT: Brock.

MR. SLABACH: I think an additional item that would help make, if we're assuming mandatory reporting, is to ensure that for -- well, for all facilities not currently reporting, that there's technical assistance that's provided in terms of the ability to get this underway within these particular groups of people, facilities.

CO-CHAIR COURT: Steve, I'm sorry. You have to like wave your hands, too, I guess. The closer you are, the harder it is to see.

DR. SCHMALTZ: Things like the VBP program, you also need a component for improvement and for what their current level is.

CO-CHAIR COURT: Yes, so include credit for improvement, not just achievement.

CO-CHAIR MOSCOVICE: How would you design that, Steve?

(Off microphone comment)

CO-CHAIR COURT: Yes, I agree.

DR. SCHMALTZ: You'd have to follow

them a couple of years, but -- so there's the currency, I guess, that would cut into that, but --

CO-CHAIR MOSCOVICE: Would there be a base that they have to reach at least even in terms of improvement to --

DR. SCHMALTZ: Yes, yes. You'd design, I'd say pretty much parallel the VBP program.

CO-CHAIR COURT: Bob.

DR. RAUNER: We just had this discussion actually with Michael's counterpart in Harvard Health Plans, like we picked a new measure, depression screening in adolescents, and because they -- how they define their denominator, they wanted the whole population whether we see them or not. We said well, how do we even start the baseline then? So, we actually decided to mix this by first six months that we establish a baseline that would be at least 10 percent.

Second six months it'll be either an improvement upon that baseline by a certain

percentage or a threshold, because most improvements will have kind of an S-shaped curve, so you can't always say 10 percent every year because eventually that doesn't get -- and you can't always get 100 percent, so we actually I think came up with, I think, kind of a unique solution where it's the baseline, then percentage on, then up to a cap because you'll never get everybody, for example. And I think that was kind of a way to blend both improvement and achievement, and we'll see how it works. I don't know, we just started.

CO-CHAIR COURT: Mike.

DR. BAER: Yes. I wasn't so sure I was thinking of having a blended program where you're saying, you know, if you have improvement there's a payment, and then if you meet a target there's a payment. But I'm -- what I was going to say before Steve said that, was that one way to look at it, and in Pennsylvania we do this in our pay for performance from the Department, as well as in some other areas where we have a goal, and if

they don't meet that goal, but year over year or measurement period over measurement period there's a percentage increase, then they would get a payment for that improvement, even if they didn't meet the goal, but they've made a significant, like a 10 percent increase in their performance over the measurement period prior.

CO-CHAIR COURT: I think the hospital VBP, that you have to meet at least a minimum threshold, don't you, to get any payment?

DR. SCHMALTZ: Well, there's two criteria, so the first is what their achievement is. If their achievement is below a certain level, then they look at improvement. If they meet the improvement goal, then they can get the payment.

CO-CHAIR COURT: Yes. Kimberly.

DR. RASK: And one of the things I would add to it, and this is slightly self-serving since I do work for QIO, but as we think about, we've talked about rolling out these measurement programs to small volume providers

who don't have a lot of infrastructure, don't have a lot of resources. As this was rolled out through all the different steps for hospitals over the last many years there was a lot of technical support, technical assistance that was available to them through QIOs and similar type programs to really help people learn how to report, what field you put in, what does it mean if this is blank, or how do you include this, that, or the other.

And I think it would be important to recommend that whatever measures get put out, and if this becomes mandatory reporting, and so for these providers that have -- are so low on infrastructure, and on other resources, having mechanisms for some kind of technical support to help them report accurately, effectively, and consistently will go far to making it a useful program, as opposed to a gigantic headache.

CO-CHAIR COURT: Ann.

MS. ABDELLA: Relative to the idea of the measures with quality improvement or

baseline, would they -- are you suggesting they would reach a certain threshold and that's okay, or are we seeking constant steps up in improvement? And one of the challenges that we've had on a -- working with -- on the commercial side is the idea behind statistically significant improvement. I don't know if that's how you all operate with your quality improvement measures for the hospitals. But, you know, they're always arguing with us statistically significant every year, it has to be in order to qualify. And when you're dealing with small numbers, that can be a real challenge, so --

CO-CHAIR COURT: Sheila.

DR. ROMAN: Just to follow-up on what Kimberly said. I think, you know, we're dealing with a population of providers that has not had a lot of experience with reporting quality improvement. And perhaps jumping to pay for performance is really too big a jump at this point, and that we should really be recommending pay for reporting at this point, rather than pay

for performance, which has higher stakes. And we really don't have the measures and measure experience with this population to know how it will play.

CO-CHAIR COURT: And then, Sheila, earlier you put public reporting in between there, so -- I guess that's implied in the pay for reporting.

DR. ROMAN: I think at this point it's implied in pay for reporting.

CO-CHAIR COURT: Yes, okay.

DR. ROMAN: It wasn't initially.

CO-CHAIR COURT: Okay. So, a phased approach is -- this isn't a one-step process.

DR. ROMAN: Right. Walk before you run.

CO-CHAIR COURT: Yes. Bob. Other things?

MS. JOHNSON: So, I think we covered our agenda. We got through what we wanted to go through today. Yes, we still have to get our public comment, which I'm not going to forget. Thank you, at this time. But I don't -- does

anybody have any objection to leaving a little early today?

Okay. So, we're going to open for public comment. Is there anything else we need to do, any housekeeping for the rest of the day? Okay, we had -- we didn't set up an official dinner for you guys. We didn't set up like reservations, but we can recommend some restaurants around if you guys are interested. I'm not sure if you guys already had plans or what have you, but there's several that are good that are very close, so we can talk about that after. But let's just open it for public comment, and then we'll adjourn for the day.

MS. GHAZINOUR: Operator, would you please open the lines for public comment?

OPERATOR: At this time if you would like to make a public comment, please press *1 on your telephone keypad.

And there are no public comments at this time.

MS. GHAZINOUR: Thank you.

MS. JOHNSON: So, just so you know what's on our agenda for tomorrow. One of the things that we're going to do is we're going to huddle here and make sure that we got what we -- we'll make sure that what we wrote down and what we think you said is what you said. And we're going to present that to you tomorrow morning, and we'll just go through and see if we missed things, did we misunderstand anything, that sort of thing. We want to go through that. And then we will just continue the conversation. I think what we got through today was some of the bigger measurement issues, so there are other ones I think that you may want to talk about, and we could talk about solutions for those.

And we've purposely not talked much yet about those bigger rural issues that are a little tangential to measurement, but apply. And there may be recommendations that you want to put forward on those kind of things, so we want to give you that opportunity to do that tomorrow.

Also, Helen, I'm not going to put you

on the spot now, but they did want to know a little bit more, and I didn't have the context to be able to say, when guidelines change, the P4P for programs don't change. They're still out there, those measures are still on the list of being -- people are still being held accountable to measures that maybe aren't quite with the guidelines. So, do you have any context on that?

DR. BURSTIN: Yes. So, I mean, it's pretty dependent, but usually what happens if it's a guideline that's had a significant change like lipids, the measures are pulled from the program. So, for example, currently the measures of lipid control are no longer in most of the federal programs. There's even still ongoing work to revise the blood pressure measures based on the new guidelines, so it isn't quite that they stay out there. I think sometimes the problem is that you've seen one guideline and then two days later there's another one saying the opposite, so I think it's often hard to figure out when the ground has stopped moving enough to figure out

what the new measure should be.

But, you know, as NQF looks at measures, and we'll do an update -- we'll do an ad hoc review on any measure any time where there's a change in evidence, so we'll do that immediately. We just did that for the sepsis guidelines, for example, when the process trial came out in the New England Journal. But it's -- we require the quality, quantity, and consistency of evidence, and consistency is most important, as certainly the clinicians in the room know. And we won't put forward a sort of evidence-based guideline unless there's consistency of evidence.

MS. JOHNSON: And then another thing, Tim had asked tomorrow morning, so maybe you and I can huddle, Helen, and just give a real brief synopsis of where we are with our SDS work, so I'm not sure if it'll be Helen, or me, or some combination. Ann.

MS. ABDELLA: You've referred a couple of times, some of you, to this MAP process, and

I'm wondering if you could add that to the mix to give everybody just an overview? Might be really helpful.

DR. BURSTIN: In terms of the SDS discussions we could talk about because there's really sociodemographics. I think part of what didn't happen when we did our initial work around thinking about what variables were there, is there really wasn't a focused discussion of what would those variables be from a real context. I think earlier, I forgot, it was Brock or Tim mentioned, you know, distance to the local facility. That didn't come up, but in a context of thinking about adjusting rural measures that might be a very useful discussion tomorrow that's directly relevant now that we've opened -- measures can now come in with that kind of adjustment. They could really use advice on what kind of variables they should be adjusting for. So, I think that would be a useful exercise, too.

MS. JOHNSON: Okay. Anything else?

All right. Thank you guys so much for

a great conversation today. I will see you tomorrow. We're starting at breakfast at 7:30 and discussion at 8:00.

(Whereupon, the above-entitled matter went off the record at 4:48 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Performance Measurement for Rural Small-Practice Health Providers

Before: NQF

Date: 02-05-15

Place: Washington, DC

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