

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE MEETING

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TUESDAY
JANUARY 26, 2016

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The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 10:00 a.m., Harold Pincus, Co-Chair, and Foster Gesten, Acting Co-Chair, presiding.

PRESENT:

HAROLD PINCUS, MD, Co-Chair

FOSTER GESTEN, MD, FACP, Acting Co-Chair

RHONDA ANDERSON, RN, DNSc, FAAN, American
Hospital Association

MARY BARTON, MD, MPP, National Committee for
Quality Assurance *

STEVEN BROTMAN, MD, JD, AdvaMed

JAYNE CHAMBERS, Federation of American Hospitals

MARK R. CHASSIN, MD, FACP, MPP, MPH, The Joint
Commission

MELISSA DANFORTH, The Leapfrog Group

CHRISTOPHER M. DEZII, RN, MBA, CPHQ,
Pharmaceutical Research and Manufacturers of
America (PhRMA) *

LYNDA FLOWERS, JD, MSN, RN, AARP *

DAVID GIFFORD, MD, MPH, American HealthCare
Association

RICHARD GUNDLING, FHFMA, CMA, Healthcare
Financial Management Association *

APARNA HIGGINS, MA, America's Health Insurance
Plans

GAIL HUNT, National Alliance for Caregiving

CHIP N. KAHN, III, MPH, Federation of American
Hospitals *

WILLIAM E. KRAMER, MBA, Pacific Business Group
on Health

SAM LIN, MD, PhD, MBA, American Medical Group
Association

LISA MCGIFFERT, Consumers Union

ELIZABETH MITCHELL, Network for Regional
Healthcare Improvement *

R. BARRETT NOONE, MD, FACS, American Board of
Medical Specialties

FRANK G. OPELKA, MD, FACS, American College of
Surgeons *

AMIR QASEEM, MD, PhD, MHA, American College of
Physicians

CAROL SAKALA, PhD, MSPH, National Partnership
for Women and Families

MARISSA SCHLAIFER, RPh, MS, Academy of Managed
Care Pharmacy

CARL SIRIO, MD, American Medical Association *

MARLA J. WESTON, PhD, RN, American Nurses
Association

STEVE WOJCIK, National Business Group on Health*

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, MS *

MARSHALL CHIN, MD, MPH, FACP

FEDERAL GOVERNMENT LIAISONS PRESENT:

KATE GOODRICH, Centers for Medicare & Medicaid
Services (CMS)

KEVIN LARSEN, MD, FACP, Office of the National
Coordinator for Health Information
Technology (ONC)

CHESLEY RICHARDS, MD, MH, FACP, Centers for
Disease Control and Prevention (CDC)

WORKGROUP CO-CHAIRS PRESENT

BRUCE BAGLEY, Clinician Workgroup *

CAROL RAPHAEL, PAC/LTC Workgroup *

ERIC WHITACRE, Clinician Workgroup *

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

MARCIA WILSON, Senior Vice President, Quality
Management

TAROON AMIN, NQF Consultant

WUNMI ISIJOLA, Administrative Director

ANDREW LYZENGA, Senior Director

DEBJANI MUKHERJEE, Senior Director*

ERIN O'ROURKE, Senior Director

SARAH SAMPSEL, Senior Director *

AMBER STERLING, Project Manager

JEAN-LUC TILLY, Project Analyst

REVA WINKLER, Senior Director *

ALSO PRESENT:

DAVID BAKER, MD, MPH, FACP, American College of
Physicians

SHAWN BITTORIE, CommPartners

HEIDI BOSSLEY, American Medical Association

EMILY BROWER, American Medical Group
Association

CAROLE FLAMM, MD, MPH, Blue Cross Blue Shield
Association *

NANCY FOSTER, American Hospital Association

RABIA KHAN, Centers for Medicare and Medicaid
Services (CMS) *

ALAN LEVITT, MD, Office of the National
Coordinator for Health Information
Technology (ONC) *

TERESA LEE, Alliance for Home Health Quality and
Innovation

SANDRA ROBINSON, American Academy of

Dermatology *

* Present by teleconference

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

2 (10:00 a.m.)

3 MR. AMIN: So good morning, everyone.

4 Thank you all for making it here in person and
5 virtually on this amazing snow conditions that we
6 were under. I want to welcome you all to the
7 coordinating committee meeting and our CMS
8 partners. I'm going to turn it over to the
9 Chairs to just say a few words of welcome and
10 then turn it over to Helen to do our welcome,
11 introductions, and disclosures.

12 CO-CHAIR PINCUS: Welcome, everybody.

13 Those on the phone, it's Harold Pincus. I'm sad
14 that Beth McGlynn, my partner in crime, is not
15 going to be able to get here. She has an illness
16 in the family that she needs to attend to, but we
17 are ably assisted by Foster Gesten, who's here,
18 who -- Foster and I have worked together on a
19 number of other different NQF and other projects,
20 and so we'll do this together.

21 It's going to be a challenging
22 meeting, obviously, because of both the sort of

1 tele-members as well as the difficulty people
2 have had in getting here. It's sort of
3 interesting to me that two days ago, I was cross-
4 country skiing in Central Park, and fortunately,
5 we were able to get a train to get here
6 yesterday. Foster?

7 ACTING CO-CHAIR GESTEN: Yes, just
8 happy to be here. I know Beth McGlynn, and I'm
9 not Beth McGlynn, but hope to help out the
10 process. I really appreciate having snow here,
11 which really makes me feel welcome, coming from
12 upstate New York. It feels really familiar, and
13 it's actually like the first winter I've really
14 experienced, so look forward to a great day.

15 DR. BURSTIN: Great. Good morning,
16 everybody. Helen Burstin, Chief Scientific
17 Officer here. Thank you so much. I'm actually
18 amazed how many of you are in the room, which we
19 know is not easy. We were betting yesterday. I
20 had said half of you, and I think you've actually
21 -- I think I won the bet, so thank you.

22 And thanks to all of you who will

1 spend a lot of time with us virtually. In some
2 ways, probably harder than it is to be in the
3 room. We can't feed you, so we apologize for
4 that, but first thing we're going to do is go
5 through the disclosures, which will be a little
6 interesting because we have a blend of those in
7 the room, as well as those on the phone.

8 And some of you -- I think what I'm
9 going to do, it's a little unorthodox, just to
10 make it easier, is I'm quickly going to do the
11 script for both organizational members as well as
12 subject matter experts, and then we'll run the
13 room, and then we'll run the people on the phone,
14 so you'll know who you are, if you're an
15 organizational member or a subject matter expert,
16 as I go through this, and if you don't know, I
17 will tell you as I run through it.

18 So briefly, we're going to combine
19 disclosures with introductions, as we often do.
20 We'll divide it into those two categories.
21 Briefly, organizational representatives, which
22 the majority of you are, we expect that you're

1 representing the interests of a particular
2 organization. So in light of your status as an
3 organizational rep, the disclosure of interest is
4 fairly minimal.

5 We really -- just one limited question
6 regarding whether you, individually, have any
7 interest of \$10,000 or more in terms of an entity
8 of the work related to this committee. Tell us
9 who you represent, if you have anything to
10 disclose, and we'll go around the table and do
11 that.

12 If you are, in fact, I've got a list
13 of these, a subject matter expert at the table,
14 you sit as individuals. You are not here as
15 organizational representatives, so we ask for a
16 bit more detail. Now again, we've seen your CVs,
17 we picked you to be at this table, they're very
18 long and lovely, and we can't have a recitation
19 of those, since we already lost an hour this
20 morning, so if you could, please give us a sense,
21 overall, of disclosure of any activities you
22 think are relevant to the subject matter of the

1 committee's work over the next couple of days,
2 particularly anything regarding grants,
3 consulting, or speaking arrangements.

4 Again, only if relevant to the
5 committee's work, and as individual members,
6 again, you're here as a subject matter expert,
7 not as an organizational representative. So I
8 think we'll proceed. Let's start with the
9 Chairs, perhaps, first, and then we'll run the
10 table, and then we'll figure out which ones of
11 you are online, if we have that list, and we'll
12 come to them second.

13 CO-CHAIR PINCUS: So this is Harold
14 Pincus. I work for New York Presbyterian
15 Hospital and Columbia University as well as being
16 a senior scientist at the RAND Corporation. I've
17 been a consultant for Mathematica. I'm on the
18 advisory committee for NCQA to develop a measure
19 and agenda at the interface between behavioral
20 health and general healthcare.

21 ACTING CO-CHAIR GESTEN: Good morning.
22 Foster Gesten. I'm the Chief Medical Officer in

1 the Office of Quality and Patient Safety at the
2 New York State Department of Health, and I'm here
3 representing the National Association of Medicaid
4 Directors, and I have nothing to disclose.

5 DR. BURSTIN: Excellent. Let's go
6 over to this side. David.

7 DR. BAKER: David Baker. I'm
8 Executive Vice President for Healthcare Quality
9 Evaluation at the Joint Comision. I have no
10 financial disclosures, but I will disclose that
11 some of the measures, at least one that will be
12 discussed, is a joint commission measure, and
13 I'll recuse myself from discussion.

14 DR. BURSTIN: Perfect. Thank you.
15 Barry.

16 (Off microphone comments.)

17 MEMBER SAKALA: Good morning. I'm
18 Carol Sakala, a program director at the National
19 Partnership for Women and Families, and I have
20 nothing to disclose.

21 MEMBER WESTON: And I'm Marla Weston.
22 I'm the CEO for the American Nurses Association.

1 I have nothing to disclose.

2 MEMBER O'BRIEN: I'm Shawn O'Brien,
3 and I represent the AFL-CIO. I have nothing to
4 disclose.

5 DR. CHIN: I'm Marshall Chin. I'm the
6 disparities person from the University of
7 Chicago. One of my grants comes from the Merck
8 Foundation. It's a philanthropy funded by Merck
9 Company. I've been working with the America's
10 Essentials Hospitals and Joint Commission on some
11 disparities work. I'm on the National Advisory
12 Board for Medicaid Innovation, which is
13 affiliated with the Medicaid Health Plans of
14 America.

15 I supplied some unpaid medical
16 assistance to some of CMMI projects having to do
17 with disparities. Oh, I'm the President of the
18 Society of General Internal Medicine this year.

19 MEMBER ANDERSON: I'm Rhonda Anderson.
20 I'm with the AHA seat, but also CEO of Children's
21 Hospital with Banner Health in Arizona. I have
22 nothing to disclose.

1 DR. RICHARDS: I'm Chesley Richards
2 from the Centers for Disease Control and
3 Prevention. I have nothing to disclose.

4 MEMBER KRAMER: Morning. I'm Bill
5 Kramer with the Pacific Business Group on Health.
6 I also co-chair the Consumer Purchaser Alliance
7 funded by grants from the Robert Wood Johnson
8 Foundation.

9 MEMBER GIFFORD: I'm Frank Gifford.
10 According to the New York Times, I'm a declining
11 rare species of geriatricians. I represent the
12 American Healthcare Association and Nursing Home
13 and Assisted Living organizational. We are a
14 measure developer, and we've had some measures,
15 but none here for today, and I have a bunch of
16 401(k)s. God knows what they're invested in, but
17 they're going down, so it can't really help
18 anything, as far as I know, so I don't think I
19 have anything to disclose.

20 MEMBER MCGIFFERT: I'm Lisa McGiffert
21 with Consumers Union. We're the advocacy arm of
22 Consumer Reports, and I run the Safe Patient

1 Project, where we work on policies to reduce
2 medical harm, and we collaborate and organize
3 patients who have been harmed by medical care so
4 that they can get involved locally and nationally
5 in committees like this and other activities. I
6 have nothing to disclose.

7 MEMBER SCHLAIFER: I'm Marissa
8 Schlaifer, I work for CVS Health, and I represent
9 the Academy of Managed Care Pharmacy.

10 MEMBER BOSSLEY: Heidi Bossley,
11 consultant to the American Medical Association.
12 Carl's on the phone and on the webinar, so I'll
13 defer to him, but if he's not here, I'll --

14 MEMBER SIRIO: Good morning, folks.
15 I couldn't get a plane in, but this is Carl
16 Sirio, nothing to declare, and Heidi and I will
17 be going a little bit of tag team, as I have to
18 be on and off a couple times today.

19 MEMBER HUNT: Hi. I'm Gale Hunt. I'm
20 the President and CEO of the National Alliance
21 for Caregiving, and I'm also on the board of
22 PCORI, the Patient-Centered Outcomes Research

1 Institute, and I have nothing to declare.

2 DR. GOODRICH: Hi. I'm Kate Goodrich.
3 I'm the Director of the Center for Clinical
4 Standards and Quality at CMS, and nothing to
5 declare.

6 DR. BURSTIN: Great. And we'll at
7 least allow him to sit down, but I will have him
8 introduce himself and see if you have anything to
9 disclose.

10 MEMBER QASEEM: Sure. Amir Qaseem,
11 Vice President, American College of Physicians,
12 and no disclosures.

13 DR. BURSTIN: And, Amber, can you tell
14 us which committee members are on the webinar who
15 I can call on? We've heard from Carl. Carole
16 Flamm, are you with us this morning?

17 DR. FLAMM: Yes, I am. Hi. This is
18 Carole Flamm. I'm Executive Medical Director at
19 Blue Cross/Blue Shield Association, and I have
20 nothing to disclose.

21 DR. BURSTIN: Great. Thank you.
22 Chip, are you on with us? Chip Kahn? He may

1 only be on the webinar portion, perhaps? Chris
2 Dezii? Chris, are you with us this morning?

3 MEMBER DEZII: Yes, I am, and good
4 morning. Chris Dezii, Bristol-Meyers Squib,
5 Director of Healthcare Quality and Performance
6 Measures, and I represent the Pharmaceutical
7 Research and Manufacturers of America.

8 DR. BURSTIN: And do you have anything
9 to disclose?

10 MEMBER DEZII: Oh, nothing to
11 disclose. Sorry.

12 DR. BURSTIN: Okay. Thanks, Chris.
13 Elizabeth Mitchell, are you on with us?

14 MEMBER MITCHELL: Hi. Thanks, Helen.
15 Elizabeth Mitchell, President and CEO of Network
16 for Regional Healthcare Improvement, and I have
17 nothing to disclose.

18 DR. BURSTIN: Great. Thank you.
19 Anybody else? Lynda Flowers, are you on with us
20 this morning?

21 MEMBER FLOWERS: I am. Linda Flowers,
22 Senior Policy Advisor with the AARP's Public

1 Policy Institute, and I have nothing to disclose.

2 DR. BURSTIN: Excellent. Welcome.

3 MEMBER FLOWERS: Thank you.

4 DR. BURSTIN: Missy, are you on the
5 phone with us?

6 MEMBER DANFORTH: I am. Good morning.
7 I'm Missy Danforth, Vice President of Hospital
8 Ratings, representing the Leapfrog Group, and I
9 have nothing to disclose.

10 DR. BURSTIN: Excellent. Thanks,
11 Missy. Rich Antonelli, are you on with us?

12 DR. ANTONELLI: Yes. I am here in
13 Boston. Rich Antonelli. I have no conflicts of
14 interest to disclose.

15 DR. BURSTIN: Excellent. Thanks,
16 Rich. Richard Gundling, are you on with us?

17 MEMBER GUNDLING: Yes, I am. This is
18 Richard Gundling, and I represent the Healthcare
19 Financial Management Association, and I'm the
20 Vice President for Healthcare Financial
21 Practices, and I have nothing to disclose.

22 DR. BURSTIN: Steve Brotman, are you

1 on with us?

2 MEMBER BROTMAN: Yes. Steve Brotman
3 of AdvaMed Advance Medical Technology
4 Association. Nothing to disclose.

5 DR. BURSTIN: Excellent. Thank you.
6 Steve Wojcik, are you on with us this morning?

7 MEMBER WOJCIK: Yes. Steve Wojcik,
8 National Business Group on Health, and I have
9 nothing to disclose.

10 DR. BURSTIN: Are there any other
11 committee members on the phone who we have not
12 introduced who are on with us this morning?

13 MEMBER OPELKA: Hello? I'm Frank
14 Opelka, can you hear me?

15 DR. BURSTIN: We can hear you. Yes,
16 thank you.

17 MEMBER OPELKA: Yes. I've joined the
18 American College of Surgeons, and I have nothing
19 to disclose.

20 DR. BURSTIN: Great. Thanks, Frank.
21 Anyone else online? All right. Wow, remarkable.
22 I think we have a -- we certainly have a quorum.

1 So just lastly, if, you know, this is -- as part
2 of this process, we always ask an opportunity for
3 anyone at the table, or virtually at the table,
4 to ask any questions of anyone else in terms of
5 what they have raised in terms of their
6 disclosures. Would anybody like to raise any
7 questions?

8 Okay. So just one request. If at any
9 point during the course of this meeting today or
10 tomorrow you have any concerns about potential
11 lack of disclosure, bias, anything along those
12 lines, obviously, organizational representatives
13 are going to represent their organizations, but
14 if you have any concerns, please come to the
15 chairs, or to any of us. It's always better to
16 have those issues ironed out in real time rather
17 than post hoc, so we would welcome, you know, any
18 discussions, any irregularities due to conflict
19 of interests or bias. Please speak up, and we'll
20 take care of it.

21 So other than that, I will turn it
22 back to the chairs. Thank you.

1 CO-CHAIR PINCUS: So as I mentioned
2 before, this is going to be a challenging
3 meeting, both with the people online as well as
4 the shortened timeframe that we have, and so our
5 main job over the course of the next few days is
6 really to respond to the CMS list of measures
7 under consideration and go through the
8 recommendations from the, number one, Post-Acute
9 and Long-Term Care Workgroup, then the Clinician
10 Workgroup, and then the Hospital Workgroup, and
11 those are the key issues that we have to go
12 through at this time.

13 Before we get into that, we're going
14 to have some discussion about some of the
15 strategic issues and also some of the issues that
16 have come up in a cross-cutting way across the
17 workgroups that have met so far, and Taroon is
18 going to lead us through that.

19 And then after we clarify some of the
20 issues and have some discussion about that, that
21 may help further with the discussion of going
22 through the individual recommendations.

1 After we go through the three
2 workgroup reports, which, hopefully, we can do
3 today, but we are considering that there's a
4 possibility that it may go over until tomorrow in
5 terms of the Hospital Workgroup. Then there's
6 some broader longer range strategic issues to go
7 over in terms of the progress of the MAP so far,
8 what we've learned, how we can improve the
9 process over time, and particularly, to go
10 through some of the core concepts that came up
11 under the vital signs report from the National
12 Academy of Medicine, and to think about how that
13 might be able to help us with thinking about the
14 issues of alignment.

15 Initially, what had been in there was
16 to have breakout groups, but it looks like that's
17 not going to be feasible with so many people
18 online, and so we're going to have, sort of, a
19 general discussion about that. So let me turn it
20 over to Taroon to walk us through some of the,
21 sort of, key strategic issues to discuss before
22 we enter into going through the reports of the

1 workgroups.

2 MR. AMIN: Thank you, Harold. One of
3 the things that I'll do first to just start out
4 is to talk a little bit about the role of the
5 coordinating committee within the process and
6 highlight a few points. I also wanted to point
7 out a few administrative elements of today's
8 meeting, given that a number of our committee
9 member colleagues are participating virtually,
10 and I'll turn it over to my colleagues.

11 Actually, with that -- actually, I
12 should just quickly just introduce myself, and
13 I'll turn it over to my colleagues just to
14 introduce themselves from the staff's
15 perspective. My name is Taroon Amin, I am an NQF
16 consultant supporting the Measure Application
17 Partnership, in addition to a number of outcome
18 measures projects.

19 And actually, if we could just
20 introduce staff real quick before we move on.
21 Wunmi, if you can introduce yourself, please.

22 MS. ISIJOLA: No problem. Good

1 morning, everyone. My name is Wunmi Isijola.
2 I'm an administrative director here at NQF. This
3 is my second year with the coordinating committee
4 and I work with a host of projects here at NQF,
5 so looking forward to the next two days.

6 MS. O'ROURKE: Hello, everyone. I'm
7 Erin O'Rourke. I'm a senior director here at NQF
8 supporting the MAP. It's my first year with the
9 coordinating committee, but actually my fifth
10 year with the PAC, LTC, and hospital workgroups.

11 MS. STERLING: Hi. I'm Amber
12 Sterling, the group projects manager here at
13 National Quality Forum, and this is also my first
14 year with the MAP coordinating committee, so I'm
15 excited to see how this meeting goes today.

16 MR. TILLY: And I'm Jean-Luc Tilly.
17 I'm a project analyst here at the National
18 Quality Forum. I also worked with the MAP
19 Hospital Workgroup.

20 MR. AMIN: Okay. Thank you, all. Oh,
21 Marcia Wilson, our new senior vice president
22 working on our quality measurement group, so feel

1 free to say hello to some of the NQF staff, and a
2 tremendous appreciation for the multiple staff
3 members that were able to come in and setup the
4 room for tech and support services here, in
5 addition to our lunch and fruit, which is
6 difficult to find, apparently, given the weather,
7 so we really appreciate that.

8 So jumping into a little bit of the
9 recommendations here, and then I'll turn it back
10 to Wunmi to talk a little bit about how we're
11 going to do comments for the workgroup that is in
12 the room, and then those that are participating
13 virtually, how the voting process will work, and
14 then just for our stakeholders in the room and
15 those that are on the phone, how we will handle
16 our public comment periods, given the change in
17 the agenda.

18 So with that being said, one of the
19 key things that we wanted to outline here is,
20 clearly, the role of the coordinating committee
21 is to review the recommendations of the various
22 different workgroups. One of the key elements

1 that came up during our discussions last year,
2 and one of the key elements of feedback that we
3 received, both from the workgroup members and
4 coordinating committee members, was folks wanted
5 to take more of an aerial view, more of a
6 strategic view, of what's happening across the
7 workgroups and not get bogged down by individual
8 measure-by-measure discussions.

9 And so one of the key changes that
10 you'll see in this year's agenda is that we've
11 asked each of the workgroups and the chairs, to
12 the extent that they can participate, given the
13 change in schedule -- changing time periods that
14 we had to deal with, we've asked them to present
15 and outline some of the key -- they'll present
16 the measures in the programs that were evaluated,
17 and then they'll outline the strategic issues
18 that emerged in their workgroups and the relevant
19 input from the MAP Dual Eligibles workgroup.

20 Actually, if you can go back to that
21 slide. We'll ask the staff leads and the
22 coordinating committee chairs to present any

1 individual measures that have been pulled for
2 discussion by members of this coordinating
3 committee. It is key that the -- it is critical
4 that the coordinating committee members who've
5 pulled the measure for discussion identify the
6 particular elements of the workgroup
7 recommendations that they disagree with, and all
8 of the other measures will be considered ratified
9 by the MAP coordinating committee.

10 Again, it's just -- that is the method
11 that we will be using as we get to the workgroup
12 deliberations, and again, this sort of format was
13 put in place this year to address many of the
14 comments that you raised during your round-robin
15 discussion last year on improvements. So you'll
16 see more of a strategic discussion around the key
17 issues that emerged within the workgroups and
18 then across workgroups.

19 Erin and I will be spending a little
20 bit of time at the beginning of this meeting
21 talking about the key process and strategic
22 issues that emerged across the different

1 workgroups. Harold?

2 CO-CHAIR PINCUS: So are there any
3 questions or concerns about that process, because
4 it does, in some ways, limit some of the
5 discussion around the things that are on the
6 consent calendar, but it does allow people to
7 pull things off and have further discussion.
8 Good.

9 MR. AMIN: Okay. So with that being
10 said, I'll actually turn it over to Wunmi to talk
11 through how we'll try to handle, you know,
12 comments to facilitate discussion in the room,
13 and then how we'll handle the voting process and
14 also the public comment period. So with that,
15 Wunmi.

16 MS. ISIJOLA: Great. Thanks. So as
17 we've done in the past, if, in fact, you would
18 like to make a comment, please use your tent
19 cards. We will be monitoring the chat, so if you
20 do have a comment or question, please raise your
21 hand in the chat box, and we'll line you up in
22 queue to make comments.

1 As we get closer to the voting
2 portion, please ensure that you are logged in in
3 your personalized link that was sent this
4 morning. We will be voting live on the webinar
5 platform. You all should have received a
6 personalized link. If you have issues getting
7 into that, please let us know and we'll moderate
8 that accordingly. But just in order that we're
9 streamlining the discussion and commenting, we
10 ask that you use your tent cards, and we'll be
11 sure that those on the phone are engaged as much
12 as possible.

13 MR. AMIN: So, Wunmi, question for
14 you, so the individual link that members
15 received, that would bring them to this web
16 platform here, so I would encourage you all to
17 login, and if you have any trouble logging in at
18 this moment, let us know so we can address any
19 login issues before we get to the voting. So I
20 would encourage you to do that.

21 And for those on the phone, if you
22 have any questions seeing where the chat feature

1 is or the raise hand function is on the webinar
2 platform, please let us know through the chat
3 feature.

4 MS. ISIJOLA: Yes.

5 CO-CHAIR PINCUS: And so login applies
6 to everybody in this room as well as everybody on
7 the phone.

8 MS. ISIJOLA: That is correct.

9 DR. FLAMM: This is Carol Flamm. Can
10 I just ask where the email came from with the
11 personalized link because I don't think I'm
12 seeing that.

13 MS. ISIJOLA: It came from Shawnn, so
14 it should have been NQF com partners link, and we
15 can resend that off again to the entire
16 committee.

17 DR. FLAMM: Thank you very much.

18 MEMBER KAHN: This is Chip Kahn just
19 to say I didn't have any conflicts.

20 MS. ISIJOLA: Thank you, Chip.

21 MEMBER SCHLAIFER: When you login,
22 it's already populated with some email address.

1 Do you want us to leave that or put our own email
2 address?

3 MS. BITTORIE: You can actually change
4 the email address. That was just for the initial
5 registration purposes.

6 MEMBER SCHLAIFER: Okay.

7 CO-CHAIR PINCUS: When it comes time
8 for voting, will there be something popping up
9 that --

10 MS. ISIJOLA: That is correct. So
11 you'll see the screen that'll prompt you what
12 choices you should select.

13 MR. AMIN: We'll, inevitably, have
14 some challenges when we get to that point, just
15 the nature of the process, but if there are any
16 issues, please let us know. We'll connect you to
17 Shawnn, who's also on the phone here, as we just
18 heard from her, so we'll try to address those
19 issues as proactively as we can.

20 Are there any other concerns or
21 questions about, sort of, how today's meeting,
22 sort of operationally, how that will work? And

1 I'm also looking to my NQF staff, colleagues, if
2 there's any other issues that I have not covered
3 here as it relates to voting.

4 The last thing I will just note, for
5 the stakeholders that are participating in this
6 meeting, is that, obviously, we'll do our best to
7 participate and keep the public comment periods.
8 Yes, for those in the room, you know --

9 MS. ISIJOLA: Just please turn off
10 your speakers if you're in the actual room.

11 MR. AMIN: That's, obviously, okay.
12 So public comment period, so obviously, we try to
13 do our best to keep the public comment periods to
14 the time that is in the published agenda.
15 Clearly, that's going to be very difficult to do
16 during today's meeting. It would be challenging
17 to stop and have a public comment period for the
18 clinician programs while we're still discussing
19 PAC/LTC, so we will address the public comments
20 prior to -- we'll have a public comment period
21 prior to each of the workgroup report-outs.

22 And so that's really more of a comment

1 for the stakeholders that are participating in
2 this process, not really a comment for the
3 workgroup members here, the coordinating
4 committee members.

5 CO-CHAIR PINCUS: Let me just make one
6 comment that members of the MAP Coordinating
7 Committee have already, essentially, pulled a
8 number of measures off of the consent calendar.
9 After we hear the report from each of the
10 workgroup chairs, we will ask people if they have
11 any other -- any other people want to pull other
12 measures off, but there's also the opportunity
13 for people to take measures that they had pulled
14 off and put them back on the consent calendar.

15 So we want to make sure people are
16 aware of that.

17 MEMBER SIRIO: Harold?

18 CO-CHAIR PINCUS: Yes.

19 MEMBER SIRIO: This is Carl Sirio.
20 Just a quick question. Did I hear you correctly
21 that those measures that have been pre-specified
22 as being up for discussion and pulled are already

1 off that consent calendar?

2 CO-CHAIR PINCUS: Yes.

3 MEMBER SIRIO: Okay. Good. Thanks.

4 CO-CHAIR PINCUS: But like I said,
5 there's an opportunity, after we've had some of
6 the strategic discussion upfront, people may
7 reconsider that and put them back on the consent
8 calendar, so that's an option.

9 DR. BAKER: Just a question. If it's
10 been sent, I still haven't received anything.

11 MEMBER DANFORTH: Hi. This is Missy
12 on the phone. I had a quick question. Should
13 the folks on the phone that want to get into the
14 queue, once we start that, use the raise hand
15 option that I see on the webinar?

16 MS. ISIJOLA: Yes, that's correct.

17 MEMBER DANFORTH: Okay. Thank you.

18 MR. AMIN: Okay. So again, just as a
19 quick recap, we will have two sessions this
20 morning, process and strategic issues that
21 spanned across each of the workgroups, and then
22 each of the workgroups will follow this format of

1 the strategic issues that emerged within the
2 workgroups, the measures that have been pulled,
3 and then all the other measures are considered
4 ratified.

5 So with that, let me turn it over to
6 Erin to kick it off.

7 MS. O'ROURKE: Thanks, Taron. Next
8 slide, please. You can actually go two forward.
9 So I just wanted to give you an overview of how
10 we got to where we are now and the process that
11 the workgroups used to make the recommendations
12 that they did about each measure under
13 consideration.

14 So the pre-rulemaking approach was
15 revised for 2015/2016. The workgroups took a
16 three-step approach to the analysis and selection
17 of measures. First, they developed a program
18 measure set framework. This was really a tool
19 they used to help organize themselves and give
20 them a snapshot of what was in the program
21 currently.

22 For the majority of the programs, they

1 used the national quality strategy. Some of the
2 clinician programs also linked to topic to give a
3 better idea of what specialties might be
4 currently covered.

5 They then took a look at the measures
6 under consideration for what those might add to
7 the program measure set, and then finally, they
8 identified and prioritized measure gaps for
9 programs and size.

10 We also convened the Dual Eligible
11 Beneficiaries Workgroup to provide cross-cutting
12 input. The Dual Eligible Workgroup sent a
13 liaison to each of the three setting specific
14 workgroups to ensure there was a voice for that
15 population at each workgroup meeting. We also
16 convened the workgroup via web meeting to review
17 all the work done by the three setting specific
18 workgroup and offer up some additional input for
19 the coordinating committee about special
20 considerations for the dual eligible population.

21 Next slide. So the MAP workgroups
22 were asked by the coordinating committee last

1 year to please reach a decision on every measure
2 under consideration. We heard your concern that
3 it's challenging to be the first body to really
4 vote, so we pushed the groups to not have split
5 decisions this year, so you do have the benefit
6 of a preliminary recommendation about each
7 measure under consideration.

8 The decision categories were
9 standardized for consistency. I will run through
10 those on the next slides. The decision
11 categories were determined for the two pathways,
12 depending on the extent of testing noted by CMS.
13 Measures under development, that is, measures
14 that have not completed testing, and fully
15 developed measures were those that had completed
16 the testing phase.

17 And each decision by the workgroup is
18 accompanied by the rationale explaining how the
19 group got to that decision.

20 Next slide. So on this slide, you'll
21 see the decision categories and some examples of
22 rationales for the measures that are fully

1 developed. The workgroups were given the option
2 to support, conditionally support, or not support
3 fully developed measures.

4 Next slide. For measures that were
5 still under development, the groups were given
6 the decision to encourage continued development
7 or to not encourage further consideration or to
8 say that they had insufficient information to
9 make a decision about that measure.

10 Next slide. So this slide briefly
11 shows you the MAP measure selection criteria. I
12 won't belabor this because it's probably familiar
13 to most of you. Essentially, these are the
14 characteristics of an ideal program measure set
15 from the MAP perspective. These aren't intended
16 to be a check-the-box list of things the measure
17 should hit; rather, what MAP would like to see a
18 measure set achieve.

19 Next slide. So to help facilitate the
20 workgroup consent calendar voting process, staff
21 conducted a preliminary analysis of each measure
22 under consideration, and it's an algorithm that

1 asks a series of questions about each measure
2 under consideration.

3 We used the measure selection criteria
4 to develop this algorithm. It was approved by
5 the coordinating committee. As you might
6 remember, this is what we spent the bulk of our
7 time at the September pre-rulemaking kickoff in
8 person going through, and it's intended to
9 provide MAP members with a succinct profile of
10 each measure and to serve as a starting point for
11 discussion.

12 Next slide. So we did have a number
13 of key lessons learned from 2015/2016 so far, and
14 we wanted to bring these to the coordinating
15 committee for your consideration and input. To
16 give you a little bit of background, we had 141
17 measures evaluated this year. The majority of
18 those were under development, 91 of the 141, and
19 50 were fully developed.

20 We had a number of concerns come up
21 about the measure under development pathway that
22 we thought warranted coordinating committee

1 discussion. Several stakeholders raised concerns
2 that measures going through the under development
3 pathway may not be treated differently than
4 measures that are fully developed when it comes
5 to the rulemaking process and what CMS is doing
6 with MAP recommendations, so therefore, MAP might
7 be making a positive recommendation to encourage
8 continued development, but the recommendation is
9 being received by CMS and the broader community
10 as a support for that measure, essentially
11 without any conditions.

12 Conversely, we also heard some
13 concerns that having this second pathway for
14 measures that are still under development might
15 slow the process too much and slow the
16 implementation of important measures.

17 Some additional concerns: MAP does not
18 have a mechanism to bring back measures under
19 development once they're fully specified, tested,
20 or NQF endorsed, and finally, some MAP members
21 suggest that we might need a new decision
22 category, something along the lines of revise and

1 resubmit for consideration, to add to the under
2 development pathway.

3 So a second key issue that came up was
4 how we might submit measures for consideration
5 that are not on the formal MUC list. So
6 stakeholders asked for clarification from CMS and
7 MAP on how we can provide input on measures that
8 are not on that formal list but could potentially
9 be considered for future years.

10 CMS has indicated that measures can be
11 submitted through the JIRA tool for consideration
12 prior to finalizing the MUC list and that MAP is
13 encouraged to identify additional measures as
14 gaps in the program for CMS to consider in the
15 future.

16 MAP does not have the ability to add
17 measures to the MUC list during the pre-
18 rulemaking process, but as I noted, we can
19 suggest additional measures for CMS to consider
20 in future cycles. And we do write these
21 suggestions up in the written deliverables, and
22 just a note that it's difficult to formally

1 evaluate these measures the same as measures
2 under consideration, given that we've got limited
3 information.

4 They don't go through the process that
5 CMS puts the formal MUCs through. We don't have
6 the opportunity to pull the background
7 information on those measures that we provide to
8 the workgroups in the preliminary analysis, so
9 that's why they are not added to the formal list
10 of measures under consideration, but rather,
11 handled as potential gap fillers and included in
12 the written reports.

13 So I think with that, I will turn it
14 to Harold for discussion.

15 CO-CHAIR PINCUS: Okay. So there were
16 two, sort of, overarching issues that came up
17 during the discussions. Number one is, the
18 concern is that this year there's a much greater
19 proportion of the measures that are under the
20 measures under development category, and it
21 raises questions about, what are the consequences
22 of saying that we support their continued

1 development?

2 Does, technically, apparently, the
3 measure does not have to come back to us as it
4 gets more operationalized, so how do we handle
5 that? What is the meaning of when we say we
6 support continued measure development for a
7 measure that's not really developed?

8 Secondly, if members of the MAP do
9 have suggestions for alternative measures, is
10 there a pathway to get those being considered?
11 So why don't we open it up for discussion on
12 those two issues, and then maybe after we have
13 some discussion, I'll ask Kate to maybe respond
14 to some of the issues. Lisa?

15 MEMBER McGIFFERT: Well, I'm glad this
16 is being taken care of at the beginning because a
17 number of the measures that I pulled were for
18 this very reason. I couldn't figure out exactly
19 what encouraged continued development meant as a
20 decision. In some instances, it seemed to mean
21 keep going until it's endorsed by NQF; in other,
22 more frequently, it was a process measure that

1 the group said continue development, and we're
2 concerned that it's not getting at the outcomes,
3 and it wasn't clear to me what that would mean.

4 Does that mean change it and try to
5 develop that or continue developing the process
6 measures? So I was very -- I felt that there
7 wasn't consistency in the use of that phrase, so
8 I'm glad you're thinking about using other
9 phrases, and I think, you know, for the public
10 and for the developers, it's kind of unclear what
11 the message is if we're saying, here's a process
12 measure. We have a lot of concerns; one of them
13 is that it doesn't get at outcome, and we want
14 you to continue to develop it.

15 I'm not sure that that message gets to
16 the developer.

17 CO-CHAIR PINCUS: So just to clarify,
18 so in some ways you're raising a question of
19 what's the it.

20 MEMBER MCGIFFERT: What does it mean,
21 encourage continued development?

22 CO-CHAIR PINCUS: Yes, are you

1 continuing the development of this and refining
2 this particular process measure, or are you
3 trying to get at something even better than that?

4 MEMBER MCGIFFERT: Yes, because
5 obviously, in some of the workgroup rationales,
6 they're listing all the things that are of
7 concern with a process measure, and their list
8 clearly says, we're concerned about these things
9 that would, maybe -- in my opinion it meant, go
10 back and come up with a whole new measure. This
11 one -- but the term was, encourage continued
12 development, which could also mean, take this
13 measure and keep developing this measure, so that
14 was the confusion.

15 MEMBER GIFFORD: So actually, I'm glad
16 we're bringing up that issue, and I've been
17 giving it a lot of thought. So harking back to
18 my state days, I decided to go back to the
19 statute and look at what the authority is,
20 because there was a lot of discussion in several
21 of the workgroups in CMS about this issue.

22 And I think the MAP, in the statute,

1 is to provide feedback on measures that are under
2 the MUC list. There's nothing about voting or
3 approving, and as Helen has pointed out, we have
4 no authority, and CMS can completely ignore.
5 We're advisory.

6 So we can say what -- we can create
7 any categories we want and they can ignore them;
8 however, the burden is that the Secretary shall
9 take in any feedback that the MAP gives on the
10 measures in rulemaking, address it in rulemaking.
11 So it's -- frankly, more important than the
12 labeling of the measure is the feedback about the
13 measures that then have to be addressed in
14 rulemaking.

15 And, you know, we heard a lot about
16 deadlines and timelines, so they couldn't get
17 certain things done that some of the workgroups
18 were concerned about, and I feel really bad for
19 CMS, and if I was at CMS, I would do exactly what
20 they have done.

21 But we have, I think, a statutory,
22 fiduciary responsibility under the statute to

1 provide feedback on those measures, and then HHS,
2 and the Secretary, and CMS can say whatever --
3 you know, then it has to provide a rationale,
4 which is Congress said we had to do the timeline,
5 so that's why we're doing it this way, or, you
6 know, we're ignoring this because we have to do
7 A, B, and C, but the burden then falls back on
8 them for that.

9 And so I think at the long-term care
10 workgroup, many of the members felt and did not
11 review many of the measures because 100 percent
12 of the measures came through the guise of under
13 development, and so they all said, oh, well,
14 we'll get to see them again, and so many of the
15 members around the table hadn't even reviewed, in
16 detail, many of the measures, including both
17 chairs, and said that to me.

18 And so I think to Lisa's point, what
19 is the it, or what does it mean, I think it's
20 really important that we think about it because,
21 in essence, what happened in the statements at
22 the long-term care workgroup from CMS was that,

1 yes, you know, they might bring them back, but
2 they don't have to bring them back, and they'll
3 consider it.

4 But because in the measure under
5 development category, the discussion of the
6 feedback on the measures was sparse. And so it
7 actually allowed us to sort of -- it almost was a
8 loophole, and I don't think CMS was trying to use
9 it as a loophole, but it creates a loophole for
10 them just to put any measure on measure under
11 development, and they actually put NQF-endorsed
12 measures in the category of under development,
13 which it wasn't clear why they did that. But as
14 soon as it was that way, then everyone just said,
15 well, it'll come back, and we'll hear some
16 feedback, but we'll get to see it again, but then
17 there was a discussion that it's not been seen
18 again.

19 So I think what I would encourage you
20 to think about is, rather than the categories, or
21 something like this, is that, we say to CMS when
22 we think measures need further work, that the

1 recommendation to the Secretary would be that
2 they come back for NQF endorsement, because a lot
3 of these measures are moving so fast they can't
4 get NQF endorsement and meet any timeline, that
5 they come back within a certain timeframe, and we
6 give them some more guidance on that, and then
7 the burden falls on them during rulemaking to say
8 why they're not going to come back and what's
9 going to happen in future rulemaking.

10 And it gives them the opportunity for
11 stakeholders to talk with Congress about the
12 timelines and everything else. But I think it's
13 more important us focusing on the feedback than
14 actually, I think, the categories of what's
15 happening out there, but the labels do have an
16 impact, and the impact by having this was, we
17 don't have to go as far and deep on this measure,
18 when it has the exact same, essentially, measure
19 under development has the same impact as support
20 with no recommendations.

21 CO-CHAIR PINCUS: So just to clarify,
22 when we say -- for the measures under

1 consideration, we can support, we do not support,
2 or we support with conditions, and for the do not
3 support and the support with conditions, the MAP
4 specifies what those conditions are or what the
5 reasons are for not supporting.

6 But what you're suggesting is that if
7 the measures that are measures under development,
8 if we support their development approach, we
9 should also have some specific comments to help
10 guide the development. Is that what you're
11 proposing?

12 MEMBER GIFFORD: No, I think I can go
13 a little further. I mean, if you look here, the
14 decision to vote to support further development
15 is the equivalent of, from a CMS standpoint and
16 statutorily, of voting that we support the
17 measure. Has the exact same equivalent. It is
18 the equivalent of voting support, and I don't
19 think that that's the impression and intent of
20 that, and nor is that the process for the MAP
21 that was laid out in the statute.

22 And so I think what's probably more

1 important is the type of feedback, whether it's
2 support or not support, or whatnot, because they
3 can proceed with do not support. They just have
4 to put a rationale of why the body says do not
5 support or go forward, but again, really, the
6 burden falls on what the comments are that we
7 make.

8 ACTING CO-CHAIR GESTEN: But just
9 building on Harold's suggestion, what I'm hearing
10 you say, David, is that while you're making a
11 recommendation that these circle back, give it to
12 NQF and MAP, ideally, that what's an unintended
13 consequence is not having the detailed comments
14 about that development, which may be varied.
15 Lisa's comment was, she's not sure what the
16 issues were.

17 My guess is, in many of them, there's
18 more than one issue and more than one opinion
19 about what needed to be developed, so at the very
20 least, that one of the forwards could be to not
21 just, sort of, pass them along the way, but to
22 articulate what some of those issues are, which,

1 as you say, creates some obligation to respond to
2 those issues going forward. Is that --- am I
3 right about that?

4 MEMBER GIFFORD: Yes. I mean, there
5 was a wide range of measures for the long-term
6 care under development. There were some, as I
7 said, that were at fully NQF endorsed and in use
8 out there right now that I think CMS wants to
9 tweak, so they put it under further development,
10 so that wasn't really portrayed in the
11 presentation.

12 To the other end, there were a couple
13 measures where the only details that the group
14 had was a numerator-denominator definition, and
15 at that, it was specified in very broad general
16 terms. And specifications for the measure came
17 out after the group and actually is still open
18 for comments right now, as of today, from CMS.

19 So essentially, what it means is CMS
20 can put on the MUC list just a measure saying, I
21 think I'm going to have defined the
22 numerator/denominator in this way, and we may

1 risk adjust it in the future, and then we're
2 going to go, well, I don't really know, and you
3 can't even comment on it, and so it's almost
4 insufficient information.

5 So I think that similar to what you're
6 saying, I agree with, sort of, that caveat of
7 understanding that it's less about this labeling
8 and more about that feedback, what we have, and I
9 think if the measures really -- certainly,
10 measures that are not NQF endorsed, I think we
11 should just sort of have as a standing
12 recommendation that they come back within some
13 timeframe after specifying in rulemaking, that
14 they come back, you know, whatever is a
15 reasonable timeframe, 18 months, 24 months, they
16 come back. Then the burden falls on CMS to say
17 why they're not getting NQF endorsement.

18 CO-CHAIR PINCUS: Marcia, did you have
19 a comment?

20 MEMBER SCHLAIFER: I think that -- at
21 first, I think it was very helpful to hear, for
22 those of us that are not associated with a

1 workgroup, from someone who had to actually
2 operationalize these. When I was reviewing this,
3 I find the fact that, you know, you mentioned
4 that there's not that much difference between
5 support and then the support continued
6 development, even though there may not be any --
7 we're sending very positive messages to both, I
8 think it's very helpful to this group because
9 we've been in the position up to now that either
10 we support, which is, yay, this is perfect, go
11 forward, or we reject, and I think being able to
12 say this is -- you know, I appreciate the staff
13 finding a way for us to say, we like what you're
14 doing, we think there's a need for this, but you
15 got some work to do, because I think we've really
16 struggled over the past several years when, you
17 know, support was too strong and reject was too
18 negative.

19 So I just appreciate this other
20 option.

21 CO-CHAIR PINCUS: Marla?

22 MEMBER WESTON: As I listen to this

1 discussion, I'm recalling that last year we made
2 the decision that if we conditionally support it,
3 that the conditions would be monitored by CMS.
4 So for example, if we support, you know, we're
5 supporting something that's NQF-endorsed if there
6 was some very specific condition that, in
7 essence, we would conditionally support for that
8 condition. It's sounding as if we actually have
9 a fourth category, which is, encourage continued
10 development, which is, in my mind, not the same
11 as conditionally support.

12 Encourage continued development is
13 almost saying, this is a measure gap area, this
14 is a really important area, but this measure is
15 not specified enough to even say that we would
16 support it with conditions. I don't know if I'm
17 muddying the waters. It's not ready for prime
18 time.

19 So I think in some ways, what we're
20 saying, and why we always wanted this category of
21 this encourage continued development, is to say
22 this is a gap area and do go forth and do

1 continued work, but there is not enough
2 specificity here to be able to say that this is a
3 good measure or not, because the specificity is
4 not in the measure.

5 CO-CHAIR PINCUS: Frank, you're on the
6 phone. I think you raised your hand?

7 MEMBER OPELKA: Yes, I sent in a
8 couple of comments in the chat. I mean, I have
9 two comments that were general. One was to the
10 overall measurement applications, partnership,
11 and their need for us to make sure that the
12 initial review that we did in the MAP was tying
13 measurement application to payment systems, but
14 those payment systems are changing.

15 And as those payment systems are
16 changing, the measurement science also changes,
17 so we have to, at least at some point,
18 strategically think ahead about how we are doing
19 that and reviewing that and looking at that.

20 The other point that I sent in was
21 there was a comment about almost an absolute
22 requirement of NQF endorsement. While I

1 completely support NQF endorsement, that is, in
2 my estimation, an older science of measurement
3 that was tied strictly to older payment systems,
4 and there are efforts by all the specialties and
5 disciplines that are dealing with clinical
6 datasets that are moving into a much more
7 sophisticated measurement science that's not
8 payment system-centric, but it's more patient and
9 condition specific-centric, and those are in
10 response to actions that CMS is taking.

11 So any effort to try and narrow that
12 focus, I don't think serves the patients or the
13 clinicians who are trying to drive quality
14 measurement and improvement. And again, I
15 support NQF endorsement, but it is not the be all
16 and end all because it needs to also mature with
17 what's happening in the field.

18 CO-CHAIR PINCUS: Taroon.

19 MR. AMIN: So I just want to provide
20 clarification in terms of the intent, but David,
21 in particular, is raising some questions about
22 how it's being operationalized, which is,

1 respectfully, a different question than I think
2 was the one for discussion, but the definition
3 and the intent of the measure under development
4 pathway, and this is something that Marla and
5 both Lisa brought up, as you guys laid out last
6 year, was specifically defined by the level of
7 testing that the measure is -- how it's specified
8 in the measure under consideration list.

9 So if a measure comes forward -- a
10 measure comes forward, and it is not fully tested
11 for the setting for which it's being proposed, it
12 is automatically put into the measures under
13 consideration pathway. So that's the definition
14 of how something goes into the measure under
15 development pathway versus a measure that's fully
16 specified.

17 Now, the extent or the results of the
18 testing is -- you know, that's up to
19 interpretation. And there were cases in this
20 year's pre-rulemaking where there were endorsed
21 measures that were in the measures under
22 development pathway, but it was because the

1 measure wasn't -- well, there may be reasons why
2 that would be the case, meaning that the measure
3 was not tested for the setting it's being
4 proposed for.

5 So that was the intent of the
6 coordinating committee's -- you know, when we
7 first developed this. Now, I think there's
8 questions being raised about how it's being
9 implemented or used, or that feedback's being
10 used. So I think, certainly, would welcome some
11 conversation or feedback from CMS about that.

12 Just, as we laid out, I just wanted to
13 clarify what the definitional intent of the
14 measure under development pathway was as you
15 structured it in your test.

16 CO-CHAIR PINCUS: So are there other
17 comments about this issue?

18 ACTING CO-CHAIR GESTEN: I just have
19 a question of what you just said, Taroon. So is
20 the previous world before this category existed
21 one in which these are measures that likely would
22 not have met criteria and simply would have been,

1 probably, voted off the island? I'm just trying
2 to figure out what problem this -- so I'm trying
3 to remember back to what problem or issue this
4 solved, and it seems like it was something like,
5 as somebody said, maybe Marla, you said it
6 previously was either yes or no, and it was, my
7 words, sort of harsh because there were some
8 measures that were promising, but did not have a
9 specific condition.

10 It was, really, just kind of a
11 ripeness issue, or it had multiple conditions,
12 and it didn't just lack NQF endorsement or
13 testing. It was really -- there wasn't enough
14 information in some cases to even make a
15 judgement.

16 So I mean, the plan B of not having
17 these categories if, in fact, they don't circle
18 back, was it fair to say that many of these would
19 simply be voted as a do not support, and that's
20 what happened previously?

21 MR. AMIN: I think what we were
22 finding was it was more of do not support and

1 conditional support, and the conditions were
2 multiple, but I'd welcome feedback from her and
3 others on exactly what that issue was. And there
4 was a growing number of measures that, again,
5 were coming through this process that folks were
6 getting very frustrated about because there
7 wasn't enough there to do much with, but there
8 was a response to CMS about, CMS was -- so this
9 is, sort of, setup for a conversation for
10 tomorrow, but CMS was articulating that they
11 wanted some early feedback before spending a lot
12 of dollars, in terms of testing, on whether or
13 not a multi-stakeholder group, such as the MAP,
14 would, sort of, recommend continued development.

15 So I think I would probably be
16 speculating about where it would end up, but that
17 was the historical problem that we were trying to
18 address.

19 CO-CHAIR PINCUS: Let me see if I can
20 summarize. I know David and David both have
21 comments, but if I could summarize what I think
22 is being discussed and potentially pose a

1 suggestion. If we change the encourage continued
2 development category so that it was clarified
3 that it was specifically designated for measures
4 that are not explicitly defined and in fact, that
5 CMS acknowledges is on the process further
6 development and wanting early input on that.

7 And that also, make it so that it is
8 expected that even if we encourage continued
9 development, there would be comments fed back to
10 CMS about the direction or issues to consider in
11 further development of that measure, and also,
12 had some expectation that as it was developed it
13 would come back if it was going to be seriously
14 considered for implementation. Would that solve
15 the problem?

16 MEMBER GIFFORD: I think the explicit
17 expectation that it would be coming back should
18 be --

19 CO-CHAIR PINCUS: Coming back, but
20 only if it was really being considered for
21 implementation, not --

22 MEMBER GIFFORD: I will be surprised

1 and shocked if the post-acute measures that were
2 passed through the workgroup, regardless of what
3 we decide today, do not show up in the
4 rulemakings for -- that come out in April and May
5 for the various post-acute settings.

6 And so I think -- CMS can't comment on
7 that now, but I think there needs to be a pathway
8 for CMS to meet this aggressive timeline that
9 Congress has set out often, the changes in the
10 payment models that they're testing, the need for
11 measures that were stated out there, and I think
12 that measures -- and I like that we created this
13 section last year of encouraged development, and
14 I don't think I would want something that would
15 slow the process down, but I think having them
16 have to come back at some point, because even
17 when they put it in rulemaking, there's still a
18 date out in the future when they implement it,
19 and even some of the information that would we
20 need to really, I think, evaluate the measures
21 cannot be collected until they issue a rule and
22 actually start collecting the data, and so they

1 need to be able to do that.

2 But I think we expect, I think,
3 collectively some iterative bring-back
4 understanding of that process, and right now,
5 that does not exist.

6 CO-CHAIR PINCUS: David.

7 DR. BAKER: I think the problem is
8 everything in this conditional support category,
9 it's so heterogeneous. They're those ones that
10 are just one small step away, and they're those
11 ones that, gosh, we like this idea. We don't
12 know if you're ever going to be able to do this,
13 right?

14 So as David, I think, alluded to, to
15 me, it's all in the comments and I would favor,
16 do not support, but we would support it if you
17 did this, or do not support, but, wow, this is
18 really a questionable idea. We don't think that
19 you're ever going to get there. I mean, to me,
20 it's all in the comments.

21 To say something like, conditional
22 support, we like this idea, but the numerator and

1 denominator are completely unspecified,
2 conditional support for that, I can't say that I
3 --

4 CO-CHAIR PINCUS: Well, conditional
5 support is encourage continued development.

6 DR. BAKER: No, but I'm just saying,
7 some of the ones that are in that conditional
8 support, to me, they seem like a very
9 heterogeneous category, but I assume there's
10 others, but, you know, I think the conditional
11 support category is problematic from the measures
12 that I looked at. It's still very heterogeneous.

13 CO-CHAIR PINCUS: Amir?

14 MEMBER QASEEM: I mean, something
15 along the lines of what David was saying, and
16 actually, these three categories, I see them
17 subcategories of do not support. I think we do
18 still need to send this message out that we are
19 not supporting these measures, and here's the
20 reason we're not supporting because once we start
21 categorizing these six, you're giving so much
22 option.

1 And what ends up happening is, many of
2 these measures, I think something along the lines
3 of what David is saying. And Kate, I always feel
4 bad whenever you're sitting in these forums.

5 MEMBER MCGIFFERT: I want to be clear
6 that I like the category, I just don't know what
7 it means, and I know that, you know, we needed it
8 to get away from just support, not support, but I
9 want to bring the conversation back to process
10 and outcomes, because that's what I care about.

11 And I think that we have to be really
12 careful, to me, there's so many process measures
13 on this list, and if we -- CMS goes down that
14 path, it'll be years before we'll see outcome
15 measures, because that's where everybody's lining
16 up to do, rather than send it back to the
17 developers or to new developers to say, look,
18 this is a really important measure.

19 I mean, we need to measure these
20 things falls, drug -- medication reconciliation,
21 whatever, we need to measure these things, but we
22 need an outcome measure. We need something

1 that's more meaningful than what we have right
2 here. We don't want to encourage to go down the
3 path of a check-the-box measure or, you know, a
4 measure that's not being influenced.

5 That's sort of my point is, how to
6 communicate that in a way that would encourage
7 further development of outcome measures or to not
8 encourage CMS to go down the path where it'll be,
9 you know, five, seven, ten years later when we
10 finally say, oh, this process measure is topped
11 out and not really giving us what we need, and
12 let's get an outcome measure.

13 ACTING CO-CHAIR GESTEN: So let me
14 just remind folks on the phone that if you want
15 to get in queue and make a comment by using the
16 Web site to do it, just click on the raise your
17 hand function and we'd be happy to call on you,
18 but, Erin, did you want to --

19 MS. O'ROURKE: Yes, I just wanted to
20 clarify a little bit. To answer what Lisa was
21 saying, so we do include a rationale for every
22 measure, including the ones that go through the

1 under development pathway, so there are the
2 comments from the discussions at the workgroup
3 level and the coordinating committee are
4 transmitted to CMS, along with a decision about a
5 measure under development, so it doesn't go in
6 isolation.

7 We also take the feedback like you
8 were saying about, you know, this is a good
9 process measure, but we need to get to an outcome
10 and include that in the three written
11 deliverables that we submit to CMS, so those
12 comments are captured and sent along.

13 CO-CHAIR PINCUS: Kate, do you want to
14 say something about what you would find from CMS'
15 perspective most helpful in terms of the kind of
16 feedback that you would get on these issues?

17 DR. GOODRICH: Sure. The comments
18 actually are the most helpful. It's not so much
19 the category. And what we do, similar to what
20 Erin was just saying, so we get, you know, the
21 determination of support, do not support,
22 whatever, with all the comments with that, and if

1 we decide to go forward with proposing a measure
2 in a regulation, we always address what the MAP
3 said about it, not just the category, but we do
4 our best to also address the comments around that
5 category.

6 So if it was conditional, you know,
7 why we decided to go ahead and propose it if the
8 conditions had met, if we intend to send it in
9 for NQF endorsement, whatever it might be. I
10 will say there have been quite frequent instances
11 when we have one that do not support, but it has
12 happened for a variety of reasons, but the
13 comments around it are, without doubt, the most
14 helpful.

15 And our staff also take copious notes
16 during the recruit meeting so that we can capture
17 as much as possible. So I don't know if you want
18 me now to sort of address the feedback loop
19 issue.

20 CO-CHAIR PINCUS: Why don't you do
21 that.

22 DR. GOODRICH: Yes. So this is

1 something that has come up every year in the MAP
2 around feedback loops and needing things to come
3 back, and I think we've always been supportive of
4 that, we've never had a process for it. And this
5 year's batch of measures was different from
6 previous years in that we did have more measures
7 that were under development than ones that were
8 fully developed, and there's a couple of reasons
9 for that, well, I can think of three main reasons
10 for that, one of which is, it just happens to
11 fall in our measure development time lines.

12 You know, we have an umbrella
13 contract, we sort of do all of our contracts at
14 the same time, many of them are at the point now
15 where they're at a place where we can actually
16 send it in to the MAP, so that's number one.
17 Number two, to get to Giff's point, which I also
18 want to address, is the IMPACT Act, and the
19 statutory requirements around deadlines from the
20 IMPACT Act, and the need to develop measures very
21 quickly to meet those statutory deadlines, which
22 is why that group saw so many not fully developed

1 measures.

2 And then number three is, we get a lot
3 of measures from medical specialty societies for
4 consideration for the clinician workgroup and for
5 the, what is now, upcoming MIPS program. And,
6 you know, we work very closely one-on-one with
7 the societies who are developing measures. Some
8 we work more closely with than others, depending
9 up on the degree of engagement they want to have
10 with us, and often get asked to put things on the
11 list early in order to get that feedback about
12 directionality to know whether or not they should
13 continue to put resources in to further develop
14 the measures.

15 I will say, not every measure that's
16 been sent to us makes it on to the list. There's
17 some we know are duplicative, or for whatever
18 reason, we know we're not going to actually
19 consider them, so they don't go on the list.

20 Regarding the feedback loop so I want
21 to start with the post-acute care workgroup and
22 then talk about it more broadly. So this year

1 was a very challenging year for us with post-
2 acute, as you know well, Giff, so we have
3 statutory requirements to get specific measure
4 domains in place, in programs, and begin data
5 collection by certain dates that drove this
6 timeline.

7 So that group did get some measures
8 that were pretty early on, but, you know, folks
9 are still working on, including the ones that you
10 mentioned, I think that you're probably referring
11 to the Medicare spending for beneficiary
12 measures, which is the payment measures for, or
13 efficiency measures, for the post-acute care
14 settings.

15 You know, we have deadlines. I don't
16 know what to say. We would much rather have
17 brought something that was more fully developed.
18 You know, the other choice was to not bring it at
19 all, because the statute doesn't require us to
20 bring it to the MAP. We never seriously
21 considered that. We figured it was better to
22 bring something rather than nothing, so that's

1 what we did.

2 So I actually talked with my team
3 quite a bit after the post-acute care workgroup,
4 because they understood and heard the
5 frustrations, and I think were feeling it
6 themselves, so we have committed to bringing
7 those measures back to the MAP if there's a way
8 we can do it before next December, we're looking
9 at whether or not we can do that as, sort of,
10 part of an ad hoc group.

11 While I, of course, cannot say, ever,
12 what we would do in rulemaking, you probably
13 would be shocked if we didn't put those measures
14 in regulation because we have statutory
15 deadlines. I mean, there is just this reality
16 about that. So that's related to that. That is
17 just a timeline situation that is very tough.

18 But we started to have more and more
19 discussions at CMS around how we can work with
20 the NQF staff to develop a feedback loop process.
21 I would say both for measures that come through
22 that are in various stages of development. I

1 think it's been articulated why we bring these
2 measures early, and that's absolutely right, so I
3 think those can come back.

4 I also think ones that are implemented
5 in programs we have some experience with, we know
6 how they're performing, we need to understand
7 from you what information to understand how the
8 measures are performing would be most useful to
9 come back. Now, that's adding more of a workload
10 to NQF, and to the MAP, by the way, and so we
11 have to think through what's the most efficient
12 way to do that, and that involves thinking
13 through our contracting cycles, and all that kind
14 of stuff, but we can do that, we will do that, we
15 are making a commitment to do that.

16 So what I'd like to see is over -- you
17 know, we always do a debrief with NQF in about
18 February, after the MAP cycle is over, about what
19 could have gone better, how can we improve it for
20 next year, what do we hear from the MAP that, you
21 know, we should do differently? And so we will
22 do that again this year, but I would like our

1 teams to maybe use some of our LEAN tools we've
2 used together in the past to improve other
3 processes, to think about how we can develop
4 these feedback loops for these two buckets of
5 measures.

6 I will say, one thing that, I don't
7 know if it's going to be a challenge or not, but
8 it's -- we have to explicitly consider it, is,
9 how do we bring back measures? I think bringing
10 back the measure that CMS is developing, we can
11 easily develop a process to do that, but a lot of
12 these measures are ones we don't develop, so
13 it'll be on us, but I also think with support
14 from all of you here, and from the NQF staff, to
15 work with those developers who submit measures to
16 us for consideration to also bring those back,
17 and so what does that process look like?

18 We think that this process will be
19 enormously helpful for us. One of the things I
20 was saying earlier to Harold, and to Helen, and
21 Taroon is that, we actually do this ongoing
22 evaluation of how the measures are doing

1 internally. It's part of our measure maintenance
2 process. We look at the performance, we look at
3 the variation, we look at the unintended
4 consequences, so we've been doing that forever,
5 but what we haven't done is we haven't brought it
6 here.

7 But I think it would be helpful for us
8 to understand what information, presented how,
9 would be most useful for this body to give us
10 further input. We obviously will have input into
11 that too, but we need to hear what you guys think
12 would be most important to see, because we're
13 probably going to have to modify some of our
14 internal processes to do that, which is fine. We
15 can definitely do that.

16 But I do want to say, we are committed
17 to doing that. We already have plans to bring
18 the post-acute care measures back to the MAP
19 earlier, but we want to do it with everything.

20 CO-CHAIR PINCUS: So let me just say
21 that I strongly endorse this notion of giving us,
22 sort of, more feedback about the experience with

1 measures. I think that, many times, I feel that
2 I'm in kind of a vacuum about what actually
3 happens out there. I mean, you know, some things
4 I track, some things I don't track, but to
5 understand what the implications are, what's been
6 learned, especially, and I also agree with you
7 that there needs to be some efficient way to do
8 this so that we're not just inundated with so
9 much data that it's incomprehensible.

10 So that I think we need to think about
11 ways by which we can build out formally into the
12 process in the most efficient way possible. And
13 number two, it also sounds that, again, trying to
14 summarize, I think, where we are on this specific
15 decision -- specific issue of these decision
16 categories is that, yes, this encourage continued
17 development is a subcategory of do not support,
18 and that for all the categories, potentially even
19 the ones for support, that to enrich our
20 conclusion of comments back to CMS so that the
21 more comments we provide are -- that can
22 influence their decision making and adjust how

1 they're implementing it, the better.

2 ACTING CO-CHAIR GESTEN: So I think
3 the comments, Kate, are really encouraging and
4 really respond to the issues that people had
5 about the measures under consideration. A
6 question, which may be too much in the weeds, but
7 assuming a process in which measures under
8 development have some specificity, comments, that
9 are useful and productive, and then there's those
10 things have been developed to the point where
11 you're looking for feedback.

12 Do you have thoughts about what you
13 need from that second boomerang process from MAP,
14 and I'm thinking, do these measures not go
15 through the workgroups? Do they go through the
16 workgroups? Do they come directly to the MAP?
17 Do you need -- do you envision a different
18 process?

19 Because if I'm hearing you correctly,
20 time is one of the issues that you confront
21 relative to having a second bite at the apple, if
22 you will, to look at these.

1 DR. GOODRICH: I'm not sure of the
2 answer, but what I will say, we will have to
3 think together about how this integrates with
4 ongoing feedback that we get on our measures
5 through our regular measure development process.
6 We have multiple public comment periods as we're
7 developing measures, when it comes to NQF for
8 endorsement, there's that process, and so, you
9 know, we get a lot of feedback on the measures
10 along the way.

11 And so thinking about what is the
12 value add above and beyond what we are -- I think
13 there is one, because it's more around
14 implementation than it is around the actual,
15 like, science and anything behind the measure.
16 You know, I don't know the answer, but we do have
17 to think very explicitly, given all the other
18 feedback that we continue to get on the measures,
19 what makes the most sense, and is the most
20 efficient.

21 And, you know, right now, you know, we
22 -- the way we do this work collectively is, we do

1 it as one big batch process once a year. And so
2 I think that's part of the problem, right? If we
3 had a way to do it, sort of, idea, I'm looking at
4 Kevin, sort of as single piece flow, or multiple
5 smaller batches, or something like that, there
6 probably is a way we can get to much more
7 efficiency with this.

8 DR. BURSTIN: Just a quick comment.

9 Thank you so much, Kate, that was incredibly
10 encouraging and I think we would very much commit
11 to us working together, and there's a lot of
12 opportunity for leaning out the processes. And
13 as many of you know, we've now completely blended
14 the teams that work on MAP and endorsement. They
15 are not different teams. They are the same
16 people who do both.

17 So as we're more and more blending our
18 data on all of these measures, this is a great
19 opportunity, I think, for us to do a
20 collaborative lean kind of effort to really go
21 soup to nuts and see where we need data, on what,
22 and how to best keep that information flowing, so

1 thank you so much.

2 CO-CHAIR PINCUS: Anybody online that
3 is also wishing to comment? Kevin?

4 DR. LARSEN: Suggestions, we need to
5 think through, this is a committee largely giving
6 its advice to Medicare, but we know that many
7 other groups look to this and that the measures,
8 we're hoping, are actually aligned across many
9 other domains. I think things specifically of
10 the states that are choosing measures for their
11 state innovation models, part of my work is to
12 give technical assistance to states as they build
13 their measure sets.

14 And this committee might consider, as
15 it looks at feedback, not just the getting
16 feedback from the use of these measures in
17 Medicare programs, but where else are these
18 measures actually being aligned and use that as a
19 sort of second part of the analysis.

20 You know, you don't want to take too
21 big a bite of the apple because that can be, you
22 know, an endless set of analysis, but for some

1 key and core things, we hear over and over again
2 that people are looking to the Medicare measure
3 sets as the starting place for where they would
4 find measures for use in other kinds of aligned
5 programs.

6 CO-CHAIR PINCUS: Other comments on
7 this issue? Now, it seems we did not comment on
8 the second issue about the ability of the
9 mechanism by which MAP members can suggest
10 additional measures. Are there comments or
11 issues that people want to bring up about that?
12 David?

13 MEMBER GIFFORD: So we talked a little
14 bit about this last in the fall and I think I
15 would disagree with -- agree and disagree with
16 the comment that we're not allowed to add
17 measures. We can't add measures to MUC list
18 because CMS has a process for it, but the statute
19 that gives us authority is to give feedback to
20 the Secretary, and if you read it through it's
21 clear that there's supposed to be a balancing
22 between new measures that are not NQF endorsed,

1 but thinking about NQF-endorsed measures.

2 And so I would say that there is a --
3 one of the things that the MAP workgroups and the
4 MAP can do is certainly review other NQF-endorsed
5 measures on the same topic, particularly when CMS
6 is coming forward with unendorsed measures, and
7 give feedback as to whether they should be
8 thinking and looking at other measures.

9 So we can't add measures, but again,
10 I think our statutory responsibility is to
11 provide the Secretary with feedback. And if
12 there are other measures, I think we should be
13 looking at those other measures and making some
14 comment as to whether we think those -- CMS
15 should be looking and considering those other
16 measures.

17 And as we've heard, we're advisory.
18 They can ignore it. They can -- but they then
19 have to comment as to why they're ignoring that.
20 And I think that that issue came up a number of
21 times in last year's cycle and again in this
22 year's cycle as well. And both times it was

1 stated that the NQF staff felt they could not add
2 or have a discussion, and so the discussion was
3 tampered down and not raised by the group.

4 And I think that that's wrong and I
5 think we should allow that discussion to be
6 brought up and there should be some awareness of
7 other measures that are NQF endorsed, not the
8 open world out there, because they've gone
9 through this body has said that those measures
10 are out there and that there should be a look at
11 that.

12 And it very well may be, and I know in
13 one of the cases, I think the CMS measure came
14 through, probably is the one that should go
15 through, but there was no discussion of that, and
16 it left a lot of stakeholders with a sour taste
17 in their mouth.

18 CO-CHAIR PINCUS: So it seems to me
19 that what's being suggested is that the
20 distinction between suggesting another measure
21 and making a comment is really, you know, a
22 distinction without a difference, that if we're

1 giving comments back on some of these measures,
2 our comments can include saying, have you thought
3 of this other existing measure? Does that make
4 sense? Rhonda.

5 MEMBER ANDERSON: I think this is
6 appropriate for this question. I know that we've
7 spoken in the past about what are the precious
8 few, if you will, that will make a difference in
9 health in this country? And when we talk about
10 all these significant number of measures, I don't
11 believe that we have always asked that question.
12 Maybe in our own individual minds we have as
13 we've read them, but it seems to me that that is
14 where there may be a gap in what measures come
15 before us and then what measures really are going
16 to make that difference.

17 So I would just like to introduce that
18 into the comments about how we might be able,
19 from a MAP perspective, to bring forward those
20 that are going to make that difference. Going
21 back to Frank's comment about this -- the changes
22 that are occurring in the payment system, et

1 cetera, I always ask the question as I read each
2 of the measures in the hundreds that are coming
3 forward, is this, if it's a payment, going to
4 make a difference by the clinician, the hospital,
5 the post-acute care in terms of the final
6 outcomes for those particular individual patients
7 that are being cared for there?

8 And I think it's really important to
9 always keep that before us.

10 CO-CHAIR PINCUS: Any further comments
11 online? I'm going to move ahead. Rather than
12 taking a break now, since we're getting close to
13 the lunch break, I thought we just sort of move
14 ahead to the next set strategic issues.

15 MR. AMIN: Okay. Thanks, Harold.
16 Again, so just a quick reminder, the purpose of
17 this next session is to have some discussions
18 about what major topics emerged across the
19 different workgroups, and again, this is in
20 response to much of the feedback that we received
21 from this group during last year's development
22 cycle.

1 So during the workgroup meetings this
2 year, there were several strategic issues that
3 emerged during the discussion, and they sort of
4 fit into four different buckets. The first was
5 the need for special consideration of issues that
6 disproportionately affect the dually-eligible
7 population. And second, closely related, was the
8 importance of appropriate risk adjustment for
9 socio-demographic status, demographic factors.

10 And then the two final ones sort of
11 relate to, actually, the conversation we've had
12 already this morning, around the challenge of
13 performance measure attribution and the need for
14 shared accountability, and finally, the
15 importance of feedback loops.

16 So the first discussion around the
17 issues that disproportionately affect the dual-
18 eligible populations span four different topics.
19 If we can move to the next slide. The first was
20 care coordination. There was continued
21 encouragement of the development of care
22 coordination measures in and out of healthcare

1 settings, and to find and measure discharge to
2 community.

3 Secondly, community resources,
4 providers should facilitate access to community
5 resources, including improved integration of
6 healthcare and community resources. Third,
7 person-centered and clinical measures that
8 support individual health goals and incorporating
9 goals into clinical measures while supporting
10 clinicians in quality improvement with clinically
11 relevant measures.

12 And finally, the disproportionate
13 impact of risk adjustment for the dual-eligible
14 population.

15 So moving on to the next slide. The
16 dual-eligibles workgroup recommended some
17 specific elements for the coordinating committee
18 to consider. First was -- and the individual
19 workgroups. The first was to encourage NQF and
20 the MAP to continue to be forward thinking and
21 anticipatory for changing healthcare quality and
22 measurement.

1 The second was to reinforce the need
2 to explore and understand the differences and
3 implications of risk adjustment for diverse
4 factors, including those that are clinical and
5 social in nature. And third, to continue to move
6 forward with goals to align and prioritize
7 measures across settings, providers, and intended
8 audiences, specifically, consumers.

9 Moving on to the second major issue
10 related to risk adjustments for socio-demographic
11 factors, the MAP workgroups noted the importance
12 of reducing disparities by selecting measures
13 that adequately identify inadequate resources for
14 special -- for these populations, poor patient
15 provider communication, the lack of culturally
16 competent care, the lack -- the inadequate
17 linguistic access, and other contributing factors
18 to healthcare disparities.

19 They emphasized across all of the
20 workgroups that all members of the healthcare
21 community have a role in promoting appropriate
22 treatment of all patients and reducing healthcare

1 disparities. The MAP workgroups, what you
2 probably have already identified in your analysis
3 of the measures that you'll be seeing in front of
4 you today, the MAP workgroup conditionally
5 supported several measures under consideration,
6 pending a review by their relevant NQF standing
7 endorsement standing committee in the NQF/SDS
8 trial period to determine if SDS adjustment is
9 appropriate.

10 The MAP workgroups encouraged these
11 NQF endorsement standing committees to ensure
12 that all decisions, to include SDS factors in an
13 outcome measures risk adjustment model, should be
14 made on a measure-by-measure basis and should be
15 supported by a strong conceptual and empirical
16 evidence.

17 And then the MAP workgroups also noted
18 the need for a high --

19 CO-CHAIR PINCUS: Just a question
20 about that, how does that process get fed back
21 into the process?

22 MR. AMIN: So broadly, actually, you

1 know, one of the things that NQF is continuing to
2 work on, which, we hope that we'll have some time
3 to discuss tomorrow as well, is the further
4 integration of the NQF endorsement process and
5 the MAP process. So all of these recommendations
6 and the workgroup rationales, as they are
7 considered, first of all, they're given to CMS to
8 consider as they are thinking about implementing
9 the project, and as these measures come forward
10 for re-evaluation, there's a special
11 consideration for the SDS question when they're
12 reviewed by the standing committees.

13 CO-CHAIR PINCUS: So let's say in the
14 current crop of measures that we're going to be
15 discussing, as some of these issues have come up
16 where there's, in a sense, a request for
17 consideration of adjustment for socio-demographic
18 factors. Does that then go to the standing
19 committee and then how does that get fed back to
20 CMS in some way?

21 DR. GOODRICH: So I'm not sure of the
22 exact process of how measures get pulled that

1 should go into the SDS, I don't know if we're
2 still calling it a pilot, what we're calling it,
3 process, whatever, there is a process for that,
4 I'm just not sure what it is. You'd have to
5 speak to that. We participate in that process.
6 So when measures get pulled, we have our
7 contractors do the analyses, bring them forward,
8 all that stuff.

9 MR. AMIN: Right. I would just add,
10 Harold, to that question, I mean, there's a key
11 stakeholder group that's part of this process,
12 which are the measure developers. So the key
13 thing that we sort of do is, as we identify these
14 measures that are of special consideration by the
15 workgroups, we inform the measure developers to,
16 you know, undergo the appropriate level of
17 testing, and then when they're ready for measure
18 -- when they're ready for re-evaluation by the
19 standing committee, the standing committee is
20 encouraged to specifically look at this element
21 as part of the validity evaluation.

22 I would also add that any stakeholder

1 can raise any measure for an ad hoc review in
2 which there's particular concerns around SDS
3 factors if there's evidence to suggest so. So,
4 you know, some of this is related to the funding
5 cycles of when these projects come up for review,
6 so it's not an immediate trigger. So the
7 standing committee is not looking at it like
8 January or February, but there's a lag as it
9 relates to getting the developers to do initial
10 analysis and then for a relevant standing
11 committee to be convened. Is that sufficient?

12 I think there's a question. Do you
13 want me to keep going?

14 CO-CHAIR PINCUS: Oh, Bill?

15 MEMBER KRAMER: I just want to make
16 sure we're clear on our role, vis-a-vis, the
17 standing committees regarding the risk adjustment
18 methodology. My understanding from what you just
19 said, and reading these slides, is that, while
20 some of the workgroups identified measures as
21 potentially being affected, or be relevant for
22 disparities issues and risk adjustment, but the

1 task, methodological task, of determining whether
2 risk adjustment is appropriate is being done
3 through that SDS trial and not an issue that the
4 MAP is -- that's before the MAP to debate, or
5 discuss, or determine whether a particular
6 measure should be risk adjusted, is that correct?

7 MR. AMIN: That is correct. Yes, your
8 characterization is accurate.

9 MEMBER KRAMER: Great. Thanks.

10 CO-CHAIR PINCUS: Missy, do you have
11 a comment on the line?

12 MEMBER DANFORTH: I do. I have a
13 follow-up question that's related to the first
14 question. So there's a few measures that have
15 this pending NQF SDS trial, or pending NQF
16 endorsement, or pending NQF re-endorsement. So
17 in those instances, also where it's up to the
18 standing committee to re-endorse the measure
19 following maintenance, or endorse the measure for
20 the first time.

21 Once that's done, does the measure
22 automatically go back on to the MUC list?

1 Because I noticed when I was comparing last
2 year's final report to this year's MUC list,
3 there were several, like, nursing measures, I
4 think, that go brought forward by the Annes here
5 that said conditional support pending NQF
6 endorsement.

7 So those measures did get NQF --
8 endorsed by NQF in 2015, then didn't
9 automatically appear back on the MUC list. So
10 I'm just trying to understand with all these
11 measures that say pending NQF something or
12 another, you know, how do we ensure that they
13 actually get back on the list once that
14 conditional -- once those conditions have been
15 met?

16 MR. AMIN: So this is true, and I
17 think this actually closely relates to the
18 conversation we were just having around the need
19 for, you know, the term that we're using in this
20 context is the feedback loops. You know,
21 currently, the process is, sort of, linear, which
22 is that, you know, the standing workgroups and

1 the coordinating committee, right, makes a
2 recommendation to the standing committees, and
3 then, you know, the measure sort of moves on, but
4 there is not a -- there is no current process in
5 which that information would be brought back to
6 the MAP to, sort of, close the loop.

7 And I think Kate has described a
8 commitment by CMS to revisit that question and
9 obviously, NQF will have a responsibility to
10 figure out how that process will work going
11 forward. But I think you can rest assure to a
12 certain extent that there is actually -- there's
13 at least interaction between the MAP process and
14 the endorsement process, so feedback that's
15 provided through the MAP process is considered by
16 the relevant standing committee when that
17 standing committee is reviewing these measures,
18 and at least that part of the process is
19 currently working, I believe.

20 CO-CHAIR PINCUS: Missy, that answer
21 your question?

22 MEMBER DANFORTH: Yes, so I mean, I

1 think, though, the really important thing I'm
2 hearing is though, even though, going back to
3 your answer to the first question, so even though
4 the standing committees are responsible for
5 deciding which measures end up having the socio-
6 demographic adjustment apply, it's kind of going
7 to be up to this group, the MAP coordinating
8 committee, and maybe even the workgroup, to
9 ensure that, sort of, that due diligence is done.

10 I mean, they're going to have to have
11 some oversight to make sure that this is tracked
12 back through the standing committees and up
13 through the workgroup and to the coordinating
14 committee.

15 CO-CHAIR PINCUS: Any other comment?

16 MR. AMIN: Yes. I would just say
17 that, yes, basically, that the conditions are
18 filled, and like any condition that would follow,
19 you know, the conditional support, there would
20 need to be an additional process. And I think
21 that's one of the overarching issues that we
22 discussed this morning, that these conditions are

1 met, and, you know, a formal feedback process
2 would need to be developed to do that, but your
3 characterization of governance is accurate.

4 MEMBER DANFORTH: Thank you.

5 CO-CHAIR PINCUS: David?

6 MEMBER GIFFORD: I just want to
7 clarify the question Taroon gave to Bill. Is the
8 SDS trial period is now for all measures coming
9 through or just those earlier? So any measure
10 can come in without it and then go into a trial
11 period.

12 MR. AMIN: Well, let me be specific
13 about what that means.

14 MEMBER GIFFORD: Yes.

15 MR. AMIN: Like -- because every
16 measure that is submitted to NQF, I believe it's
17 April of 2015, is in the SDS trial period. Now,
18 that doesn't mean that every measure should be
19 adjusted for SDS. It means that, as part of the
20 validity assessment by the NQF endorsement
21 committee, they should be evaluating whether the
22 risk adjustment approach is valid, and that

1 includes an assessment of the clinical factors
2 and the relevant social factors.

3 And so I just wanted to be specific
4 about what that means that a measure is in the
5 trial period. Every measure that is being
6 evaluated by the -- but in this case, when there
7 are specifically measures that the MAP wants the
8 CDP committees to look at, the endorsement
9 committees to look at, they will get that
10 feedback from the MAP and, you know, consider
11 that much -- you know, the feedback from the MAP
12 process is considered, you know, very seriously
13 by the relevant standing committees.

14 So it's paid special attention. Maybe
15 that's a better way to describe it.

16 DR. BAKER: A quick question, do the
17 measure developers propose the SDS risk
18 adjustment methodology or are you envisioning
19 somewhat of a standardized risk adjustment
20 methodology across measures? Just thinking about
21 actually being able to implement these on a large
22 scale.

1 DR. BURSTIN: Thanks, David, and
2 Marshall Chin is here, who's the co-chair with
3 Ninez Ponce of our new disparity standing
4 committee. At this point it is up to the measure
5 developers to propose both what their assessment
6 is of a conceptual basis of why you would adjust,
7 as well as their own empirical analyses. Part of
8 what we're hoping the disparities committee will
9 help us is more of that standardization as we go
10 forward.

11 This is, frankly, a learning
12 experience, as we're seeing for some of the
13 initial measures that have gone through.
14 Clearly, conceptual basis and the data is still
15 pretty difficult and I don't know if Marshall
16 wants to add anything.

17 DR. CHIN: Yes, we had our first
18 meeting last week, actually, deja vu here with
19 this table, Erin and Helen were there, as Helen
20 says, it's going to be a learning process. And
21 one of the, I guess, early things for -- you need
22 to find is that it may be a challenge of the

1 existing measures which are readily available
2 which accrued for such evidence as versus for --
3 we had a presentation of a more detailed dataset
4 being much more sensitive than for to be included
5 to determine these practically important
6 differences whether you risk adjust or not.

7 So this will be a learning process,
8 but this is something that may come down the pipe
9 that the existing crude measures may not be
10 sensitive enough for it than yet of reality.

11 ACTING CO-CHAIR GESTEN: Mary Barton,
12 on the phone.

13 MEMBER BARTON: Yes, I just wanted to
14 say, from the measure developer point of view, we
15 are working on this, but it will definitely -- I
16 can't imagine a standard process that could work
17 across all measures, given the evidentiary burden
18 of SES. That's one point. And then the second
19 point is, as you might imagine, this is still
20 very early days, as Marshall just said, for
21 figuring out how to implement, given the very
22 sparse availability of relevant data to measure

1 to the entities that are being assessed.

2 There's some data that might be
3 available, but we don't know yet how to use it,
4 and then there's a whole bunch of data that we
5 would like to be available that is not yet
6 available.

7 CO-CHAIR PINCUS: Lisa, then Kevin.

8 MEMBER MCGIFFERT: I just want to be
9 sure I heard correctly that the -- through the
10 NQF process, all the measures will be -- the
11 committees are required to consider the measures
12 for SDS adjustment. And my memory was that that
13 was not to include patient safety measures, so if
14 you would address how those are handled.

15 DR. BURSTIN: Now, that's a great
16 point, Lisa, and again, it's always heard because
17 I feel like we've explained this in different
18 ways to different groups. I'll just try to be
19 very clear for the MAP. Again, with the SES
20 trial period came out as clearly saying, and the
21 report came out as saying, is that all measures
22 should be considered, but to do so, to actually

1 move it forward, there has to be a conceptual
2 basis of why those factors would, in fact, be
3 relevant to that outcome.

4 So to your point about patient safety,
5 for example, hard to imagine easily coming up
6 with a conceptual basis of why an in-hospital
7 safety event would have anything to do with any
8 of the SDS factors. Again, I'm being pretty
9 broad here, but just in general. So most of
10 those safety measures would likely fail on the
11 conceptual basis, which is the first requirement.

12 You have to get past the conceptual
13 basis before you even then entertain the empiric
14 analyses, so in general, anything that's kind of
15 generally been within the hospital setting,
16 particularly around patient safety, as we've seen
17 so far, have not been measures that have been
18 raised for consideration as part of the panel.

19 More so, I think, when there are these
20 issues that often extend beyond the walls or have
21 issues that get into other patient factors beyond
22 in-hospital care. Does that help, Lisa? Okay.

1 DR. LARSEN: I just want to be sure
2 we're also cognizant there are a number of
3 technical questions about how we'll collect and
4 validate this kind of information and ensure the
5 appropriate privacy and security around its
6 sharing. We've been doing some of that through
7 the -- as the national coordinator. In our 2015
8 certification edition for meaningful use, there
9 is a social and behavioral factors for data
10 collection that you can certify in your
11 electronic health record.

12 But we got a fair bit of input, as
13 part of that rule, that people are concerned
14 about the increased potential burden of that data
15 collection, and there are also people that are
16 concerned about when and how the information will
17 be used and shared. And that was just the, sort
18 of, front end of the sphere, I think, from this
19 kind of information that, if we want this to be
20 specific to measures and very broadly used across
21 all sorts of measures, there should be some
22 really thoughtful discussion at a strategic

1 level, how much of that do we want 1000 flowers
2 to bloom and how much of it do we want there to
3 be a kind of cohesive set of the main factors we
4 want to collect and reuse over and over again for
5 the purposes of lots of different measures so we
6 can really be sure that we've nailed things like
7 privacy and security, data sharing, collection
8 burden as part of this process.

9 ACTING CO-CHAIR GESTEN: So I
10 recognize how early this is in the challenges,
11 Marshall, that you mentioned, and Mary as well,
12 but I'm just wondering, you know, what your early
13 thoughts are or what the early conversation is
14 about, you know, data that suggests that networks
15 and providers that take care of multiple
16 populations may actually be better on a number of
17 quality measures compared to other populations,
18 and/or measures that deal with overuse, for
19 example.

20 You know, what folks might
21 traditionally think of as challenge and
22 vulnerable populations, those measures may

1 actually do better. So as folks are thinking
2 about the evidence to support adjustment and look
3 across the country and look at what some systems
4 have been able to do in terms of performance,
5 which may be counterintuitive, or some areas
6 where lower SES populations may do better on
7 certain measures, how is your group thinking
8 about handling this?

9 In other words, does adjustment go in
10 all different ways? So for overuse measures,
11 would you adjust for folks who are higher income,
12 or different status, or how do you think about
13 that?

14 DR. CHIN: Well, in some ways, I think
15 like your point, Foster, gets to, what's going to
16 be up on the post on the next slide, that I was
17 actually heartened to hear that the MAP
18 workgroups had agreed that there's a need for,
19 sort of, a high level more encompassing roadmap
20 for reducing disparities.

21 This will be, like, my fifth year on
22 NQF activities and my impression is that, you

1 know, there are stakeholders here, NQF, CMS, the
2 payers, the health organizations, they're all
3 well-meaning about disparities, but on the whole,
4 the efforts have been siloed or scattered, or
5 often times, crowded out by other important
6 competing demands.

7 And so, for example, the committee,
8 when we had our meeting last week, the risk
9 adjustment is an important part, but only one
10 part of the overall charge. Probably more
11 important in the long term is to come up with
12 this roadmap, which is going to be on the next
13 slide, which will incorporate things like, well,
14 how do you think about some of the organizations
15 that do particularly well, for getting to your
16 diverse populations, what are they doing? How do
17 we encourage others to do that, whether it's with
18 technical assistance or other types of
19 incentives?

20 And the specific charge that you can
21 actually look at goes from, for disparities, the
22 selection of performance measures, the use of

1 those performance measures, as well as their use
2 within payment programs.

3 I was thinking, one of the top
4 priorities for the disparities committee for NQF,
5 one of the prior challenges with the other ones,
6 I actually know he's been on them, also, has been
7 that they've been siloed. And as hard as it is
8 to talk about, like, selection of the measure
9 divorced from its use, including the payment, so
10 this is the first of the disparities committee is
11 to get that broad charge.

12 So it's going to be, in some ways, a
13 more watchful -- the charge we've been given, and
14 hopefully we'll be able to have more when it
15 comes to look -- such as, risk adjustment is only
16 one part of the puzzle for looking at
17 disparities. And your point, too, is very
18 important about trying to encourage, what can we
19 do to encourage different organizations to do a
20 better job, because we know that it is possible
21 to deliver right here and have great outcomes for
22 all types of populations.

1 CO-CHAIR PINCUS: Why don't we move on
2 to talk a bit more about some of the issues
3 around accountability and attribution?

4 MR. AMIN: Yes, that was a perfect
5 segue, Marshall. So just to finish up that last
6 topic, I mean, again, just as Marshall pointed
7 out, across the workgroups there was an
8 identified need for a high-level roadmap around
9 the elements that Marshall just pointed out, and
10 there was definitely support for the disparities
11 standing committee to take a more aerial view of
12 this and to inform the MAP process in general.

13 So again, as we're talking about some
14 of the strategic issues that emerge across the
15 workgroups, the first was this issue about the
16 MAP dual eligibles, the second was a discussion
17 around disparities and risk adjustment.

18 The third was around the discussion
19 around measure attribution and the share -- and
20 the need for shared accountability, particularly
21 in the way, honestly, even the MAP workgroups are
22 structured, which are generally setting specific

1 or provider specific, so across several of the
2 workgroups and measure-specific discussions,
3 there was an acknowledgment of the importance of
4 identifying the appropriate accountable entity
5 for patient care and outcomes.

6 The MAP workgroups encouraged shared
7 accountability for providers for important
8 outcomes, but however, MAP workgroups often found
9 it challenging to define how to appropriately
10 assign patients and their outcomes to multiple
11 organizations, and providers that have a role and
12 influence in these outcomes.

13 And I would just remind us last year
14 of our discussion around advanced care
15 directives, sort of fit the same domain, an
16 important topic and who's ultimately accountable,
17 and what role do they have in improving those
18 outcomes?

19 Moving on to the next slide, the MAP
20 workgroups noted the challenge of attribution and
21 the importance of shared accountability in
22 several illustrative examples, which we'll talk

1 about later on today. The first is around these
2 30-day readmission measures, mortality measures,
3 and episode-based payment measures that look
4 longitudinally, and the second was around
5 clinician measure -- clinician-level measurement
6 when there is increasing emphasis on team-based
7 care, and the third about how do we advance
8 population health goals in the context of, sort
9 of, setting specific measurement, the example of
10 smoking cessation.

11 All interesting topics I'm sure we'll
12 get to later on today. The MAP workgroups
13 cautioned that measures and programs need to
14 recognize that multiple entities are involved in
15 delivering care and there is an individual and
16 joint responsibility for improving quality and
17 cost performance, and also identified the need
18 for a multi-stakeholder evaluation of these
19 attributes and issues to provide guidance to the
20 field on theoretical and empirical approaches to
21 attribution to guide measure selection and future
22 rulemaking activities.

1 And then finally -- and finally there
2 was a discussion around the importance of
3 feedback loops, again, very consistent with our
4 conversation earlier this morning, with MAP
5 workgroup members noting the importance and the
6 need for feedback loops from those using measures
7 under consideration by the MAP workgroups.

8 This type of user experience can help
9 identify trends in measures, overall performance,
10 overall variation in performance, provide
11 guidance on specific interventions that lead to
12 performance measurement, and understand whether
13 the measure is having the desired effect and to
14 the extent to which the measure is being used.

15 These feedback loops can also help
16 provide guidance on measures under development.
17 Again, very consistent with our conversation
18 earlier today, and very encouraging that CMS is
19 interested in moving forward with this.

20 And finally, the MAP workgroups
21 encourage feedback through its enhanced public
22 commenting period to gain insight into user

1 experience with select measures.

2 And I know we've had a chance to
3 really move forward and have a discussion around
4 some of these topics already, but, you know, just
5 some conversational topics here, you know, for
6 discussion, but again, these two sessions that we
7 had today, this morning, that Erin covered, and
8 what I've just covered here, is to give the MAP
9 coordinating committee a more strategic view of
10 what we identified across each of the workgroups,
11 and again, there's not necessarily a decision
12 point around these topics, but we would welcome
13 any discussion before we move to public comment
14 period.

15 ACTING CO-CHAIR GESTEN: Thank you,
16 Taroon. Lisa.

17 MEMBER MCGIFFERT: What this brought
18 up to me is not really shared accountability, but
19 sometimes accountability is shared when it
20 shouldn't be shared. For example, a Medicare
21 patient who gets an infection in a hospital and
22 leaves the hospital, and has to -- and needs lots

1 of care subsequent to that infection. And, you
2 know, the pay-for-performance programs don't
3 account for that, that responsibility to the
4 hospital, it's a little bit different than what
5 we're talking about here, but there could be --
6 there often is a cascading event -- effect after
7 something like this happens, and that patient
8 could be in a nursing home, or could be in home
9 healthcare, or some other setting that, you know,
10 that is directly affected by that first act.

11 And I don't know how to measure that
12 or how to point accountability for that, but I
13 know that's not what people are talking about
14 here, and I think, you know, patients are taken
15 care of -- I understand patients are taken care
16 of by many different providers and I would like
17 to see, you know, some kind of record that
18 follows that patient, and what happens to that
19 patient, but that should also include
20 accountability for the providers who were
21 originally accountable, should be held
22 accountable, for the original patient safety

1 event, for example.

2 ACTING CO-CHAIR GESTEN: Barry.

3 MEMBER NOONE: Well, I have a question
4 about the SDS adjustments. Are they adjusted for
5 each of the measures specifically or is there a
6 general adjustment across the entire measurement
7 category? I was a little confused on that.

8 ACTING CO-CHAIR GESTEN: My
9 understanding is the former rather than latter,
10 but do you want --

11 MEMBER NOONE: Thank you.

12 ACTING CO-CHAIR GESTEN: David?

13 MEMBER GIFFORD: The attribution one
14 is just so hard. I think the theme and feedback
15 I'd like to give to CMS, and I think they're
16 moving in that direction, is, when measures span
17 providers, this is when the accountability comes
18 up, you need to do that in -- both providers need
19 to have that measure held accountable to them and
20 it needs to line up with other programs, the
21 payment programs and regulatory programs, because
22 measure by itself, or measure that's held

1 accountable to one provider and not another, does
2 not allow that coordination, the very essence of
3 the law, and some of it's out of sequence,
4 because as Jay pointed out, there's a sequence
5 issue, and I think CMS is trying to remedy that,
6 but it would be worth reinforcing that.

7 I think the other thing that's not on
8 this list, which I think needs feedback, you may
9 want to think about, and interested to hear other
10 opinions, is, as these measures evolve and as
11 answered on the phone, payment models are
12 changing and everything, should measures be
13 contained to Medicare only fee-for-service,
14 should they be only certain insurer type, or
15 should they be all payers?

16 And we have mixes of measures out
17 there and I think we're learning more and more
18 that Medicare fee-for-service does not
19 necessarily represent the other populations
20 and/or the practices of those providers, so as we
21 go to attributing stuff, we have a lot of
22 measures that are being developed on claims

1 because of convenience, and other issues, and
2 trying to balance the claims, or other -- you
3 know, and as EMRs are evolving out there, so I
4 would think it would be helpful to move to all
5 payer measures faster than we're moving in this
6 direction.

7 ACTING CO-CHAIR GESTEN: Kevin.

8 DR. LARSEN: One of the areas of
9 interest I see from states and others is how to
10 have accountability -- redefining accountability
11 more broadly, and so I think being explicit about
12 when the measures actually have defined the
13 accountability within the measure specification.
14 What -- so for example, in a lot of the physician
15 measures you need to have two visits with a
16 particular physician so that measure can be
17 counted for that physician.

18 In newer models, or in places where
19 people want population-based accountability, or -
20 - and some kind of empaneled group that you're
21 accountable for the year, that means that you
22 can't use that measure to measure the success

1 because the measure itself has said you had to
2 have two visits this year in order for us to
3 actually count you in the measurement.

4 So I think that that kind of -- those
5 kind of technical issues with how the measures
6 actually are built to the current payment systems
7 should be thought of someplace so that we are
8 clear about measures that we want as the payment
9 systems evolve to this more attributed
10 accountability and population-based care.

11 DR. BAKER: I just wanted to comment
12 on the disparities issue. Marshall and I have
13 been on this working group for America's
14 Essential Hospital and talking about this, and
15 through that discussion I think the two things
16 that have emerged for me is, first,
17 stratification of existing quality measures, and
18 I know CMS has talked about that, and that's been
19 talked about for many years, but in particular, I
20 think stratification of the measures, the age
21 gaps measures, to be able to look at differences
22 in trust, and being treated with respect, and a

1 lot of these issues are really cross-cutting and
2 not specific to the elite clinical condition.

3 And then the other thing is, I think
4 it is probably time for us to move beyond
5 measuring preferred language and actually get at
6 the issue of English proficiency, and if we can
7 capture that information then to be able to look
8 at the proportion of people with limited English
9 proficiency to get an interpreter or a language
10 employment provider, and I think those are two
11 very concrete things that can help us move
12 forward.

13 ACTING CO-CHAIR GESTEN: Other
14 comments? One of the bullets here, we talked
15 about it a little bit, the second one about
16 learning from the field about how measures are
17 being used. Kate, you talked about the
18 information that you get, you know, on some days,
19 probably more than you need, feedback about how
20 measures are being operationalized, but also, you
21 do your own evaluation, I think like lots of
22 folks may do, either developers or payers, to see

1 what kind of variation, what kind of changes
2 you've seen over time.

3 So I think I heard you suggest that
4 bringing some of that information back in some
5 format to be -- yet to be sorted out may be one
6 way of getting more information back from the
7 field, but I just wonder if the group has other
8 ideas about other sources of information, or
9 rather, processes where by information from the
10 field could be brought back to the MAP? Rhonda?

11 MEMBER ANDERSON: Being from the
12 field, we have every -- almost every payer that
13 has different measures, and when we negotiate our
14 contacts, we have, you know, Payer X versus Payer
15 Y versus Payer Z that has different measures,
16 some are consistent across the board and some are
17 very different.

18 I'm just wondering if we have, at the
19 national level, asked some of the major managed
20 care companies what they are using and/or why
21 they are using it, because I know they come to
22 the table with a whole set every time we sit down

1 with them.

2 MS. STERLING: Kate, do you want to
3 speak about the ongoing efforts with the payers
4 collaborative?

5 DR. GOODRICH: Yes, so there's an
6 effort, which many of you know about, Amir has
7 been a major participant in it, as have others, I
8 think, on the phone, where America's Health
9 Insurance Plans has convened, many of the large
10 private payers, as well as CMS, physicians,
11 societies, consumers, employers, to develop
12 consensus around core sets of measures for at
13 about seven different sets at this point.

14 So, as part of that effort, we don't
15 have a process yet, but we are hoping to, in sort
16 of the next step, develop a process to understand
17 implementation of these core sets across the
18 different payers and within CMS, and the impact
19 that that has. And there may be opportunities to
20 collect information, whether it's, you know, hard
21 data, or whatever kind of information would be
22 most useful, not just from CMS, I don't want to

1 speak for AHIP or other payers, but there may be
2 an opportunity there, especially since, you know,
3 there will be much more alignment, we believe,
4 across payers with certain measure types.

5 The other thing I also wanted to
6 mention is, you know, one of the sets of analyses
7 that we do with a lot of our measures,
8 particularly our outcomes measures, is looking at
9 the disparities, so looking at performance of
10 providers who have higher proportions of patients
11 who are low SES compared to providers who have
12 lower proportions of patients with low SES.

13 And so that kind of information,
14 bringing that back to this committee, just to
15 highlight, we do actually have that and we look
16 at that, you know, for many of our measures,
17 especially our outcome measures, might be useful
18 to this committee as well.

19 CO-CHAIR PINCUS: At some point it
20 might be useful to solicit from the coordinating
21 committee what type of information would be most
22 useful about the experience with individual

1 measures and to actually try to think about how
2 one could, sort of, format that information.

3 Any other comments, either online or
4 in the room? So we're actually running about an
5 hour ahead, which is good. So, that's good. And
6 we're about to ask for public comment on this
7 first section, and then what we thought would be,
8 just to give you sort of a heads-up about our
9 discussions about the schedule, is maybe have the
10 post-acute care, long-term care, workgroup
11 introduce issues and then break for, you know,
12 lunch very briefly, and then come back and
13 discuss the measures that have been pulled.

14 So before we do that, Lisa?

15 MEMBER MCGIFFERT: I just wanted to
16 clarify what you just said is that you have some
17 data that you could bring to us and did you say
18 please do? I didn't hear you say that, but I --

19 CO-CHAIR PINCUS: Yes. Well, yes,
20 it's please. Yes. Well, from my perspective,
21 yes, but I think we want to, you know, think
22 about it in a systematic way, what kind of input

1 -- what kind of information would be most useful,
2 because I'm sure we could be flooded with all
3 kinds of data, and so it'd be useful for us to
4 think about, what are our priorities, and also
5 what format would be the most digestible way to
6 make use of the data.

7 ACTING CO-CHAIR GESTEN: I also wonder
8 where in the process it comes, because in the
9 logical place to get information about how
10 measures are being used is usually where they're
11 being reconsidered at some interval and I don't
12 know that there's a clear process whereby MAP or
13 the workgroups are being asked to, after some
14 interval, say, can you re-evaluate these measures
15 and say whether they should be in or not, but
16 maybe I'm missing.

17 DR. BURSTIN: I think you're right.

18 ACTING CO-CHAIR GESTEN: Is that
19 right?

20 DR. BURSTIN: I mean, certainly,
21 there's a logical place for the endorsement path.
22 We have measures come back for maintenance, but

1 even existing measures are often times put on
2 these lists as well, so CMS could provide
3 information about the experience of existing
4 measures, even if they aren't in a particular
5 program yet.

6 So again, I think this goes back to
7 Harold's comment about we need to collectively
8 work with all of you to think about the kind of
9 information you would like to see, and then I
10 think this is very much, goes back to Kate's
11 earlier comments about, needing to look across
12 the entire process, across NQF and CMS, and think
13 logically where best to find the best possible
14 information machine.

15 DR. BAKER: Throw out a couple of
16 concrete things that, you know, the obvious
17 things just to be able to look at the rates and
18 the variation and the trends over time. I mean,
19 we've looked at this for the joint commission and
20 some of our measures, I mean, the performance has
21 not changed at all, and it really makes you
22 question the value of these measures. Are they

1 really doing anything to promote quality
2 improvement?

3 So it still may be something that you
4 want for accountability, but those would be basic
5 things, and I haven't seen that. I think we did
6 have that presented a few years ago, for one of
7 these meetings, we had something presented, but I
8 haven't seen it for long.

9 CO-CHAIR PINCUS: So public comment.
10 Right. So are there members of the public either
11 in this room, let's start with in this room, that
12 want to speak?

13 MS. FOSTER: Thank you very much,
14 Erin. I'm Nancy Foster with the American
15 Hospital Association. Appreciate the richness of
16 the conversation that you've just had this
17 morning and the issues that you've raised. They
18 are very important. Two quick comments. One is,
19 earlier in the discussion, as you were talking
20 about the measures that come forward and their
21 various states of readiness, one thought might
22 be, having served on the hospital workgroup for

1 any number of years now, it often strikes me that
2 we're in this state of saying, we like the
3 concept of the measure, but we don't like the
4 measure, and you talked about that.

5 And sometimes I wonder if we really
6 like the concept of the measure or we like the
7 topic. We want more on X. We don't really like
8 this measure, but we're not presented with that
9 choice of, we would like more on X, but not this
10 measure. So that might be something you'd want
11 to think about including was -- is a sort of --
12 and it comes to mind as I think about some of the
13 measures that the hospital workgroup dealt with
14 this year.

15 There was a, I think I made the
16 comment, that we would like more measures of
17 children's health because we don't have very many
18 yet, but the measure that was being brought
19 forward had some issues that we didn't -- that
20 you all will deal with later.

21 And secondly, to the question you
22 raised a few moments ago about how can we get

1 more information about the usefulness of measures
2 and so forth, if there's anything the American
3 Hospital Association can do around either the
4 hospital measures or any number of other
5 measures, we'd be glad to help poll our members,
6 do anything. It's a vital part of the process
7 and I am sure we are not alone in being ready to
8 help you get the information you need to make
9 even wiser choices. So thank you.

10 CO-CHAIR PINCUS: Others in the room?
11 On the phone, Operator, if you can open the lines
12 of the public as well. If there's any public
13 comments through the phone.

14 OPERATOR: Okay. At this time if you
15 would like to make a public comment, please press
16 star then the number one.

17 MR. AMIN: I would just like to note
18 for public commenters, this is your opportunity
19 to also make any public comments on the PAC/LTC
20 measures that will be discussed. We'd also
21 welcome those public comments as well.

22 OPERATOR: Okay. And we do have a

1 public comment from the line of Sandra Robinson.

2 MS. ROBINSON: Yes. Hi. This is
3 Sandy Robinson from the American Academy of
4 Dermatology. Like Nancy Foster, I want to thank
5 you for the rich discussion, particularly around
6 measures under development. I'm not sure where
7 you all have landed in that discussion, so I look
8 forward to the written discussion in the report.
9 It's a really important issue, particularly for
10 medical societies that are -- have long term
11 efforts in place to sort of fill the measures'
12 gaps, so we look forward to that.

13 The more, sort of, specific your
14 feedbacks the better. We use this in -- for
15 refining our measures development programs. And
16 particularly for the American Academy of
17 Dermatology, we're putting in place a clinical
18 data registry, so I also appreciate the
19 discussion about how data systems for measurement
20 is in transition and that it would be sort of
21 helpful to understand the vision of how the
22 endorsement process will be evolving to

1 accommodate the new way we'll be able to develop
2 measures in the future.

3 So thank you again for your discussion
4 today and I look forward to reading the final
5 report.

6 ACTING CO-CHAIR GESTEN: Thanks,
7 Sandy.

8 MS. ROBINSON: Oh, one further thing.
9 Also to echo what Nancy just said, in terms of
10 how these measures are being used in the
11 implementation, we will have some potential for
12 that as our clinical data registry goes into
13 implementation and look forward to any
14 discussions with CMS or the MAP about how we can
15 feedback information into the process.

16 ACTING CO-CHAIR GESTEN: Great. And
17 thank you. Any other comments from the line,
18 Operator?

19 OPERATOR: There are no comments at
20 this time.

21 ACTING CO-CHAIR GESTEN: David, did
22 you have a comment or was that -- okay.

1 MEMBER GIFFORD: Just on public
2 comment in general, I think the workgroups and
3 other committees I've been on really have
4 appreciated the switch where public comment comes
5 before discussion, not just before vote or after
6 vote. I think it was really helpful, I've
7 watched, and found that it helped shape the
8 discussion.

9 And as we think about public comment
10 here, it might be -- I know we weren't
11 necessarily doing any voting, per se, but we were
12 shaping some stuff. What the right timing is,
13 and I'm not sure on discussion issues, but I
14 think the more we can get to public comment
15 earlier, that'll help a lot of us to sort of not
16 have to revisit a topic or comment on it.

17 Not that I think that there's anything
18 we've said that requires revisiting, but I'd
19 encourage us to think about flipping as much of
20 that around.

21 ACTING CO-CHAIR GESTEN: To that
22 point, just to remind folks that we're seeking

1 public comment on the next section of
2 conversation we're going to have on post-acute
3 care and long-term care, so this is an
4 opportunity for some of those comments that may
5 shape or help inform thinking before lunch and
6 after lunch. Taroon, did you want --

7 MR. AMIN: Yes, we just wanted to --
8 there's I think three members that haven't had a
9 chance to formally introduce themselves and do
10 disclosures. Kevin, I know you're up and --

11 DR. BURSTIN: Mary on the phone.

12 MR. AMIN: And Mary Barton on the
13 phone, and Sam Lin on the phone. Well, let's
14 start with Kevin, introductions and just any
15 disclosures that you may have.

16 DR. LARSEN: Kevin Larsen, Office of
17 National Coordinator of Health IT and no
18 disclosures.

19 MR. AMIN: Sam Lin?

20 MEMBER LIN: Hey, it's Sam Lin,
21 American Medical Group Association, medical
22 affairs consultant. No disclosures.

1 MR. AMIN: Mary Barton.

2 MEMBER BARTON: Hi. This is Mary
3 Barton, Vice President for Performance
4 Measurement at the National Committee for Quality
5 Assurance. I have -- I'm obviously a measure
6 developer, but I have no disclosures.

7 MR. AMIN: All right. Welcome all
8 three of you. Thank you very much for joining us
9 as well today.

10 Okay, so if we could just move one
11 slide. I just want to review the process before
12 I hand it back to Harold to do some introductions
13 of the -- if you go one more, I believe, that
14 slide. Yes.

15 So again, I just wanted to remind
16 everybody about how each of these workgroup
17 report outs will occur, just to make sure that
18 we're all on the same page. We will ask the
19 relevant NQF staff supporting each of the
20 workgroups, and the workgroup chairs, to present
21 the measures and the programs that were
22 evaluated.

1 Again, we appreciate all the workgroup
2 chairs that were able to fight for a time to be
3 able to meet with the changing agenda today. Not
4 all of the workgroup chairs will be able to join
5 us, given the changing agenda, but we appreciate
6 that time.

7 We've asked them to focus on outlining
8 the strategic issues that have emerged in the
9 workgroups to give you, as a coordinating
10 committee, more of an aerial strategic view of
11 what happened in the workgroups, and then also
12 review the relevant input from the MAP dual-
13 eligible beneficiaries workgroup.

14 Our co-chairs here for the
15 coordinating committee will ask if any individual
16 measures will need to be pulled for discussion.
17 In your discussion guide, we've already
18 identified those measures that have been pulled
19 in advance of today's discussion, so this may be
20 the appropriate time to encourage you to sort of
21 shift from using the slide deck as your main tool
22 for today's meeting to the discussion guide.

1 Obviously, we'll be sharing that on
2 the webinar platform as well, but for those of
3 you -- for all of you in the room, and then all
4 of you on the phone, I would encourage you to
5 pull up that discussion guide. Again, if you do
6 not have access to it or have any questions about
7 how to access it, please let our NQF staff know
8 and we'll be happy to point you to the relevant
9 material.

10 That will be the main material that
11 we'll use to guide the discussion for the rest of
12 the day. And finally, for those -- for the
13 coordinating committee members that have pulled
14 discussion -- that have pulled measures for
15 discussion, please be prepared to review the
16 workgroup recommendations and the particular
17 elements that you have some disagreements with.

18 Any measure that's not pulled for
19 discussion will be ratified with the workgroup's
20 recommendation.

21 CO-CHAIR PINCUS: So Taroan, just to
22 clarify, there's not a way to go directly from

1 the webinar into the decision guide.

2 MR. AMIN: Is there a link on the left
3 side of that webinar, team? I actually am not
4 plugged into the webinar myself. No, there
5 isn't. So maybe ---

6 MS. ISIJOLA: We could work on it
7 during lunch.

8 CO-CHAIR PINCUS: Right. But I just
9 want to know where people have the link, to make
10 sure --

11 MR. AMIN: So we can resend the link.
12 Is that right, Wunmi?

13 MS. ISIJOLA: Yes.

14 MR. AMIN: We can just resend the link
15 to the rest of the coordinating committee and
16 please feel free to use that as the most updated
17 material. But again, I would encourage you to
18 use that as the primary material that we'll use
19 for the rest of the day.

20 MS. O'ROURKE: And just to clarify,
21 for those working off of tablets, staff are
22 coming around with laptops for you. We'll be

1 using the web platform to conduct the voting, so
2 if you're working on a tablet, please make sure
3 staff gets you a laptop so that you're able to
4 vote.

5 CO-CHAIR PINCUS: And also to clarify,
6 so you'll be -- for the examination of these
7 issues and discussion of these issues, we'll be
8 using the link to the discussion guide, but to
9 vote, it's going to be through the webinar
10 platform.

11 MS. O'ROURKE: We apologize. We know
12 that's a little clunky. We usually have a system
13 in the room to allow you to vote, but given that
14 so many of the coordinating committee members
15 were unable to join us in person, we're merging
16 all of the voting through the web platform.

17 MEMBER QASEEM: Quick question, so
18 what's the difference between measures identified
19 for voting versus not voting? I'm forgetting.
20 Can you remind me? Some says no vote required
21 versus others say voting required.

22 MR. AMIN: Some of your colleagues on

1 the coordinating committee have pulled measures
2 for discussion, that there's a clarifying item on
3 the measure or a clarifying item in the
4 rationale, and so they don't disagree with the
5 workgroup recommendation, but they're looking for
6 clarifying information before they felt
7 comfortable with the measure moving forward.

8 Again, if there are measures that are
9 pulled for discussion that you do want to change
10 a vote, but the conversation doesn't require a
11 vote anymore, please state that upfront because
12 the voting process, as seamless as we try to make
13 it, is clunky and will take some time to get
14 through. It just is the nature of voting in
15 general. It's not any criticism of the platform,
16 it's just it takes time to get through it.

17 So with that being said, Harold, I
18 will turn it back to you to introduce the co-
19 chairs of the workgroups and if there are any
20 other questions or comments that folks have.

21 CO-CHAIR PINCUS: With regard to that,
22 so somebody who just pulled it off for discussion

1 and not for a vote, going back to our earlier
2 discussion about the meaning of, you know,
3 supporting the direction, if we are simply adding
4 -- in our discussion of those that have been
5 pulled for discussion, will those comments be
6 incorporated into the ultimate recommendation?

7 MR. AMIN: Absolutely. Any discussion
8 that occurs here will be added. Well, the
9 workgroup -- it's currently labeled the workgroup
10 rationale, it will be updated to say the MAP
11 rationale, and it will include all of the
12 discussion from this meeting.

13 CO-CHAIR PINCUS: Okay because that's
14 important, because there may be some people that
15 pulled things for a vote really intending for it
16 to be more discussion, and so we want to sort of
17 get that clear as we sort of go through the
18 process.

19 MR. AMIN: Right.

20 MEMBER FLOWERS: This is Linda
21 Flowers. You might have said this, I've been
22 having some technical difficulties. So do I need

1 to close out of this webinar and then go back
2 into another link for the discussion guide or
3 will the discussion guide appear on this webinar?

4 MR. AMIN: So no, there are -- well,
5 so there are two tools that you should have
6 available to you. You should have the individual
7 linked webinar open, not only to be able to
8 follow along with what's going on in the room,
9 but also to be able to vote, so please do not
10 close that. Please have that available to you.

11 But we also would encourage you to
12 have the link open in a separate screen, the
13 discussion guide, so that you can follow -- if
14 you have your own questions and you want to
15 navigate through it, you can do that as well.

16 So that's the purpose of these two
17 tools that are in front of you.

18 PARTICIPANT: But on the discussion
19 guide, where is the voting? I don't see any
20 place to vote. Will it come up?

21 MR. AMIN: Once we get to that point
22 in the process, we will take a moment to stop and

1 walk you through exactly how the voting will
2 occur, but it will show up on your screen and we
3 will walk you through, on the webinar screen, how
4 that will occur.

5 PARTICIPANT: Okay.

6 MEMBER FLOWERS: All right, thank you
7 very much.

8 CO-CHAIR PINCUS: Okay. So do we have
9 Carol and Sarah on the phone?

10 MS. SAMPSEL: Hi, this is Sarah
11 Sampsel. I'm not sure if Carol was able to join
12 yet. Erin, have you heard back from her?

13 MS. O'ROURKE: She was in another
14 meeting. She's attempting to step out. She
15 should be joining us in a few minutes. Sarah, if
16 you want to kick us off and we'll open. We'll
17 have Carol join when she's available?

18 MS. SAMPSEL: Sure. So hi, this is
19 Sarah Sampsel and I'm the NQF senior director who
20 was working with the PAC/LTC workgroup. The
21 PAC/LTC workgroup reviewed 32 measures under
22 consideration for federal programs. They're

1 listed on the slide. The inpatient rehab,
2 facility quality reporting program, where there
3 were five measures, the long-term care quality
4 reporting program where there were seven
5 measures, the skilled nursing facility quality
6 reporting program, and the skilled nursing
7 facility evaluated purchasing program, the home
8 health quality reporting program, and then the
9 Hospice quality reporting program.

10 I think as has already been brought up
11 a little bit this morning, the PAC/LTC workgroup
12 is the group that is heavily impacted, and I hate
13 using the word, but by the IMPACT Act. And just
14 to refresh your memory, the IMPACT Act has some
15 goals and some requirements for alignment of
16 measurement across settings using standardized
17 patient assessment data and the MAP -- I think
18 the workgroup really acknowledged the work being
19 done by CMS to meet the requirements of the
20 IMPACT Act, but also acknowledged there's
21 importance in looking at the measures under
22 consideration and the importance of preventing

1 duplicate efforts, maintaining data integrity,
2 and reducing burden.

3 And so it was balancing not only the
4 issues of a lot of these measures that were under
5 development or had only been tested as presented
6 to the workgroup in the development phases or
7 tested in one setting, but understanding how
8 those might translate into the bigger picture.

9 They did recognize the challenging
10 timelines and I think we've talked about that
11 earlier, and really did express some discomfort
12 about supporting measures with specifications
13 that had been not fully defined, delineated, or
14 tested, but I think also welcomed the opportunity
15 to give some feedback to CMS and to the CMS
16 developer contractors regarding some kind of
17 industry input on, perhaps, considerations for
18 the measures, whether it was for the
19 specifications themselves, for testing in certain
20 populations, but also in some of the definitions
21 and work that has gone on in the field for some
22 time.

1 And then, you know, there was some
2 significant discussion regarding the cost for
3 beneficiary measures which were proposed for four
4 of the programs, and really wanted some
5 consideration to make sure that the measures are
6 inclusive of not only both cost and quality, but
7 considering the concept of value and how that
8 translates, and then we received a number of
9 public comments regarding how the cost for
10 beneficiary measures may or may not translate
11 well to the public and to consumers.

12 As was discussed just a few minutes
13 ago, there was a lot of discussion about shared
14 accountability across the continuum of care, and
15 specifically we're looking at the post-acute and
16 long term care settings. There are a number of
17 transitions of care and hand-offs of care that
18 need to be considered when looking at alignment
19 of measures.

20 So the MAP did encourage and discuss
21 the importance of incentivizing creative and
22 improved connections in post-acute and long-term

1 care, and they did discuss the fact that the
2 IMPACT Act can go, and translation of the IMPACT
3 Act requirements, go a long way toward that
4 route, especially when you're using the same sort
5 of assessment and the same measures across the
6 tools, but there's also the need to reflect the
7 differences in the patient populations when
8 looking at this handoff.

9 They found it important to promote
10 shared accountability and to engage patients and
11 caregivers as partners, especially the engaging
12 the caregivers and patients in the hospice
13 setting and measures that are intended to improve
14 quality in hospice care and understanding the
15 unique considerations in that care, all to ensure
16 the effective care of transitions and
17 communication.

18 There was some discussion about
19 recognizing the uniqueness and variability of
20 care provided by the home health industry and the
21 fact that there is not only a lot of regional
22 variation in home health, but also national

1 variation in home health, and there should be
2 significant discussion about, and consideration
3 of, how you look at benchmarks in home health and
4 how to translate home health measures so that
5 they're understandable to consumers.

6 And then, you know I mentioned earlier
7 about concerns regarding some of the definitions
8 and specification delineation. I think where we
9 had a lot of discussion was in the discharge to
10 community measures and the encouragement for
11 further development to ensure that the measures
12 are defined appropriately for each setting.

13 There was also a lot of discussion on
14 the discharge to community measures to ensure
15 that there was not duplication in readmission
16 measures and a lot of that comes down to some of
17 the definitions and coding that still need to be
18 worked out in the measure specifications and
19 testing.

20 Next slide. Yes, I think I really
21 mentioned some of the bullets on this slide
22 already, but, you know, not only is there a need

1 to focus on transitions of care across PAC
2 settings, but from the acute setting, and from
3 the hospital setting, to the PAC/LTC providers.
4 Where there was a lot of discussion about that
5 was really, not only in the handoff of the
6 patients, but also the coding, and the fact that
7 some of these measures, the way that they're
8 specified, some of the things that you really
9 need to look at are how codes from inpatient
10 admission to discharge might change and might
11 vary based against the codes that are used for
12 admission into the PAC/LTC settings.

13 One of the other things that came up
14 is this whole concept of measured care planning
15 and how you actually put that into action and
16 take the measure's path planning into the actual
17 transition of care and ensuring that goals are
18 defined collaboratively between the patients, the
19 providers, and the caregivers, because really,
20 when you come down to quality and assessing
21 things in the future about experience of care,
22 it's really not just about having a care plan in

1 place, it's about the interpretation and the
2 actual translation of that care plan into action.

3 And then, you know, I think that has
4 been -- this last bullet has been a theme for
5 quite some time, and that's the idea that there
6 needs to be better data sharing and
7 interoperability of data to facilitate discharge
8 planning and transitions of care. And again,
9 some of that hopefully is going to come out of
10 the IMPACT Act requirement and implementation of
11 those requirements.

12 And as we move towards standardization
13 or alignment of those tools and measures, the
14 interoperability should hopefully improve, but
15 then there's still the caution of we're looking
16 at different patient populations, and sometimes
17 much sicker populations, in some of these post-
18 acute care settings. Next slide.

19 MS. O'ROURKE: And, Sarah, I'm sorry
20 to interrupt you --

21 MS. SAMPSEL: Okay. So before I go
22 here, let me see if Carol had an opportunity to

1 jump on?

2 CO-CHAIR PINCUS: Hello, Carol, are
3 you there?

4 MS. SAMPSEL: Okay. So I will
5 continue. What I just presented were the
6 overarching themes that we felt that the
7 workgroup came up with. There were also some
8 more specific, I guess, themes and comments when
9 we looked at consideration of the set of measures
10 across each of the long-term care settings.

11 So for inpatient rehabilitation
12 facility, and again, this is one of the QRPs, or
13 quality reporting programs, as mentioned, the
14 measure focus continued to be on implementation
15 of the IMPACT Act, however, the workgroup
16 acknowledged and identified that there are other
17 high-priority leverage areas that are starting to
18 be filled for the IRF/QRP, and so we are seeing
19 some of the gaps in measurement closing in that
20 program.

21 One of the strong themes with the IRF
22 program is that there is the need for attribution

1 and ensuring that it's appropriate to the level
2 of care that most impacts the discharge decision
3 and admission to the IRF. And again, this goes
4 back to the whole making sure that there is
5 alignment in the measure and the coding, and
6 ensuring that both admission and discharge are
7 respective, and any measurement for discharge and
8 readmission are aligned with the patient
9 population.

10 The long-term care hospital reporting
11 program, there is a measure in that program, and
12 in one of the others, regarding the use, and
13 specifically potential overuse of anti-psychotic
14 medication. And two of the things that there was
15 significant discussion for this program had to be
16 with encouraging the exclusion of bipolar
17 disorder.

18 The way the MUC list was submitted,
19 the inclusion of bipolar disorder in the metric
20 was still, or the exclusion, was still being
21 considered in the testing. And I think we heard
22 pretty clearly from workgroup members that they

1 really suggested the exclusion of bipolar
2 disorder. And then also thinking about how
3 duration of exposure to the anti-psychotic
4 medications could impact the measure
5 specifications.

6 And, you know, this goes from the
7 transition of care and then how that duration is
8 implemented, or measured, within the long-term
9 care setting.

10 With the home health quality
11 reporting, this is the program that really has
12 been up and running longest for CMS, and has the
13 biggest burden of measurement and the largest
14 number of measures. So the overarching theme
15 from the workgroup was a recommendation for a
16 parsimonious group of measures that addressed
17 burden to the providers and ensure that CMS is
18 considering the retiring of topped out measures
19 and exploring opportunities to implement
20 composite measures, and there were composite
21 measures introduced on the MUC list that took a
22 number of the previous individual measures and

1 considered them, and they're going through the
2 testing phase for the composite measures.

3 And I think this is in line with what
4 Kate mentioned earlier, is that, CMS is
5 constantly looking at the programs, and home
6 health is one of those programs, and looking at
7 how the measures fit or don't fit, and how the
8 measures need to evolve over time, and
9 specifically, the measurement sets over time.

10 Next slide. Okay. Skilled nursing
11 facility, with the skilled nursing facilities,
12 some of the measures on the MUC list were
13 measures that had appeared, or adaptations of
14 measures that had appeared on the MUC list last
15 year for IRF. And those are some of the
16 functional status measures, those process
17 measures ensuring that functional status measures
18 are -- functional status assessments are being
19 done, but then change in functional status.

20 These measures were encouraged for
21 further development because the way they were
22 submitted was adaptations of the IRF measures and

1 how they had been tested in IRF, and further
2 testing needed to be done in the SNF program.
3 The workgroup really encouraged further
4 development to promote alignment of the
5 assessment tools, and measure reporting across
6 settings, and also consideration of burden in
7 implementation of any new assessments.

8 I already talked a little bit about
9 the anti-psychotic use measures and here, with
10 skilled nursing facility, it was really --
11 there's a significant discussion about the
12 special considerations in SNF regarding the
13 prevalence of dementia and how these measures may
14 or may not look with the population with higher
15 prevalence of dementia.

16 With the skilled nursing facility
17 value-based purchasing program, there was
18 acknowledgment of the importance of 30-day
19 preventable readmission measure, but I think, you
20 know, it's important with all of the 30-day
21 preventable readmission measures that we saw
22 across programs, there was a lot of discussion at

1 the workgroup across each of the programs, and
2 then in public comment, about ensuring that
3 there's not double dipping or double penalties
4 due to, perhaps, conflicting or 30-day
5 readmission measures that may look very similar
6 in the different programs.

7 And then finally, the Hospice quality
8 reporting program, which I should mention, is one
9 of the programs that is not impacted by the
10 IMPACT Act. The discussions were about the
11 continuation of gaps in tested and endorsed
12 outcome measures, and the need for continued work
13 on hospital quality measures. There were only
14 two measures on the MUC list for hospice.

15 But I think there was a lot of support
16 for those measures and that the meaningfulness of
17 hospice visits and care provided as reported by
18 the patients and caregivers are probably one of
19 the critical aspects in assessing quality, and so
20 determining how you measure those aspects and
21 getting feedback from both the patient and the
22 caregiver is really critical to implementation of

1 the measures. Next slide.

2 CO-CHAIR PINCUS: Wait, is Carol on?

3 WORKGROUP CO-CHAIR RAPHAEL: I am on.

4 I just got on, but it's fine to continue, so just
5 let me know if you want me to join in the
6 presentation at any point.

7 MS. SAMPSEL: Carol, this is Sarah.

8 Do you want to go ahead and pickup on the core
9 concept discussion?

10 WORKGROUP CO-CHAIR RAPHAEL: Sure. I

11 can pick up on that. I don't -- you know, did we
12 spend a little time on the context and the IMPACT
13 Act? I'm assuming that we did and kind of the
14 very tight timelines that that Act has set up for
15 measure implementation, so I think it's important
16 to understand that, but I'm assuming we framed
17 that for the coordinating committee.

18 MS. SAMPSEL: Yes, we talked about it
19 not only specifically for PAC/LTC and kind of the
20 challenges for our workgroup, but that was also a
21 broader conversation earlier this morning before
22 you were able to jump on, so I do think that

1 framework is set, but, you know, I'll defer to
2 Harold if you think we need to talk about that a
3 little bit more.

4 WORKGROUP CO-CHAIR RAPHAEL: Okay.
5 Great.

6 CO-CHAIR PINCUS: Yes, that was
7 discussed a lot this morning, and then also
8 brought up by Sarah.

9 WORKGROUP CO-CHAIR RAPHAEL: Very
10 good. So just to jump in at this point, you
11 know, we developed, now several years ago, core
12 concepts and we were very parsimonious. We
13 really had 6 domains and 13 core concepts that
14 have guided our work, and I would say it is
15 gratifying that the IMPACT Act and the proposed
16 measures by CMS in fact reflect the direction
17 that we have been headed, but we did step back at
18 this point to kind of reassess our core concepts
19 and see if we want to modify them at this
20 juncture.

21 And I'll just highlight a few of the
22 main points that emerged from that discussion.

1 And I think in addition to quality of care, we
2 really believe we need to add quality of life,
3 and that encompasses symptom management,
4 particularly for hospice, social determinants of
5 health, particularly in the long-term care area,
6 and just the importance of autonomy and control.

7 I think the other area which really is
8 very, very much germane to the post-acute long-
9 term care areas, if you're going to reflect the
10 preferences of patients and their families, they
11 really do need access to lower and more
12 appropriate levels of care.

13 I think the next area that we kind of
14 continued to emphasize is trying to move to
15 outcomes and not just have the processes, but
16 really make sure that we're targeting the
17 outcomes to the fullest extent possible.

18 On one of our areas where we really
19 wanted to zoom in on the need to establish
20 patient, family, and caregiver goals, we wanted
21 to shift that to not just only establishing the
22 goals, but really assessing the degree to which

1 the goals have been achieved.

2 And then in thinking through how we
3 really bring patients and their families in as
4 genuine partners in care, we really came to the
5 conclusion that we need to be sure that education
6 and information are available so that patients
7 and the families have the tools that they need to
8 really be true partners.

9 Okay. We, you know, are fortunate, we
10 have a member of the Dual-Eligibles Workgroup on
11 our workgroup, and so we are building a bridge to
12 the work that's been done in that area. And that
13 just, I think, reinforces for us where we're
14 already headed directionally, which is we have a
15 number of post-acute and long-term care settings,
16 and we need to be sure that people are receiving
17 care in the right setting at the right time, as
18 well as in the right way, and facilitate the
19 comparison of quality measures across settings by
20 being sure that they're aligned.

21 We talked a good deal about how to
22 have a common definition of discharge to the

1 community and how to measure this concept across
2 settings, given the fact that the settings often
3 do serve different populations in different
4 environments, so we need to just be cognizant of
5 that. And then also recognizing the great
6 variability among markets and communities so that
7 resources do vary and we need to take that into
8 account.

9 And so I guess now it's time to turn
10 to all of you and, you know, ask if there are
11 measures in the development that we should be
12 considering, and are on the MUC list, and that
13 would close gaps in the key areas for us, the key
14 leverage area, the key core concept areas, or the
15 IMPACT Act domains. And then any thoughts you
16 have about a recurring theme as we try to promote
17 more partnerships with inpatient and outpatient
18 settings, what can we do to also promote shared
19 accountability, so thank you.

20 And thank you to the staff for pinch-
21 hitting for me.

22 ACTING CO-CHAIR GESTEN: Thank you,

1 Carol, and thank you, Sarah. We had one
2 question. I just want to make sure if there's a
3 clarifying question from Rich Antonelli, we can
4 get to that, and then I don't know if we're going
5 to break for lunch next or not, but, Rich, did
6 you have a question?

7 DR. ANTONELLI: Actually, yes, just
8 two quick points. First of all, I just want to
9 commend the team. That is really exciting work.
10 Many of the points that you've raised are
11 actively being discussed now in the care
12 coordination standing committee, and so I think
13 to ensure that there is alignment on these issues
14 around getting to outcomes, but looking across
15 those care teams is going to be essential.

16 You know, what our standing committee
17 in care coordination, and Don Casey and Gerri
18 Lamb are the co-chairs of that, you know, what we
19 are looking for here is really a dearth of
20 measures that have come forward, and I think some
21 of that you raised in your approach to care
22 planning. So here in my day job, medical

1 director integrated care, Boston Children's,
2 we've backed away from having an uber-care plan.

3 But we've got work now around care
4 planning and that enabled us to take a step away
5 from attribution to a single entity and measuring
6 with the patient in the middle around this notion
7 of integration, so it's not so much a question,
8 but really, it's an endorsement of this wonderful
9 approach, and I think if we could cultivate the
10 connection between the standing committee care
11 coordination and the work that's being done here,
12 it will really help us fill some of those gap
13 areas.

14 WORKGROUP CO-CHAIR RAPHAEL: Well,
15 Richard, Gerri Lamb sits on our workgroup, so she
16 has been a source of really terrific information
17 about the work that you're engaged in.

18 DR. ANTONELLI: Terrific. Well, thank
19 you.

20 CO-CHAIR PINCUS: Are there other sort
21 of general comments about the PAC/LTC Workgroup
22 report, about the questions that Carol raised

1 that you want to bring up now, and so we're going
2 to be discussing general issues right now, if
3 people have them, and then we're going to take a
4 break for lunch, and then we're going to come
5 back and go over individual measures. So, Lisa?

6 MEMBER MCGIFFERT: I had a question
7 about the IMPACT Act. I'm not thoroughly
8 knowledgeable about it, but I noticed that -- I'm
9 wondering if someone can tell us, what -- did the
10 IMPACT Act say you have to have measures about
11 certain areas or is it -- do they specify
12 measures? I noticed that some of the comments,
13 for example --

14 WORKGROUP CO-CHAIR RAPHAEL: You know,
15 I can start. It was specific about areas that
16 needed to be measured, with dates of
17 implementation. So, you know, the total
18 estimated Medicare spend per beneficiary was
19 explicitly mentioned as a measure, and it's
20 supposed to be implemented in nursing homes in
21 October 2016 and rehab facilities October 2016,
22 et cetera.

1 There was also mention of measures
2 having to do with discharge to community, all
3 condition, risk adjusted, potentially preventable
4 hospital readmission rates, function, and
5 cognitive function, incidents of major falls,
6 medication reconciliation, so those were all
7 specified in the Act.

8 And I'll turn to the staff for, you
9 know, amplifying that.

10 CO-CHAIR PINCUS: Kate, did you want
11 to add to that?

12 DR. GOODRICH: Yes. It's mostly
13 measure -- I think they call them domains, but
14 some of them have some more specificity around
15 what that means than others.

16 CO-CHAIR PINCUS: At some point we
17 should talk about, you know, the language in
18 terms of what's called domains versus core
19 concepts versus subdomains versus measurement
20 concepts. Gail?

21 MEMBER HUNT: Okay. All right. I
22 just had a quick question about why this group

1 focused so much on bipolar and not other mental
2 illness that could impact the measurement of
3 long-term care quality? Does anybody know? I
4 mean, that was just on the list.

5 DR. GOODRICH: So I don't know, maybe,
6 Giff, you may know this better. I think the
7 issue was around excluding patients who have
8 bipolar disorder, but you can probably speak to
9 it.

10 MEMBER HUNT: If I could just say, I
11 understood the rationale for that, I was
12 wondering why just people -- why not people with
13 schizophrenia, for example?

14 MEMBER GIFFORD: Because the measure
15 excludes schizophrenia, Tourette's, Huntington's.
16 It does not exclude bipolar, which is an FDA-
17 approved diagnosis, which has irked a few
18 providers.

19 CO-CHAIR PINCUS: Are there other
20 comments sort of on the general issues raised by
21 the PAC/LTC Workgroup, either in the room or for
22 MAP members online? Okay. So why don't we take

1 a break now for lunch? Let's come back at five
2 after. Is that okay with everybody? So we can
3 do this -- Amber, you're raising a question? No.

4 MS. O'ROURKE: Carol, thank you so
5 much for stepping out of your meeting to join us.
6 We really appreciate you providing the overview
7 of the PAC meeting.

8 WORKGROUP CO-CHAIR RAPHAEL: Okay.
9 Thanks, everyone. Bye-bye.

10 CO-CHAIR PINCUS: Okay, bye. And so
11 we'll be coming back and going over the specific
12 measures, those that have been pulled off of the
13 consent calendar.

14 (Whereupon, the above-entitled matter
15 went off the record at 12:43 p.m. and resumed at
16 1:10 p.m.)

17 CO-CHAIR PINCUS: So now we're going
18 to get into the individual -- the discussion
19 about individual measures that were pulled off of
20 the consent calendar, and based upon our
21 discussion earlier today, I'm going to ask each
22 person who's pulled them off the consent calendar

1 to just let us know whether they would like to
2 change it from being pulled off for a vote versus
3 pulled off for just discussion, since we're going
4 to include the content of the discussion in the
5 recommendation to CMS.

6 So it would save a lot of time if it
7 turned out that we -- you know, it wasn't really
8 a re-voting that we needed to do, but rather
9 simply augmenting the discussion and documenting
10 it for CMS.

11 We're also going to ask whether it's
12 okay to cluster together several different
13 measures that are around the same measurement
14 concept, but that are being applied to different
15 settings. Let's get rid of those so we can sort
16 of condense some of the discussion.

17 MEMBER GIFFORD: Can I pull one other
18 measure just for discussion purposes?

19 CO-CHAIR PINCUS: What? I didn't
20 hear.

21 MEMBER GIFFORD: Can I just pull one
22 other measure for discussion purposes.

1 CO-CHAIR PINCUS: Yes, I was going to
2 get to that.

3 MEMBER GIFFORD: Oh, okay. Sorry.

4 CO-CHAIR PINCUS: To see if there were
5 other measures that people wanted to pull. And
6 then after the discussion of each measure, there
7 will be a response from --

8 MS. O'ROURKE: Well after the
9 discussion of each measure, we'll look to the
10 person who pulled the measure to say why they
11 pulled the measure, so why you either want to
12 discuss it further for the discussion-only
13 measures or why you disagree with the workgroup's
14 recommendation for the ones requiring a re-vote.

15 After that, for these we'll turn to
16 our lead discussants Carol and Gail, and they'll
17 share their perspective of -- the lead
18 discussants are welcome to say if they agree with
19 the workgroup's recommendation, they agree with
20 the person who just identified it for a re-vote,
21 or if they have a totally different opinion.

22 After that, we can open for workgroup

1 discussion on that measure.

2 CO-CHAIR PINCUS: Okay. Are there
3 other members of the MAP, either in the room or
4 online, that have additional measures they would
5 like to pull off the consent calendar for
6 discussion? David, you said you had one that you
7 wanted to add for discussion?

8 MEMBER GIFFORD: Measure 462, the SNF
9 discharge community measure.

10 CO-CHAIR PINCUS: For discussion, not
11 for vote?

12 MEMBER GIFFORD: Correct.

13 CO-CHAIR PINCUS: Okay. Why don't we
14 then proceed, first with 151048, skilled nursing
15 facility, 30-day potentially preventable
16 readmission measure. David, you pulled it off.
17 Do you intend for it to be pulled off for a vote
18 or for discussion?

19 MEMBER GIFFORD: Discussion.

20 CO-CHAIR PINCUS: Okay. Did you want
21 to discuss that now?

22 MEMBER GIFFORD: May I?

1 CO-CHAIR PINCUS: What?

2 MEMBER GIFFORD: Yes, I would like to.

3 CO-CHAIR PINCUS: Okay.

4 MEMBER GIFFORD: I wasn't sure if that
5 was a question or --

6 CO-CHAIR PINCUS: Well, the first
7 question was whether it was for a vote or a
8 discussion.

9 MEMBER GIFFORD: No, it's for a
10 discussion. So the discussion point and the
11 feedback on it is that this measure double counts
12 with the other potentially preventable set of
13 measures that were developed under the IMPACT
14 Act. So the IMPACT Act, there's four sets of
15 measures that we didn't pull, that measure
16 readmissions during the 30-day window after
17 discharge from a PAC provider.

18 That also developed a 30-day
19 potentially preventable readmission measure
20 during the PAC provider stay, so there's an IRF
21 measure out there. I believe there's one that
22 already exists for LTAC, so they're already out

1 there. This measure 1048, that we have before
2 us, measures potentially preventable re-
3 hospitalizations during a SNF stay and after the
4 SNF stay if the SNF stay is less than 30 days.

5 And so it will double count
6 readmissions during that time after discharge
7 with the other measure that's potentially
8 preventable. Now, while it's for a different
9 program, the payment program does not -- other
10 than it specifies in the Act, that they have to
11 develop a potentially preventable measure. It
12 does not say that it has to align with the
13 hospitals, doesn't have to align with anything
14 else.

15 The rationale that CMS has given in
16 last year's rule, and again, was to try to
17 coordinate care, which we support and agree with,
18 and have supported a measure of re-
19 hospitalization after discharge from SNFs, but
20 now that there is a potentially preventable
21 measure after SNFs, we think that this measure
22 should just be during the SNF stay, otherwise

1 it's double counting for the other measure.

2 That's the point.

3 CO-CHAIR PINCUS: So that's the kind
4 of information you'd like to pass on to CMS.

5 MEMBER GIFFORD: Yes. We -- the
6 recommendation would be to change the
7 specifications measure to be just within stay to
8 align with the IRF measure and align with the
9 greater program of the other potentially
10 preventable measures they have there.

11 CO-CHAIR PINCUS: Okay. So, Carole?

12 DR. FLAMM: Hi. This is Carole on the
13 phone.

14 CO-CHAIR PINCUS: The workgroup
15 discussant. Who were the workgroup discussants?

16 ACTING CO-CHAIR GESTEN: It was Gail
17 or Carole.

18 DR. FLAMM: It's fine. I think you
19 may be asking me to sort of chime in. This is
20 Carole Flamm on the phone. I think there's been
21 a lot of great discussion about the overall
22 context of what these measures are trying to

1 accomplish in terms of creating accountability in
2 the medical neighborhood, and that this isn't a
3 very important area, just speaking from, you
4 know, all the work that has been done around
5 other settings of care and readmission, so I
6 think this will face the same challenges of these
7 are kind of complicated and difficult measures,
8 but it doesn't mean we should let the perfect be
9 the enemy of the good.

10 So just general support for the
11 direction of this measure. I think the
12 discussion around sorting out how this fits in
13 with the suite of other measures focusing on
14 readmission to sort of refine the signal that
15 skilled nursing facilities are being asked to
16 manage around makes a lot of sense.

17 So those are just some of the general
18 comments that I would add, as well as, you know,
19 kind of the challenge but the need to deliver the
20 results around this measure in a way, hopefully,
21 that can support both that broad accountability,
22 but also the actionability of the information to

1 those that are trying to, you know, use the
2 information internally.

3 CO-CHAIR PINCUS: Are there other
4 comments about this measure? Kate?

5 DR. GOODRICH: I raised my hand with a
6 full mouth. Sorry.

7 MEMBER GIFFORD: I would move to put
8 it back on the consent calendar.

9 DR. GOODRICH: The only point I was
10 going to make is for the program where this would
11 affect payment, which would be the SNF VBP
12 program, would only be using one measure at a
13 time, so it wouldn't be double dinging in that
14 way that we usually talk about it. I understand
15 what you're saying about the overlap, but in
16 terms of -- it wouldn't be, like, double dinging
17 for payment. It would just be a single measure.

18 MEMBER GIFFORD: I'm assuming that's
19 the language we'll see in the proposed rule.

20 CO-CHAIR PINCUS: Are there other
21 comments about this measure. Okay. Let's move
22 on to the --

1 MEMBER GIFFORD: Harold, then I want
2 to make sure, I move to put it back on the
3 consent calendar.

4 CO-CHAIR PINCUS: Okay. I don't think
5 we have to move it, because it was taken off for
6 discussion, but thank you.

7 MS. O'ROURKE: Jayne, you had also
8 pulled the discharge to community measure. Did
9 you have similar concerns, additional comments?

10 MS. CHAMBERS: No, I think what David
11 commented on was the same concern that we had and
12 so I'm fine with that. I appreciate the
13 recognition.

14 CO-CHAIR PINCUS: Any further comments
15 from the people on the phone? Okay. So let's
16 move on to measure 15207, the fall risk composite
17 measure, so Sam and Lisa both requested that be
18 pulled off. Now, is that for discussion or for
19 re-voting?

20 MEMBER MCGIFFERT: Would you explain
21 the difference? Voting would mean that we're
22 trying to get it off and we want the group to

1 vote, discussion means we just want to discuss
2 it.

3 CO-CHAIR PINCUS: Re-voting is if you
4 want to change the recommendation.

5 MEMBER MCGIFFERT: Okay.

6 CO-CHAIR PINCUS: For discussion is if
7 you want to augment the content that goes back to
8 CMS.

9 MEMBER MCGIFFERT: Okay. I'm happy
10 with discussing since we've been kind of told
11 that's what matters.

12 CO-CHAIR PINCUS: Okay.

13 MEMBER MCGIFFERT: Do you want me to
14 go forward?

15 CO-CHAIR PINCUS: Sure.

16 MEMBER MCGIFFERT: Okay. So no
17 surprise that I pulled this one because it was a
18 process measure. When I looked at -- I'm on the
19 patient safety committee at NQF and I look back
20 at some of the information and it indicated there
21 was not a great evidence of the benefit of the
22 measure. The measure includes three parts that

1 are outlined in the documents we got for this
2 committee, and they appear to be -- well, the
3 information I got for MAP was that the patient is
4 assessed for falls, this was -- a risk was noted
5 in the plan and the plan was implemented, but the
6 actual measure, if it's the same measure that was
7 NQF endorsed, has screening for future fall risk,
8 risk assessment, and a plan of care.

9 It's just a percentage of who has a
10 plan of care documented, not whether it was
11 actually implemented. So I just -- one of the
12 things that came up when I looked at this is it
13 would be really helpful on the MAP discussions,
14 if it was related to a specific NQF-endorsed
15 item, that that was also on the chart somewhere,
16 and maybe it was on one of the charts. I really
17 like the way you guys have consolidated the
18 information, it's very easy to see, but I mistook
19 this for another measure at one point, and then I
20 realized it was aligned with, I think, 0101.

21
22 So my concern is that this does not

1 actually measure whether these three steps make a
2 difference or prevent falls, and that's what I'm
3 interested in is, a measure of falls. So I would
4 like to have that fourth element of this measure
5 of how many falls the patient had, or counting
6 the falls.

7 Now, I looked at the comments and
8 someone else, I think Sam is going to talk after
9 me, wanted to eliminate that third part, and I
10 think that third part is pretty essential, that
11 it's documented in the plan, but, you know, I
12 want to see this go a little bit further in
13 actually implementing the plan.

14 And so, you know, I really wanted to
15 convey that information to CMS that I felt like
16 it just didn't go far enough and there was a lot
17 of discussion in the patient safety committee
18 about these measures that just kind of go to the
19 edge and then they don't really get us where we
20 want to be, so hopefully we can get there
21 eventually.

22 CO-CHAIR PINCUS: Sam, did you want to

1 make your comments as well? Is Sam on the line?

2 MS. BROWER: Hi. This is Emily Brower
3 for AMGA. I told Sam I would chime in on this
4 one.

5 CO-CHAIR PINCUS: Go ahead.

6 MS. BROWER: Okay. So I think that --
7 I mean just to follow up on the previous comment,
8 we would -- I think we have a hypothesis, right,
9 that if we measure for risk of falls and put in a
10 plan, that will reduce falls. What I would ask,
11 and what Sam and I had talked about from the
12 medical group perspective, is just having --
13 since this was recommended for continued
14 development, that in that continued development,
15 have real specificity and clarity around what is
16 evidence in a care plan and what is evidence that
17 the care plan was implemented.

18 This is really from a process
19 perspective, right, so that we're not having to
20 do tremendous amount of chart reviews for all
21 these measures, but that if there was -- if it's
22 really clear around the specifications, then you

1 can do more automated pulls to be able to meet
2 the measure, so it was really mostly a process
3 comment asking for very clear specificity around
4 what does it mean to say it's in the care plan
5 and what does it mean to say it was implemented?

6 CO-CHAIR PINCUS: Okay. Are there
7 other people who -- actually, Gail or Carole, do
8 you want to respond on this measure?

9 MEMBER HUNT: Yes. I agree
10 wholeheartedly with Lisa said. I think that
11 without specifying and documenting
12 implementation, and then finding out whether the
13 person actually did fall afterwards, I think it's
14 just a process measure, but an outcome measure
15 would really be important to have.

16 CO-CHAIR PINCUS: Are there any other
17 comments that people would --

18 DR. FLAMM: This is Carole, I would
19 just add that this might be a situation where
20 looking at the existing performance data, given
21 that some of these measures have been in place,
22 and kind of looking at where the real performance

1 gaps are, and is it towards that third element of
2 the sequence that we've been talking about and
3 trying to focus in on that as a composite measure
4 might be able to bring a tighter focus into that.
5 Would this be a helpful piece of understanding
6 how a composite measure might perform?

7 CO-CHAIR PINCUS: Lisa?

8 MEMBER MCGIFFERT: And I guess it
9 would be helpful if I had one of my -- I had kind
10 of a question about the description. Is this
11 measure 0101? Is that what it is or no? It's
12 something completely different.

13 CO-CHAIR PINCUS: No, it's 207.

14 MS. O'ROURKE: I think we've got Alan
15 on the phone from CMS, if he's able to help, or
16 Tara. Operator, could you ensure Alan Levitt and
17 Tara McMullen have open lines?

18 OPERATOR: Their lines are open.

19 DR. LEVITT: Yes. Now, what's the
20 question? It's Alan Levitt.

21 MS. O'ROURKE: If you could explain
22 the relationship of the falls risk composite

1 that's on the MUC list to the current falls
2 measures in the home health program. Is this a
3 roll-up of the ones that we've currently got?

4 DR. LEVITT: Correct. It would be a
5 roll-up of some of the existing items that are on
6 OASIS into a composite of those different
7 processes.

8 MEMBER DANFORTH: Hi, I'm sorry. This
9 is Missy Danforth on the phone from Leapfrog. In
10 the measure description it says that it is NQF
11 0101 and, Lisa, that is the measure that was
12 recently re-endorsed by our committee in 2015.
13 So is it not that measure? Someone referenced a
14 different number, 207?

15 MS. O'ROURKE: I think that was just
16 the MUC list versus the NQF-endorsed number.

17 CO-CHAIR PINCUS: I see.

18 MEMBER DANFORTH: Okay. So it is the
19 NQF-endorsed 101, just to be clear.

20 CO-CHAIR PINCUS: David.

21 MEMBER GIFFORD: Last year, there was
22 an outcome measure for home health that was

1 approved and I think it was in the -- it was in
2 the home health proposed rule this year, wasn't
3 it, Kate? I think it was 674.

4 DR. GOODRICH: Alan, can you comment
5 on that?

6 DR. LEVITT: Well, there is an outcome
7 measure for falls with major injury in the falls
8 with major injury domain, which was one of the
9 domains of the IMPACT Act, and that is a falls
10 outcome measure that appears to be applied in all
11 four settings, including home health.

12 CO-CHAIR PINCUS: Lisa.

13 MEMBER MCGIFFERT: Yes, I think that
14 the problem with that is that -- well, I should
15 have it in front of me, but I think that major
16 injury, some major injuries are excluded from
17 this measure, so -- still, I think the point I
18 want to make is that we need something that
19 actually measures whether these three steps
20 actually prevented falls and did they have an
21 impact on the number of falls, whether they --

22 DR. LEVITT: Yes, this is Alan Levitt.

1 We agree. We at CMS agree and that's why we
2 brought it to the workgroup to get the idea as to
3 which way we should go in the development of this
4 measure, and so we certainly have taken the
5 feedback from the workgroup that they believe
6 very much that any process measure that we would
7 be developing should have some type of outcome
8 associated with it.

9 CO-CHAIR PINCUS: Anyone else care to
10 comment? Rhonda?

11 MEMBER ANDERSON: I agree that an
12 outcome piece is important to this. I just want
13 to make sure, as we look at the home health piece
14 of it, especially that the socio-demographics are
15 in that assessment as part of it because there's
16 a whole other set of complications that -- and
17 challenges that happen in the home setting, as we
18 all know, so I don't want to forget that piece.

19 CO-CHAIR PINCUS: Okay. Any other
20 comments on 15207?

21 MR. AMIN: Can I just clarify
22 something? There is this question that arose

1 whether this is an NQF-endorsed measure, Lisa,
2 that you asked. I'd actually look to the project
3 workgroup team on this. The measure
4 specifications and the literature review, the
5 rationale provided by HHS, references NQF number
6 0537, it just references the literature view, but
7 that's not --

8 MEMBER MCGIFFERT: That's what sent me
9 there, and that measure was put on reserve
10 because it had topped out.

11 MR. AMIN: Right.

12 MEMBER MCGIFFERT: So when I first
13 pulled it, I thought it was that, and then when I
14 was preparing my remarks, I realized it wasn't
15 that.

16 MR. AMIN: Okay.

17 MEMBER MCGIFFERT: It was this other
18 one. So I think that references just that the
19 literature is in that measure and not that it is
20 the same measure.

21 MR. AMIN: Right. I just want to
22 clarify that it is not currently an NQF-endorsed

1 measure.

2 MEMBER MCGIFFERT: This one is, but
3 0537 --

4 DR. BURSTIN: This one is not.

5 MR. AMIN: The MUC ID Number 15207
6 does not appear to be an NQF-endorsed measure, so
7 I would ask clarification from the project team
8 who was working on this, this does not appear to
9 be an NQF-endorsed --

10 MEMBER MCGIFFERT: Well, maybe we
11 should ask Missy where she found that reference
12 to this is 0101, because I know that was approved
13 by the patient safety committee. It could have
14 been removed in the process before it got
15 accepted.

16 MR. AMIN: Can you just clarify that?

17 MS. O'ROURKE: Sure. So from my
18 understanding -- Alan or Sarah, please correct me
19 if I'm wrong, this will be developed as a
20 composite of a number of measures that are
21 currently NQF-endorsed that are in the home
22 health compare program. This is -- the composite

1 itself is not currently endorse as a freestanding
2 NQF measure, that it's still undergoing
3 development.

4 CO-CHAIR PINCUS: Okay.

5 DR. LEVITT: Right. This is a
6 composite of existing measures.

7 CO-CHAIR PINCUS: Okay.

8 MEMBER MCGIFFERT: 0101 is a
9 composite.

10 DR. LEVITT: The composite has not
11 been endorsed because we're still developing the
12 measure.

13 DR. BURSTIN: 0101 is an NCQA measure,
14 so it is not for home health. That is the issue.

15 CO-CHAIR PINCUS: It's also being
16 applied in a different setting.

17 MEMBER MCGIFFERT: The other one was
18 not -- there's one for home health and there's
19 one for -- I think there are two of them on this
20 list for another setting. I'm trying to remember
21 what it was.

22 MEMBER DANFORTH: Helen, to my

1 knowledge, NCQA stores a version of 0101 in PQRS.
2 I'm not sure how that's related to this though.

3 DR. BURSTIN: And this measure is for
4 the home health program. I suspect that's why
5 it's under continued development, to modify it to
6 meet home health needs.

7 CO-CHAIR PINCUS: David?

8 MEMBER GIFFORD: This sounds like it
9 might meet the criteria for insufficient
10 information of the three categories we have to
11 vote on here. I mean, certainly, I think
12 everyone would encourage further development, but
13 if we had to classify it in the three categories
14 of either encourage further development or, I
15 forgot the middle, but don't develop at all, or
16 no, what's the middle one?

17 Return with insufficient information,
18 it sounds like this a measure that hasn't been
19 even specified yet because it's a composite of
20 three existing measures and they haven't figured
21 out how to composite them together, which is a
22 big deal, so I'm not certain how you comment on

1 that.

2 MEMBER MCGIFFERT: So 0101 is an NCQA
3 measure not a home health, so that's what you
4 were saying, but it's the same elements, pretty
5 much.

6 DR. BURSTIN: Correct. Yes. Just
7 pulled up that one. Missy's right, it looks a
8 whole lot like 0101.

9 CO-CHAIR PINCUS: So it sounds like
10 we've discussed this, we've augmented the
11 comments from the earlier workgroup, CMS has
12 heard it, so is there any further discussion?
13 Okay. Why don't we move on to Hospice and
14 palliative care composite process measures.

15 MEMBER QASEEM: Harold, before we move
16 on, David did ask that maybe we should re-vote on
17 this. I think he's raising a valid point.

18 MEMBER GIFFORD: I'm not making that
19 motion. I just raised it as a discussion. If
20 someone else wants to raise it.

21 MEMBER QASEEM: Oh, you just raised it
22 -- oh, okay.

1 MEMBER GIFFORD: It sounds, actually,
2 like there may be enough with -- I don't know
3 enough because I didn't delve into it, but
4 there's was a lot of confusion, but it sounds
5 like the NCQA measure is pretty well specified
6 and they're just going to try to apply it to a
7 different setting. That may be enough. It going
8 to be semantics. It goes back to, Harold, you
9 said earlier on, oh, well, if they specify the
10 measure then it should go forward, well, what
11 constitutes specifying a measure.

12 CO-CHAIR PINCUS: Right. So let's
13 move on to the Hospice and palliative care
14 composite process measure. And, Lisa, you pulled
15 it?

16 MEMBER McGIFFERT: I did.

17 CO-CHAIR PINCUS: Is this for re-vote
18 or for discussion?

19 MEMBER McGIFFERT: Discussion. So
20 this can be short. My problem with this is it's
21 a check-the-box process measure and even the
22 workgroup noted that in its decision and we've

1 had a discussion about what encouraged continued
2 development means, so that was really the reason
3 I pulled it.

4 I just felt like the workgroup noted
5 all of the things that were concerns with this,
6 and yet, they still encourage continued
7 development and I'll just leave our conversation
8 earlier today standing, because this was one of
9 the measures that was my concern, that, you know,
10 what we really want is for this measure to become
11 something else that addresses all the issues that
12 were raised rather than continuing to develop it
13 as is as a process measure, and so that was the
14 reason I pulled it.

15 It doesn't really give us the kind of
16 information we need. It just says, you did a
17 certain thing that may or may not be connected
18 with an outcome. We think it's connected to an
19 outcome, but we don't really make that
20 connection. That's it.

21 MEMBER BARTON: So this is Mary
22 Barton. I guess I'm curious about this because

1 do they think a composite -- I mean, it's good to
2 retire the other seven, how many measures in
3 this, like, six or seven, so obviously, the
4 burden, though, doesn't change if a facility
5 still has to report each component of a
6 composite, so I can understand you saying
7 composite if the underlying measures were topped
8 out, each of them, and you wanted to push further
9 improvement if you had a clear-cut tie between
10 evidence and the pieces of the composite, but if
11 you don't, then I guess I would support Lisa's
12 question about how is this really moving things
13 forward.

14 CO-CHAIR PINCUS: Gail, Carole, you
15 want to respond?

16 DR. FLAMM: No, I was going to say
17 something similar to what Mary said, so I have
18 nothing further to add. Thanks.

19 MEMBER HUNT: I don't either.

20 CO-CHAIR PINCUS: Okay. So, Lisa, do
21 you feel that your comments are, you know,
22 something that will be -- are you okay with

1 transmitting those comments to CMS sufficiently?

2 MEMBER MCGIFFERT: Yes.

3 CO-CHAIR PINCUS: Okay. So let's move
4 on to the next one, which is MUC 15236,
5 application of IRF functional outcomes measures
6 changes healthcare score for medical
7 rehabilitation patients. And, Amir? And are you
8 asking for a re-vote or for discussion?

9 MEMBER QASEEM: I'm not sure, and then
10 the reason for that is, I think the workgroup
11 recommendation is continue to develop, and I'll
12 be honest with you, I'm not really clear on our
13 wrap-up over this morning's discussion of what
14 does that mean? I mean, are we going to stick to
15 those categories or should we be saying that you
16 need to get this measure right before bringing it
17 back? That's why I'm not really sure if I'm
18 asking for discussion or a re-vote.

19 CO-CHAIR PINCUS: So the assumptions
20 we're working under is that recommending
21 continued development is that we want to make
22 sure that we have comments about that measure as

1 it's being developed, and that we're expecting
2 that it will be brought back to us for further
3 discussion in the future.

4 MEMBER QASEEM: But then it does not
5 necessarily mean it will be brought back, right?
6 It can --

7 CO-CHAIR PINCUS: It's --

8 DR. GOODRICH: That's what I was
9 trying to say this morning. You're right. We
10 don't have a requirement, statutorily, to bring
11 it back, however, we are committed to doing that
12 and developing a process by which we can bring
13 back all these types of measures, ones under
14 development and ones that have actually been
15 implemented to talk about how they're performing,
16 et cetera.

17 MEMBER QASEEM: Okay.

18 DR. GOODRICH: So we do plan to bring
19 these back.

20 MEMBER QASEEM: And meanwhile, this
21 can get implemented in any of the federal
22 programs while this is under continued

1 development though, right?

2 DR. GOODRICH: They could. I think
3 for this particular category of measures, part of
4 it, that is going to depend on our statutory
5 requirements related to the IMPACT Act, but they
6 certainly could.

7 MEMBER QASEEM: So for this one, I can
8 live with this discussion. How about that? I'll
9 start out nice.

10 CO-CHAIR PINCUS: Okay. No pressure.

11 MEMBER QASEEM: And the reason is some
12 of the things have already been discussed in the
13 workgroup; the implementation issues, the
14 variation of patients across various skilled
15 nursing SNFs, and as well as I think that some
16 patients are just not going to attain the
17 significant improvement in self-care.

18 And I mean those issues that we just
19 need to keep it in mind, but again, I think this
20 is the one that is something that we've already
21 discussed in the past as well, those concerns are
22 still there, so hopefully the continued

1 development will take some of these issues into
2 account.

3 WORKGROUP CO-CHAIR RAPHAEL: No, we
4 did spend time at the workgroup discussing the
5 importance of understanding that for much of this
6 population the best we could attain is
7 stabilization and prevention of decline and that
8 you were not necessarily going to get
9 improvement.

10 CO-CHAIR PINCUS: Other comments?
11 David.

12 MEMBER GIFFORD: This is the one
13 measure in particular I was raising about. There
14 are other NQF-endorsed measures. Particularly as
15 the IMPACT Act moves to requiring cross-setting
16 measures between LTAC, IRF, SNF, and home health,
17 there are a number of NQF-endorsed measures that
18 were developed and designed for one of those
19 settings that is potentially applicable, with
20 some modifications, to go to other settings.

21 And what we saw last year, and again
22 this year, is CMS has picked one from one setting

1 to then apply to the other settings without any
2 discussion about whether there's value in using
3 the other measures out there, so my feedback
4 would be, this is where I think it's important to
5 consider that discussion of it.

6 In particular --

7 CO-CHAIR PINCUS: You mean to discuss
8 comparative advantages in the different areas.

9 MEMBER GIFFORD: You know, in essence,
10 what you're going to is almost a best-in-class
11 measure discussion now, which didn't occur before
12 because you could easily say, I had a SNF
13 measure, you had a IRF measure, no best-in-class
14 discussion would occur. Two of the measures are
15 approved. Now, with the IMPACT Act and the
16 shift, they can pick one measure, then go
17 forward, then there's no more discussion of best
18 in class.

19 Whereas, before, there was a process
20 at NQF for harmonizing measures that were similar
21 across there. So I think that that's a point I
22 wanted to make on the measure.

1 The second part of this measure's a
2 little bit in the weeds is, this and the other
3 NQF-endorsed measures are all out there, won't
4 work as currently specified because CMS, last
5 year, specified Section GG in all of our post-
6 acute assessment tools, the IRF, probably the
7 LTAC care, the MDS and the OASIS, as required
8 under the IMPACT Act, but this was based off of
9 the care tool that was designed and tested before
10 they finalized what went into the IRF-PAI and
11 into the MDS.

12 So you don't have all the elements to
13 actually calculate this measure, so I mean, I
14 certainly would agree with encourage continued
15 development, they need to do a lot of continued
16 development. And as far as, like, best in class,
17 I'm not sure whether it really matters or not
18 which one is out there.

19 I mean, having done a lot of work in
20 this, and full disclosure, we have a measure that
21 we put in on the SNF side, I'm not sure which
22 one's better, because actually, I don't know

1 because none of them's actually been tested
2 across settings and none of them have the data
3 for across settings. I think there's benefits
4 from all the measures.

5 The last point I'd like on the
6 discussion side is, CMS has, on our MUC list, a
7 self-care and a mobility improvement measure and
8 a self-care and mobility discharge score measure.
9 I would encourage them to go back and look at
10 whether the relative ranking differ at all,
11 because we actually developed the same measure,
12 they're essentially correlated at, like, 0.98,
13 they're the same measure, so I don't -- well,
14 conceptually, they make a lot of difference.

15 It's one of those circumstances where
16 we had a bunch of clinicians and experts around
17 the room, we thought they were two different
18 measures, and we worked with CMS on it, and
19 everything else, and they correlate at 0.98, so I
20 would encourage them to go back and look at
21 whether they need to have both of those measures
22 and pick one of them to use, because otherwise,

1 it's just two sets of measures that'll add
2 confusion out there where there's no confusion,
3 but it will be confusion when they correlate that
4 high.

5 CO-CHAIR PINCUS: Good. Any other
6 comments. I think this is a useful discussion.
7 Jayne.

8 MS. CHAMBERS: And I agree with
9 everything that Giff just said. The comment I'd
10 like to make is that, as these measures are
11 developed and before they actually get rolled
12 out, we really need to test them in the multiple
13 different settings, and that's more than, you
14 know, testing in 25 locations. They need robust
15 testing across the various settings to see how
16 they really will work.

17 And it's a challenge that we find on
18 the inpatient side when measures are rolled out
19 without testing, but to the extent that we can
20 include comments about having testing prior to
21 making final decisions, I think it would be
22 important. Thanks.

1 CO-CHAIR PINCUS: Well, thank you. I
2 think that was a useful discussion. Anything
3 further? Okay. Let's move on now. There's a
4 group of measures that are all very similar, but
5 in different settings; the drug regime review
6 conducted with follow-up, and Lisa and David are
7 the people who pulled it out. Two question, is
8 this for vote or for discussion, and secondly,
9 can we discuss these as a group?

10 MEMBER MCGIFFERT: My comments are for
11 discussion and I definitely would discuss it as a
12 group because the comments are the same for each
13 measure.

14 MEMBER GIFFORD: Mine are for a vote
15 and I would discuss them as a group because the
16 comments are the same across them. Because
17 actually, what you're seeing with this IMPACT Act
18 is the measures are almost identical across all
19 the settings.

20 CO-CHAIR PINCUS: Okay. So this would
21 be for a vote.

22 MEMBER GIFFORD: I would move for a

1 vote, yes.

2 CO-CHAIR PINCUS: Okay.

3 MEMBER GIFFORD: And my move would be
4 to change the recommendation from encourage
5 continued development to insufficient data.

6 CO-CHAIR PINCUS: Okay. So do you
7 both want to sort of --

8 MEMBER GIFFORD: Well, yes, because I
9 think I'm stuck within those three categories,
10 because at the MAP workgroup we were told we
11 couldn't switch -- if the CMS comes in and says
12 the measure is under consideration, then you're
13 stuck with those three categories, if they say
14 it's done, you're stuck with the other three
15 categories. You can't move between the two.
16 That's not correct?

17 MR. AMIN: No, that's correct.

18 MEMBER GIFFORD: That's correct. So
19 the only option to change vote right now are
20 those three categories and I would go with
21 insufficient information.

22 CO-CHAIR PINCUS: Can you say a little

1 bit more about your rationale?

2 MEMBER MCGIFFERT: My rationale is
3 pretty simple. Again, it's a process measure and
4 my understanding is the IMPACT Act does require
5 measures of medication reconciliation and this
6 measure is not a reconciliation measure, it is,
7 sort of, a review measure and there were a number
8 of comments from the public that talked about
9 this, and it seems to me that this needs to be
10 reworked.

11 In the patient safety committee there
12 was a lot of discussion about this type of
13 measure that just says you did a review of the
14 medications without the obvious result being the
15 medications were corrected or they did match, or,
16 you know, that kind of step is missing from this,
17 and there was a lot of concern in the endorsement
18 process on what we're actually measuring here.

19 So that's, really, the point, and I
20 kind of said, the recommendation should be no,
21 let's wait until we have a real reconciliation
22 measure rather than continued development.

1 CO-CHAIR PINCUS: David?

2 MEMBER GIFFORD: I have a hard time
3 deciding what to do. I mean, clearly, I think
4 drug regimen review is important issue, patient
5 safety needs to be done, would encourage further
6 development on it, but given the sequence, and
7 what that meeting is, and everything else, I
8 think CMS is trying to meet the deadline on
9 IMPACT Act, and the IMPACT Act is, Lisa was
10 saying, specifies a medication reconciliation.
11 It doesn't say anything about drug regimen
12 review, so the Secretary can do any measure that
13 she wants, so it certainly can fit under IMPACT
14 Act.

15 And it's a good measure in that sense,
16 but in rushing to do this, this measure is
17 predicated on collecting information about drug
18 regimen review from the post-acute assessment
19 instruments, the LTAC CARE, IRF-PAI, MDS, and
20 OASIS, on items that have not been specified yet
21 at all, and have not been tested.

22 And CMS is, right now, trying to test

1 a post-acute instrument that they haven't yet
2 designed in five SNFs, five home health, five
3 IRF, and five LTAC, so it's really early in the
4 development. And without knowing more about how
5 all that performs and how -- you know, I don't
6 have any idea about the information, I think this
7 measure really is insufficient information to
8 determine what's going on.

9 I mean, I think they should keep
10 developing it, but it's too early to put into
11 rule and I think it's insufficient information,
12 so that's sort of the rationale. I mean, there's
13 also other issues that there is, under the
14 definition, a lot of things about clinical
15 significance and how you assess medication
16 appropriateness in the drug regimen review.
17 That's just sort of generic, there's no guidance
18 on it yet, and how that guidance is, I think,
19 will dictate whether this is a valid and reliable
20 measure or not.

21 And it also, some of the definitions
22 that seem to be in the documents that CMS put out

1 potentially conflict with some of the
2 requirements and conditions of participation in
3 those settings as well, so I think for all those
4 reasons, I would move that we -- that these
5 comments be certainly transmitted and that it
6 would be insufficient for us to make a
7 recommendation at this point.

8 But in those comments, it's a
9 reasonable measure to afford, but if they're
10 trying to comply with the IMPACT Act, I think
11 we'd rather see them put their energy first in
12 the med reconciliation and then a drug regimen
13 review measure.

14 CO-CHAIR PINCUS: What exactly is the
15 difference between the two?

16 MEMBER GIFFORD: The drug regimen
17 review measure looks to see whether the drugs an
18 individual is on are appropriate dose, and drug,
19 and class for the person, and again, something
20 else, the med reconciliation, is really just
21 reconciling -- as these poor, frail elderly are
22 being shuttled through the healthcare system,

1 that at least they're getting the drugs they're
2 supposed to be getting and they're not, sort of,
3 aligning.

4 So you see a lot of duplicate drugs
5 or, you know, a patient will come in and the
6 discharge summary will say, this set of drugs,
7 the home order will be this, the last order in
8 the hospital will be this, and they don't --
9 just, how do you reconcile those drugs? That
10 would be a drug reconciliation measure, where, a
11 drug regimen measure, which they have here, goes
12 the next level.

13 And again, I would encourage
14 development, I think, as a geriatrician
15 clinician, it's a good thing for them to work on.
16 It's, are the drugs appropriate, so are they on a
17 Beers criteria of drugs and they shouldn't be
18 taking it or not, you know, there's a drug-drug
19 interaction, so maybe all of Dave's drugs when he
20 comes in are appropriate and there's no
21 confusion, but three or four of the drugs I would
22 not give to Dave as an elderly person.

1 That would be the drug regimen review
2 measure, not a med reconciliation measure.

3 CO-CHAIR PINCUS: So Carole, Gail, do
4 you want to respond?

5 DR. FLAMM: Oh, this is Carole, I
6 would just, this is a great discussion, add that
7 I think there is, kind of, insufficient
8 information with where things are right now. And
9 very important area, but, you know, being able to
10 clearly define and work into the specifications
11 what are potentially significant medication
12 issues and the, sort of, clinical judgement
13 aspects that come along with that are incredibly
14 important to making this work from an
15 implementation perspective, so I think I really
16 agree with the thrust of the discussion so far.

17 CO-CHAIR PINCUS: Gail?

18 MEMBER HUNT: Yes, and I would just
19 note that the MAP members, to highlight some of
20 the things that the MAP members mentioned, and
21 one is about if you're in home health that it's
22 typically going to be the family caregiver that's

1 going to be responsible for bringing -- for
2 maintaining and creating the medication list, and
3 then being responsible for it, and some attention
4 ought to be paid to the expectations of time and
5 effort that that would take, along with the issue
6 that I think has already been raised a little bit
7 is, how do you ensure that the older person who's
8 in these circumstances, particularly in home
9 healthcare, is going to be understanding what he
10 or she needs to understand to take these
11 medications.

12 So it's one thing to have the
13 physician say, well, you got the right meds, and,
14 you know, you're supposed to be taking them now,
15 but there are so many issues around the accuracy
16 and ability of the older person to be able to
17 implement that, and to what do we hold -- how
18 much do we hold the physician, or pharmacist, or
19 other members of the team responsible for how
20 that works, and just checking the box that
21 they've gotten the medication list is maybe not
22 enough.

1 CO-CHAIR PINCUS: Kate and then
2 Rhonda.

3 DR. GOODRICH: Oh, I'm going to start,
4 but Alan also, on the phone, has -- because he
5 knows this measure far better than I do, so I
6 think the feedback we've been hearing has been
7 really helpful, and I will, just as a general
8 comment, say, already, from the feedback that
9 we've gotten from the workgroups has already
10 started to inform a lot of these -- you know,
11 across all three workgroups, has actually started
12 to inform how we move forward with some of these
13 measures, so I just wanted to say that, and this
14 has been helpful.

15 But I also wanted to -- because Alan
16 is very close to the measure development, have
17 him say a word or two about the med rec comments.

18 DR. LEVITT: Thank you, Kate, and
19 thank you all for the discussion that you're
20 giving here. This is, affectionately call,
21 medication reconciliation on steroids. This is a
22 measure that includes medication reconciliation

1 as part of it, but goes beyond that. It really
2 goes beyond the fact that, as David was just
3 saying, comparing to also looking for the
4 potential adverse effects, and also, having
5 contact that not only are these recognized, but
6 that they need to be brought to the attention of
7 the prescriber.

8 And this just doesn't get done one
9 time during their episode of care, or
10 hospitalization, but that this is something that
11 is done throughout their episode. We feel that
12 this does fall under the domain of medication
13 reconciliation because that is part of this med.
14 The three items that are being used are almost
15 verbatim three items that are on the OASIS
16 instrument already.

17 They've been collected on the OASIS,
18 they were tested when they originally came out
19 with the OASIS, and so these are items that have
20 been used and have been used successfully in that
21 setting without, you know, many issues going on
22 in terms of the ability to collect these items.

1 What a reconciliation measure may look
2 like 20 years from now, when we have electronic
3 medical records across all settings versus what
4 we're starting out with now, where we don't have
5 anything in post-acute care settings, it'll be a
6 lot different. Hopefully it'll be a lot
7 different sooner than that, but we are under
8 statutory guidelines in terms of applying
9 measures within this domain.

10 These items have been used and tested
11 within the home health setting, and therefore, we
12 thought that this would be a great place to
13 start. We appreciate the workgroup, the
14 workgroup was wonderful in terms of their
15 discussion, both involving this type of
16 discussion and also some of the questions we
17 brought to the workgroup, which were not the
18 specification for the measure, but really, what
19 type of guidance or guidelines do we really need
20 to give with the measure, because the guidance
21 has been general in the home health settings.

22 The home health community has not

1 asked for any real particular guidance in terms
2 of, well, what medications are you specifically
3 talking about, or whatever, because there are
4 different sorts of guidelines that may be state
5 guidelines, or there are types of guidelines we
6 didn't know how specific the, really, entire
7 public wanted us to be on this, and the workgroup
8 recommended that we be more specific than we, you
9 know, originally decided to do.

10 And we've taken that back with us, but
11 the specifications are the same, the
12 specifications are items that have been used in
13 OASIS, they are being tested in the other three
14 settings, and the analysis of that testing is
15 going on right now, and this measure that we are
16 very comfortable with that will meet the domain
17 as Congress has asked to do for the IMPACT Act.

18 CO-CHAIR PINCUS: Thank you. So,
19 Rhonda, you put yours down. David? Okay. Any
20 other comments about this set of measures? So
21 it's being pulled for a vote and so we need to
22 initiate the voting process.

1 ACTING CO-CHAIR GESTEN: Let me just
2 make sure, David, is it okay if these get voted,
3 anybody object to voting as a block versus
4 individually? Can't do it. So one at a time.
5 Okay.

6 MS. O'ROURKE: We'll vote on --

7 MEMBER GIFFORD: I might recommend
8 that we vote for one after the vote of one,
9 depending on how that vote goes, we'll see what
10 we can do with the others.

11 MS. O'ROURKE: I think with that,
12 Shawn, could you run through the voting
13 instructions for the committee?

14 MS. BITTORIE: Absolutely. So what
15 we're going to do is put a sample slide on the
16 screen, you'll be voting directly on the
17 informational slide for each individual measure.
18 Right now, on your screen, you should see a
19 question with two answer choices below, yes or
20 no, just simply click in the box next to the
21 answer of your choice, this would be for voting
22 members only, and the votes will calculate in

1 real time.

2 Right now, it looks like we have about
3 29 voting members on the call, and in the room.
4 And if for any reason you have any trouble
5 clicking in the boxes next to your choice, you
6 can refresh your session by pressing F5 on your
7 keyboard of Command-R for a Mac. Looks like
8 we're at about 25 right now, 26, 27, one more,
9 bingo. We're at 28.

10 And I'll turn it back to you Amber and
11 Wunmi.

12 CO-CHAIR PINCUS: So what's next?

13 MS. O'ROURKE: One more point of
14 order, for the Federal Government liaisons, just
15 a reminder that you are excluded from the vote,
16 so please don't cast one.

17 MS. STERLING: Okay. So your choices
18 are encourage continued development, do not
19 encourage continued development, or insufficient
20 information, and this is for MUC 151127, 1128,
21 1129, and 1130.

22 CO-CHAIR PINCUS: Just check.

1 ACTING CO-CHAIR GESTEN: I appreciate
2 there's no chads involved in this process. I
3 just want to say that out loud.

4 CO-CHAIR PINCUS: So where are we?

5 DR. TAVALLAEE: We have 26 votes. We
6 just need three more. We're good.

7 CO-CHAIR PINCUS: So it's 16, 3, and
8 8.

9 MS. O'ROURKE: And one vote, we're
10 having some -- one person's having technical
11 trouble, so it's actually 17, 3, and 9.

12 ACTING CO-CHAIR GESTEN: And passage
13 is 60 percent, is that right; 60 percent of what
14 number, of 29?

15 MS. O'ROURKE: Of 29.

16 CO-CHAIR PINCUS: So 15.

17 MS. O'ROURKE: Technically, we do not
18 have consensus at this time.

19 MS. O'ROURKE: So counting in the one
20 vote that was cast. Okay. So to clarify the
21 process, Taron was just whispering in my ear, we
22 needed 60 percent to change a vote, so we will

1 default to the workgroup's recommendation, so if
2 that changes your vote. So right now, the
3 workgroup recommendation would stand because this
4 vote would be if you want to change from the
5 current one to insufficient information, so we
6 need to cross a 60 percent threshold to get to a
7 change vote.

8 DR. BAKER: So what happens to do not
9 encourage continued development? I mean, are we
10 only voting for insufficient versus encourage?

11 CO-CHAIR PINCUS: No, I think what
12 we're saying is that, there would have to be a 60
13 percent of people would have to vote in something
14 other than the workgroup's original vote.

15 DR. BAKER: Right. That was my point,
16 so it shouldn't just be one category.

17 CO-CHAIR PINCUS: Yes.

18 MS. BITTORIE: Amber, Wunmi, as you
19 come to the end of voting on a particular
20 measure, the allowable timeframe for voting, if
21 you uncheck the box at the bottom to allow
22 voting, it will close the poll and freeze your

1 results.

2 CO-CHAIR PINCUS: So, David?

3 MEMBER GIFFORD: I move the other
4 three measures go on to the consent calendar. We
5 don't have to vote for them.

6 CO-CHAIR PINCUS: Okay. Thank you.

7 MEMBER QASEEM: So can I ask a
8 clarification question?

9 CO-CHAIR PINCUS: Sure.

10 MEMBER QASEEM: So there are 27 people
11 who are voting right now, out of which 17 have --
12 I'm still trying to figure out the percentages
13 over here, because the 17 out of 27 -- oh, you
14 can't see that?

15 (Off mic comments)

16 MS. ISIJOLA: So the official
17 percentage is 60.7 percent encourage continued
18 development, 10.7 percent do not encourage
19 further development, and 32 percent insufficient
20 information, so the measure remains its default
21 decision.

22 CO-CHAIR PINCUS: Okay. Is that clear

1 to everybody? Everybody comfortable with this?

2 MEMBER QASEEM: Clear, yes,
3 comfortable is a separate issue.

4 DR. BURSTIN: So your lack of comfort
5 is the percentage who still disagree with the
6 measure.

7 MEMBER QASEEM: Yes.

8 DR. BURSTIN: I think we should
9 capture the discomfort.

10 MEMBER QASEEM: Ten people are against
11 it, right, so it's significant, so 40 percent are
12 almost saying no, so I think that just needs to
13 be conveyed in some way or form so that that
14 doesn't just disappear; that number.

15 CO-CHAIR PINCUS: Yes.

16 MEMBER QASEEM: It's not 90 versus 10
17 percent. You're looking at almost pretty close,
18 because your number is like 57 or 60 percent? So
19 you're right at the cusp of it too.

20 CO-CHAIR PINCUS: Well, no, but don't
21 forget, it's 60 percent to overturn.

22 MEMBER QASEEM: Oh.

1 CO-CHAIR PINCUS: Okay. Because there
2 already is kind of an existing vote by the
3 workgroup, so that's why it's, you know, kind of
4 like an overriding veto kind of thing.

5 MS. O'ROURKE: And we can capture all
6 of the feedback we got through the discussion
7 here and we can, in the comments --

8 CO-CHAIR PINCUS: Yes, I think it was
9 a very rich discussion, I think, that went back
10 and forth, and I think people got it. Okay? So
11 we now have another cluster of measures that have
12 to do with Medicare spending per beneficiary,
13 again, in different settings. And, David, are
14 you pulling this for discussion or for a vote?

15 MEMBER GIFFORD: Vote.

16 CO-CHAIR PINCUS: Okay. And is it
17 okay that we discuss them all together?

18 MEMBER GIFFORD: Yes.

19 CO-CHAIR PINCUS: Okay. So you want
20 to give your perspective?

21 MEMBER GIFFORD: I would recommend
22 that we vote insufficient information. I knew

1 the last one was an uphill battle on it. I think
2 this one's a little bit clearer. Again, I want
3 to make sure our comments are construed with not
4 -- we support the general idea of a Medicare
5 spend per beneficiary, we supported the IMPACT
6 Act, you know, we support the idea of having it.

7 As always, you know, the devil's in
8 the details. This measure, of all the measures
9 that CMS has been working, has been the slowest
10 one to come out from them, and the actual
11 specifications in this measure were not sent out
12 for CMS public comment until two weeks ago with
13 the deadline for comment tomorrow at midnight
14 after the MAP.

15 And so while there was a
16 numerator/denominator definition in the
17 information provided to the workgroup, none of
18 the details behind any of it were provided to
19 anyone, including the TEP that was out there.
20 There's been a lot of disagreement by the TEP in
21 the TEP report that CMS released just last week
22 that have not been incorporated into the measure.

1 The measures, in particular, out the
2 IMPACT Act, were to collect information for cost
3 per beneficiary across providers for allowing
4 comparison across providers. As specified in the
5 specifications CMS just put out, these are with
6 in-provider measures that they've developed. It
7 does not allow cross-provider comparisons because
8 they double count across providers. They do not
9 double count with in-providers.

10 The other thing is that the measures
11 have different timeframes for LTAC and SNF based
12 on however long someone is in there, so the
13 measure, essentially, the new specification they
14 just put out, is the costs that occur from
15 admission to a PAC provider, through discharge,
16 and then 30 days after, except for home health,
17 they're in 60-day fixed intervals, because of the
18 way the payment issue is.

19 So there's different timeframes on
20 that issue that goes out there. There's some
21 other details about the measures that just have
22 come out that we're still trying to wade through

1 on the measure issue, but I would say that what's
2 been put before the workgroup and what's been put
3 before us really is insufficient and the comment
4 period hasn't even closed, so we don't know what
5 the final specifications are.

6 A lot of discussion about whether this
7 matches up the IMPACT Act or not. I think that's
8 a semantic argument, and as you've heard,
9 basically, CMS can do -- the Secretary can do
10 whatever they want, because there's a close in
11 there they can do whatever they want, so I think
12 it fits, certainly, within that, but there are a
13 lot of members.

14 I would say, since I am supposed to be
15 an organizational member, Helen reminded me at
16 the beginning, I did reach out. This is a
17 position, I believe, of the home health
18 associations I've talked to and the other nursing
19 home associations, I've not been able to talk to
20 the hospital associations, or a representative of
21 IRF and LTAC on these block of measures, but we
22 had all recommend that it be re-voted as

1 insufficient information.

2 Then I have a more general comment
3 about risk adjustment that at some point I want
4 to talk about all the claims measures, the
5 potentially preventable discharge to community,
6 and this -- that sort of cut across all of them
7 as well. I'll bring it up now.

8 All the risk adjustments and all the
9 claims measures are only claim based. In the
10 IMPACT Act it talks about needing to align claims
11 with the post-acute assessment instruments and
12 the IMPACT Act requires, sort of, standardizing
13 some of those assessments. We know that in
14 discharge to community, re-hospitalization, and
15 cost, the major drivers are functional status.

16 And functional status, you can't get
17 from claims. Functional status is available on
18 all the PAC instruments. You can easily link the
19 PAC instruments to claims and do that in the risk
20 assessment. And so we would strongly urge CMS to
21 incorporate some of the functional status
22 measures, cognitive status, and functional in

1 particular, but others, from the post-acute
2 assessment instruments into the risk adjustment
3 models.

4 And when you do that, the risk
5 adjustment models become much more robust and
6 much better. And so the measure that this is
7 modeled after, the hospital cost per beneficiary
8 measure, has been criticized for this as well,
9 and that doesn't have functional status in it.
10 And so I think when you add that in, it helps
11 there, so this is why we'd argue for insufficient
12 information at this time.

13 CO-CHAIR PINCUS: Gail, do you want to
14 respond?

15 DR. FLAMM: This is Carole. I'll just
16 add to the discussion. You know, this is an
17 incredibly important area of focus. To make
18 interpretation of these results meaningful, it
19 feels very important to have some level of risk
20 adjustment, risk stratification, you know, all of
21 the kind of discussion that just went before me,
22 so I do think that those components of the

1 methodology are incredibly important to sort of
2 start to get clear as we head down this journey.

3 CO-CHAIR PINCUS: Gail, did you --

4 MEMBER HUNT: Yes. I just think I
5 would definitely agree. I was concerned about
6 this ability to compare across providers, which
7 clearly is an important element and one that I
8 don't think we're ready to have yet, and also,
9 with regard to the home health quality reporting,
10 I think that the issue raised by the MAP members
11 that this could put a huge responsibility and
12 additional burden on the family caregiver is
13 really an important one that I hope CMS would
14 take very seriously.

15 CO-CHAIR PINCUS: Jayne, I see you
16 have your card up.

17 MS. CHAMBERS: I thank everyone for
18 their comments as well and we, speaking from the
19 hospital perspective, do have concerns about how
20 this is going to go forward. We don't think it
21 has appropriate risk adjustment at this point.
22 There isn't enough specification in what we've

1 seen so far to be able to help us understand how
2 the measure is going to work across settings.

3 I was in lengthy conversations this
4 morning with some of our LTAC members who were
5 trying to figure out how to respond to the
6 comments because they keep saying, we don't have
7 enough information. We don't really know how the
8 measure's going to work because there's not
9 enough detail in here for us to understand it.
10 So I think at this point we would vote for
11 insufficient information.

12 CO-CHAIR PINCUS: Are there other
13 comments either in the room or on the phone.

14 ACTING CO-CHAIR GESTEN: Frank has
15 one. Frank, on the phone.

16 MEMBER OPELKA: Yes. Thank you. I
17 guess I'm a little bit confused about my options
18 here. I hear that there's a lot of discussion
19 about whether or not you have all the bits and
20 pieces ready to go with this measure, and I don't
21 disagree with what people are saying. When I
22 looked at my options as I encourage continued

1 development, I don't encourage continued
2 development, or I have insufficient information
3 to decide whether to encourage or not encourage.

4 And I think we have to have these cost
5 measures and therefore, to me, if you either
6 encourage or don't encourage, you can always make
7 the argument there's insufficient, but what is it
8 insufficient for? Is it insufficient to
9 encourage or not encourage? Do you have enough
10 to make the decision?

11 To me, what I'm hearing everyone say
12 is, we need to have this measure, but it's not
13 ready yet. And if that is indeed the case, I'm
14 encouraged to continue development, realizing
15 risk adjustment deficiencies and other points
16 that everyone has made. I'm not hearing that I
17 have insufficient information to either encourage
18 or not encourage.

19 CO-CHAIR PINCUS: So, Kate, can you
20 help us out of this epistemologic dilemma?

21 DR. GOODRICH: I appreciate all the
22 comments and, Frank, I think your clarification

1 of what insufficient information means is
2 helpful. Just a couple of responses to a couple
3 of the issues. First of all, as I'm listening to
4 all of you what I'm hearing in the details of the
5 comments is actually the most helpful piece, not
6 so much the adjudication of whether we encourage
7 or not, although that is important.

8 Two things on sort of the issue that
9 does come up a lot around, sort of, the, you
10 know, overlap, or double dinging, or whatever you
11 want to call it, I mean, this is a situation
12 where you have, you know, the goal is a
13 standardized measure across all of these settings
14 that patients transfer back and forth from all
15 the time.

16 So it is actually, an alternative
17 viewpoint might be that it's actually appropriate
18 that you have some overlap in measuring of costs
19 between the SNF and the home health agency, who
20 are both responsible for certain aspects of that
21 care, and that was something that I know has been
22 discussed a lot in the development of this

1 measure, so just wanted to offer that up as well.

2 On the risk adjustment piece, you
3 know, that's also come up quite a bit about the
4 functional status being such an important
5 predictor of a lot of different things. And as
6 we have done with our other risk adjusted outcome
7 measures, as we get more input and have more
8 data, so what the law requires is that we may
9 include standardized data in addition to claims
10 when we have that standardized data that we could
11 include, and do all the testing, and all those
12 things we need to do, I think we can do that.

13 So just as a point of saying that for
14 these risk-adjusted outcome measures, as with
15 lots of other measures, they go through evolution
16 over time as we learn and as we get better data,
17 and I would anticipate that the same would be the
18 case here.

19 CO-CHAIR PINCUS: Other comments,
20 again, in the room or on the phone?

21 MEMBER GIFFORD: Since Kate opened the
22 door for more comments on the details issue and

1 appreciates it, while the measure description
2 here talks about the national median, which is
3 appropriate, given the skewness of the data, cost
4 data, the numerator and denominator definitions
5 for the ratio that's multiplied by the national
6 median is averages, and I would encourage them to
7 at least go back and look at that. And actually,
8 some of it actually uses averages and medians, so
9 I'm not sure why they keep flipping between
10 averages and medians.

11 And I haven't been able to delve
12 through the details enough to understand that
13 issue, but I think it makes more sense to
14 probably be consistent with medians throughout
15 than to switch between averages back and forth.

16 I think the other is that, you know,
17 in the lexicon of NQF and CMS' guidance,
18 efficiency measures really are a combination of
19 resource and outcome. This is not an efficiency
20 measure, though it claims to be an efficiency
21 measure, because it just measures resource and
22 cost, and so I would encourage CMS to be a little

1 bit more judicious in defining the difference
2 between efficiency and a resource measure that
3 goes on out there.

4 And I would concur with Kate that it's
5 important to have measures across and count costs
6 across settings, and encourage that coordination,
7 and I think this doesn't do that the way this
8 measure is constructed out there. And I
9 appreciate the earlier comment, I do think that
10 they need to keep developing a cost measure, but
11 what we have before us, if anything, I would
12 actually want to say they should not continue
13 with this measure. They should start with
14 another measure.

15 And if you look at the TEP comments,
16 the TEP had a lot of comments and concerns with
17 this measure as well. So I think a compromise, I
18 sort of split the baby, I think this goes back to
19 our earlier discussion in the morning, what does
20 it mean to be encourage development? I mean, I
21 think all of us would agree a Medicare spend per
22 beneficiary is a good thing that we'd encourage

1 development, but it really is then what the
2 measure is in front of us that we're needing to
3 pay attention to.

4 And I just think that there's
5 insufficient information to determine whether
6 they should continue this measure or not. If
7 we're voting that they should just continue any
8 measure with Medicare spend per beneficiary, then
9 I'd say the process really is not doing -- we're
10 not meeting our statutory requirement and giving
11 good feedback and voting on that, because it's
12 really about the measure in front of us.

13 CO-CHAIR PINCUS: Thank you. Last
14 chance. Any other comments? Okay. Why don't we
15 proceed to vote.

16 MS. STERLING: Are we voting on all of
17 these as a group?

18 CO-CHAIR PINCUS: Yes. Is that okay
19 with David?

20 MEMBER GIFFORD: I don't know if the -
21 - I'll defer to Erin and I wouldn't encourage
22 people to vote one way just because they don't

1 want to vote and go through the process, but I
2 suspect if we -- if the first measure of votes
3 does not achieve the 60 percent threshold to
4 continue with it, then I think we have to vote on
5 each of the four measures, is that right? I
6 mean, I'm okay with doing it as a group.

7 CO-CHAIR PINCUS: Everyone okay to
8 vote as a group? Is it Kosher?

9 MEMBER GIFFORD: Yes, I'm okay with
10 doing it as a group. Okay.

11 CO-CHAIR PINCUS: Okay.

12 MEMBER GIFFORD: Yes, I don't want to
13 make us do more work.

14 CO-CHAIR PINCUS: Okay.

15 MS. STERLING: Okay. So this vote is
16 going to be for the Medicare spending per
17 beneficiary post-acute care, while it's going to
18 be for MUC1134, MUC287, 289, and 291. Your
19 options are going to be encourage continued
20 development, do not encourage continued
21 development, or insufficient information, and you
22 can now vote.

1 So the official breakdown is 57.1
2 percent encourage continued development, 17.8
3 percent do not encourage continued development,
4 and 25 percent insufficient information, which
5 means we did not get to the required threshold.

6 CO-CHAIR PINCUS: There's not enough
7 to overturn.

8 MR. AMIN: And so the recommendation
9 remains encourage continued development.

10 CO-CHAIR PINCUS: With lots of
11 comments. Yes.

12 MEMBER GIFFORD: I guess I'm confused.
13 I think the last time -- I thought the threshold
14 was 60 percent for --

15 CO-CHAIR PINCUS: 60 percent to
16 change.

17 MEMBER GIFFORD: Oh.

18 CO-CHAIR PINCUS: Okay. So we have
19 three more measures to go over under the PAC/LTC.
20 So, Jayne, there's two measures that have to do
21 with discharge to community post-acute care that
22 you took off for discussion.

1 MS. CHAMBERS: Right. And I think
2 most of that discussion also was around being
3 sure that these measures are appropriately risk
4 adjusted. We want to be sure they take account
5 of demographic, socio-demographic, status that we
6 felt that we needed additional information to
7 understand better what was going on. We not
8 opposed with them going forward for additional
9 discussion, we just think it's important that the
10 report provide feedback to CMS that they need to
11 --

12 CO-CHAIR PINCUS: By the way, do you
13 have your --

14 MS. CHAMBERS: Sorry.

15 CO-CHAIR PINCUS: If you could speak
16 into the mic.

17 MS. CHAMBERS: Sorry. So we're not
18 opposed to going forward with continued
19 development of these, which is what I think the
20 recommendation is right now. Our concern is that
21 there be appropriate risk adjustment of the
22 measures as they go forward and that CMS further

1 look at the socio-demographic adjustment and
2 what's going on when you discharge to a
3 community, where things are headed, so that was
4 our concern we wanted to be sure was brought out
5 for discussion.

6 CO-CHAIR PINCUS: Are there other
7 comments either in the room or -- well, actually,
8 first, are there any comments from Carole or
9 Gail?

10 DR. FLAMM: This is Carole, I would
11 just add, in thinking about, kind of, the risk
12 adjustment or stratification, possibly
13 considering, you know, sort of, where the patient
14 came from in the pre-acute care setting as part
15 of maybe a stratification approach, or something,
16 in terms of the success of discharging to the
17 community.

18 CO-CHAIR PINCUS: Kevin?

19 DR. LARSEN: A question, are you
20 thinking of risk adjustment by the patient, or by
21 the community, or both? So do you risk adjust
22 that this is a community that's difficult to get

1 services in or is it because the patient doesn't
2 have resources or something specific to the
3 individual?

4 MS. CHAMBERS: Sorry, Kevin, I was
5 trying to figure out where I was in the
6 electronic version.

7 DR. LARSEN: I was just asking if your
8 thinking of risk adjustment at the patient level
9 of socio-economic status at the community level,
10 if the community one that has less resources than
11 another community, or are you doing both risk
12 adjustment by the patient and by the community?

13 MS. CHAMBERS: I think we need to do
14 risk adjustment both by the patient and by the
15 community, and also the setting from which
16 they're coming. I mean, I think it makes a
17 difference where they have been and where they're
18 going, and so it's both the patient and the
19 community.

20 CO-CHAIR PINCUS: David?

21 MEMBER GIFFORD: So a couple comments.

22 One, CMS should think about, right now, if

1 there's a re-hospitalization and a 30-day window
2 after discharge, they don't count, which we
3 support. We would encourage them to maybe add
4 admitting to a SNF in that 30-day window as not
5 counting either as successful discharge.

6 The others, to pile on to the risk
7 adjustment, I just want to make sure the comment
8 on functional status really is critical here.
9 Probably the strongest predictor is your
10 mobility, overall ADL function, to being able to
11 go home and live independently, to need to be
12 able to do that.

13 Secondly, on the -- sorry. Oh, the
14 other issue is that -- and I've seen different
15 versions of this measure, so I'm not sure, I just
16 want to make sure it's on the record --
17 individuals who are residing in a skilled nursing
18 facility as their permanent residence, go to the
19 hospital, then go to LTAC, IRF, or SNF, their
20 discharge is back to a SNF. They should be
21 excluded from this measure because it's not
22 reasonable to expect them to be going back to the

1 community at that point.

2 I've seen different versions where CMS
3 has excluded and has not excluded them with that
4 measure.

5 CO-CHAIR PINCUS: Any other comments
6 either on the phone or in the room? Okay. Now,
7 David, you also added 462 as something for
8 discussion?

9 MEMBER GIFFORD: Bundle them all. I
10 mean, I think the comments are all bundled
11 together. All the comments that were made on the
12 previous two are applicable to 462.

13 CO-CHAIR PINCUS: Okay. Good. So any
14 further discussion about any of the
15 recommendations around the post-acute care, long-
16 term care workgroup? So, Rhonda?

17 MEMBER ANDERSON: I just wanted to add
18 that I think we had said before, and I'd like to
19 underscore it, because I didn't hear it now, that
20 we'd like to see these tested as they proceed,
21 and then be able to go forward with potential
22 implementation, so I don't want to lose that

1 comment that was mentioned before.

2 MEMBER GIFFORD: And can I have my
3 comment of moving towards a measure that's all
4 payer not just fee-for-service for this as well,
5 especially since they all have PAC assessment
6 instruments.

7 CO-CHAIR PINCUS: Okay. So the
8 question has come up, we're about to move to the
9 clinician workgroup report, do people feel the
10 need for a break or should we plow ahead? Plow
11 ahead?

12 PARTICIPANT: Let's plow.

13 CO-CHAIR PINCUS: Okay. Foster?

14 ACTING CO-CHAIR GESTEN: So thanks. I
15 think we're going to start by opening up for
16 public comment, both in the room and then
17 sequentially on the phone. And the public
18 comment that we're inviting is for any issues or
19 comments around the clinician measures and the
20 program, and what we're going to be talking about
21 shortly. So why don't we start with the room.
22 Is there anyone in the room that wants to make a

1 comment, and if so, come up to the mic and
2 introduce yourself.

3 MS. LEE: Theresa Lee with the
4 Alliance for Home Health Quality and Innovation,
5 and I want to thank this group for the time and
6 energy it takes to look at so many different
7 measures that are of critical importance to
8 healthcare. I just wanted to express overall,
9 you know, alignment with Dr. Gifford's concerns
10 and also Jayne Chambers' concerns about some of
11 the IMPACT Act measures.

12 I think that, you know, we all
13 understand that CMS is under tremendous pressure
14 because of legislative timeframes to pursue
15 measures in the domains that are in the IMPACT
16 Act. I think that we continue to be concerned
17 about the speed that this is going forward at.
18 We're supportive of pursuit of these measures.
19 In the home health setting, we recognize that
20 these are very important domains, but we also
21 want to make sure that there is appropriate and
22 adequate time for testing, validation, that

1 things like risk adjustment are addressed very
2 appropriately because -- particularly for some of
3 the ones that involve things like discharge to
4 community, MSPB -- these are really critically
5 important to make sure that we don't provide
6 incentives that could really harm patients.

7 And finally, that kind of testing and
8 validation, afterwards, it really should follow
9 with reporting only to provider communities for
10 at least a year so that everybody has -- all the
11 providers have a chance to make sure that it's
12 looking right before anything is made public. I
13 think that's critically important because we want
14 to make sure that we don't release misleading
15 information to the public and do harm when we're
16 really intending to do good, so thank you very
17 much.

18 ACTING CO-CHAIR GESTEN: Great. Thank
19 you. Any other public comments for the room.
20 Operator, if you can review instructions for
21 folks on the phone if people want to make public
22 comments, again, about the clinician programs,

1 which we're about to, and clinician measures,
2 talk about?

3 OPERATOR: Yes, sir. At this time, if
4 you would like to make a comment, please press
5 star, then the number 1. Okay. You do have a
6 public comment from Sandra Robinson.

7 ACTING CO-CHAIR GESTEN: Go ahead,
8 Sandra.

9 MS. ROBINSON: Yes, hi. I, too, would
10 like to thank you. I've been listening in on the
11 discussion and the sheer breadth of issues that
12 you all are dealing with is astounding, so thank
13 you very much for your time and attention. I
14 wanted to make a comment in support of the non-
15 melanoma skin cancer biopsy reporting time
16 measure.

17 Just a little context on these
18 measures, they're submitted by the American
19 Academy of Dermatology; the majority of skin
20 biopsies are to evaluate skin cancer, and basal
21 cell carcinoma and squamous cell carcinoma are
22 the most common kinds of skin cancer. We

1 submitted two measures, one was a measure about
2 reporting time from the clinician, reporting
3 results to the patient.

4 The one that's on your agenda here is
5 MUC216, which is reporting from the pathologist
6 to the clinician. These measures fulfill gap
7 areas in that there are few measures about skin
8 cancer and there are very few measures for a
9 pathologist to report.

10 In the workgroup discussion and I'm
11 sure you're going to be talking about this, Dr.
12 Bagley, there was quite a lot of discussion about
13 general measures versus measures for specialty
14 care. We think that's an incredibly important
15 discussion that deserves a deeper dialog between
16 CMS, the medical specialty societies, and MAP, so
17 I'm looking forward to hearing what you all say
18 about that.

19 But in essence, the Academy believes
20 there are instances where you should have
21 specialized measures and that this measure of the
22 reporting time for non-melanoma skin cancer

1 biopsies, be careful of that, where they looked
2 at the usual kinds of tests that are required,
3 and the timing of the measures to accommodate
4 that, so I look forward to hearing your
5 discussion and encourage your support.

6 ACTING CO-CHAIR GESTEN: Great. Thank
7 you. Operator, any other questions or comments
8 from the public?

9 OPERATOR: There are no comments at
10 this time.

11 ACTING CO-CHAIR GESTEN: Great. Thank
12 you. Well, before I turn things over to the
13 clinician program chair and staff, I just first
14 want to acknowledge the group and the work that
15 they've done over this interval and to bring
16 forward recommendations, and Bruce Bagley and
17 Eric Whitacre, who are the workgroup co-chairs,
18 and Reva Winkler and Andrew Lyzenga from NQF, who
19 are the staff.

20 So we've been through this once, we've
21 been through the drill once, so now we saw one,
22 we're going to do one, we're going to teach one

1 after, so you kind of get a sense of what the
2 drill's going to be. There's going to be a set
3 of slides that go over some of the general themes
4 and issues that came up in the clinician program
5 group, which Bruce and Eric will take us through.

6 And then following that, we have a
7 list of, currently, nine, but we'll open it up if
8 there are any other measures that folks that are
9 part of the coordinating committee want to pull
10 for discussion or vote, and we'll go through the
11 same sort of process and ask the same questions,
12 beginning with whether based on the conversation
13 we had earlier whether the measure's for vote, we
14 still want to vote or discuss, and if we want to
15 vote, and we'll go through the same process that
16 we just went through, which I think went
17 reasonably well.

18 So why don't I turn things over to
19 Bruce or Eric.

20 WORKING GROUP CO-CHAIR BAGLEY: Well,
21 good afternoon, this is Bruce Bagley, just to say
22 hello, and then have Eric say hello, and I think

1 Reva's going to lead off our presentation, and
2 we'll be working through it together.

3 WORKGROUP CO-CHAIR WHITACRE: This is
4 Eric Whitacre. Thank you very much for the
5 opportunity.

6 MS. WINKLER: Okay. Thanks to Bruce
7 and Eric. This is Reva. We want to present to
8 you the discussion of the measures from the
9 clinician workgroup. I think we can move ahead a
10 couple of slides. The clinician workgroup looked
11 at two programs this year. And most importantly,
12 was the new program that -- the merit-based
13 incentive payment programs -- or MIPS -- that was
14 created as part of the MACRA legislation last
15 year.

16 This new program combines parts of the
17 existing quality programs for clinicians and
18 aligns them into a single program that will be
19 used to adjust physician payment. There are
20 already almost 300 measures in the clinician
21 measure set currently in use in federal programs.
22 And CMS has indicated they will draw from that

1 existing list for the quality portion of MIPS.

2 And so the measures on the
3 consideration list this year were for measures
4 that are for MIPS because they will go into data
5 collection a couple years before MIPS actually
6 comes online as the formal program in 2019.

7 And so there were 58 measures reviewed
8 for this MIPS program. Notably, only four of the
9 measures were fully developed. And so the issues
10 around measures under development was prominent
11 and overarching for the clinician workgroup
12 looking at measures for this program.

13 Now, most of the measures were focused
14 on specialty areas that currently have few
15 measures available for reporting. They have been
16 submitted by medical specialty societies,
17 generally, using registries that are developed or
18 being developed, in often very narrow areas. We
19 saw measures in dermatology, eye care,
20 interventional radiology, gastroenterology,
21 urogynecology, genetic gynecologic oncology, and
22 so you can see that they tended to be very

1 specialized to fill gaps in the clinician measure
2 set for these specialists that really don't have
3 many measures.

4 Next slide, please. The other program
5 that the clinician workgroup addressed is the
6 Medicare shared savings program. And this is a
7 program that's been around for a few years that
8 facilitates coordination and cooperation among
9 providers that are in an ACO. And so there is a
10 strong relationship between clinicians working in
11 ACOs with other physicians.

12 And so the desire to align the
13 measures from the clinician work measure set for
14 the Medicare shared savings program is important.
15 So only five measures were reviewed for the MSSP
16 this year. There were, of the five, two of the
17 measures -- one for falls and advanced care plans
18 -- are already in the existing clinician measure
19 set, are now just under consideration for MSSP.

20 The other three are composite measures
21 -- one an all or none composite for
22 cardiovascular care, and two composite measures

1 for the PQIs --- are on the list for
2 consideration for both the MIPS program and MSSP.

3 So that alignment for the clinician
4 measures has really advanced quite considerably,
5 particularly with the consolidation of the
6 clinician programs into the one.

7 So with that introduction to the
8 programs, I'm going to turn it over to Bruce and
9 Eric to discuss the issues that were overarching
10 and strategic for the clinician workgroup. Next
11 slide, please.

12 WORKING GROUP CO-CHAIR BAGLEY: Okay.
13 This is Bruce Bagley and as Reva just outlined,
14 of course, the MIPS program, the goal, of course,
15 is to combine and integrate and align quality
16 measures into a unified program linking quality
17 to payment levels. And as you're aware, the
18 timeline is that the measures will be finalized
19 by the end of this year, beginning in January
20 2017, data will be collected, and then that data
21 will be analyzed to determine payment levels
22 beginning January 1st of 2019. Most of you are

1 fully aware of that program.

2 At this point, we do want to thank,
3 the clinician workgroup would like to thank, Kate
4 Goodrich and her staff for their active
5 participation and guidance throughout our
6 deliberation. So it was very helpful to have
7 them clarify many of the issues around this new
8 program. Can I have the next slide, please?

9 So Reva also mentioned some of the
10 challenges that we had to deal with because many
11 of the measures were under development,
12 therefore, not completely specified in some
13 cases, and really had not been tried or tested,
14 at least we didn't have information about that.
15 And I think although measure developers were
16 invited to attend the meeting or be available by
17 phone, very few were actually available for real-
18 time Q&A during our deliberations.

19 There were times when the technical
20 details or the clinical implications of a
21 particular measure were unclear and having
22 developer input would have been very helpful.

1 More often, the MAP did not have good information
2 about the real gap in care or opportunity for
3 improvement, which made it difficult to weigh the
4 impact of a measure on the quality or its
5 effectiveness in driving systematic improvement.

6 So some of the measures were also --
7 the measures under consideration seemed to be
8 about compliance with accepted guidelines or
9 standardized treatment protocols. Others
10 outlined an expected outcome from a procedure
11 with no data about how often that outcome is
12 currently achieved, so it seemed like these
13 measures didn't appear to have a lot of impact
14 because of that.

15 And then finally, the workgroup
16 suggested as we continue the development process,
17 we continue to push for patient-oriented outcome
18 measures and composite measures that are more
19 likely to drive systematic improvement at the
20 point of care.

21 Can I have the next slide, please?

22 This probably, this slide, brings up a much

1 larger issue and that is, the need for eligible
2 providers to have NQF-endorsed or CMS-approved
3 measures as "a condition for participation" in a
4 CMS MIPS program has generated a plethora of
5 narrowly-focused, mostly process-oriented
6 measures that are unlikely to have broad impact
7 on patients, or for that matter, on population.

8 So I think that that's something that
9 we're going to have to struggle with in the
10 future, and you'll see it reflected in some of
11 our questions at the end of our presentation.

12 The other thing is that there seems to
13 be a little bit of a disconnect between the
14 national quality strategy six priorities, which,
15 by the way, are very patient-centric. And the
16 long list of provider-centric measures that we
17 have under consideration, again, a much bigger
18 issue than we have time to resolve this
19 afternoon, but it continues to be an issue about
20 how effective the measures that we endorse or
21 approve will be in the improving quality.

22 So can I have the next slide, please,

1 and I think this is where Eric will talk about
2 some of the specific discussions that we had.

3 WORKGROUP CO-CHAIR WHITACRE: Thank
4 you, Bruce, and again, thank you for the
5 opportunity to present. I'd like to take just a
6 couple minutes to go over some of the more
7 important or salient discussions we had centered
8 around only a handful of measures on the MUC
9 list. The first, and this was quite remarkable,
10 had to do with non-recommended PSA screening.

11 In 2012, the USPSTF gave routine PSA
12 screening as a screen for prostate cancer a Grade
13 D recommendation. Any measure development was on
14 the MUC list and met with just a firestorm of
15 controversial comment and criticism. This came
16 from multiple professional organizations and
17 major cancer centers, and for that reason,
18 despite, perhaps, the science -- and as a breast
19 surgeon, I was reminded of recommendations
20 concerning screening mammography -- we felt that
21 the measure would not be effectively implemented,
22 and therefore, didn't encourage further

1 development of this measure in its current form.

2 Perhaps over time, phrased differently
3 or with appropriate risk adjustment, it could be
4 brought back and would be more acceptable just as
5 the mammography guidelines were a couple years
6 later.

7 And the other extreme was the measure
8 concerning potential opioid overuse. Everyone
9 recognizes this as a serious public health
10 problem that needs to be addressed. This has to
11 do with the number of patients who receive more
12 than 90 days of a 90 milligram equivalent of
13 morphine.

14 The time period was thought to be
15 important in order to take the post-operative
16 recovery and patient out of that window, but
17 there were concerns about the actual dosage, and
18 this was raised by a number of members, and there
19 was a concern from palliative care organizations
20 during the comment period that the measure could
21 limit appropriate end of care and palliative use,
22 although very honestly, that is listed as an

1 exemption from the measure, so it would not
2 apply.

3 Here again, we continued -- encourage,
4 rather, continued development, although that was
5 with a sense that this is really, really
6 important and should be done. Could I have the
7 next slide, please?

8 The next set of measures have to do
9 with the potential quality indicator composites,
10 and these were an issue -- and I'll jump down to
11 the bottom part of the slide because these were
12 originally developed by AHRQ for population-based
13 measurement. And the question was whether these
14 would be appropriate for ACOs and the Medicare
15 shared savings program or for clinicians because
16 these measures were being considered for both
17 shared savings and MIPS.

18 And there were questions of
19 appropriate attribution, weighting, risk
20 assessment, socio-demographic factors, in
21 particular, and going back to the top of the
22 slide, there was some concern that the acute

1 conditions -- and just as a reminder, these
2 concern bacterial pneumonia, dehydration, and UTI
3 -- would lead to inappropriate use of antibiotics
4 in order to avoid potentially being dinged for
5 such an admission.

6 At the other end, the chronic
7 conditions, which were largely complications of
8 diabetes, COPD, asthma, and angina, would be
9 tremendously affected by socio-demographic
10 factors. Still, it was pointed out to us that
11 some of these components are already in use at
12 the clinician level. Several of these measures
13 are being used in calculating the quality
14 resource utilization reports -- the QRURs --
15 which lead directly into the value-based payment
16 modifier.

17 So they're effectively being used at
18 that level, but the workgroup felt that it was
19 important to feel confident that population-based
20 measures were being appropriately applied at the
21 ACO and clinician level. Could I have the next
22 slide, please?

1 The next two measures were important
2 because one is already an NQF-endorsed measure,
3 and that is the proportion of patients who died
4 from cancer who were admitted to Hospice, but
5 stayed there for less than three days. This was
6 widely supported. The discussion here was
7 whether or not the three-day window was
8 appropriate, and interestingly, that discussion
9 actually took place during the NQF endorsement
10 and assessment.

11 Because this is being reviewed in the
12 upcoming cancer project, the workgroup decided to
13 effectively take the recommendation of the NQF
14 review as the recommendation, although this
15 measure was effectively supported as is. A
16 similar condition existed for one of the vascular
17 all-or-none outcome measures.

18 It seems that the NQF already has an
19 optimal vascular care measure, which is currently
20 undergoing review as well. The MUC measure for
21 ischemic vascular disease all-or-none outcome was
22 very, very similar to the existing NQF measure,

1 and the workgroup felt that it would be best to
2 let the NQF make the comparison and choose the
3 better of the two measures, with the caveat that
4 it was extremely important to implement a
5 composite measure.

6 There was a strong feeling that while
7 it's possible to achieve optimal outcomes on one
8 component of this composite measure, it was very
9 important to bring the totality together, and
10 that one of the two measures should be endorsed.
11 Could I have the next slide, please?

12 Lastly, during this year's clinician
13 workgroup meeting, we were asked to assess the
14 presentation of public reporting information,
15 understanding that all PTRS, MIPS, and shared
16 savings measures are available somewhere for
17 public reporting because Physician Compare is
18 ramping up and there is an opportunity to make
19 some of this information very visible when the
20 patients and other users click on the pages.

21 We were asked to give some direction
22 as to what should be prominently displayed and

1 readily accessible on the physician compare site
2 compared to information that would be available
3 in downloadable documents. And during the course
4 of the meeting, the workgroup adhered to the
5 principles which had previously been outlined for
6 assessing measures for Physician Compare, and
7 that included measures which were based on
8 outcomes, patient-reported outcomes, composites,
9 appropriateness, measures that were readily
10 understood by the public, but there was a
11 discussion which did clearly emphasize that there
12 are times when very detailed, specific
13 information would be of value to the user.

14 And this had to do with some very
15 specific, say, ophthalmology outcomes, we
16 discussed during the meeting some very detailed
17 specialty specific information, and this is
18 something that came home to me recently when a
19 family member needed surgery for a cholesteatoma.
20 I needed to know, what's the facial nerve, you
21 know, outcome result? What's the result in terms
22 of hearing and so forth?

1 So balancing the information displayed
2 publicly, and yet, making the other information,
3 essentially, readily available was also thought
4 to be important. And I think at this point,
5 Bruce or Reva, we're going back to a general
6 overview?

7 ACTING CO-CHAIR GESTEN: The slide is
8 regarding dual-eligible beneficiary input. Is
9 there somebody who's going to --

10 MS. O'ROURKE: Yes, Debjani, are you -

11 -

12 MS. MUKHERJEE: Yes, can you hear me?

13 ACTING CO-CHAIR GESTEN: Yes. Go
14 ahead.

15 MS. MUKHERJEE: This is Debjani
16 Mukherjee. I'm the senior director for the dual-
17 eligible beneficiaries workgroup and we thank the
18 committee for being able to provide some
19 perspective on the clinician recommendations. We
20 would like to push for including a present goal
21 of care into measurement, while recognizing that
22 this very difficult with current measurement

1 science, we would like it to be more patient-
2 centered and our duals are a very special
3 population with multiple needs, and so we wanted
4 to highlight that.

5 Secondly, we would like to recommend
6 re-evaluating clinical practice guidelines with
7 appropriateness for high-risk populations. And
8 by that we mean that we would like to move away
9 from measures of tight control of clinical values
10 that may have unintended consequences for
11 individuals with multiple chronic conditions, be
12 able to sort of incorporate the patient's
13 perspective as well as, sort of, goals when
14 determining what kind of control a measure is to
15 use, as well as incorporate appropriate
16 exclusions in the current available measures.

17 And finally, we would like to second
18 as well as accelerate the development of
19 consumer-facing quality measures where the
20 patient, sort of, has a face and, sort of, is the
21 person to, sort of, determine which way their
22 care goes. And thanks. I think that's the only

1 slide we have for this one.

2 ACTING CO-CHAIR GESTEN: Great. So
3 there are three discussion questions that are
4 teed up. Should I go through? Okay. So, first
5 of all, thank you all for the presentations. I'm
6 struck by the themes that keep coming up again
7 and again with each of the workgroups, the issue
8 of the challenge of filling gaps -- in this case,
9 gaps for certain physicians, or conditions, and
10 what's good -- the desire to fill the gap, the
11 desire to fill it with something meaningful.

12 The issues about the appropriate
13 entity, accountable entity, came up in the
14 population health measures and whether it's
15 appropriate for physicians, the value and
16 importance of composite measures, and as well as,
17 in the last presentation, patient-centered
18 measures and the issue of potentially unintended
19 consequences relative to certain guidelines and
20 measures that spring from those.

21 So we have the questions that we can
22 deliberate on that, how do we balance the issue

1 of wanting to have a wide number of measures
2 applicable to a broad amount of specialty care
3 and specialty providers, versus trying to have,
4 you know, a parsimonious and limited number of
5 measures that can apply to a broad population.

6 There are issues related to the timing
7 of guidelines as they change, and what's
8 appropriate in terms of integrating them, making
9 changes in measurement efforts, and then how do
10 we think about -- and we talked about this some
11 this morning -- evaluating these measures,
12 particularly ones which are very new, to sort out
13 what the opportunity is for improvement, and I
14 think that that's a challenge with lots of the
15 new measures under development, so would invite
16 any conversation both on the phone or in the room
17 around any of these issues, or clarifying
18 questions from the presentation.

19 I think I saw, David, your card up
20 first and then Rhonda. David, no? That was old?
21 Rhonda? Old. Okay. Harold, then Marshall.

22 CO-CHAIR PINCUS: A couple of times I

1 heard allusions to the issue of registries, and I
2 wonder if members of the workgroup might want to
3 comment on how those are being handled and also
4 hearing a little bit from CMS, because I mean,
5 registries seem like an ideal model for how to
6 capture quality related information, you know,
7 especially the chronic disease or for, you know,
8 follow-up after acute incidents, but they are
9 generally very highly specific, so it kind of
10 goes with, you know, that first bullet.

11 WORKING GROUP CO-CHAIR BAGLEY: This
12 is Bruce Bagley, maybe I could I just comment. I
13 think that there's kind of a misunderstanding
14 about at what level a registry might be used. I
15 think that most of the registries record
16 information that then is aggregated and
17 standardized and then fed back at some later time
18 to the clinicians.

19 When we're really thinking about
20 proactively managing chronic illness, it really
21 needs to be a point-of-care registry where the
22 registry is available showing gaps in care during

1 any encounter with a patient. So I agree with
2 you. I think that registries are a tremendously
3 powerful tool, but we don't -- at least up until
4 now -- have enough support from our electronics
5 and IT to get that point of care concept, so yes,
6 we've got a ways to go.

7 ACTING CO-CHAIR GESTEN: Kate, did you
8 want to comment as well?

9 DR. GOODRICH: Sure. Just to remind
10 folks how those are used in our programs, and I
11 agree with what Bruce just said. So we have two
12 registry recording options within the PQRS
13 program, which will translate over very lovely
14 into the MIPS program. One is what we call our
15 traditional registry, so these tend to be
16 organizations. Well, you have some that are like
17 ACC and STS that have been around a long time,
18 very sophisticated, lots of really good outcome
19 measures that a high proportion of their
20 membership uses, and those are very valuable.

21 We also have a lot of registries that,
22 sort of, exist for the purpose of collecting PQRS

1 measures as a service for clinicians to send data
2 in to CMS, whether those data be based upon
3 mining claims or actual abstraction from a paper
4 or electronic chart. All of that is out there.

5 And then there's something called the
6 qualified clinical data registry, which came
7 about as a result of the American Taxpayer Relief
8 Act, which required CMS to develop a mechanism to
9 allow clinicians who are submitting data to a
10 registry for another purpose -- so their
11 specialty society registry, their board, what
12 have you, a local quality collaborative -- for
13 those data to also be used for CMS payment
14 purposes, so for PQRS value modifier, going
15 forward, MIPS.

16 The MACRA legislation further
17 emphasizes the use of these QCDRs, as we call
18 them. We have now one year of experience with
19 the QCDRs, as we call them. And we have ones
20 that, again, this is the minority, that are sort
21 of the more advanced, have been around a long
22 time, really know what they're doing, and we have

1 others that are coming along that are probably
2 more in their learning, so it's a really spectrum
3 of what's out there right now, I would say.

4 I think we do -- well we definitely do
5 see use of registries as our, probably, most
6 rapidly growing submission mechanism, but it
7 definitely, I would say, is in its earlier stages
8 as, sort of, Bruce was just describing, in terms
9 of the kind of data that are abstracted, validity
10 of the data, the need for it to be useful at the
11 point of care.

12 The other thing that MACRA does is to
13 address the point that Bruce was making about the
14 need to be able to use registries -- not just to
15 collect data elements and send them to CMS,
16 that's one thing, but to actually be able to use
17 the registries to improve the health of the
18 patient panel, patient population, to be able to
19 be used as a tool for quality improvement, and
20 that is one of the interesting things that MACRA
21 does, it actually is very clear about us putting
22 requirements, or the possibility anyway, in place

1 for incentivizing the use of registries for that
2 purpose, through the clinical practice
3 improvement activities piece of the new MIPS
4 program.

5 So we are actively thinking about how
6 we can tie together the four different components
7 of the MIPS program so they actually work in
8 concert with one another, but in particular,
9 around qualified clinical data registries as a
10 tool for reporting measures, but also for finding
11 ways to incentivize their use as a tool for
12 improvement.

13 ACTING CO-CHAIR GESTEN: Okay. Thank
14 you, Kate. Marshall? Kevin, did you want to --
15 I know you probably want to add on to registries.

16 DR. LARSEN: Yes. Just some addition
17 on the electronic component, so we know that a
18 number of registries actually do get a live data
19 feed from their electronic health records, and
20 some of those are at scale, for example, the
21 American Academy of Ophthalmology has, you know,
22 like, almost 50 percent of ophthalmologists live

1 with data feeds into their registry.

2 What we're learning from that is that
3 not only are those registries able to provide
4 this level of point of care support for care
5 gaps, they also are rapidly becoming a measure
6 development engine in and of themselves, and I
7 think the question for the MAP is going to be at
8 what level should those measures stay localized
9 within a registry and what level they should be -
10 - where's the bar for when they get raised up as
11 important enough or studied enough to be part of
12 a policy program?

13 Because the most robust of these have
14 really incredible data analytics expertise and
15 they can sometimes do hundreds of little small
16 measures that are very helpful for those
17 practices and for managing that specific work.

18 And the clearer it is which of the
19 things out of that huge analytics capability that
20 they have should become national measures for
21 national programs, the better chance they'll of
22 proposing those as opposed to proposing something

1 else.

2 So to my mind, that's the kind of
3 strategic question. For us, that work is going
4 to happen, it should happen, it will happen.
5 When does it get here, and when does it stay
6 within those registries as part of quality
7 improvement as opposed to measures in federal
8 programs?

9 ACTING CO-CHAIR GESTEN: Great.
10 Marshall?

11 DR. CHIN: Yes, I wanted to follow-up
12 on the excellent comment from the dual-eligibles
13 group about individualization of care, which they
14 gave in the context of the multiple chronic
15 disease group, but it applies more generally just
16 to the geriatric group. And so especially for
17 the CMS measurement, it's still predominantly 65
18 and older.

19 As a whole, the performance measures
20 that NQF and CMS have used haven't really caught
21 up to the rest of the clinical field about the
22 individualization of the older patient, and it's

1 because I think somebody said this is relatively
2 new. I mean, like -- using diabetes as an
3 example -- 15 years ago, the clinical practice
4 guidelines didn't mention geriatric at all, 10
5 years, this is central too about the geriatric
6 issues, to like the most recent guidelines from
7 two or three years ago are pretty specific about
8 different risk stratification categories and who
9 you should be aggressive with and who you
10 shouldn't be aggressive with.

11 And it goes both ways that mostly, as
12 mentioned by the development group, not wanting
13 to be too aggressive on the frail folks where,
14 you know, life expectancy, high glycemic control
15 is going to be the least of the issues, and the
16 fact localized is probably going to be the bigger
17 issue over treatment.

18 And it goes the other way too of the
19 healthy 65-year-old person where you should be
20 aggressive, and so that you're supposed to have
21 different clinical guidelines, but CMS and NQF,
22 you know, we need to make sure that we are

1 staying up with this, because otherwise there's
2 going to be a lot of very bad unintended
3 consequences of providers, organizations, meeting
4 performance measures and payment, but really not
5 being an interest of patients.

6 ACTING CO-CHAIR GESTEN: Thanks.

7 Lisa.

8 MEMBER McGIFFERT: I just had a
9 question about the registries. I don't know a
10 whole lot about them. I know some about them.
11 They all seem to be privately controlled and I
12 wonder, it sounds like CMS is working with them
13 and that there can be an exchange of information,
14 but I'm not sure what kind of assurances for
15 quality control of the data, for revealing the
16 data to the public at clinician level, or are we
17 just talking about group levels?

18 I totally am glad to see registries
19 building up, but the information is pretty
20 inaccessible to the public.

21 ACTING CO-CHAIR GESTEN: Kate, do you
22 want to brief?

1 DR. GOODRICH: Yes, I can address
2 that. So there are actually parameters laid out
3 in the legislation that authorize this around
4 transparency of information. And so in terms of,
5 you know, the measures, and the risk adjustment
6 methodologies, and all that, we do require -- we
7 have a number of parameters we've laid out in
8 regulation, and sub-regulatorily, around what the
9 QCDRs have to do to be qualified as a QCDR.

10 You know, there's a lot in there
11 around transparency. Now, having said that, that
12 means that they have to publish everything that
13 they have in their registry, essentially, on a
14 Web site. Can a consumer go and find that Web
15 site? I'm sure they can Google it and find it,
16 but it's not, like, right there in front of you,
17 right? So that's one thing.

18 I would say that on the data accuracy
19 part, we definitely had a significant learning
20 curve, along with the registries this past year,
21 on data validity and accuracy, and a lot of the
22 data were not usable. We didn't use the data for

1 anything. It wasn't very good data -- not across
2 the board, but for some.

3 But what came out of that was quite a
4 few lessons learned; we had, like, a two-day
5 summit with the registries and the EHR vendors on
6 how to fix the issues that we all found that were
7 on both sides -- both CMS and the registries --
8 and we think we fixed a lot of those, but it's
9 going to be a learning curve as we go along, but
10 I think we're in a better place than we were
11 before.

12 And finally, we are required to make
13 measure information available, publicly
14 available, on Physician Compare. We have made
15 clear in our regulations, we will be publicly
16 recording the measures that come out of the
17 QCDRs, even if they're not part of the core, sort
18 of, PQRS/MIPS, you know, set measures, so that
19 information will be made publicly available, you
20 know, as we have already talked about in our
21 regulations.

22 Regarding the individual level versus

1 group level, as you know, the way the programs
2 have worked, and this has been a tension, is that
3 clinicians can choose whether to report at the
4 individual level or to report at the group level.
5 What that means is that when a group of
6 physicians report to us, they report as a group
7 aggregated up.

8 So we do not report publicly
9 individual clinician data when they're reporting
10 as a group. I think it's a tension we're still
11 trying to think about how we can work out, given
12 those options that we currently have, because we
13 know from the consumer and patient community they
14 very much want individual level data, so we do
15 understand that, so I think that's something we
16 are still trying to think about how we can work
17 through when they report at the group level.

18 That may be more information than
19 anybody wanted, but there you have it.

20 ACTING CO-CHAIR GESTEN: Thanks, Kate.
21 We're really giving you a workout today. We're
22 getting our money's worth. Barry?

1 MEMBER NOONE: I'd like to ask Kate,
2 thank you, how many of the independent
3 organizations actually go to the Web site and
4 enter data? That's my first question. And then
5 because there are a tremendous amount of
6 innumerable registries out there, medical
7 societies, certifying boards, independent
8 organizations that look at the quality of
9 ambulatory surgical facilities, national
10 organizations, such as NSQIP, which looks --
11 started with the VA system, but many hospitals
12 participated in the national surgical quality
13 insurance program.

14 So how does Medicare get that data?
15 Do these groups actually use it -- use your Web
16 site?

17 DR. GOODRICH: So let me be clear what
18 I meant by posting on a Web site. What we
19 require each registry to do is to have all of the
20 information about their measures that are within
21 the registry that physicians and clinicians can
22 report on on their Web site; every detail about

1 the specifications, the risk adjustment, et
2 cetera.

3 When the data on physician
4 performance, or group level performance, comes in
5 to us, what we will ultimately do -- and we
6 haven't yet because we've only had this method
7 for one year -- is ultimately, where we have
8 valid and reliable data, we will post performance
9 information on Physician Compare, which is
10 required by law for us to do.

11 So the database sent us for use for
12 the new MIPS program, so to effect to their
13 payment, will also be the data that are used for
14 public reporting, and that sort of gets back to
15 the discussion that we had at the clinician
16 workgroup, which was: what's the most useful
17 information to have on Physician Compare that's
18 meaningful to consumers?

19 Understanding, no matter what, for all
20 valid and reliable data, we're going to put it up
21 at least in a database that people can download,
22 but what is actually best for consumers to be

1 able to go and look at to compare, you know, one
2 provider or one group practice to another, like
3 in the star rating format, for example. I don't
4 know if that answers your question or not.

5 MEMBER NOONE: I was just wondering
6 how many people really respond to that. Sure,
7 you can put data in there about individual
8 physicians in your group, or in whatever registry
9 you're using, but does everyone respond to that?

10 DR. GOODRICH: When you say everyone,
11 do you mean like consumers going to look for
12 information?

13 MEMBER NOONE: No, not consumers, but
14 medical organizations, for example, specialty
15 societies. There are lots of them who have
16 registries going. What is their impetus to put
17 the data on the Medicare Web site?

18 DR. GOODRICH: Well, we put it on the
19 Web site; they don't.

20 MEMBER NOONE: Okay.

21 DR. GOODRICH: So if a clinician or an
22 ophthalmologist, you know, wants to use the IRIS

1 registry that AAO has to report their measure
2 information for the purpose of PQRS, or in the
3 future, MIPS, those data will go up on Physician
4 Compare. We, by law, have to do that. We make
5 that very clear in our regulations. That's,
6 again, if it's valid and reliable. We have to do
7 that testing to be sure that it is.

8 So I guess the impetus goes back a
9 little farther than that -- what's the incentive,
10 or impetus, for a physician to participate in a
11 CMS-quality program? Some of that's financial,
12 because if they don't participate, they get the
13 maximum downward adjustment, but along with that
14 does come public reporting, just as it does on
15 the hospital side and for every other facility as
16 well.

17 ACTING CO-CHAIR GESTEN: Right. I
18 assume the alignment issue is around getting a
19 two-fer -- that is, if physicians are already
20 reporting to registry, why not use that process,
21 right? That's the intent.

22 DR. GOODRICH: That is exactly right,

1 yes.

2 ACTING CO-CHAIR GESTEN: Jayne?

3 MS. CHAMBERS: So building on this
4 conversation and some of Kevin's remarks earlier,
5 one of the things, I think, from a hospital
6 perspective that we've been concerned about is
7 the data accuracy and validity that are in the
8 registry, so I'm glad that that's being addressed
9 and that, Kate, you addressed that, that the
10 agency is looking at how you evaluate the data
11 accuracy and validity.

12 And then I think the other question is
13 -- and because I'm married to an eyeball guy, I
14 know a little bit about the ophthalmology
15 registry -- I question whether some of the
16 measures that are in there, many of them are
17 appropriate for quality improvement and for
18 quality control within their own organizations,
19 they're not necessarily usable for comparative
20 purposes across entities.

21 And so I think that's one of the other
22 issues we really need to struggle with as we look

1 at registry development.

2 ACTING CO-CHAIR GESTEN: Thank you.
3 Frank, I know you've been waiting patiently.

4 MEMBER OPELKA: Yes, there's been a
5 couple conversations that have piled on, so I'm
6 going to try and hook these all together into one
7 stream of thought, and I'm going back to the
8 dual-eligibles, and I really applaud the comment
9 that they made. We think that this actually goes
10 into these clinical metrics that are being
11 discussed in terms of registries, but we think
12 the issue of what's happening in the clinical
13 data ecosystem, registries represent only a small
14 piece of that.

15 So first of all, we applaud a patient-
16 centric approach rather than a payer program-
17 centric approach, so within the domains of
18 surgery, we would think of cholecystectomy as
19 measurement that has to go across PCP, surgery,
20 anesthesia, and so forth. Appendicitis would
21 hook emergency care together with surgical care
22 and anesthesia, and cancer care would even be

1 more broadly considered, that we ought to be
2 thinking and building these MAP programs along
3 clinical service lines that map to the patient-
4 centric solutions that were outlined in the dual-
5 eligibles, with goals and care plans, and things
6 of that sort as being part of the metrics.

7 And we think that is a very good place
8 to go. I realize where we started, but what
9 makes sense to most clinicians is not the program
10 we're in, they're very frustrated by that program
11 and they're thinking in more clinical patient
12 terms. In terms of these registries, they have
13 made leaps and bounds, but they're a little bit
14 after the fact for the most part, and I think
15 Bruce was talking about real-time analytics --
16 and I think Kevin referred to this as well -- it
17 is these new clinical applications that are
18 emerging in the clinical data ecosystem that need
19 to be planned and mapped out into where we go in
20 measuring process, and outcomes, and preventable
21 harms, and safety, and care.

22 And there's a part of the NQF that has

1 a significant role in validating those algorithms
2 that are part of this. If we don't get started
3 on it now, we'll never catch up to it. There's
4 also part of the MAP that has to move to it, and
5 I think Kevin hit it on the head, that these
6 things are going to bubble-up relatively quickly
7 because they're in programs.

8 And as they bubble-up, we need
9 processes different than we have in the NQF today
10 to look at how these measurement sciences map to
11 what was said by the dual-eligible groups because
12 that makes more sense to us as we look at this as
13 clinicians, and I'll end there.

14 ACTING CO-CHAIR GESTEN: Thank you.

15 David?

16 DR. BAKER: My question was for Kate,
17 again, on the registry issue. Have you
18 established criteria for deciding how good does
19 the data need to be before you can use it for
20 accountability, payment programs, and public
21 reporting? So for example, with SDS, I talked
22 with David, and they do a 10 percent audit to

1 confirm the data accuracy, and they also -- this
2 is, I think, very impressive -- they do an
3 assessment of the completeness by linking it to
4 billing data. I'm not sure how they do that, but
5 that's been a concern for us since we talked to
6 AHA, and we heard that they do not require
7 complete reporting for the guidelines.

8 So I'd be interested in hearing that
9 and also, whether this is something that maybe
10 MAP should weigh-in on and try and really, you
11 know, get clear criteria from that.

12 DR. GOODRICH: I would welcome that,
13 first of all. So we did have criteria for the
14 first year, I don't think they were as rigorous
15 as what SDS has done. Now having a year of
16 experience under our belt, we are revising those
17 criteria for a lot of different things, but
18 absolutely around the data validity and accuracy.
19 And we've definitely had conversations with the
20 more advanced registries to understand what
21 they're doing.

22 I don't know what they are off the top

1 of my head, but that is very much on our minds,
2 and we'll definitely be evolving for even this
3 next upcoming reporting period, I think. But I
4 definitely would welcome input on that. No
5 question.

6 DR. BAKER: Sorry for jumping in,
7 because I forgot to mention, the patient reported
8 outcomes, this is also key, because in talking
9 with the American Joint Replacement Registry, the
10 pilots they've done, they've had very low
11 participation rates, as low as like 30 percent,
12 but yet, the FORCE Registry for Joint
13 Replacement, they say they're getting, you know,
14 85-90 percent, and that's the follow-up
15 assessment as well as the pre-assessment.

16 So that would be another really
17 important area to weigh-in and some methodologic
18 challenge in dealing with, you know, the non-
19 response parts.

20 ACTING CO-CHAIR GESTEN: Kevin.

21 DR. LARSEN: Yes, I'll just add on to
22 that, as we've had a lot of conversations with

1 registries, they're really interested in being
2 part of the solution here, and they're looking
3 for standards and recommendations, so we just
4 take something like risk adjustment, they are
5 going to be figuring out risk adjustment, maybe
6 they have figured out risk adjustment, but unless
7 there's some recommendation about an approach and
8 the kind of data that should be collected
9 routinely, we will get a different risk
10 adjustment model for each and every registry
11 that's out there, even if they're measuring the
12 same thing.

13 So we've done a little bit of work
14 with, also, the joint registries around
15 functional status, outcomes after knee and hip
16 surgery, and without some careful coordination,
17 each registry will do it their own way because
18 the natural character of it is to build what your
19 stakeholders and your group think makes sense.

20 They're very willing to coordinate,
21 but the clearer the recommendations are and the
22 direction to head, the better chance we have of

1 getting to a place I think that we want to be,
2 which is a consistent approach for things like
3 risk adjustment and attribution, the kind of
4 things we mentioned earlier.

5 ACTING CO-CHAIR GESTEN: Okay. Well,
6 you've managed to delay having a conversation
7 about specific measures by having a really
8 important and productive, and rich, conversation
9 around both the questions that were posed here,
10 but a whole host of other things, so thank you,
11 everybody, the clinician workgroup for teeing
12 them up, and for the group for having such a
13 great conversation illuminating so many important
14 issues.

15 So let me just go through the process
16 again so that we're clear. We have nine measures
17 that were identified for a vote, and they may
18 change and become a discussion item, we'll see as
19 we go through and ask the individual who pulled
20 them. For folks who pulled measures -- and I see
21 Sam and Amir, and Lisa, and Elizabeth -- get
22 ready, because we're going to ask you to voice

1 your concern and issue soon.

2 That'll be followed by -- we have lead
3 discussants in Amir and Lisa, obviously, there
4 are measures, Amir, that you have, we'll ask for
5 Lisa to start out the discussion, invite other
6 folks to discuss as well, and then if we're
7 heading towards a vote, then we'll take the votes
8 in the way that we did in the previous section.

9 Let me just start, though, by asking
10 whether any of the coordinating committee members
11 have any additional, and I'm not asking you to do
12 this, but just creating an opening. Measures to
13 be pulled from the consent calendar for either
14 vote or discussion, now's the time to mention
15 them. Kevin?

16 DR. LARSEN: Yes, not to really pull
17 it for a vote, but just a quick comment on one,
18 the opioid measure, and the quick comment is that
19 the Secretary's convened the states around the
20 issue of opioid overuse, and many states are
21 building, and already have in place, a similar
22 measure, but each state, again, is building their

1 own.

2 And so even though that measure didn't
3 get supported here, just to let you know that
4 state-by-state-by-state, it's getting built, and
5 that with a different specification state to
6 state for looking at which providers are
7 prescribing, potentially, too much opiates, so
8 that's just more to highlight that as we're going
9 to have 50 versions rather than one.

10 ACTING CO-CHAIR GESTEN: Okay.

11 MEMBER BARTON: This is Mary Barton.
12 Kevin, I would support that, then, bringing it up
13 for a vote.

14 ACTING CO-CHAIR GESTEN: So, Mary,
15 you'd like to make a motion -- you'd like to
16 bring that one up for a vote.

17 MEMBER BARTON: Well, given that
18 information about the environment and the
19 likelihood of there being a proliferation of
20 measures that do not align with each other, as
21 one of the early members of the NQF alignment
22 workgroup, yes, I would say that's an untenable

1 situation, and we should, instead, do whatever we
2 can do to encourage CMS to lay down the template
3 and say, everybody start with this.

4 ACTING CO-CHAIR GESTEN: Can someone
5 on the staff just label for us what that number
6 is? Which measure are we talking about?

7 MR. AMIN: It would be helpful if
8 who's raising it -- I mean, Amir has got four
9 additional, 210, 211, 220, and 1082, but this
10 additional measure, I'm actually not following
11 what number that is myself.

12 MS. WINKLER: Hi. This is Reva.
13 Foster?

14 ACTING CO-CHAIR GESTEN: Yes.

15 MS. WINKLER: Yes, it's MUC 151169,
16 potential of opioid overuse, and the
17 recommendation out of the workgroup was to
18 encourage further development.

19 ACTING CO-CHAIR GESTEN: Thanks, Reva.
20 That wasn't totally clear from the workgroup
21 presentation.

22 DR. LARSEN: Yes, this is Kevin. I

1 apologize. I had thought it wasn't supported
2 and, so I must have misread the supporting
3 material.

4 ACTING CO-CHAIR GESTEN: Okay.
5 Taroon, you mentioned that there were some others
6 added, and I don't think I -- I have -- which
7 ones did you mention?

8 MR. AMIN: So we can add them to the
9 bottom of the list if that makes sense: 210, 211,
10 220, and 1082. Is that correct, Amir? Am I
11 missing any?

12 ACTING CO-CHAIR GESTEN: Okay. So we
13 have four more to the nine.

14 MR. AMIN: Yes, you have 13.

15 ACTING CO-CHAIR GESTEN: Okay. Are
16 these all from you, Amir? Okay. That's all
17 right.

18 CO-CHAIR PINCUS: Just to be clear, do
19 we need to anymore discussion for the opioid
20 measure or is it --

21 DR. LARSEN: No, I had misread it. I
22 thought they had not supported further

1 development, and it sounds like they had, so I
2 apologize.

3 CO-CHAIR PINCUS: I guess you already
4 added some to the discussion.

5 ACTING CO-CHAIR GESTEN: Okay. So why
6 don't we proceed, and we'll start going down the
7 measures that I have currently on my list for a
8 vote, and they start with the MUC 212, which is
9 surveillance colonoscopy for dysplasia and
10 colonic Crohn's disease, and this was pulled by
11 Sam. First, let me just ask, Sam, do you still
12 want to bring this up for a vote?

13 MEMBER LIN: Well, here's -- yes.
14 Well, yes and no. Let me try to respond to that
15 correctly. The discussion this morning was
16 extremely helpful with regards to what a quality
17 -- the definitions or limitations of the concept
18 called encourage continued development, and that
19 was part of our issue in trying to understand
20 what that meant.

21 I mean, our interest in pulling some
22 of these was to ensure that select, what I'll

1 call concerns or parameters are included in the
2 continued development, and this is similar to, as
3 many of you know in the association, at the House
4 of Delegates, some of the things that are passed
5 are tasked for referral for study, some are
6 referral for action, but the most important part
7 is a little clause that may or may not come up
8 that says, and refer for study, refer for study
9 and report, so it doesn't go into a dark hole.

10 And so that was our concern was that
11 there's some issues here we thought that, you
12 know, we support the proposed MAP recommendation,
13 but we want to ensure that certain things are
14 looked at in this continued development, rather
15 than uh-huh, yes, one of those kind of things.

16 So that's a non-answer to your
17 question because, you know, in some of these it's
18 just a matter of saying, can we get certain
19 parameters included in that continued
20 development?

21 ACTING CO-CHAIR GESTEN: Sam, that is
22 helpful, but when I look at this measure, the

1 workgroup recommendation was one of do not
2 encourage further consideration.

3 MEMBER LIN: Yes. There are two to
4 three that come up before --

5 ACTING CO-CHAIR GESTEN: Okay. I'm
6 sorry. So we're starting with 212, and we'll
7 take them in order, because you may have
8 different answers to the question based on which
9 measure it is, so starting at the top of my list
10 is MUC212, which is the surveillance colonoscopy
11 for dysplasia and Crohn's disease, and that
12 workgroup recommendation was do not encourage
13 further consideration, and you had pulled this
14 one.

15 MEMBER LIN: Yes, sir, we did. And
16 the reason for pulling that one is that, one,
17 there aren't that many specialty metrics to start
18 off with, so this was one that might fit into
19 that category, so that we're not just totally
20 into primary care or preventative medicine.

21 The second part was that in trying to
22 read and understand the workgroup rationale, the

1 American Society for Gastrointestinal Endoscopy
2 guidelines that are referenced recommends -- it
3 seems like it recommends this kind of a measure,
4 and yet, further down they sort of comment
5 referring not about the measure, but more about
6 the concern that this might promote utilization,
7 and it seems to me those are, sort of, two
8 different things.

9 It's utilization for whom. And then
10 probably the overriding issue is that you've got
11 to have baselines, and so it's important to have
12 a baseline so that you know where you've been
13 when you come to another point. And so with all
14 this, it was sort of like it was a little bit
15 confusing, so we sort of felt that rather than
16 dropping it because of these -- I think the
17 recommendation, proposed recommendation, is do
18 not encourage further consideration when there's
19 questions that are involved, and the issue of
20 having a baseline in everybody's record.

21 So that was sort of the concern on
22 this as to just dropping it completely versus the

1 fact that we might actually have something that's
2 worthy of saving in this.

3 ACTING CO-CHAIR GESTEN: That's
4 helpful. So your desire would be that it go
5 forward for further development, recommend for
6 further development.

7 MEMBER LIN: For continued
8 development. Yes, sir. Absolutely.

9 ACTING CO-CHAIR GESTEN: Okay. Amir
10 or Lisa, do you want to -- David, did you have a
11 question?

12 MEMBER GIFFORD: I just think it's
13 going to be helpful as we go through the voting
14 measures if the person who's speaking can
15 recommend what the vote they're recommending we
16 change to, because it would be helpful to know
17 what's in front of us. I'm not sure what they're
18 asking us to vote to.

19 ACTING CO-CHAIR GESTEN: Great. Okay.
20 You know what it is for this one. We'll try to
21 do that for each --

22 MEMBER GIFFORD: Yes, now, but it's

1 hard to figure out what they're -- put all their
2 comments in context as to where they're going.

3 ACTING CO-CHAIR GESTEN: That's
4 helpful. Okay. We'll start with that. Amir or
5 Lisa, either of you have any comments?

6 MEMBER MCGIFFERT: My comment is that
7 this is a process measure, and I think that it
8 would be better to try to get a different kind of
9 measure, more outcome-based.

10 ACTING CO-CHAIR GESTEN: Okay. Bill,
11 you put your card down? Change your mind? You
12 were going to say the same thing. Any other
13 comments on this? Any comments from the staff or
14 from anyone on the phone?

15 MEMBER GIFFORD: What was the vote by
16 the workgroup? Was this a split vote or was this
17 -- yes, no, was it, like, unanimous? They all
18 stood up and cheered when they voted this way, or
19 was it a split vote on it?

20 ACTING CO-CHAIR GESTEN: So I don't
21 think we've gone down that path yet of getting
22 vote counts. Do you --

1 WORKING GROUP CO-CHAIR BAGLEY: This
2 is Bruce Bagley. You know, I think the major
3 concern was that the two societies that represent
4 the standards of care were not in favor of this
5 measure, and it was primarily because the lack of
6 evidence about the periodicity of the
7 colonoscopy, so I think that we're not saying
8 that this isn't important, but they didn't seem
9 to be ready to use the existing evidence to put
10 forward a measure.

11 MEMBER LIN: Yes, Bruce, this is Sam,
12 I appreciate the comment. That's what I was
13 trying to reference is the confusion because one
14 of those societies, their guidelines, their own
15 guidelines, recommend this kind of a baseline
16 measurement, and then further down they sort of
17 say, oh, we're concerned about overutilization.
18 Those are two different topics.

19 If you look at the last quote in the
20 workgroup rationale, it's from that same society
21 that says, this might not be true,
22 overutilization of colonoscopy, and yes, it might

1 or might not, but the point is, if it's patient-
2 centric, we need a baseline, and so therefore, of
3 the two, it would seem to me that the baseline
4 recommendation is more critical than the concern
5 about overutilization.

6 That, again, sort of dings that
7 physicians are going to be purposely
8 overutilizing it, which, I think, is an unfair
9 observation.

10 ACTING CO-CHAIR GESTEN: So that's
11 great. So I think that we're headed to a vote on
12 this, and we're voting on measure 212, which is
13 surveillance colonoscopy for dysplasia and
14 colonic Crohn's disease. As you know, the
15 workgroup recommendation was do not encourage
16 further consideration. And Sam has recommended
17 and described rationale for why he would like to
18 see this become encourage continued development,
19 so I think we can -- folks remember how to vote?

20 CO-CHAIR PINCUS: I just have one
21 question. Sam, are you recommending encourage
22 continued development, or is this is an example

1 where there's, sort of, insufficient information?

2 ACTING CO-CHAIR GESTEN: Encourage
3 continued development is what he said.

4 MEMBER LIN: Yes, this goes back to a
5 conversation about an hour ago where someone else
6 was saying, trying to figure out what the
7 outcomes are under this, and I think the most
8 positive is that we encourage continued
9 development on the basis that if you continue to
10 develop it, you will come up with, hopefully,
11 more sufficient evidence.

12 If you say insufficient, it's dead-
13 ended there. At least, that statement is dead-
14 ended to me, whereas, continued means that, yes,
15 we're going to try to find some sort of end of
16 the rainbow.

17 ACTING CO-CHAIR GESTEN: David?

18 MEMBER GIFFORD: Sorry. Clearly, this
19 is going back to the confusion about what this --
20 I mean, I think when we developed this in the
21 fall, we had good intentions that, clearly, have
22 caused more confusion than probably helping the

1 process. Kate alluded to the fact that the
2 IMPACT Act measures and the PAC group, CMS would
3 be working with NQF to bring back measures
4 considered encourage further development back to
5 the MAP, didn't guarantee it, but is working
6 towards it.

7 Is that similar for all measures and
8 all settings or just for the PAC setting? Does
9 that make, you know --

10 DR. GOODRICH: All measures and all
11 settings. And I will say for measures such as
12 this one where we're not the owner, we're not the
13 steward, it was submitted to us, we would need to
14 work with the owner to see if it's something
15 they're still interested in and would like to
16 bring back.

17 ACTING CO-CHAIR GESTEN: Any other
18 questions before we vote? So can we go to the
19 slide that has the vote?

20 MS. STERLING: The vote is now open.
21 It's encourage continued development, do not
22 encourage continued development, or insufficient

1 information. And that's for MUC15212.

2 ACTING CO-CHAIR GESTEN: So I'm a
3 little unclear, is it a timeframe, or is it a
4 number that we're looking for when we're done
5 with this? What are we looking for?

6 MS. STERLING: We're looking for the
7 number, not the timeframe.

8 ACTING CO-CHAIR GESTEN: And the
9 number is?

10 MS. STERLING: Twenty-seven, is that
11 correct?

12 ACTING CO-CHAIR GESTEN: Okay. We're
13 there.

14 MS. STERLING: Twenty-eight?

15 ACTING CO-CHAIR GESTEN: Twenty-eight.

16 And so my understanding of the vote is that there
17 was not sufficient votes to overturn the
18 recommendation of do not encourage further
19 consideration. So why don't we move on to the
20 next one, and, Sam, you're up again, and this one
21 concerns biopsy reporting time by pathologists.
22 It's MUC measure 216, and the workgroup

1 recommendation was do not encourage further
2 consideration.

3 And, Sam, can you just, at the
4 beginning, say what your recommendation is and
5 then describe the rationale.

6 DR. LARSEN: Sure. As before, it
7 would be encourage continued development.

8 ACTING CO-CHAIR GESTEN: And can you
9 say a little bit more about rationale?

10 DR. LARSEN: Sure. I'm sorry. And
11 again, it's an issue of there aren't enough
12 metrics for specialties to start off with, but,
13 you know, we've been making a lot of Triple Aim
14 type of reasons for doing things, but we also
15 have to remember the IOM STEEP principles, and
16 this meets at least four of them in my mind:
17 timeliness, that's self-explanatory, efficiency,
18 that's self-explanatory, it's equitable in the
19 sense that all clinicians caring for a patient
20 have some equitable responsibility and ought to
21 be held accountable, and P, patient-centered.

22 And the part of it that's patient-

1 centered is that, and this is maybe down the
2 line, but at some point, you know, there's a lot
3 of work going on now of something called open
4 notes where patients have access to their
5 records. And part of it, I would like them to be
6 able to see that somebody actually took the time
7 to make sure that there was timeliness, that
8 there was efficiency, and all those wonderful
9 things relative to their care.

10 The specialists in this case should be
11 held accountable, not just the biopsying
12 clinician who may be a primary care, who may be a
13 dermatologist, but especially in an integrated
14 team-based setting, everybody's got to bear full
15 responsibility and not be able to slough off one
16 other person.

17 As far as societies, there was a
18 difference of opinion between the derms and the
19 paths on this one; the derms in support and the
20 pathologists not in support, so my recommendation
21 is that there's enough of this, and it's not
22 insufficient evidence. It's putting together the

1 different pieces, but I'm going to take that
2 route and recommend that we go for encouraging
3 continued development.

4 ACTING CO-CHAIR GESTEN: Thank you.
5 Frank, you want to make a comment?

6 MEMBER OPELKA: No, I need to lower my
7 hand.

8 ACTING CO-CHAIR GESTEN: Okay. Rich
9 Antonelli?

10 DR. ANTONELLI: Yes, thank you for
11 letting me weigh-in. So one of the things that
12 we are spending a fair amount of time in the care
13 coordination standing committee is this notion
14 of, you know, measuring a one-sided handshake,
15 and so if you look at this, it's the transmission
16 of the information from one provider to the
17 other, and that's partially what we're about
18 here.

19 In a true patient-centered framework,
20 the patient would be aware that the information
21 was received and not just transmitted, so there
22 is a little bit of a gap there. And the reason

1 I'm calling this out is not specifically on this
2 measure, but I think measures like this are
3 really emblematic with what the field is like
4 right now around trying to really measure
5 patient-centered care coordination.

6 ACTING CO-CHAIR GESTEN: Thank you.

7 David?

8 MEMBER GIFFORD: Having done a year of
9 pathology, I don't like a length measure.

10 Regardless of the vote, just want to put on the
11 record a comment that it really should be about
12 percent of people who get it done within a timely
13 time period, because by length, you start
14 encouraging people to run reports on difficult
15 biopsies and not get second opinions and all that
16 stuff.

17 And particularly in this type of skin
18 biopsy and other biopsies, you're going to often
19 want second opinions, and you should notify the
20 people why it's going on, because you're not sure
21 what's going on, but these are something very
22 hard to read, and just an average time could have

1 the unintended effect of getting quick reads out
2 just to meet some sort of measure, unintended, so
3 whoever the developer is, to really think about
4 restructuring it that way and continuing to
5 develop it fully.

6 ACTING CO-CHAIR GESTEN: And I don't
7 know if you want to translate that comment into
8 what you're recommending, these three things, but
9 if you do want to, where does that lead in terms
10 of what you're --

11 MEMBER GIFFORD: Let me ask, this was
12 on the MUC list, Kate. Why was this put on the
13 MUC list?

14 DR. GOODRICH: This was submitted to
15 us by, I guess, AAD. It was because both
16 dermatologists and pathologists have so few
17 measures to choose from, and we felt this was
18 reasonable for consideration by this body.

19 ACTING CO-CHAIR GESTEN: The other
20 David.

21 DR. BAKER: The other David? I
22 thought I was the David.

1 ACTING CO-CHAIR GESTEN: Oh, the
2 David. You're the David. He's the other David.

3 DR. BAKER: I think our quality and
4 safety problem here is with the time limits. You
5 know, as David said, the problem is there are
6 still errors in reading pathologic specimens and
7 we want them to take the time that they need to
8 get it right, so I am not in favor of this
9 measure.

10 ACTING CO-CHAIR GESTEN: Our two lead
11 respondents, either Amir or Lisa, have any
12 comments?

13 MEMBER MCGIFFERT: Who's the other
14 respondent?

15 ACTING CO-CHAIR GESTEN: Amir.

16 MEMBER MCGIFFERT: Oh, okay. You
17 know, this is another process measure, and I
18 agree with the recommendation of the workgroup,
19 so I don't really have anything else to add.
20 Somebody earlier said something about, I wrote it
21 down on this measure, I'm not sure if I got it
22 right, that there was a cancer project that was

1 working on this measure?

2 MS. STERLING: There is a cancer
3 project, but it is not working on this measure.

4 ACTING CO-CHAIR GESTEN: Barry?

5 MEMBER NOONE: I'm a little confused
6 about what we're looking to vote for. Is this
7 the measure of surgical or office removal, or
8 currettage, of non-invasive squamous cell
9 carcinomas and/or keratoacanthoma-like cancers
10 versus Mohs resection, is that what we're doing?

11 ACTING CO-CHAIR GESTEN: So as I look
12 at the description, I don't have a clear answer.
13 I read, like you can read, what it says, but is
14 there anybody on the phone from that group that
15 can clarify, or here?

16 MS. WINKLER: Foster, it's Reva. You
17 might want to push the link on measure
18 specifications and look at the numerator and
19 denominator. That might help. The numerator
20 says it's the number of final pathology reports
21 diagnosing cutaneous basal cell carcinoma or
22 squamous cell carcinoma, to include in situ

1 disease, sent from the
2 pathologist/dermapathologist to the biopsying
3 clinician for review within five business days
4 from the time when the tissue specimen was
5 received by the pathologist.

6 MEMBER NOONE: Okay. Thank you.

7 ACTING CO-CHAIR GESTEN: That answer
8 your question? Okay. Any other --

9 WORKING GROUP CO-CHAIR BAGLEY:
10 Foster, I had a comment.

11 ACTING CO-CHAIR GESTEN: Go ahead.

12 WORKING GROUP CO-CHAIR BAGLEY: Yes,
13 this is Bruce. One of the things that's not
14 reflected in the workgroup rationale is that this
15 is very, very specific only to these two
16 diagnoses, and we would be very interested in
17 seeing a measure that dealt with all pathology
18 reports across the board be much more broadly
19 applicable.

20 And, you know, the alternative is to
21 have a measure for every last diagnosis, which is
22 nuts. So we kind of think that we should

1 reconsider this in a more broad base.

2 ACTING CO-CHAIR GESTEN: Thanks.

3 MR. BRUCE: This is Sam Bruce, I would
4 say that's a friendly amendment. Thank you.

5 ACTING CO-CHAIR GESTEN: So could we
6 go to the vote? And we'll be voting, again, on
7 the MUC216, which is biopsy reporting time, and -
8 - or we could re-vote on colonoscopy, but that's
9 not much fun. And the choices are encourage
10 continued development, do not encourage continued
11 development, or insufficient information. Just
12 to recap, the workgroup recommendation was do not
13 encourage further consideration.

14 MS. STERLING: Great. So this is MUC
15 15216. It's biopsy reporting time. And again,
16 your options are encourage continued development,
17 do not encourage continued development, or
18 insufficient information.

19 ACTING CO-CHAIR GESTEN: You didn't
20 like the way I said it, did you? All right.
21 I'll let you say it.

22 DR. LARSEN: Sorry, this is Sam. I'm

1 not getting the right screen, so let me just cast
2 it for the first one, encourage continued
3 development.

4 ACTING CO-CHAIR GESTEN: Are you guys
5 able to capture that? Does Sam need to refresh
6 his screen, is that, potentially an issue? Try
7 that, Sam.

8 DR. LARSEN: All right, sir. Thanks.

9 MS. STERLING: Okay. The official
10 results are, 7 percent encourage continued
11 development, 86 percent do not encourage further
12 consideration, 7 percent insufficient
13 information, the workgroup recommendation stands.

14 ACTING CO-CHAIR GESTEN: All right,
15 Sam. Hang in there. There's more. You may have
16 better luck going forward. We're going to give
17 you a break, though, and go to the third one on
18 the list, which is MUC229, Hepatitis C virus
19 sustained virologic response, and this one was
20 pulled by Amir. Amir, let me just ask you first,
21 do you want to take this to a vote, conversation?

22 MEMBER QASEEM: It's actually a

1 clarification question, so probably is just a
2 discussion item. I just want to make sure that
3 the patients who cannot afford the treatment or
4 patient preferences are considered, they are part
5 of the denominator. The way it reads, it was
6 just not clear. The way it reads right now is,
7 all patients age 18 years and older with
8 diagnoses of Hepatitis C who are initiating or
9 receiving anti-viral treatment.

10 So the initiating part, does that mean
11 that they have started, they are already on
12 treatment? That part, I'm okay with, but if it
13 includes the patient population, you know, it's
14 an incredibly expensive medication. A lot of
15 insurance companies don't even cover it.

16 ACTING CO-CHAIR GESTEN: So you're
17 asking a question about whether the
18 specifications account for that.

19 MEMBER QASEEM: Correct. So if it's -
20 - and probably it's a question either for Bruce
21 of Eric. You guys can answer this.

22 ACTING CO-CHAIR GESTEN: So the

1 steward here is the American Gastroenterologic
2 Association, right, so we can't pick on Kate.
3 Sorry, Kate. Is there anyone who can answer that
4 clarifying question?

5 MEMBER QASEEM: Because if the way the
6 measure reads right now, then I think we have a
7 problem because you have a big chunk of
8 population that cannot afford this treatment as
9 well as where patient preferences are going to
10 be. I mean, the co-payment, I was asking around
11 for this, and I was writing notes, it's around
12 \$140 per month, the cheapest option.

13 MS. WINKLER: Amir, this is Reva. I
14 think maybe the exclusion specification could
15 help a bit. It says that the measure only needs
16 to be reported if initiation of anti-viral
17 treatment took place before October of the
18 measurement year, 11 weeks before the end of the
19 period, so I think this more clearly states that
20 initiation is those patients who actually have
21 begun taking the drug.

22 DR. BURSTIN: But just a quick

1 comment. I mean, either way, this is a measure
2 still under development, so your comment will
3 still go to the developer, even if they're not
4 here, so they will then hear this discussion of -
5 - and we'll emphasize that in the report as well,
6 that there were concerns about potential patient
7 inability to get the medicine and consider it as
8 a potential exclusion.

9 Again, it's not a fully baked measure,
10 so they clearly have some opportunity there to
11 modify it.

12 ACTING CO-CHAIR GESTEN: Amir, is that
13 responsive to your concern?

14 MEMBER QASEEM: Yes, I just want to
15 make sure this comment does go back the
16 developers.

17 ACTING CO-CHAIR GESTEN: But there may
18 be some patients who, their financial status
19 changes, and a month later they're really
20 struggling, so I think dealing with patients,
21 some exclusion criteria around inability to pay
22 would be a reasonable one. Any other -- go

1 ahead.

2 MEMBER QASEEM: So the current
3 recommendation is continued development, right?

4 ACTING CO-CHAIR GESTEN: Encourage
5 continued development.

6 MEMBER QASEEM: Yes, I can go with
7 that.

8 ACTING CO-CHAIR GESTEN: Okay. Any
9 other conversation about this one? So we will
10 not vote on this one. We'll move to the next
11 one. All right, Sam, I hope you enjoyed your
12 very brief break here. So we're moving to
13 MUC251, which is screening endoscopy for varices
14 in patients with cirrhosis. It was pulled by
15 Sam. The workgroup recommendation was do not
16 encourage further consideration.

17 And, Sam, two things, if you can just
18 reiterate whether you want to move this to a
19 vote, and then second, just describe what it is
20 your recommendation is.

21 DR. LARSEN: Sure. Well, I'll first
22 say that I'm doing much better than the

1 Powerball. So the recommendation here is, as
2 before, encourage continued development. The
3 reason being very similar to the previous one is,
4 there's an issue of a baseline that you have to
5 have.

6 Now, in this case, there's something
7 referenced here as the AASLE, which is the
8 American Association for Study of Liver Disease,
9 and their guidelines recommend, et cetera,
10 similar to the proposed metric. Towards the end,
11 the American Society for Gastrointestinal
12 Endoscopy comments, similar to the previous
13 comment, and they're bringing up the concern
14 about deterring overutilization.

15 Again, to me, that's two separate
16 issues. So I think for the purpose of a baseline
17 for good patient care, you know, you don't know
18 where you're going until you know where you've
19 been relative to a patient's diagnoses and data,
20 so our recommendation is that this ought to go
21 for continued development rather than not
22 encouraging or just dropping it.

1 ACTING CO-CHAIR GESTEN: Great. Thank
2 you. Other comments? Barry, is that a leftover
3 or do you have a new comment? Bill.

4 MEMBER KRAMER: I'll just comment that
5 this is another process screening measure, and
6 reading the workgroup rationale, it appears
7 there's questions about the evidence of the
8 usefulness of this with regard to outcomes, so I
9 don't see a compelling reason to overturn the
10 workgroup's recommendations.

11 ACTING CO-CHAIR GESTEN: So comments
12 either from lead discussants, Amir or Lisa, or
13 from Bruce?

14 MEMBER MCGIFFERT: I was going to say
15 just what Bill said.

16 ACTING CO-CHAIR GESTEN: You guys are
17 kind of tag-team. When you were talking last
18 time, Bill was nodding. Bruce, did you have any
19 comments?

20 WORKING GROUP CO-CHAIR BAGLEY: No,
21 nothing further.

22 ACTING CO-CHAIR GESTEN: Okay. David.

1 DR. BAKER: I'll just go on record as,
2 I'm in favor of process of care measures for
3 many, many things, including screening measures,
4 not this one though because it's Level C
5 evidence.

6 MEMBER MCGIFFERT: I think that --
7 well, my understanding is that all of these
8 measures are for public reporting or payment
9 programs, right? Or both. This one's for both.
10 So I mean, I'm not saying that process measures
11 aren't valid in some situations, but for public
12 reporting and pay-for-performance, I think
13 they're not good measures to use, so that's why I
14 keep bringing it up.

15 I think it is good for providers to
16 use them internally, and they're really
17 important, and I think they're important
18 sometimes for consumers to know what they're
19 doing, but I don't think that they're good
20 measures for this purpose.

21 ACTING CO-CHAIR GESTEN: Any further
22 discussion? Can we bring up the slides for a

1 vote? We're voting on MUC251, which is screening
2 endoscopy for varices in patients with cirrhosis.
3 The workgroup had recommended do not encourage
4 further consideration. It was pulled with a
5 recommendation that this be changed to encourage
6 continued development.

7 MEMBER DEZII: I had raised my hand.
8 May I be able to comment?

9 ACTING CO-CHAIR GESTEN: Oh, sorry.
10 Go ahead.

11 MEMBER DEZII: Not a problem. Chris
12 Dezii, Pharma. It's late, and this is about
13 esophageal varices, right? I swear I see
14 something about, this measure would not deter
15 overutilization of colonoscopy. I suspect that's
16 a typo.

17 MS. WINKLER: Yes. This is Reva. I'm
18 sure it is.

19 MEMBER DEZII: Okay. Thank you.

20 MS. WINKLER: You can blame me.
21 That's my bad.

22 ACTING CO-CHAIR GESTEN: Thank you.

1 MEMBER DEZII: Okay. Let's rock and
2 roll.

3 ACTING CO-CHAIR GESTEN: Yes. It's
4 under workgroup rationale. It's like the third
5 line from the bottom. Thank you for pointing
6 that out. So the vote is up there?

7 MS. STERLING: Yes. We are voting on
8 MUC15251, the screening endoscopy measure. Your
9 options are encourage continued development, do
10 not encourage continued development, or
11 insufficient information. The vote is open.

12 All right. So the results are 3.6
13 percent encourage continued development, 89
14 percent do not encourage further consideration,
15 and 3.5 percent insufficient information. The
16 workgroup recommendation stands.

17 ACTING CO-CHAIR GESTEN: David.

18 MEMBER GIFFORD: General comment
19 before I forget. I think it'd be helpful to make
20 sure all of our comments, they go back to CMS,
21 well, they're all going to go to CMS because this
22 is on the MUC list, but also the other developers

1 out there, that what I'm hearing from these
2 comments was clearly some confusion about what it
3 meant for encourage further development and not -
4 - and that some of these measures as specified,
5 people are unhappy with, but they like the
6 concept to be explored further.

7 I wouldn't want -- just like there was
8 confusion on this, them to have the confusion at
9 CMS or the developers end for some of these
10 measures to say, well, we can't develop it. NQF
11 doesn't want it, or CMS doesn't want that. I
12 don't think we've heard that anywhere here.

13 You know, there's been some debate
14 about process and outcome measure, which I think
15 is a healthy debate to have, and when to do that,
16 but I don't want -- I think, the endorsement of
17 the voting here of not do it, and it looks like
18 there seem to be different ways different
19 committees voted on what was considered encourage
20 further development and not, even workgroups
21 interpret it differently, so I just wanted to
22 make sure that that gets captured and the message

1 goes out.

2 ACTING CO-CHAIR GESTEN: Makes sense.

3 Yes, we'll do that. Okay.

4 DR. LARSEN: This is Sam talking. One
5 observation if I may, is that, about ten years
6 ago when we were in the P-for-P, pay-for-
7 performance, it was all about process and not
8 outcome, and then we sort of made a transition,
9 we think, through MIPS and things of that sort,
10 to where we're trying to get outcomes, which is
11 really what the patient care is about, the
12 bottom-line, but at the same time we can't
13 forsake the fact that if you don't have the
14 process, if you don't have the data, if you don't
15 have the baseline, you have no idea whether your
16 outcome is successful or not.

17 And so this is -- we have to find some
18 harmonization or balance between -- in this
19 concept of process and the ultimate outcome that
20 the patient needs. End of soapbox.

21 ACTING CO-CHAIR GESTEN: Thank you,
22 Sam. So the next measure is MUC275. It's

1 ischemic vascular disease all-or-none outcome
2 measure, and the workgroup recommendation was
3 conditional support. It was pulled by Amir, so,
4 Amir, again, same set of questions. Want a vote,
5 and what's your position on the recommendation?

6 MEMBER QASEEM: So for this one, I
7 think it would be worth voting, and so this is a
8 very important topic area. I think it is
9 valuable to have this composite measure, but I
10 think what caught us was the coronary artery
11 disease-like condition, that has been one of the
12 issues, and I was just talking with David, so
13 they have this, for example, diabetes.

14 So are we essentially saying we're
15 going to give aspirin therapy to every diabetic
16 patient? And then the blood pressure, for
17 example, they use in this measure is 140/90, and
18 we have discussed this to death in the journals.
19 Now, you know it's incredibly controversial
20 whether it's 140 or 150, what level we should be
21 using, and the third issue with this measure is
22 that the indications for statin use, they're

1 based on the outdated guideline. You already
2 know the issue of the LDL levels versus
3 individual risk factors as well.

4 So there are three issues that are
5 concerning with this measure and if this was just
6 limited to, maybe, coronary artery disease, it
7 would have been okay, so I think it's the CAD
8 risk equal and condition that really made this
9 measure worse.

10 ACTING CO-CHAIR GESTEN: So I'm sorry,
11 your recommendation is?

12 MEMBER QASEEM: What are my choices?
13 To be honest with you, I'm not sure.

14 ACTING CO-CHAIR GESTEN: So it was
15 conditional support. It's do not support,
16 support, or conditional support.

17 MEMBER QASEEM: Do not support.

18 ACTING CO-CHAIR GESTEN: Okay. David?

19 DR. BAKER: So I may have left one
20 out, which is the smoking part of the component,
21 and I've had a problem with this for a long time.
22 The current smoking rate in Utah is 10.3 percent,

1 and in West Virginia, it's 27.3 percent. So if
2 you look across the states in this country, this
3 will be a very biased measure, even in the best
4 of hands, in the best randomized control trials,
5 intensive therapy, behavioral therapy,
6 pharmacologic therapy.

7 If you get 20 to 40 percent of your
8 patients who smoke to quit, you're doing really
9 well, and I'll bet you it's even much, much lower
10 for the patients with ischemic vascular disease.
11 So I've always had a problem with this. I think
12 it's biased for those states that -- it's biased
13 against those states that have a high prevalence
14 of smoking.

15 ACTING CO-CHAIR GESTEN: Helen.

16 DR. BURSTIN: I just want to make a
17 comment. This measure and a very similar measure
18 are up for endorsement review, so all these
19 issues are being debated significantly in the
20 cardiovascular group, so I think we can certainly
21 take some of these comments back. The smoking
22 issue, in particular, I don't think we've talked

1 about yet, but it is teed up, and lots of the
2 same discussion, as you might imagine, that
3 you're having right here, but among a group of
4 people for whom cardiovascular illness is
5 something they care deeply about.

6 PARTICIPANT: But the other measure is
7 not on our list, is that true?

8 DR. BURSTIN: That is true. This is,
9 I believe -- Reva, help me here. I think this is
10 a variation of the Minnesota measure from
11 Wisconsin.

12 MEMBER DANFORTH: Right. This is
13 Melissa. Yes, this is the Wisconsin measure.
14 The Minnesota measure is up for measure review up
15 in phase 4, and this is the updated statins
16 guidelines, which, Minnesota, which is up for
17 review, is reinserting the statin guideline, so
18 they will be competing head-to-head, so that's
19 why we deferred them from cardiovascular phase 3,
20 so the committee can review them side-by-side,
21 but they're basically identical measures.

22 MS. WINKLER: Yes. And this is Reva,

1 just to note that the MAP has recommended the
2 Minnesota version of this measure in the past
3 several times as it's gone through iterations
4 responding to the changing guidelines, and so it
5 has been in PQRS. It, in the most recent rule,
6 was removed, but MAP and PQRS certainly has seen
7 the Minnesota version of this measure previously.

8 ACTING CO-CHAIR GESTEN: Bill.

9 MEMBER KRAMER: Just to clarify,
10 Helen, maybe it's a question for you. My
11 understanding is that, from what you said and
12 what I heard before, this measure is under
13 consideration by the steering committee, and in
14 fact, what will come out of that process will be
15 two things, one is updates of the clinical
16 guidelines for statins and for blood pressure
17 control and so on, and second, looking at which
18 one is considered the best in class.

19 And so the conditional support
20 recognizes both, one, the support is important
21 because this is a really important measure, and
22 second, however, that because of the changes in

1 clinical guidelines, and the fact there are two
2 competing measures out there which are under
3 review, that it's only conditional support
4 pending the results of the updating of the
5 clinical guidelines and the selection of the best
6 in class. Is that correct?

7 DR. BURSTIN: That is correct. The
8 committee will update it based on the updated
9 guidelines, look at the measure, consider all the
10 issues raised here, and we'll actually go ahead
11 and pass along whatever. Again, in our age of
12 trying to be very linked here, we'll make sure
13 whatever discussion was brought up here will go
14 back to the standing committee as well as they
15 review those measures going forward.

16 MEMBER KRAMER: Great. Well, I would
17 strongly recommend that we support the
18 workgroup's recommendation of conditional support
19 for this.

20 ACTING CO-CHAIR GESTEN: David? And
21 let me just remind, David, before you start,
22 folks on the phone that are coordinating

1 committee members, that if you want to get in the
2 queue, just raise your hand on the webinar, and
3 we'll be happy to call on you. Go ahead, David.

4 MEMBER GIFFORD: I'm just curious why
5 this measure went through on a conditional
6 support voting, not measure under development,
7 since it seems to be just like a lot of the other
8 measures that go through under development. What
9 was the rationale as to who got to pick when they
10 went that way, and it sort of restricts the MAP
11 on voting.

12 DR. BURSTIN: It's fully developed and
13 tested.

14 MEMBER GIFFORD: But I'm just hearing
15 it's not fully developed and tested because
16 there's guideline changes, and we need to update
17 the criteria, and we need to do a forward on it.
18 That's no different than some of the other
19 measures that went through on measures under
20 development.

21 DR. BURSTIN: Right. Currently, right
22 now, the measure is fully developed and tested.

1 Those modifications may come up as part of the
2 upcoming evaluation process. But for right now,
3 it's not a measure that is being developed. It's
4 fully developed and tested, although it may
5 change. You could say that for the majority of
6 the measures we look at.

7 MEMBER GIFFORD: Right.

8 DR. BURSTIN: Many of them will change
9 as the evidence changes.

10 MEMBER GIFFORD: So is the measure
11 being proposed to be used as is? As is, not
12 future changes or planned changes of the review
13 process it's going through. It's going to go
14 into rulemaking as is.

15 DR. BURSTIN: Except that it
16 specifically -- at least the workgroup rationale
17 specifically said, MAP conditionally supports
18 this measure pending the outcome of the NQF
19 evaluation by the cardiovascular committee. So
20 it's yes. I mean, this is like many of the other
21 -- we haven't done very many conditional supports
22 today, but that is typical that the measure is

1 supported with the condition that whatever
2 emerges out of the endorsement process will be
3 incorporated in.

4 CO-CHAIR PINCUS: Incorporated. Now,
5 are our comments being incorporated into the
6 measure evaluation by the cardiovascular
7 committee?

8 DR. BURSTIN: Yes. We will most
9 definitely pass these comments to the CV
10 committee as they look at this updated composite,
11 yes, from both of them. I mean, this is what's a
12 little difficult. Mainly changes the denominator
13 for one to the other, not these issues of
14 evidence from the two measures.

15 ACTING CO-CHAIR GESTEN: Bill.

16 MEMBER KRAMER: Just a process
17 question. When we just had this recent
18 conversation, Amir stepped out of the room for a
19 call, and since he was the one who pulled this
20 measure, I think, and raised the initial
21 concerns, it might be worth recapping for his
22 benefit in case he has any response.

1 DR. BURSTIN: I was saying, again,
2 because it is fully developed and tested in its
3 current form and going to the CV committee, if it
4 gets conditional support, what's listed here by
5 the workgroup as the condition is that it's
6 conditionally supported pending the outcome of
7 what the cardiovascular committee says.

8 So in some ways, you're deferring to
9 the expertise of the CV committee, although, we
10 will bring forward all the commentary from here
11 to that committee, but it's not supported. It
12 doesn't fly in. It's conditionally supported
13 pending that evaluation.

14 MEMBER KRAMER: And that evaluation
15 includes addressing the changes in the clinical
16 guidelines that you raised in your initial
17 concerns.

18 MEMBER QASEEM: And I can probably
19 live with the conditional support, but I'll tell
20 you, it goes back to what I started out by
21 saying, I'm not really clear on the voting
22 categories that we are using because half of them

1 we are saying, we've got a lot of these concerns,
2 and you continue development, or it's conditional
3 support, and I think that that's where I'm a
4 little bit struggling, with our voting
5 categories.

6 And that's why I think it went back to
7 what I said, Harold, this will wrap it up, that
8 we should have wrapped up that conversation from
9 this morning because you can see we are all
10 struggling in terms of what are we voting on.

11 CO-CHAIR PINCUS: So let me, like,
12 it's kind of the way I think about it, so the
13 measures that are under consideration are
14 measures that have not been well-defined, that
15 they're in development and so that they're not
16 ready for prime time.

17 And the question is, do we recommend
18 that CMS sort of invest the effort in trying to
19 further develop them with our, you know, with our
20 comments, or do we say it's not worth further
21 developing.

22 For the measures that actually are

1 well-defined and well-operationalized, then it's
2 a different set of questions. Are they ready to
3 actually be implemented or are they not ready to
4 be implemented, or are they almost ready to be
5 implemented, but there's going to be another
6 process they have to go through?

7 And so this is an example of something
8 that's further along the development process, but
9 I guess the recommendation is it's not ready to
10 be implemented; it needs to get further input
11 from this other process.

12 MEMBER QASEEM: I mean, and that's
13 what probably I'll say. The way the measure
14 currently reads and stands, I think it's going to
15 do more harm than benefit. So I think I will
16 need to see the revised measure before we can go
17 forward with that. That's why I said that the do
18 not approve or whatever is the recommendation.

19 MEMBER DANFORTH: Hi, this is Melissa
20 again. And let me clarify that this measure is
21 already in use in the state of Wisconsin. They
22 provided about, I think, three quarters of data

1 to us. So it is in use in Wisconsin.

2 ACTING CO-CHAIR GESTEN: David.

3 MEMBER GIFFORD: So Harold, I would
4 agree with you, and I think that was the general
5 feeling of this group when we created the
6 continued further development pathway, but that's
7 not in reality how it's going to be implemented.

8 So I think the language you just used
9 to put in the report back to HHS and the
10 Secretary that those are under development, feel
11 like they, you know, if they'd gone the other
12 pathway they would've probably gotten not support
13 because they weren't ready enough.

14 You know, I think that was earlier,
15 Amir said that earlier, that essentially, I think
16 that was the impression that we had. And the
17 reason we created it was a lot of these measures
18 were getting voted do not support because that
19 was one of only three categories we had. It was
20 unfair to CMS, unfair to the patients and
21 providers out there for very good measures that
22 needed further development, but that they weren't

1 ready.

2 Now, the twist is CMS is under a huge
3 timeline, so they're going to forward. But they
4 could do that anyway and it trumps it. But I
5 think that that's then an important statement to
6 say if that's what the classification is. And
7 that's the way the PAC group when they met, that
8 was the way they started out their meeting and
9 under their impression with the measures.

10 CO-CHAIR PINCUS: On this measure it's
11 a judgement that even though it's well -- and
12 this is the judgement that the committees make,
13 even though it is well-specified and has been in
14 place and so forth, is it still considered under
15 development because of all the issues that have
16 been raised and therefore it needs to go on these
17 as well, or is it well-enough specified that it
18 simply needs to go through this other hoop?

19 MEMBER GIFFORD: Yes, but the
20 committees don't decide that. CMS decides that
21 on what they put on the MUC list. Committees
22 can't change that. Taroon just said that earlier

1 on, right?

2 MEMBER GIFFORD: So how we have
3 operationalized this to take the subjectivity out
4 of the process -- now, whether it's subjective
5 still is up to interpretation. Clearly, there's
6 a lot of disagreement about that, is that CMS
7 presents to us the level of testing that the
8 measure has undergone. And if it's not fully
9 tested in the settings that it's intended to be
10 used, it goes into the measure development
11 pathway.

12 That is an objective evaluation of the
13 measure. We don't assess the extent of the
14 testing or the results of the testing. That's
15 really up to either the Endorsement Committee or
16 the work groups.

17 In this case, this measure is tested
18 as specified. And the question in front of the
19 committee, as specific as it could be, is to
20 evaluate the measure in front of you.

21 Now, if there are suggested changes or
22 the measure in front of you is not a -- the

1 conditional support is challenging because it's -
2 - to a certain extent, you're asking for some
3 elements of the measure to be changed or to go
4 through a process.

5 Typically, we've asked it to go to the
6 NQF endorsement process to look at certain
7 things. But essentially, the measure as
8 constructed is a support.

9 In the case that we're discussing
10 today, I think the question in front of the
11 committee is is this sufficiently the measure
12 that you would agree that should be implemented
13 in the program or not?

14 If it's not, then I think Amir is
15 proposing it's a do not support. If there are
16 certain conditions in which you would support it,
17 and I think there is a grey zone here. This what
18 I think we're struggling with, which is how far
19 do you go with the conditions? You could say
20 develop a whole new measure.

21 That wasn't, I don't believe, the
22 intent of the Coordinating Committee when we

1 first developed that. I'm not suggesting that's
2 what you're saying here, but, you certainly don't
3 want to attach so many conditions to it that it's
4 no longer the measure that you're evaluating. So
5 that's up to this group to make a judgment call.

6 MEMBER GIFFORD: I think that makes
7 total sense. I think that makes total sense. I
8 think the confusion is what does it mean to
9 encourage further development. And I think what
10 you said is that if it would have gone through
11 the other pathway it probably would have been do
12 not support, or it would have had a bazillion
13 conditions put on it because it wasn't fully
14 tested or developed yet.

15 DR. BURSTIN: The measure is in use.
16 It's fully developed and tested. They're --

17 MEMBER GIFFORD: I'm not talking about
18 this measure.

19 DR. BURSTIN: -- planning to update --

20 MEMBER GIFFORD: I'm just talking
21 about --

22 DR. BURSTIN: Oh, you mean in general.

1 Okay.

2 MEMBER GIFFORD: -- the distinction in
3 general.

4 DR. BURSTIN: Right.

5 MEMBER GIFFORD: No --

6 DR. BURSTIN: I agree.

7 MEMBER GIFFORD: -- I'm just saying
8 this just raises that question again.

9 DR. BURSTIN: Yes.

10 MEMBER GIFFORD: I agree with this way
11 this measure is. I agree with what his
12 definition is. I'm just saying that to Amir's
13 question to close the discussion we had in the
14 morning, what it seems to imply as we coalesce as
15 a group, it means that a measure that is
16 classified, and I think it's a good criteria that
17 you have, as being under the development pathway.

18 If we had not created it, there was a
19 high likelihood, not guaranteed, that it was
20 going to get do not support. And so I think that
21 that message needs to be clear to CMS because
22 these are measures under consideration for

1 putting in rules. And so that feedback to the
2 Secretary, I think, is an important message for
3 this MAP to give.

4 MEMBER QASEEM: So where does this
5 measure stand in the NQF Committee? How are they
6 reviewing it, or what's happening, and just what
7 are they doing with it?

8 DR. BURSTIN: It'll come up. And I
9 don't think it's actually there yet. I think it
10 is -- right? Jean-Luc's not saying. Oh, it is
11 coming forward as for full re-evaluation for both
12 evaluation of this Wisconsin measure as well as
13 the original Minnesota measure, which is
14 currently endorsed.

15 And I know that at least the Minnesota
16 group has -- you know, Minnesota Community
17 Measurement, they tend to update their measure
18 pretty commonly based on evidence. So, you know,
19 that's the question.

20 We routinely do have measures that
21 come forward where MAP has traditionally put the
22 condition that it come through the endorsement

1 process and let the science play out there rather
2 than at this table.

3 MEMBER QASEEM: So --

4 DR. BURSTIN: So that --

5 MEMBER QASEEM: -- Minnesota Measure
6 is a better measure, and Wisconsin one never got
7 a thumbs up, or you guys have given it a thumbs
8 up?

9 DR. BURSTIN: We've never looked at
10 the Wisconsin measure. They're different only in
11 denominator. The numerators are almost
12 identical.

13 MEMBER QASEEM: Okay. So is that --

14 DR. BURSTIN: So they'll look at them
15 both and then make a determination of best in
16 class.

17 MEMBER QASEEM: Okay.

18 ACTING CO-CHAIR GESTEN: Any other
19 comments on this measure?

20 WORKING GROUP CO-CHAIR BAGLEY:

21 Foster, this is Bruce. The only thing I would
22 add that has not been discussed is the Clinician

1 Workgroup really felt strongly about sending a
2 message to CMS that we do think that composite
3 measures and maybe even all or nothing measures
4 have value.

5 Because one of the reasons they
6 dropped the Minnesota measure was because very
7 similar individual measures were present in the
8 Million Hearts campaign. So we're trying to send
9 back the message that we think composite measures
10 have a valuable place.

11 ACTING CO-CHAIR GESTEN: Thank you,
12 Bruce. So I think we're ready for a vote. I
13 don't see any other --

14 MEMBER QASEEM: Can I ask --

15 ACTING CO-CHAIR GESTEN: Go ahead.

16 MEMBER QASEEM: -- just one more
17 question?

18 ACTING CO-CHAIR GESTEN: Yes.

19 MEMBER QASEEM: Bruce, this is Amir.
20 Just clarification question, can you just tell or
21 give us a feel for did you guys discuss these
22 issues that we just discussed related to this

1 measure in your Clinician Work Group?

2 WORKING GROUP CO-CHAIR BAGLEY: Well,
3 I think that both measures need to be reevaluated
4 because of the change in the guidelines. And
5 that's the purpose of the re-look by the NQF
6 appropriate committee.

7 ACTING CO-CHAIR GESTEN: Okay. So we
8 are voting on, this is Measure 275. It's
9 ischemic vascular disease all or none outcome
10 measure. The work group recommendation was
11 conditional support, and we spent some time
12 talking about what those conditions are just now.

13 This was pulled by Amir, and the
14 recommendation was for this to be a do not
15 support based on concerns about various elements
16 of the measure. So, Amber, you're going to re-
17 say what I just said.

18 MS. STERLING: I am. MUC15-275
19 ischemic vascular disease all or none outcome
20 measure is open for vote. It's support,
21 conditional support or do not support.

22 MR. TILLY: We just need a couple more

1 votes. I'm sorry. If you could try clicking
2 again.

3 And the results of the vote are zero
4 percent support, 89 percent conditional support,
5 and 11 percent do not support. So the result of
6 the vote is conditional support. The
7 recommendation stands.

8 ACTING CO-CHAIR GESTEN: Great. Thank
9 you. Let me just process and time check. We
10 have, I don't know, I'm counting them, seven,
11 eight, nine, something like that, more measures
12 to go. It's about 4:30, we're supposed to close
13 at 5:00 and we had Hospital Workgroup on today.

14 Clearly, we're not going to get to the
15 Hospital Workgroup today. But we had already
16 talked about that as being able to steal some
17 time tomorrow based on other changes that we had
18 made in terms of the breakout sessions and so on,
19 so I think we do have one person who is on the
20 line who will make a comment before we close
21 around the hospital measures, who I guess can't
22 be here tomorrow.

1 DR. BURSTIN: He's actually here in
2 person, but we'll see if we can get --

3 ACTING CO-CHAIR GESTEN: Oh.

4 DR. BURSTIN: -- to it.

5 ACTING CO-CHAIR GESTEN: Okay.

6 DR. BURSTIN: We've got to finish this
7 work today.

8 ACTING CO-CHAIR GESTEN: But we'll do
9 this just to reassure you that we're not going to
10 keep you until 7:00 going through hospitals.
11 Although that might be kind of a nice threat. I
12 don't know.

13 So we are back to -- we have two
14 measures that are related to PQIs, and this is
15 MUC 576 and 577. And I'm just guessing, and Sam
16 and Carl you can tell me if I'm wrong, that there
17 might be issues in common that you want to talk
18 about relative to these.

19 These are prevention quality
20 indicators out of chronic composite. Another one
21 is acute composite. These were recommended.
22 These were the workgroup recommendation for both

1 of these was encourage continued development.

2 And they were pulled by Sam and Carl.

3 These are measures, just to be clear,
4 that are both applied to MIPS and the Medicare
5 Shared Savings Program. And so Sam and Carl, I
6 guess the first is just clarify whether you want
7 to bring this to a vote and then -- versus
8 discussion, and then second, what your counter
9 recommendation is.

10 MEMBER SIRIO: So I think it's going
11 to be -- Heidi's in the room and it's going to be
12 a little bit easier, I think, for her to do it in
13 person, so I'm going to pass my comments, because
14 she's got them, to Heidi.

15 ACTING CO-CHAIR GESTEN: Okay. And
16 Sam, are you still on? Okay. Or Emily? So are
17 you charged to answer those two questions as well
18 to --

19 MEMBER BOSSLEY: Yes.

20 ACTING CO-CHAIR GESTEN: -- start out?
21 Yes.

22 MEMBER BOSSLEY: Yes. Although Kate's

1 not in the room and we do have a question. Maybe
2 Reva can answer it. So AMA has significant
3 concerns with recommending these measures in both
4 programs.

5 So you have them listed I think four
6 times or they would technically be four times, so
7 we'll handle them altogether, hopefully get us a
8 little bit ahead of or on schedule.

9 But the question that we have is that
10 these were put forward as under development, but
11 we also see in the rationale and we know the
12 VBPM, the payment modifier, the measure is in --
13 both measures are of use. So one of the
14 questions we have is, and it goes to how the
15 recommendation would be changed, it's either
16 insufficient information or do not support.

17 And so I don't know if it's that the
18 measures were significantly being updated and
19 that's why they're resubmitting them as under
20 development, but they are in use in a program
21 right now. So I --

22 MS. WINKLER: Yes. Heidi, this is

1 Reva.

2 MEMBER BOSSLEY: Yes.

3 MS. WINKLER: Yes. The information
4 that came to us on the MUC list stated that the
5 specifications are undergoing significant
6 revision and that a risk adjusted methodology was
7 in development.

8 MEMBER BOSSLEY: Okay. That's
9 helpful. Okay. So then I guess our
10 recommendation is insufficient information. And
11 it is in part, again, MSSP would be that the
12 measure's being used at the ACL level and then,
13 obviously, MIPS would be at the individual
14 physician level.

15 We have not yet seen information on
16 how this measure is specified for either level of
17 measurement. We have concerns about whether the
18 reliability and validity would be adequate at
19 either level.

20 In large part, ACOs, again, are very
21 different in construction. Knowing how they
22 might work across those different types is

1 unclear. And then our further concern is if you
2 take it down to the individual physician level,
3 small sample sizes most likely will be an issue.

4 And these measures have been tested
5 and in use for metropolitan or county level. So
6 transferring it to a different level of
7 measurement without any information is very
8 concerning.

9 We also just don't know what the
10 unintended consequences are of this type of
11 measure until it is used. So for that reason,
12 assuming these are under development, we would be
13 asking for insufficient information as the
14 recommendation.

15 ACTING CO-CHAIR GESTEN: Thank you.
16 Other comments, folks on the phone?

17 MEMBER LIN: This is Sam and I -- yes,
18 I agree with everything that Heidi said. Well, I
19 guess we were again trying to be positive looking
20 at continued development.

21 And one of the problems on the two
22 that are for MSSP, using ACOs as the example, is

1 that it's a number. It sets a bar of 100,000.
2 And, you know, some ACOs just aren't going to
3 make it to 100,000 population. So there's got to
4 be some adaptation or consideration as mentioned
5 to that.

6 The other thing is there's timing.
7 Going back to the ST thing again, timing in this
8 is that ACOs don't receive their CMS measure
9 except once a year and, at this point, at least
10 six months after the year is finished. So they
11 are put in a bind relative to being responsive
12 until they get data. So there's additional
13 things that we think would be helpful in the
14 continued development.

15 There is a word clarification that
16 would be helpful. In all four of these, they
17 talk about admissions for one of the following
18 conditions. The word admissions, is that the
19 correct word? Because to me, if we're talking
20 about prevention, or preventing admissions rather
21 than admission per se, or is the appropriate word
22 the patient presents with one of the following

1 conditions? We're a little confused on that.

2 ACTING CO-CHAIR GESTEN: Mary Barton
3 on the phone?

4 MEMBER BARTON: Thanks. Yes, I think
5 just to quickly answer Sam's question, the issue
6 is that the admission is seen as a failure, so
7 that the count per 100,000, you don't have to
8 have 100,000. It's just that it's a count. You
9 know, you average it up.

10 You change the numbers so that it's
11 per 100,000 in the population. But I wanted to
12 speak to an issue that's really more important
13 for the Medicare Shared Savings Program than it
14 is for MIPS.

15 These AHRQ measures were designed for
16 a commercial age population 18 and older. And
17 NCQA's actually endeavored to do a bit of work to
18 design a measure that was relevant to the
19 Medicare 65 and over population, which is
20 slightly different than the way the AHRQ's set
21 up.

22 The PQIs, it has it -- if you lose a

1 couple of conditions, it adds a couple of
2 conditions. And for that reason I would
3 recommend that for anything that's focused for 65
4 and older specifically, that they take a look at
5 the work, at least, that NCQA has done to, you
6 know, not have it -- to benefit from the research
7 and the years of work that we've put into that
8 and as well as the relevant risk adjustment.

9 ACTING CO-CHAIR GESTEN: Thank you,
10 Mary. David?

11 MEMBER GIFFORD: I'm going to beat the
12 dead horse. I would support insufficient --
13 voting for insufficient information. I think if
14 we use the criteria that just the topic of the
15 measure is important to further development, then
16 there's no need to have any of the other
17 categories.

18 I think we're voting for what comes
19 before us and the information before us on this
20 measure and insufficient information doesn't mean
21 that whether we support and encourage
22 development. This measure's not been specified

1 enough to even give appropriate guidance to CMS
2 where to go on this measure. And I think that's
3 an important -- so I would strongly encourage us
4 to think about voting for insufficient
5 information of this.

6 ACTING CO-CHAIR GESTEN: Thank you.
7 Bill?

8 MEMBER KRAMER: I would recommend that
9 we do support continued development. In my mind
10 we do have information. These are established
11 measures as they are currently specified.

12 What needs development is the
13 application to other populations to make it
14 relevant to ACOs. And that's the development
15 work that is needed.

16 This is an important measure. If we
17 were to say insufficient information we'd be
18 saying we don't even know if this is important.
19 We don't know if it's useful as it's currently
20 specified.

21 I think we do know those things. It
22 is important, it's useful as currently specified,

1 but it's not relevant, it's not useful in a
2 Medicare Shared Savings Program because it hasn't
3 been developed and tested in that setting.

4 So that's the development work that
5 needs to be done and so I think that's the basis
6 that I think to my understanding as to why the
7 workgroup came up with this recommendation and
8 why I would support that.

9 ACTING CO-CHAIR GESTEN: So thank you,
10 Bill. I think we're happy to vote these two
11 separately when we get to that, which I think
12 we're headed towards.

13 But I just want to make sure before we
14 get to that that there's not any nuanced or
15 specific concerns that folks who raised this want
16 to make about chronic -- the two measures,
17 chronic versus acute.

18 In other words are all the comments
19 that have been made apply equally to both or is
20 there any more nuanced or specific consideration
21 that you want folks to think about relative of
22 one to the other?

1 MS. KHAN: So this is Rabia Khan from
2 CMS and I just want to add some additional
3 thought for this. So for both of the PQIs, we
4 intend to use the specifications as AHRQ has
5 developed them. But we are working closely with
6 AHRQ to further develop the risk adjustment
7 approach to also include comorbidity since the
8 measures themselves are only risk-adjusted for
9 age and gender.

10 The other piece of this that we are
11 looking at at CMS is how to apply this measure at
12 an ACO level. We do have two individual PQIs
13 within the Medicare Shared Savings Program that
14 have been specified and tested at an ACO level.

15 So what we're trying to do here is to
16 replicate the process that we have for our two
17 existing PQIs, but just at a composite level.
18 And we're also working with the Physician Value
19 Modifier Team who's been applying both of these
20 composites for the value modifiers in order for
21 us to have an aligned approach that we can use,
22 potentially, these PQIs at an ACO level, but then

1 also at a clinician level for MIPS as it's
2 already being used under the VM.

3 ACTING CO-CHAIR GESTEN: Thanks.

4 Bill, is that card a residual that you have up
5 there? Okay. No problem.

6 MEMBER GIFFORD: We were actually just
7 debating -- having a very interested side debate
8 of whether --

9 ACTING CO-CHAIR GESTEN: Would you
10 like to tell us about it?

11 MEMBER GIFFORD: Yes, I would.
12 Whether you would consider insufficient evidence
13 as a vote that the measure shouldn't be
14 considered further development or not. And both
15 of us would agree that the measure needs to be
16 further developed. We're just disagreeing on
17 what the category meant, and could it be
18 misinterpreted to not pursue further development.

19 I think that goes back to my earlier
20 comment. I think all these measures, whether
21 they do not support -- really merit further
22 development. But if we do that, then just

1 everything should be further development and why
2 are we voting on everything. So I think that's
3 the point we were trying to debate over.

4 ACTING CO-CHAIR GESTEN: So I want to
5 make sure I understand your question. Are you
6 asking whether if something is voted as
7 insufficient information it means it disappears
8 from the planet or sends a signal that it should
9 not be further developed?

10 MEMBER GIFFORD: I think it does not.
11 Bill's concern was it would. And so I was
12 throwing that out there because if people are
13 voting concerning with Bill, if Bill's correct, I
14 would change my vote. If Bill's not, if I'm
15 correct, I don't know whether Bill would change
16 his vote, but he might think differently about
17 it.

18 ACTING CO-CHAIR GESTEN: So does
19 anyone hold the truth of what happens to things
20 that are in that category of insufficient
21 information? I don't know if we've had much
22 precedent for it or not, but want to take a guess

1 at what happens?

2 DR. LARSEN: This is Kevin. I'll take
3 a guess since Kate's out of the room. I think
4 what Kate said earlier that what's really
5 important to CMS and HHS is this discussion and
6 comment. And that being really clear when the
7 discussion comes that we add narrative to what
8 the vote has been to say this is what we think
9 specifically about this domain. It is really
10 important input and feedback in the measure
11 development process.

12 ACTING CO-CHAIR GESTEN: Go ahead.

13 Yes.

14 PARTICIPANT: Sorry I don't have a
15 tent card.

16 ACTING CO-CHAIR GESTEN: Before you
17 go, I just want to make sure it's -- we lack
18 clarity about exactly what happens. I mean, I
19 think your point is you describe what you would
20 like to see happen or how you'd like to interpret
21 it and that may resonate with others. And I
22 take, Kevin, your comment, but there is some lack

1 of clarity about --

2 MEMBER KRAMER: Just to clarify what
3 I'm thinking, the way I interpret that, is that
4 there was one earlier that I voted insufficient
5 evidence. That meant to me I don't know. I
6 mean, I didn't even know whether to vote one, you
7 know, did I like it or didn't like it. It's an,
8 I don't know. It's not that a group thinks it's
9 insufficient evidence, it's that I don't know.
10 It's a don't know category. It's a personal kind
11 of insufficient evidence.

12 So if we think that this is an
13 important area, this topic is measuring an
14 important thing, but the measure needs to be
15 developed further because it's not currently
16 specified for the uses that they applied to, then
17 we ought to vote for needs further development.

18 I'm concerned if we vote for
19 insufficient evidence it might be misinterpreted
20 as the group thinks there's just insufficient
21 evidence that this would be worth developing.

22 MS. O'ROURKE: And I'm not sure if

1 this clarifies, but this is a category we have
2 not used much in the past few years. It was
3 really an artifact from earlier days of MAP when
4 the measures under consideration list was much
5 less complete and CMS was sending us measures
6 without numerators and denominators. And that is
7 where the group really felt they did not have
8 much information and did not want to make a
9 decision based on a measure title.

10 ACTING CO-CHAIR GESTEN: So if nothing
11 else I think an output at least of today is
12 revisiting these categories and what they mean
13 and articulating them and trying to be clearer
14 about them.

15 I think, as David mentioned earlier in
16 the day, these are meant to solve a particular
17 problem which I think they did. I think they've
18 also, like most things that are meant to solve a
19 problem, created potentially some other ones in
20 its wake. And some of these categories, may or
21 may not -- they may be titles without a
22 distinction or not meaningful, so. I'm sorry,

1 Rhonda.

2 MEMBER ANDERSON: I enjoy the
3 conversation, but I still have difficulty
4 understanding. We're talking about clinicians,
5 yet I believe a lot of it is around population
6 health management where the denominator isn't
7 large for an individual clinician.

8 So I think what I think about is how
9 does the individual clinician manage chronic
10 illness and what are the components that would
11 tell us, from an outcome perspective, that that
12 clinician is managing it effectively? And from
13 my perspective that's the real question. And
14 that's why I believe there's insufficient
15 evidence as to the real purpose behind this with
16 the individual clinician.

17 ACTING CO-CHAIR GESTEN: Thank you.
18 Heidi.

19 MEMBER BOSSLEY: So I think the only
20 thing I would add, too, is we just heard that
21 this measure is in use. It's being changed
22 slightly, risk adjustment is underway. If we say

1 encourage continued development, we still have a
2 measure in use. And we've already heard
3 conversations and concerns that their measure may
4 not be constructed adequately for either program.

5
6 So that's where I struggle with maybe
7 you do go back to insufficient information
8 because we're signaling to CMS we actually are
9 concerned with how this is constructed. So I
10 think that was part of our reasoning for this.

11 ACTING CO-CHAIR GESTEN: Jayne.

12 MS. CHAMBERS: So I want to be sure I
13 understand sort of where we are in the measure.
14 I think that what I heard from Kate earlier, or
15 somebody in the room earlier, was that this
16 measure is being critically looked at from top to
17 bottom, that AHRQ is really sort of redoing this
18 measure to look at for use in other populations
19 than where it's currently specified and so it'll
20 be undergoing substantial change.

21 And if that's the case are we re-
22 looking at the risk adjustments that are in there

1 and how that's going to be used going forward.
2 You know, I think --- I guess I'm starting to --
3 originally I was going to say conditional
4 support, but now I'm not sure because I'm not
5 sure we even know what the measure is we're
6 looking at.

7 ACTING CO-CHAIR GESTEN: Any other
8 comments?

9 MEMBER GIFFORD: The definition of
10 harmonization is when the denominators are the
11 same, not necessarily the numerator. I mean if
12 your denominators are different population, then,
13 correct me if I'm wrong, Helen, you don't have to
14 -- it's an argument for why harmonization may not
15 be necessary.

16 The numerator topic gets you into the
17 pathway of potential harmonization, but you get
18 out of harmonization when you say you're
19 measuring different groups.

20 DR. BURSTIN: No.

21 MEMBER GIFFORD: No?

22 DR. BURSTIN: Actually, no. It's --

1 MEMBER GIFFORD: Okay.

2 DR. BURSTIN: -- either group. The
3 reason to potentially pick a best in class is if
4 you have both, same numerator, same denominator.
5 You could have different denominators. You would
6 still want to harmonize on the measure concept in
7 the numerator. So that doesn't necessarily --

8 MEMBER GIFFORD: Yes, okay.

9 DR. BURSTIN: Yes, right.

10 MEMBER GIFFORD: But if you're numbers
11 on the numerator, but they are considered then
12 different measures. You don't vote best in
13 class.

14 DR. BURSTIN: Correct.

15 MEMBER GIFFORD: Okay.

16 DR. BURSTIN: Correct.

17 MEMBER GIFFORD: So this is --

18 DR. BURSTIN: Right.

19 MEMBER GIFFORD: This would be a
20 measure that's changing the denominator, not
21 necessarily the numerator?

22 DR. BURSTIN: Right. And I'll just

1 put out, at least in the past when we've had
2 discussions around risk adjustment, those are
3 usually in the camp of things you would continue
4 to work on.

5 I mean, I think this has come up
6 before in other measures, just to point that out,
7 certainly around some of the SDS issues last year
8 and other issues.

9 MR. TILLY: Okay. Everybody remember
10 how to vote? We're going to vote these one at a
11 time. I think this is the way we do things.
12 They'll come up. And how about if I just, Amber,
13 just let you do this? Is that all right?

14 MS. STERLING: I'll do it. Great. So
15 this is for MUC15-576. This is PQI 92,
16 prevention of quality chronic composite measure.
17 And this is -- is it okay if you do it both for
18 MIPs and MSS at the same time because that's how
19 we have our slides set up? So I don't --- just
20 want to make sure.

21 MR. TILLY: Anybody have a problem if
22 we do the two of them together, vote on them for

1 MIPS and for Shared Savings at the same time? I
2 see no objection.

3 MS. STERLING: Okay. And the options
4 are, encourage continued development, do not
5 encourage continued development, or insufficient
6 information, and voting is open.

7 MR. TILLY: We need some nice
8 background music going forward. I make a motion
9 to have something, you know, like Jeopardy music
10 or something.

11 We have 28. Okay. The results of the
12 vote are 69 percent for encourage continued
13 development, zero percent for do not encourage
14 further consideration, and 31 percent for
15 insufficient information. The recommendation
16 stands.

17 ACTING CO-CHAIR GESTEN: So lest folks
18 feel disheartened about the votes and none of
19 these being overturned, I would just point out
20 that the conversation and the comments have been
21 rich. And I think we've already talked about how
22 we see them going forward and informing the

1 process, so take heart. So next one.

2 MS. STERLING: Great. We are going to
3 move on to MUC15-577, PQI 191, prevention quality
4 acute composite. And again, this is for both
5 MIPs and Medicare Shared Savings.

6 Your options for voting are one,
7 encourage continued development, two, do not
8 encourage continued development, or three,
9 insufficient information. And voting is open.

10 MR. TILLY: The results of the vote
11 are 70 percent encourage continued development,
12 zero percent do not encourage further
13 consideration, and 29 percent insufficient
14 information. The recommendation is encourage
15 continued development. The MAP recommendation
16 stands.

17 ACTING CO-CHAIR GESTEN: Okay.
18 Thanks. We're going to go down to the next
19 measure which is MUC 579. It's falls screening
20 risk assessment plan of care to prevent future
21 falls.

22 This particular measure part of MSSP.

1 The workgroup recommendation was to support.
2 This was pulled by Sam and Lisa. And if you can
3 -- you know what the two questions are, vote yes
4 or no and I forgot the other question. Vote yes
5 or no -- what's that?

6 MEMBER LIN: And why.

7 ACTING CO-CHAIR GESTEN: Why.

8 MEMBER BARTON: And what's your
9 justification.

10 ACTING CO-CHAIR GESTEN: Is it like
11 quarter to five or what? Go ahead.

12 MEMBER LIN: Okay. This is Sam. The
13 recommendation here is support A and B under the
14 three rates. But we've got a problem with Rate C
15 which is known as planner care for falls. The
16 whole point simply being that rather than why
17 they're leading to improvements, this element
18 increases the length, the complexity of currently
19 used care plans or whether it's sometimes
20 referred to as after-visit summaries.

21 And part of it is that today's care
22 plans are still static paper trails. The lack

1 patient centricity, flexibility, usefulness with
2 the patients and families. And that will not
3 support the intent of this particular MUC. So we
4 propose, you know, support A and B and defer the
5 third one for maybe continued development.

6 ACTING CO-CHAIR GESTEN: Lisa, did you
7 want to make a comment?

8 MEMBER MCGIFFERT: Okay. I am looking
9 at my notes and I have similar comments that we
10 had with 207 that, you know, we're concerned that
11 this doesn't complete the measure. We don't know
12 if it had an impact on falls. We think it's
13 important to measure this issue and our concerns
14 are that it really isn't complete.

15 ACTING CO-CHAIR GESTEN: So let me
16 make sure for you and Sam.

17 MEMBER MCGIFFERT: It's been my
18 understanding --

19 ACTING CO-CHAIR GESTEN: Is it support
20 with modifications? Is that what you're
21 advocating?

22 MEMBER MCGIFFERT: It's the same --

1 well, we have the same concerns as we did with
2 207. And I just wanted to --

3 MEMBER LIN: Correct.

4 MEMBER MCGIFFERT: -- voice those
5 concerns.

6 ACTING CO-CHAIR GESTEN: Okay. And do
7 you want to translate that into a recommendation
8 for how people should vote?

9 MEMBER MCGIFFERT: I wasn't
10 necessarily pulling it for a vote. I did note
11 that my understanding is that this is already
12 being used in the physician quality reporting
13 system, if anybody can validate that.

14 And if so, is there any way to look at
15 the data that's already been collected and figure
16 out, you know, if there actually has been a
17 reduction in falls based on these measures. I
18 would like to see that. I just pulled it for
19 discussion because I feel like it's an incomplete
20 measure.

21 ACTING CO-CHAIR GESTEN: Okay. Gail.

22 MEMBER HUNT: Yes. I would agree and

1 I don't think there's anything here that says
2 that they've actually looked at --- it's all the
3 process of doing the risk assessment and then
4 saying does the person have a documented risk
5 assessment in the plan of care. But it doesn't
6 say anything about whether or not it actually
7 made a difference in their falling -- in
8 preventing falls, which is what the whole purpose
9 of it is, right?

10 ACTING CO-CHAIR GESTEN: So, Lisa, you
11 had said that you saw this as a discussion. I
12 just want to check with Sam who also pulled this.
13 Sam, I won't answer for you. Would you like us
14 to take a vote on this?

15 MEMBER LIN: Well, we took a vote on
16 207, so I'm wondering whether we should be
17 consistent or not.

18 ACTING CO-CHAIR GESTEN: What did we
19 do with 207? Did we vote?

20 MEMBER LIN: Well, I thought -- gosh.
21 Maybe I've got the wrong one. I thought the
22 issue at that point was about implementation.

1 And again, this is process versus outcome, but
2 how would you measure implementation and how do
3 you be consistent about that? This is was sort
4 of the same thing with the care plans. There's
5 not consistency and a current process at this
6 point.

7 If we support it we'd have to support
8 all three parts. And I can't support the third
9 element.

10 CO-CHAIR PINCUS: For the 207 we
11 didn't vote, but we took additional comments.

12 MEMBER LIN: Oh.

13 CO-CHAIR PINCUS: Yes, sort of, you
14 know, urging further examination of building in
15 some kind of outcome as you're into this and
16 looking at sort of relationship to outcome.

17 MEMBER LIN: Okay. And I'm struggling
18 here because it's late in the day, but how's that
19 different from continued development?

20 ACTING CO-CHAIR GESTEN: The measure's
21 specified in use and it's NQF endorsed. That's
22 why it's not continued development.

1 MEMBER LIN: Okay.

2 ACTING CO-CHAIR GESTEN: Lisa.

3 MEMBER LIN: Okay.

4 MEMBER MCGIFFERT: I just want to
5 clarify as I did before in 207, that we think the
6 third measure is an important measure. We're not
7 in agreement with the reasons that we pulled this
8 out with Sam, yes. We want an outcome measure
9 and we do think the third point of this composite
10 is important.

11 ACTING CO-CHAIR GESTEN: Okay. Any
12 other discussion on this? Sam, I would just want
13 to be crystal clear. We're happy to vote if you
14 want to take it to a vote or we cannot vote.
15 Consistency is nice, but it's not the only value
16 in life, so up to you.

17 MEMBER LIN: Yes. No, if we're going
18 to be consistent with 207, let's move on.

19 ACTING CO-CHAIR GESTEN: Okay. So we
20 would take the comments under discussion and
21 bring those forward.

22 MEMBER LIN: Right. Thank you.

1 ACTING CO-CHAIR GESTEN: Okay. The
2 next --

3 MEMBER LIN: The next part really
4 quick, I promise.

5 ACTING CO-CHAIR GESTEN: I'm sorry?

6 MEMBER LIN: The next one is really
7 quick, Number 11.

8 ACTING CO-CHAIR GESTEN: Number 11. I
9 don't have a Number 11. I was moving on to my
10 Number 9, which is MUC 928 which is a paired
11 measure. Is that -- am I out of order?

12 PARTICIPANT: No, you're right.

13 ACTING CO-CHAIR GESTEN: I'm good?

14 PARTICIPANT: Yes.

15 ACTING CO-CHAIR GESTEN: All right.

16 Sam, hang in there. It's a paired measure,
17 depression utilization, the PHQ9, depression
18 remission at six months, depression remission at
19 12 months. This one --

20 MEMBER LIN: Right.

21 ACTING CO-CHAIR GESTEN: -- was given
22 conditional support. This is part of MIPs and it

1 was pulled by Elizabeth Mitchell. And Elizabeth,
2 are you on the phone still?

3 MEMBER LIN: No, but this is Sam. But
4 this is one actually I thought we had pulled and
5 it's a quick issue. If you look, it's a typo.
6 It keeps showing up, so we just thought we might
7 as well say something.

8 Under description, fourth line says
9 demonstrate remission, that is PHQ score of
10 greater than five. It's less than five. That's
11 all it is. It's just a typo, but it's been
12 showing up all the time.

13 ACTING CO-CHAIR GESTEN: Well, that's

14 --

15 MEMBER LIN: Because the numbers run
16 the opposite way.

17 ACTING CO-CHAIR GESTEN: That's really
18 easy. But let me just make --

19 MEMBER BARTON: Thanks, Sam.

20 ACTING CO-CHAIR GESTEN: Elizabeth, is
21 that you? No.

22 MEMBER BARTON: No.

1 ACTING CO-CHAIR GESTEN: Okay. I'm
2 just -- David.

3 DR. BAKER: So I have concerns about
4 the numerical cutoff for this. I have seen many
5 patients who start off with a PHQ of 14 to 17.
6 They get down to seven. This is the best that
7 they've felt in the last ten or 15 years.

8 And this measure would encourage me to
9 actually have to start a second agent to get them
10 down into quote remission. So I think there is
11 significant unintended consequences from this
12 measure.

13 WORKING GROUP CO-CHAIR BAGLEY: This
14 is Bruce. I think somebody should check the
15 measure specifications. I think that's a change
16 of five or more as an indicator of improvement.

17 CO-CHAIR PINCUS: There's actually two
18 different measures that exist out there, one is
19 clinically significant improvement, the other is
20 remission. So -- and this sounds like this is
21 the remission one.

22 ACTING CO-CHAIR GESTEN: Well, we can

1 clarify, but David, I'm not sure whether you're
2 raising this as further commentary or discussion
3 or whether you're raising it because you think
4 that we should vote on this?

5 DR. BAKER: I'd like to see a vote on
6 this, even though I know that we'll lose. But I
7 think that this is -- the idea of a change score
8 is one thing, but the idea of a cutoff, you know,
9 of less than five, I think for so many patients
10 it's just not realistic and it's got adverse
11 consequences. So I --

12 ACTING CO-CHAIR GESTEN: Okay.

13 DR. BAKER: I would suggest that we
14 vote to not support it.

15 ACTING CO-CHAIR GESTEN: Okay. Harold
16 and then Bill.

17 CO-CHAIR PINCUS: Just one issue. I'm
18 not sure if on the overall MUC list this is
19 paired with a clinically significant improvement
20 measure, which is an NQF measure.

21 MS. WINKLER: No.

22 MEMBER QASEEM: Reva, do you --

1 MS. WINKLER: Yes. What this is is it
2 has three components to it. Each of those three
3 components individually is already in the
4 clinician measure set.

5 What this does is bring forward an
6 obligatory combination of the two remission
7 measures, both at six and at 12 months where
8 before within the clinician measure set you could
9 choose among the three, use the PHQ9, remission
10 at six months or remission at 12 months. What
11 this does is bring in a measure that obligates
12 you to use both.

13 CO-CHAIR PINCUS: But, Reva, isn't
14 there also a sort of like complementary measure
15 that also looks at six and 12 month clinically
16 significant improvement?

17 MS. WINKLER: There may be, but it
18 wasn't on the MUC list.

19 CO-CHAIR PINCUS: Okay.

20 DR. BAKER: Can I read this? So it
21 says adult -- this is, again, it's a complicated
22 measure, but Number 711, adults age 18 and older

1 with a diagnosis of major depression or dysthymia
2 and an initial PHQ9 score greater than nine to
3 achieve remission at six months as demonstrated
4 by a six month plus or minus 30 day PHQ9 score of
5 less than five. And then there's similar wording
6 for the 12 month measure.

7 MEMBER GIFFORD: Dave, do the
8 conditions that the workgroup put on there
9 satisfy you, though, where consider target rates
10 for different types requires and consider risk
11 stratification to minimize adverse target rates,
12 looking at different or --- I mean do you just
13 want to send a signal by saying do not support to
14 really make sure that they change this, or
15 putting it as conditional support with your
16 recommendation leave it as conditional support
17 and just get the recommendation on the record?

18 CO-CHAIR PINCUS: I mean, I might make
19 a recommendation to incorporate in the conditions
20 to consider pairing it up with the clinically
21 significant improvement measure that already is
22 NQF approved.

1 DR. BAKER: That would make a lot more
2 sense if there was another way, you know, of
3 dealing with these patients that really have high
4 baseline scores.

5 ACTING CO-CHAIR GESTEN: Bill.

6 MEMBER KRAMER: I wanted to raise a
7 process question. David and others who raised
8 issues like this around specific measures, I
9 wonder if MAP is the right setting to debate
10 those very specific clinical cutoffs or criteria.

11 It's already been through NQF
12 endorsement where these issues, I assume, were
13 addressed, and as well as the workgroup itself
14 which has commissions on it. And I don't feel
15 able to have a useful dialogue about that in this
16 setting, so I rely a lot on the endorsement
17 process where I know this expertise has been
18 applied as well as a clinician workgroup.

19 So while I have tremendous respect for
20 your judgment and others, it's hard in this
21 setting to have that -- for me to enter into that
22 conversation and decide whether it's a good idea

1 or not.

2 I will say this, from a consumer
3 perspective, this is really, really important. I
4 think all of us feel that depression's a very,
5 very important measure and this is one of the few
6 where you have really good patient-reported
7 outcome measures.

8 I question whether we should actually
9 go ahead and support this, understanding that
10 there will be further improvements in the measure
11 and remove the conditions for our support.

12 This is an important measure, a good
13 measure. I am somewhat concerned that if we send
14 a message of conditional support that CMS might
15 be inclined to withdraw it from its current use,
16 which I think would be net a mistake.

17 CO-CHAIR PINCUS: I think I would just
18 say, I think this solution that we were just
19 discussing doesn't go against a notion of the
20 endorsement process because, you know, the
21 initial process initially approved a measure that
22 was focused solely on remission.

1 And then subsequently to sort of
2 complement that was a measure that was added on
3 clinically significant improvement for exactly
4 the reasons that David suggested. So pairing
5 them both is -- provides very limited incremental
6 burden, but also deals with the problem David
7 suggested.

8 ACTING CO-CHAIR GESTEN: Any other
9 comments?

10 DR. BAKER: I just want to comment
11 because I think the issue that Bill brings up,
12 the broader issue about what we're able to really
13 discuss here is an important one. But at the
14 same time, I see this as kind of the last time
15 that we really think about the issue of
16 unintended consequences. And this discussion, I
17 think, is a great one.

18 I mean, if we can come up with a
19 combination or suggest that to prevent those
20 unintended consequences, I think that's really
21 important. Because once it goes to that next
22 level, I'll say in our clinic at Northwestern

1 when I was there, the use of the PHQ9 was
2 revolutionary.

3 We would all agree it dramatically
4 improved our care, but if we all of a sudden said
5 okay, now you have to get everybody less than
6 five to get credit -- so, you know, 17 to seven
7 doesn't count, then that's the level when all of
8 a sudden we start seeing some of these unintended
9 consequences.

10 So I do think it's important to
11 discuss it. Again, not to try and get the cutoff
12 right, but to raise issues about unintended
13 consequences or other issues or to think
14 creatively about how to combine them.

15 ACTING CO-CHAIR GESTEN: Helen.

16 DR. BURSTIN: Just a brief comment.

17 Again, I don't think it's the final common step
18 by any means. I mean, these measures are
19 continuously evaluated on the endorsement side.
20 In fact, your co-chair is the co-chair of the
21 Behavioral Health Committee with Peter Briss.

22 So these issues are seriously

1 considered. And again, all this feedback will
2 flow into endorsement. And it's exactly, I
3 think, the reason why Minnesota Community
4 Measurement brought forward the companion measure
5 of percent improvement of 50 percent reduction
6 for exactly those reasons. But all those
7 comments will certainly be kept.

8 ACTING CO-CHAIR GESTEN: Seeing no
9 raised hands or cards I'm thinking we can move to
10 a vote. Again, we're voting on MUC 928. The
11 workgroup recommendation was conditional support.

12 It was pulled and a suggestion was
13 made to have this do not support. All right.
14 Okay. And there was also comments that
15 potentially a conditional support from the
16 workgroup meeting should be moved up to support.
17 So it'll be interesting to see how the voting
18 goes, and -- Amber.

19 MS. STERLING: Great. This is MUC
20 15928. It is the paired measure depression
21 utilization of the PHQ9 tool, depression
22 remission at six months, depression remission at

1 12 months. Your options are one, support, two,
2 conditional support, three, do not support. And
3 you are open for a vote.

4 MEMBER QASEEM: Remind me what's the
5 workgroup recommendation. I lost track of it.

6 ACTING CO-CHAIR GESTEN: Conditional -

7 -

8 MS. STERLING: It was conditional
9 support.

10 ACTING CO-CHAIR GESTEN: -- support.

11 MR. TILLY: So the results are 11
12 percent support, 89 percent conditional support,
13 zero percent do not support. The workgroup
14 recommendation stands as conditional support.

15 ACTING CO-CHAIR GESTEN: Okay. We
16 have three measures. Question? Yes, Kevin.

17 DR. LARSEN: Just a quick comment
18 follow up from that falls question. There was a
19 question about whether that falls measure was
20 already in PQRS. It is already in the PQRS
21 Program, the falls measure that we looked at a
22 couple measures ago, and I think for

1 recommendation for MSSP. So it already exists in
2 the current program.

3 ACTING CO-CHAIR GESTEN: So my
4 understanding is we have three measures that
5 currently were in -- at least on my list, were in
6 the discussion only that potentially moved into
7 votes. And I'm going to ask Amir to clarify
8 that. We have 210, 211 and 220.

9 MEMBER QASEEM: So what are you asking
10 me?

11 ACTING CO-CHAIR GESTEN: So my
12 understanding is that on the list that I have
13 these were for discussion, not pulled for vote.
14 I have a note saying that these were to be pulled
15 by you for a vote.

16 MEMBER QASEEM: Yes, so you know what,
17 let's just leave it as they're all conditional
18 support, I think, all these three, right, or
19 four?

20 ACTING CO-CHAIR GESTEN: So 210 is
21 encourage continued development. That's --

22 MEMBER QASEEM: Okay.

1 ACTING CO-CHAIR GESTEN: -- Hep A
2 vaccination for patients with cirrhosis. 220 is
3 Hep B vaccination for patients with chronic Hep
4 C, was also encourage continued development.

5 MEMBER QASEEM: Yes.

6 ACTING CO-CHAIR GESTEN: And 211 is
7 Hep B vaccination for patients with cirrhosis,
8 encourage continued development. So they were
9 all encourage continued development. They were
10 identified by Sam for discussion and you --

11 MEMBER QASEEM: Yes.

12 ACTING CO-CHAIR GESTEN: -- for --

13 MEMBER QASEEM: So I'll keep it at
14 discussion as well because I think the voting, I
15 think it's just that it doesn't change anything
16 anyways. So I'll actually combine all my
17 comments for these three into one because I think
18 pretty much they all fall under the same
19 category.

20 Essentially, the same concerns that I
21 think Bruce also mentioned during his
22 presentation that the gap information is just not

1 provided. We don't even know what's happening in
2 some of these population right now.

3 So for example, if you like to look at
4 the Hep A vaccination for patients with
5 cirrhosis, I don't even know how many patients
6 are getting this vaccination are not getting the
7 information. If this is an issue or a concern
8 where we should even have a performance measure
9 of what is a variation in performance measure.

10 And then there always going to be
11 exceptions in certain patients as well. That was
12 not mentioned in some of the exclusions here as
13 well.

14 And if you look at some of the
15 comments that came from like these ACP sub-
16 specialty societies, AGA and ASGE, they all
17 actually did not agree with these performance
18 measures for exactly the same reasons as well.

19 So I'm happy to leave it as a
20 discussion since again, the voting is going to be
21 -- keep what workgroup is recommending anyways.
22 But I think, again, these are the issues that

1 Bruce also brought up as well. I think these are
2 incredibly important ones that are missing from
3 many of these measures.

4 ACTING CO-CHAIR GESTEN: Okay, Amir.
5 Let me turn if Sam's still on. Do you want to
6 amplify or second or have any other additional
7 comments that you want to make about this since
8 you had pulled this for discussion? Anybody else
9 who wants to make comments on any of these three
10 measures?

11 MEMBER LIN: Oh, I'm sorry. This is
12 Sam again.

13 ACTING CO-CHAIR GESTEN: Go ahead, Sam.

14 MEMBER LIN: I agree with Amir. Our
15 only concern again was a process issue that it
16 would help to be able to put something like the
17 word titer in this simply because, again, it
18 clarifies how we actually determine the capacity
19 of this thing.

20 It just sort of says, you know,
21 documented vaccination. Does that mean somebody
22 got a needle in their arm or does that mean there

1 actually was titer taken to know that it took and
2 was the right level. That's all.

3 ACTING CO-CHAIR GESTEN: Lisa.

4 MEMBER MCGIFFERT: I had a note that -
5 - I had it on 220. We're taking all these
6 together, yes?

7 MEMBER LIN: Yes.

8 MEMBER MCGIFFERT: That it sounded
9 like the -- this is another case where the
10 committee sounded like they were recommending
11 something else on the conditional recommendation.
12 They strongly considered consolidating the
13 measure, they -- let's see, so that was one
14 thing.

15 The registry was not specified and the
16 public comments on the measure were pretty mixed
17 with some strongly supporting and others not. It
18 just seemed like there was not real strong
19 agreement to encourage continued development, so
20 I was curious about that. And then -- yes, that
21 was mainly it.

22 WORKING GROUP CO-CHAIR BAGLEY: Yes,

1 this is Bruce. I think that these three measures
2 really come under the category of standard of
3 care and following protocols and things like
4 that.

5 So we didn't really feel, especially
6 without the current level information, that we
7 could strongly support these. So we thought that
8 encourage continued development might be the
9 right answer and find out what the rates were.

10 ACTING CO-CHAIR GESTEN: Any other
11 comments? So we have one other measure for
12 discussion and that was -- oh, I'm sorry, David.

13 DR. BAKER: I just had a question --

14 ACTING CO-CHAIR GESTEN: Sorry about
15 that.

16 DR. BAKER: -- for Bruce. Bruce, did
17 you look at process outcome link for these?
18 Because I just question, you know, the evidence,
19 if this really makes a difference for outcomes.

20 WORKING GROUP CO-CHAIR BAGLEY: I
21 would say the answer to that is no, we did not.

22 ACTING CO-CHAIR GESTEN: The last

1 remaining measure that we have is MUC 436 for
2 discussion, overutilization of mesh in the
3 posterior compartment. And this was encourage
4 continued development and was pulled by Sam.
5 Sam, you have the --

6 MEMBER LIN: And I'll be --

7 ACTING CO-CHAIR GESTEN: Go ahead.

8 MEMBER LIN: -- very quick. Thank
9 you. Thank all of you for your patience. We
10 agree with the MAP recommendation of continued
11 development on this. But the reason for the
12 discussion was, and I'm crossing the street
13 relative to process and outcome to the outcome
14 side, and that is there needs to be some
15 clarification as how is the use of a mesh
16 considered an outcome as opposed to a process.
17 That's all.

18 ACTING CO-CHAIR GESTEN: Okay. Any
19 other comments on that measure?

20 MEMBER MCGIFFERT: I think this is a
21 really important measure just because there has
22 been a lot of controversy about surgical mesh and

1 this particular kind of mesh. And so I would
2 just strongly encourage continued development. I
3 mean, it's especially an issue in the Medicare
4 population I think.

5 ACTING CO-CHAIR GESTEN: Okay. Well,
6 the only thing standing between us and break is
7 public comment. So why don't we start if there's
8 any persevering folks left -- I need a rearview
9 mirror, is what I need -- who want to make a
10 comment here and then I'll let the folks on the
11 line. Anything during day.

12 PARTICIPANT: Anything, but not --

13 ACTING CO-CHAIR GESTEN: Anything.

14 PARTICIPANT: -- even anticipation of
15 this discussion.

16 ACTING CO-CHAIR GESTEN: No.

17 (Off-microphone comments.)

18 PARTICIPANT: Can you explain to why?

19 ACTING CO-CHAIR GESTEN: No, sorry.

20 Operator, can you give folks instructions on the
21 line if they want to make a public comment.

22 OPERATOR: If you would like to make a

1 public comment, press Star 1.

2 And there are no public comments.

3 ACTING CO-CHAIR GESTEN: So first,
4 thanks to all the presenters and all of you for
5 hanging in for a long day. Apologies to the folks
6 on the Hospital Group who are really excited and
7 ready to roll this afternoon, but believe that
8 we're going to start with that tomorrow morning.
9 Is that right? Any other business?

10 CO-CHAIR PINCUS: I just want to thank
11 my co-conspirator here who was pulled in at the
12 last minute and did a terrific job. And even
13 though the --

14 ACTING CO-CHAIR GESTEN: It took a
15 little longer.

16 CO-CHAIR PINCUS: -- post acute thing
17 --

18 ACTING CO-CHAIR GESTEN: Yes.

19 CO-CHAIR PINCUS: -- was a lot shorter
20 than --

21 ACTING CO-CHAIR GESTEN: A bit less
22 measures.

1 CO-CHAIR PINCUS: But look forward to
2 talking with everybody tomorrow.

3 MR. AMIN: All right. So just quickly--

4 MEMBER BARTON: Hi.

5 MR. AMIN: -- maybe we can --

6 MEMBER BARTON: Real quick, can you
7 say what time we're starting tomorrow?

8 MR. AMIN: Yes, let's just quickly
9 review the agenda for tomorrow. We're going to
10 still start tomorrow at 9:00 a.m. and we'll start
11 with the recap. But we will move directly to the
12 hospital programs.

13 We'll have a public comment period,
14 sorry, after the recap and then move to the
15 review of the hospital programs. We'll still
16 review the MAP at 5:00.

17 The breakout sessions and the MAP core
18 concepts will likely have to wait until another
19 time. However, we will introduce the idea of
20 core concepts to the extent that we still have
21 time and then have a discussion around
22 improvement.

1 So we'll try to stick to as much of
2 the schedule as possible, but obviously get
3 through our main task of reviewing the
4 recommendations of the workgroups. So --

5 DR. BURSTIN: Yes. We won't miss --

6 MR. AMIN: Yes.

7 DR. BURSTIN: -- your deadline. It
8 will be --

9 MR. AMIN: No, we will definitely end
10 to accommodate for travel for tomorrow. So again
11 thank you all.

12 MS. BITTORIE: And just --

13 MR. AMIN: Any questions on the phone?

14 DR. BURSTIN: Missed question, yes.

15 MS. BITTORIE: Just a reminder for our
16 committee members, you will receive a different
17 link tonight to access tomorrow's meeting.

18 MEMBER LIN: Okay. Thanks.

19 MR. AMIN: Okay. Thank you all for
20 your time and contributions today.

21 (Whereupon, the above-entitled matter
22 went off the record at 5:12 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: Measure Applications Partnership
Coordinating Committee Meeting

Before: NQF

Date: 01-26-16

Place: Washington, DC

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