

NATIONAL QUALITY FORUM

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ALL-CAUSE ADMISSIONS AND READMISSIONS
STANDING COMMITTEE

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THURSDAY
JUNE 9, 2016

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., John Bulger and Cristie Travis, Co-Chairs, presiding.

PRESENT:

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System

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ALSO PRESENT:

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* present by teleconference

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Adjourn

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

2 9:08 a.m.

3 CO-CHAIR BULGER: Okay. We're going
4 to get started here for day two. Welcome back.
5 Thank you again to Bruce for working us through
6 this stuff yesterday while I traveled down here.
7 I missed Dr. Krumholz yesterday morning, but I
8 got to see his tweets last night once I got on
9 the Twitter, so I know everything he said.
10 Although he missed a "not" in one of his tweets
11 and he said he -- there was some comment about
12 thinking that there should be a double standard
13 instead of I do not think there should be a
14 double standard for SES.

15 (Laughter.)

16 CO-CHAIR BULGER: I was thinking about
17 correcting it, but I let it alone.

18 CO-CHAIR TRAVIS: Oh, then he fixed
19 it.

20 CO-CHAIR BULGER: Oh, he fixed it.

21 CO-CHAIR TRAVIS: I emailed him, yes.

22 CO-CHAIR BULGER: All right.

1 CO-CHAIR TRAVIS: I didn't think he
2 wanted to --

3 (Simultaneous speaking.)

4 CO-CHAIR BULGER: Yes, I saw that and
5 I was like I don't think that's what he wanted to
6 say.

7 Welcome also to the public and anyone
8 else who's on the phone. This is the second day
9 for the Readmissions Project Standing Committee
10 for those that aren't sure where they are.

11 So we have a host of measures this
12 morning. The first three this morning are very
13 similar, so I think we'll probably end up having
14 the same type of discussion we had with some of
15 the other ones yesterday, where the first one
16 there's a lot of discussion and then the
17 following two are very similar to that.

18 So we'll get right into it. The first
19 measure is 2886. It's a new candidate measure,
20 Risk-Standardized Acute Admission Rates for
21 Patients with Heart Failure. And as I said,
22 there's this one, which is heart failure. The

1 next one is diabetes and the one after that is
2 AMI.

3 So we'll start with the developer.

4 DR. DRYE: Hi, I'm Elizabeth Drye and
5 one of the directors at the Center for Outcomes
6 Research and Evaluation at Yale. I'm also a
7 pediatrician and I've been working on developing
8 outcome measures for a long time with our
9 wonderful team.

10 I was going to provide some background
11 remarks on these ACO admission measures just to
12 give you an overall picture of their differences
13 and similarities with the measures you looked at
14 that CORE developed yesterday. And the Erica
15 Spatz who's a cardiologist and led the
16 development of the first measure that is on the
17 docket, the heart failure measure, will give you
18 a couple more detailed remarks about that
19 measure, if that sound okay. I'll try to be
20 quick.

21 So thanks again for the opportunity to
22 introduce these measures. We're really excited

1 about these measures because they move from
2 looking at hospital care for patients who are
3 acutely ill to looking at outcomes for the
4 management of ambulatory care patients with these
5 chronic conditions: heart failure, diabetes. And
6 the third measure is for patients with multiple
7 chronic conditions. They're similar in their
8 approach to the measures you looked at yesterday
9 in that they share some of the same modeling and
10 risk-adjustment strategies. And also we test
11 validity and reliability and disparities in the
12 same way, but I'm going to focus now on their
13 differences.

14 The biggest difference is that we're
15 measuring ambulatory care quality over the course
16 of an entire year for non-hospitalized Medicare
17 fee-for-service patients. And the measures are
18 really looking -- the measure concept is evaluate
19 how well the providers are working with each
20 other and with their patients to improve
21 outcomes.

22 The outcome we use is acute unplanned

1 admissions per 100 person-years, which is a count
2 of admissions. And the reason that we're using
3 acute unplanned admissions is we are evaluating
4 how well providers are working together to avoid
5 catastrophic complications of the chronic
6 conditions that are the focus of the measure, but
7 also lower the overall risk of a hospitalization
8 for these generally more vulnerable patients
9 through providing best preventive care, early
10 intervention in acute exacerbations of illnesses
11 and also avoiding complications of chronic
12 disease management such as adverse drug events,
13 drug interactions, etcetera.

14 Second, we're in a very different
15 program context, which is exciting for us to be
16 pioneering. These are accountable care
17 organizations. And actually these measures are
18 already in use in the ACO, CMS' ACO quality
19 measure set. They'll be reported for the first
20 time this summer. They didn't way for NQF
21 endorsement, but they're very interested
22 obviously in getting endorsement. And they are

1 reported over a calendar year and we use data
2 from the prior years to develop our patient
3 cohort and evaluate risk-adjusters. And they'll
4 be reported on 2015 performance within the next
5 month or so.

6 The Medicare Shared Savings Program
7 and the other ACO Programs at CMS Pioneer, and
8 that's evolving into the next gen programs, use
9 these measures. These are very different than
10 inpatient quality reporting in that they're
11 voluntary programs. Providers come together and
12 opt to participate and take shared responsibility
13 for the Triple Aim essentially of providing
14 better care, better health. So population health
15 management and lowering costs. And they're
16 jointly responsible for the outcomes of care, so
17 that makes it a wonderful environment to be
18 evaluating population-based outcomes.

19 As a result of the way the programs
20 are structured and their goals, our conceptual
21 approach to these measures is it takes an
22 expansive view of how providers might act to

1 lower the risk of acute admissions. We have a
2 conceptual model that for this first measure is
3 on page 42 of the testing part of the form, but
4 we lay out there; and this is relevant to how we
5 think about disparities and risk-adjustment, a
6 really broad range of factors that I think
7 everyone is aware of that could influence the
8 risk of admission including health factors,
9 health behaviors in the environment,
10 environmental factors and community resources,
11 etcetera.

12 And we had a lot of discussion with
13 this about our expert panel and with CMS and we
14 took public comment on it and decided that we
15 would focus our risk-adjustment on patient health
16 status and age at the outset of the year and not
17 adjust for these factors, because broadly within
18 the ACO community there is much innovation going
19 on to mitigate the relationships that these other
20 broader factors have with the risk of admission.
21 So that was a policy methods decision we wanted
22 to share with you and that we can discuss more.

1 And finally, one of the wonderful
2 things about working in this environment is we
3 have many, many patients, so these ACOs have from
4 hundreds to thousands, even more than 10,000
5 patients in the measure cohort. And you can
6 imagine that's much different than what we see in
7 the hospital-based measures. As result we are
8 able to easily detect statistically significant
9 differences.

10 And so, you'll see that as a group
11 they show highly varied performance. On average
12 they do better than fee-for-service providers on
13 this outcome, and we norm the measure against the
14 national group of fee-for-service providers that
15 if they are doing better, they will show up as
16 better. But the range of their performance is
17 really wide. So for example, the minimum and the
18 maximum risk-standardized acute admission rates
19 is after risk-adjustment. For heart failure it
20 ranges from 54 to 120 person-years, which is very
21 a clinically policy-meaningful range. For
22 diabetes it's from 24 to 68. For the multiple

1 chronic condition measure it's from 48 to 107.

2 So finally, I just wanted to note we,
3 as you know, submitted a supplemental memo on
4 disparities analysis using the AHRQ nine-digit
5 ZIP code. And in that more updated analysis,
6 which it looks at 2013 ACOs, 220 ACOs, we still
7 see -- we do see variation and somewhat of a
8 trend with the ACOs with the largest proportion
9 of low-socioeconomic status patients having
10 slightly higher scores on the measure.

11 But even in the group, the quartile
12 with the most low-SES patients, we see for each
13 one of these measures that 30 to 40 percent of
14 the ACOs are performing better than the national
15 rate. We see some really outstanding performers,
16 which is consistent with, for example, what other
17 ACO Programs have seen. The one I'm thinking of
18 right now is the Blue Cross Blue Shield Quality
19 Contracts where some of their best performers
20 have been provider groups that have a high burden
21 of low-SES patients.

22 So it's a really exciting environment

1 to be working in and we're really looking forward
2 to your input. I'm going to have Erica say a few
3 words about heart failure before we focus on the
4 measure. Thanks.

5 DR. SPATZ: Great. Thanks, Elizabeth.

6 My name is Erica Spatz. I'm a general
7 cardiologist and I led the heart failure measure.
8 And so, I'd just like to take a moment just to
9 focus specifically about heart failure and how
10 this measure we think helps to advance quality of
11 care.

12 So the heart failure measure is a
13 risk-standardized measure evaluating quality of
14 care of heart failure patients cared for ACOs.
15 In conceptualizing this measure we focused on
16 hospital admissions, because for patients with
17 heart failure hospitals admissions are associated
18 with high morbidity and stress, they increase
19 their risk for dying, and they're extremely
20 costly to the healthcare system. So we think
21 that we're measuring something that's important
22 to patients as well as to healthcare systems.

1 And so, why is this measure all-cause
2 unplanned hospitalizations needed? For people
3 with heart failure they are at risk for a range
4 of different kind of admissions. It's an
5 extremely vulnerable population. So they're at
6 risk for heart failure exacerbations, AFib and
7 other cardiovascular diseases. They're also at
8 risk for related complications like renal failure
9 or electrolyte disturbances, but they're also at
10 risk for a range of other hospitalizations.

11 For example, due to hemodynamic
12 instability. They may be at risk for falls due
13 to immune incompetence. They may be at risk for
14 pneumonia. And we wanted to capture all of these
15 different kinds of complications and really
16 incentivize a range of providers, not just
17 cardiologists like myself, but to work with a
18 range of providers throughout the healthcare
19 system as these ACOs are set up to do to provide
20 hospitalizations in this very vulnerable
21 population.

22 We wanted to move beyond the only

1 other outcome measure for patients with heart
2 failure, which is the AHRQ PQI, the Prevention
3 Quality Indicator. That PQI only measures heart
4 failure exacerbations so it misses almost two-
5 thirds of the other kinds of admissions that
6 people with heart failure are coming in for.
7 So we think that this measure adds to what
8 currently exists.

9 I wanted to highlight also that we
10 think that admissions are important because we
11 have really good evidence that we can lower the
12 risk of hospitalization by providing highly
13 coordinated care, by providing care navigation
14 for people, home-based services, participation in
15 cardiac rehab. These are examples of
16 interventions that have reduced hospitalizations
17 in the heart failure population.

18 The third thing I'd like to highlight
19 as you review our measure is the risk-adjustment
20 model. We take into account a range of risk
21 factors that increase the risk of admission,
22 including a variable capturing pacemakers and

1 ICDs. We know that prior hospitalizations is a
2 significant predictor of future hospitalizations,
3 but we don't adjust for them. And the reason
4 that we don't adjust for them is that we think
5 that prior hospitalizations are a marker of
6 quality of care. We don't want to adjust for
7 variables that can confound quality. So that's
8 one of the reasons why you won't see that in our
9 risk-adjustment model.

10 As Elizabeth referred to as well and
11 as you heard about yesterday, we also don't risk-
12 adjust for socioeconomic status. And our team
13 put a lot of thought into this. We know that
14 these patients have a lot of challenges. We know
15 that they're at increased risk for admission, but
16 we also know that in particular the ACO Programs
17 are designed to work with their patients, to work
18 with their communities to mitigate the effects of
19 poor access to care, medication non-adherence,
20 health illiteracy, increasing opportunities for
21 healthy eating, cardiac rehab. These are things
22 that ACOs can actually improve for patients to

1 improve their outcomes.

2 So, and as Elizabeth mentioned, we
3 found a number of positive deviants in the ACO
4 population, meaning ACOs that were caring for the
5 most number of low-SES patients, and we did a
6 number of things to look and see that these
7 patients were truly low-SES. We looked by the
8 nine-digit AHRQ SES Index, we looked by Medicaid
9 dual-eligibility to really clarify that these
10 were low-SES patients. And in that group of ACOs
11 that were providing care to the most number of
12 low-SES patients there were a significant number,
13 almost a third, that were performing better than
14 the national rate.

15 So we are excited about these ACO
16 programs because we think that they can
17 meaningfully impact outcomes and we think that
18 this measure helps to eliminate those differences
19 and drive quality care improvements.

20 So we look forward to your comments
21 and happy to answer any questions that you may
22 have.

1 CO-CHAIR BULGER: Thank you. So we'll
2 go to -- the discussants are Bruce and Karen.
3 And Paula was not able to be with us this
4 morning. So we'll start with Karen.

5 PARTICIPANT: You want to go one by
6 one?

7 CO-CHAIR BULGER: Yes, we're going to
8 go one by one. We'll talk about evidence first.

9 MEMBER JOYNT: Yes, I think I agree
10 with the measure developers that this is a
11 measure that fills an important gap and has
12 evidence, at least in terms of the theoretical
13 relationship between clinical interventions and
14 the ability to keep people out of the hospital.

15 At what point would the AHRQ PQI --
16 should I leave that alone for now, and the
17 overlap with other admission measures or any
18 differences with other admission measures?
19 Should I leave that alone for now?

20 CO-CHAIR BULGER: Yes, we'll come back
21 to it.

22 MEMBER JOYNT: Okay.

1 MEMBER BRUCE HALL: I agree with
2 Karen. So in general, as you heard, unplanned
3 admissions per 100 patient-years with the
4 diagnosis, fee-for-service Medicare data, all-
5 cause admission except for the planned algorithm,
6 LVADs excluded, transplants included, conceptual
7 model seems very sound as they portray in their
8 figure 1. So in terms of importance, literature
9 provided seemed to support the importance of the
10 topic.

11 CO-CHAIR TRAVIS: Any comments from
12 the Committee members?

13 (No response.)

14 CO-CHAIR TRAVIS: Okay. Oh, go.
15 Sorry, Leslie. Go ahead.

16 MEMBER LESLIE HALL: It seems in all
17 three of these, as you're bringing up all three
18 of these, there is overlap. And potentially an
19 intervention for a patient with diabetes might be
20 a heart-related intervention and a primary
21 diagnosis might actually be any of all three of
22 these. How do you account for the overlap and

1 the interventions that might be compatible with
2 one measure, but actually affects multiple
3 measures? How do you get around the confusion?

4 DR. DRYE: Okay. That's a great
5 question. So another thing that we had to
6 grapple with in this setting that is different
7 from the hospital measures that are focused on
8 admissions for an acute condition, there is
9 overlap in the cohorts with these three measure
10 and the patients included.

11 And so, by design a multiple chronic
12 condition measure includes patients with heart
13 failure. It doesn't have diabetes as a
14 qualifying condition, but half the patients who
15 have multiple chronic conditions have diabetes,
16 so many patients there are also in the diabetes
17 measure. And I can give you some numbers if this
18 doesn't -- I'll just give you the amount of
19 overlap and then I want to address your question.

20 So about a million patients have heart
21 failure, but not by diabetes. This is in the
22 Medicare fee-for-service cohort in 2012 that we

1 used for this measure. And about a million have
2 only diabetes but not heart failure. And about
3 1.1 million patients have both conditions. And
4 then those groups do overlap with a multiple
5 chronic condition cohort in about 30 -- actually
6 it's about 36 percent. So 1.8 eight million
7 patients are in the multiple chronic condition
8 cohort with neither of those conditions.

9 So, yes, there's a lot of overlap, but
10 there's also a lot of distinct patients in each
11 group. And I think it's okay. I mean, the
12 measure performance is going to be correlated
13 because it's some of the same patients. And some
14 of the interventions will cross. I think that's
15 programmatically okay to have them in those three
16 measures, nonetheless in the same program,
17 because it provides different information to the
18 ACOs. But, yes, there is overlap.

19 MEMBER HEIDENREICH: Yes, maybe this
20 is just for CMS, but I'd encourage them to
21 coalesce around maybe one chronic condition
22 measure. I think when we've looked at people on

1 heart failure in the VA who are identified off
2 their outpatients; so you need your two
3 diagnoses, a lot of those people you wouldn't
4 think that was heart failure patients, their
5 heart failure is number seven on a list of a ton
6 of things, and it's a completely, or a very
7 different cohort from those with discharge with a
8 primary heart failure. And I think the
9 interventions really aren't heart failure-
10 specific that we're thinking they could benefit
11 from.

12 So I would encourage you to go -- in
13 future potentially combine these.

14 MS. SHAHAB: John, Frank Briggs had a
15 comment as well.

16 Frank, did you want to --

17 (Simultaneous speaking.)

18 MEMBER BRIGGS: Good morning. I had
19 a question. Since these measures involve the
20 ACOs and the ACOs are coming and going into that
21 program at different starting points, unlike
22 hospital readmission programs and such where

1 everybody was measured starting essentially at
2 the same point, the interventions given by the
3 developers, while I believe can make a impact,
4 many of them take a long time to establish and
5 then to really see that impact, but how do you
6 adjust for an ACO coming into the program, new
7 into the program as compared to an ACO who might
8 have been into the program for three, four, five
9 years and may have been working and have these
10 interventions established?

11 DR. DRYE: Good question. So one
12 challenge for these measures versus again the
13 hospital-based measures is that there isn't a
14 clear time zero, or as clear of a time zero
15 before which we want to adjust for the patient
16 status and after which we're going to evaluate
17 the outcome. It's a bit arbitrary. Like you
18 say, there's action going on all the time and if
19 you improved your patient last year, the risk
20 factors will be lower. And so we won't estimate
21 as high of an expected rate of admission for that
22 patient.

1 But we tried to be pretty structured
2 about that. We vetted it in public comment and
3 with our expert panel and what we do is we just
4 take the start of the measurement year as the
5 beginning point for evaluation. We accumulate
6 risk factors up to that point and then we
7 evaluate for the outcome. And that is going to
8 capture ACOs at different points in their
9 progress.

10 I would just add that in the ACO
11 Program they've just added another dimension,
12 which is measuring year over year improvement in
13 the quality measure set and allowing ACOs to earn
14 bonus points for improvement. Separately from
15 this project we're working on a method for that
16 and for measuring that on risk-adjusted outcome
17 measures specifically on these measures, which
18 we'll share later at AcademyHealth later in the
19 month. But there is not a clean start-stop time
20 that we can identify. We would expect to see
21 ACOs that are improving, getting better on this
22 measure score and also that improvement showing

1 up in the improvement component of the ACO
2 evaluation.

3 CO-CHAIR BULGER: Ye, I mean, I think
4 these measures, just like most of the other ones,
5 the crux of the matter comes down to how they're
6 used. And from an ACO perspective the end-all,
7 be-all is the total cost of care for the
8 population and using measures such as this will
9 help you drill into the total cost of care. But
10 I think there is concern about how all the
11 overlap is among all the measures.

12 And I think one of the things I do now
13 is running our ACO and measures like this are
14 very helpful again to improve the quality and to
15 really drill into that total cost of care, I
16 think. And we'll probably talk about this more
17 when we get to use, too, but how they're used is
18 going to be important because, this has already
19 been said, they overlap with a whole bunch of the
20 other measures as well.

21 Any other comments?

22 (No response.)

1 CO-CHAIR BULGER: Okay. Vote on
2 evidence.

3 MS. HERRING: Voting is now open on
4 the evidence criterion for Measure 2886. Your
5 choices are one, yes; two, no. We're looking for
6 18 votes.

7 (Voting.)

8 MS. HERRING: If everyone could submit
9 their votes just one more time. Sometimes it
10 takes a minute for the clickers to wake up since
11 this is the first vote this morning.

12 (Voting.)

13 MS. HERRING: The results are 18 yes,
14 0 no, so 100 percent yes.

15 CO-CHAIR BULGER: Okay. So we'll
16 start with Bruce this time and go with the next
17 question on evidence.

18 MEMBER BRUCE HALL: Opportunity in
19 terms of opportunity or gap. The developers
20 quote a pretty impressive unplanned admissions
21 rate of about 85 per 100 person-years in the
22 crude Medicare population, fee-for-service

1 population. And then in those assigned to ACOs
2 about 82 per 100 person-years with the range, as
3 they mentioned earlier, being about 53 to 121.
4 So quite a bit of apparent variation in
5 opportunity.

6 I terms of the ACO level scores, about
7 half of the ACOs were rated as either high
8 outliers or low outliers by their method with
9 actually about twice as many being rated high as
10 low as they portray in their figure 3. So a
11 couple of axes indicating that there's
12 opportunity for improvement.

13 MEMBER JOYNT: Yes, I agree. I think
14 the gap is probably greater for admissions than
15 readmissions, especially since you're moving --
16 if you move your admission denominator, you can
17 change your readmission denominator and I think
18 the evidence here would suggest both in terms of
19 the ability to find outliers and probably in
20 terms of the ability to focus attention that
21 there's a gap here that's quite notable.

22 CO-CHAIR BULGER: Any comments from

1 the Committee?

2 (No response.)

3 CO-CHAIR TRAVIS: On the phone?

4 (No response.)

5 CO-CHAIR TRAVIS: Okay. So we'll vote
6 on the gap.

7 MS. HERRING: Voting is now open for
8 performance gap on Measure 2886. Your choices
9 are one, high; two, moderate; three, low; four,
10 insufficient. We're looking for 19 votes.

11 (Voting.)

12 MS. HERRING: The results are 11 high,
13 8 moderate, 0 low, 0 insufficient, so 58 percent
14 high; 42 percent moderate.

15 CO-CHAIR BULGER: So to reliability,
16 Karen?

17 MEMBER JOYNT: So reliability testing
18 was performed at multiple levels, and the sort of
19 test-retest as well as the data element
20 reliability were good.

21 I have a couple clarifying questions,
22 if that's okay.

1 The reliability, I couldn't tell from
2 the documentation if it was in the total sample
3 or in the ACO sample. Particularly with some of
4 the new programs coming out of CMMI and CMS for
5 support trying to get smaller ACOs in and more
6 rural ACOs, is there a limit at which the
7 reliability starts to fall off by size or are
8 they all big enough that that wasn't an issue? I
9 couldn't tell what the locus was of reliability
10 testing.

11 DR. DRYE: Well, as I mentioned
12 before, the smallest ACOs are a couple hundred
13 patients in each one of these cohorts. For
14 diabetes it's even bigger than that.

15 The way we tested it was we include in
16 the measure score calculation all the fee-for-
17 service patients and then we compared just the --
18 we split the sample, we compared the risk-
19 standardized acute admission rates from those two
20 random samples from each ACO, just like in the
21 measures we discussed yesterday, and we looked at
22 the ICC, which here is 0.81 or above for all

1 these measures.

2 We don't do that by looking individual
3 at each ACO per se. I think that might be what
4 you're asking, Karen. I'm not sure.

5 MEMBER JOYNT: Well, for the hospital
6 measures you have a 3-year sample and generally
7 under 25 doesn't get --

8 (Simultaneous speaking.)

9 DR. DRYE: Yes.

10 MEMBER JOYNT: I wasn't sure if that
11 had been empirically derived and if so if there
12 was an empirical derivation here.

13 DR. DRYE: Oh, for the minimum? Yes.

14 MEMBER JOYNT: Yes, whether it's
15 reliable, or if that's sort of a future --

16 (Simultaneous speaking.)

17 DR. DRYE: Yes, so that's a great
18 question. The measures are -- it would be great
19 that -- see, the contractor working with CMS
20 that's actually crunching the numbers for the
21 2015 data might be able to help us here. I don't
22 think we're going to see any of these ACOs have

1 an unreliable score. I don't think they've had
2 to set a minimum. I could say some of the
3 learning around that really came when we started
4 working on measuring improvement year over year
5 in the year after -- in this past year, because
6 we could actually fit a whole model right on
7 every single ACO. There wasn't a single ACO that
8 didn't have enough data for us to fit a GLM
9 easily. So I don't think there's any ACO that is
10 too small.

11 The minimum ACO size in the Medicare
12 Shared Savings Program is 5,000, but these are
13 such common conditions that we've been having
14 absolutely no problems with sample size. But I
15 can get back to you specifically on that just to
16 see if there was anything that was even close to
17 too low.

18 CO-CHAIR BULGER: Actually, I do want
19 to follow up on that because while we're talking
20 about the measure for ACOs -- it could be used
21 for any cohort, correct? So let's say for
22 example a state wanted to go into a global

1 payment program like Maryland does and wanted to
2 assign hospitals a -- each hospital has a cohort
3 of patients. They could do that and they could
4 end up having lower numbers of patients. I mean,
5 the current Medicare Shared Savings Program and
6 other ACOs do have minimum numbers. And it
7 wouldn't get to the number, but there is a
8 possibility that someone -- if this is endorsed,
9 someone could pull this measure and use it for
10 smaller cohorts than a current ACO Program has.

11 DR. DRYE: I agree. And I just wanted
12 to ask if our statistician Haikun Bao at CQN from
13 Yale is on the line. Do you want to make any
14 comments?

15 DR. BAO: This is Haikun. I think we
16 -- for the ACO we have a -- for individual ACO we
17 have enough for sample size. So for each
18 individual ACO I think that this measure is okay.

19 DR. DRYE: And I think just to add
20 also; and Jeff Herrin who's one of our
21 statisticians on the hospital measures is here
22 today, when we got that number 25 on the hospital

1 side, we actually did a lot of modeling to figure
2 out what kind of -- what do we need to get a
3 stable estimate. We just haven't done that for
4 these measures because we didn't need to, but if
5 you were going to apply it in ACOs with fewer
6 patients or some kind of population, health plans
7 that might be small, yes, you would need to do
8 that testing.

9 MEMBER LIND: Okay. So given the
10 shift from inpatient to outpatient and the impact
11 that people think that the readmission penalties
12 are having, notwithstanding some articles to the
13 contrary, did you look at what effect you might
14 have in terms of outcomes if you included the
15 outpatient set, or at least the emergency room
16 contacts? I mean, why would you restrict it to
17 just inpatient admissions, I'm just wondering,
18 since presumably there's -- in terms of the
19 quality of ambulatory case care-sensitive
20 management, condition management, it seems like
21 an emergency room contact would be as important?
22 Maybe not quite as important, but it would be

1 important.

2 DR. DRYE: Your last words are exactly
3 the reason. I mean, we were looking for an
4 indicator of acute decomposition, and if we moved
5 to ED visits or ob stays, it just -- there's
6 different -- as you know, different providers
7 have that bar in a different place. When would
8 you admit versus treat in the ED? But we just
9 felt like using acute unplanned admissions was a
10 pretty high bar and relatively more even across
11 providers. But there isn't a reason you couldn't
12 evolve towards looking at ED visits, too.

13 And as I say, for CMS under this same
14 contract to build outpatient outcome measures we
15 are looking at -- we combine actually ED visits,
16 observation stays and hospitalizations for post
17 -- a measure of colonoscopy quality, because the
18 predominant outcome there is ED visits, not
19 admissions. So we looked at that, but for this
20 measure we wanted to keep the bar pretty high.

21 I don't know if you want to add
22 anything for heart failure, Erica.

1 DR. SPATZ: Yes, I think I would agree
2 with that, and I think that that's somewhat
3 validated by the high proportion of admissions
4 that we see in these very vulnerable groups where
5 they are meeting a threshold for admission.

6 Lynne Stevenson, one of the giants of
7 heart failure who talks a lot about this, really
8 just presents a model which is kind of
9 interesting to think about because we're so
10 focused on heart failure readmissions. And she
11 talks about these three phases of heart failure
12 management, and one is the transitional
13 management that is right on the heels of a
14 hospitalization where we're talking about high
15 touch and all the interventions that we're
16 testing to lower readmissions.

17 And then she talks about this plateau
18 phase. And it is complex care. It's
19 multidimensional care, it's looking at their
20 medications, looking for both evidence, guideline
21 concordant medications, as well as drug
22 interactions and potential adverse events. And

1 we think that the outcome of admissions is
2 reflecting that high vulnerability. Certainly ED
3 admissions are important and might be something
4 to consider, but in this very vulnerable
5 population the hospitalizations alone kind of
6 stand on their own.

7 MEMBER LIND: I mean, I think I see
8 your point with congestive heart failure, but I'm
9 thinking on the other two cases also where
10 diabetes, maybe hypoglycemia, ketoacidosis, maybe
11 a leg ulcer could be managed in the ER. Multiple
12 chronic conditions could be -- not meet that
13 inpatient threshold. It seemed like it might be
14 more likely, might be more useful to have more
15 information in those less-acute situations.

16 CO-CHAIR BULGER: Leslie?

17 MEMBER LESLIE HALL: Yes, I just had
18 a question about -- as we transition from fee-
19 for-service to any sort of value-based bundle
20 payment or any new payment does that put anything
21 at risk as far as data collection, because your
22 data collection is now coming from fee-for-

1 service-only claims. And so, how do we evolve
2 something that is touching such a broad group of
3 people when the data collection methodology may
4 actually be incented to be pulled away from the
5 data elements you're requesting?

6 DR. DRYE: Helen, how are we going to
7 do this?

8 I agree that's a threat over the
9 longer term to the data that we're using. And
10 right now Medicare fee-for-service is our one
11 full national data set that we can use for these
12 kind of analyses and has high feasibility. I
13 think we have to keep an eye on that.

14 My understanding of the -- within the
15 ACO Program all the claims are still filed, and
16 that's partly how their shared savings is
17 reconciled, but I think it's a dynamic situation
18 that as -- those of us working in quality
19 measure, we have to keep thinking how can we get
20 the right data to understand utilization as these
21 incentives for actually filing a claim are
22 diminishing.

1 CO-CHAIR BULGER: Cristie?

2 CO-CHAIR TRAVIS: Well, I couldn't
3 help but think about Keith's question and then
4 remember the measures that we looked at yesterday
5 for excess acute care days for heart failure,
6 specifically on the hospital side.

7 So I think to a certain extent -- and
8 maybe I'm not thinking about this correctly, but
9 in the ACO environment there are -- I guess are
10 there hospitals? And I would think there are.
11 And then so, to a certain extent if we move to
12 looking at holding hospitals accountable, the
13 excess days which include ER and observation as
14 well as inpatient admissions, then we're
15 beginning to move into that arena for heart
16 failure anyway.

17 And so, I guess I'm trying to kind of
18 reconcile the discussion we just had with the
19 fact that we looked at those measures yesterday,
20 albeit for a different -- it wasn't for ACOs, but
21 they're usually part of ACOs, I would think.

22 DR. DRYE: Yes, great. And great

1 point. And some of these outcomes are
2 overlapping. The ACOs -- I mean, this just
3 really surprises me, but fewer than half actually
4 have a hospital, but many of them do and most of
5 them don't. So we have over 400 ACOs right now.
6 And so there are incentives to hold down costs.
7 So that's one difference.

8 And the other difference is the
9 cohort. So those hospital-based measures that
10 are looking at patients who have been
11 hospitalized for heart failure, we're looking at
12 anyone that is diagnosed with heart failure. So
13 there's overlap. It does mean that when you look
14 at these scores they travel together to some
15 degree, but I think that's one thing we could
16 spend more time really understanding is how
17 they're traveling together. but they are looking
18 at separate domains of quality and at different
19 -- they're profiling different providers, even
20 though there's some overlap in the providers as
21 well.

22 CO-CHAIR TRAVIS: Wes?

1 MEMBER FIELDS: Sorry. I want to
2 follow this line for a second just so I
3 understand your methods and how the data is going
4 to flow.

5 One of my theses is that there's a lot
6 of really creative things going on inside of the
7 Medicare Advantage groups and the integrated
8 systems and that it's for a number of reasons
9 obscured in proprietary data. And there's
10 reasons why it doesn't get shared with CMS.

11 But my question is CMS did provide a
12 waiver on the three-day rule, for example, to
13 Pioneer ACOs. I believe that was in '14,
14 calendar '14. And I've tried to track this at
15 the local ACO level with a fairly large one in
16 Southern California, and it's hard to get at the
17 data. So I'm just curious, in terms of episodes
18 of care other than admission are you tracking
19 admission to short-stay SNF facilities, for
20 example?

21 DR. DRYE: Okay. Let me just answer
22 that last part, and then I'm not sure if I fully

1 -- if you wanted me to address part of what came
2 before.

3 So in terms of SNFs, we aren't looking
4 at it. I know in the hospital setting we've
5 looked at whether readmission rates are related
6 to the prevalence of SNFs. The reason we're not
7 focused on SNFs per se is the use of SNFs is so
8 variable across the country and it's definitely
9 going to vary widely across ACOs. So we try to
10 just be neutral with respect to those kinds of
11 factors that if we use them they're going to
12 perturb our scores. So we're ignoring SNFs per
13 se. And so, is your concern that maybe that
14 people are diverting to SNFs or -- I'm not --

15 MEMBER FIELDS: No, nothing as
16 nefarious as that. I've heard an ex-CMS
17 administrator refer to ACOs as HMO-like, and one
18 of the reasons I think that's true is, at least
19 for the acute care continuum, one of the things
20 which is pretty easy to do without the statutory
21 requirement for a three-day inpatient stay on the
22 Medicare Advantage side is to be able to

1 aggressively evaluate and refer somebody with
2 MCC, especially things like diabetes or a true
3 MCC patient, to basically preemptively screen,
4 stabilize and transfer to a skilled nursing
5 facility in lieu of what would be a
6 hospitalization for a traditional Medicare A/B
7 patient.

8 And so, my point is that CMS has been
9 enlightened about providing a three-day waiver to
10 ACOs, but that means I think for you to really
11 track innovation well you really need to -- I
12 think you should reconsider the inclusion of SNF
13 services.

14 DR. DRYE: I don't know, also someone
15 from CMS may want to comment on this if they're
16 on the line, but I think it's a really
17 interesting point. I mean, Susannah Bernheim
18 mentioned yesterday we do a tracking of some of
19 these effects of measurement for CMS as part of
20 our broad set of work. And I think earlier on we
21 were a little more focused on SNFs and thinking
22 about how they might be related to readmission.

1 I think it's a good question.

2 My advice or my suggestion would be to
3 look at that, but I don't think we would add them
4 into the measure, again because if you start
5 adding SNFs into a measure -- SNFs are just --
6 could be SNFs versus home health versus some
7 other strategy. So we try not to pull provider
8 types that -- post-acute care choices into these
9 types of measures.

10 CO-CHAIR BULGER: Derek and then --

11 MEMBER LIND: I think the three-day
12 waiver only applies to two-sided risk ACOs, not
13 the one-sided risk. So it's only the dozen or so
14 Pioneers.

15 CO-CHAIR BULGER: Correct. Derek?

16 MEMBER ROBINSON: Thank you. The
17 discussion regarding the migration of your data
18 source as we move from claims-based payments to
19 other models just sparked another question in my
20 mind, and that is that there have been a lot of
21 efforts especially for activities focused on ACOs
22 to try to harmonize the use of minimum measure

1 sets. And because it appears that this measure
2 set is focused on the Medicare population, I just
3 wonder is there any thought to the applicability
4 of this measure to maybe an age group of 45 to
5 64, for example. I just say that because of some
6 of the recent activity with the Core Measures
7 Collaborative.

8 And so if you've got multiple payers
9 designing a minimum core set of ACO measures and
10 CMS likes this one and says, hey, this is a great
11 measure to move forward with but then it's not
12 applicable to other age groups, is there a way to
13 harmonize that? So just a question.

14 DR. SPATZ: Thanks. It is a good
15 question, and we are always considering who else
16 is this applicable to? I think in the case of
17 heart failure we need to pay careful attention to
18 our ability to adequately risk-adjust, especially
19 in the younger population where there are centers
20 of excellence that young people with
21 cardiomyopathies or advanced heart failure will
22 go to. It's a little bit less of a bread and

1 butter population than in the elderly population,
2 which is not to say that we couldn't go to non-
3 Medicare patients.

4 But I think it's a really important
5 consideration that needs a lot of thought and
6 development to make sure that we can adequately
7 risk-standardize across ACOs so that we're not
8 getting discrepancies in performance based on
9 differences in case mix.

10 DR. DRYE: I would just add that one
11 of the things, one of the reasons it's a
12 privilege to work on these kind of measures is we
13 are very transparent with our methodology. We
14 will share it with anyone who's interested,
15 whether that's a state trying to move under the
16 state innovation models to a core set of measures
17 or Blue Cross Blue Shield or others who are
18 looking to set up -- use measures in their all-
19 payer environment.

20 So you can ask for status specs, you
21 can ask for the specs. And we have done testing
22 of many measures in the all-payer setting and

1 looked for how well do they stand up in that 18
2 and over population. We haven't done it with
3 these measures.

4 CO-CHAIR BULGER: Other questions from
5 the Committee?

6 MEMBER JOYNT: Sorry, I was just
7 flipping through this. So this is 65 and older
8 only, right? It does strike me that -- I agree
9 that under 65s may be different, but they're also
10 really important, really expensive and really
11 under-studied. So the rationale is just that you
12 can't risk-adjust well enough for the under 65s,
13 or they're different somehow?

14 DR. DRYE: Yes. Well, for this
15 measure we haven't pulled in those that are
16 eligible for Medicare who are under 65 because
17 they're typically a lot sicker. And in all of
18 our measures that we're using fee-for-service
19 Medicare data for we made that decision.

20 But I'm totally sympathetic. I think
21 we'd want to be able to in a lot of settings --
22 for example, in in-state innovation models where

1 we're trying to come to single core sets of
2 outcome measures that are population-based, to
3 bring that all the way down to whatever threshold
4 makes sense. I mean, for COPD we'd bring it down
5 to 40 in some settings.

6 So it's just these are new and we
7 haven't gotten there yet. And I think in the
8 program, the Medicare Shared Savings Program,
9 this is -- it makes more sense to keep it at 65
10 and older.

11 DR. SPATZ: Just to clarify, the
12 under-65 group that are Medicare fee-for-service
13 are a really unique population, because to
14 qualify for Medicare under 65 -- there's very
15 special populations that do so. And so, that
16 does raise their level of severity of care. End-
17 stage renal disease patients, for example.

18 MEMBER JOYNT: I think many have
19 argued that's exactly who we should be trying to
20 prevent admissions in, right? I mean, and if you
21 look at the MedPAC data for Medicare Advantage,
22 and actually claims data for -- encounter data

1 for Medicare Advantage are now available. So in
2 theory we could be rolling this across multiple
3 types of patients. But anyways --

4 DR. DRYE: Well, just to that point,
5 if I could, we would love to have the data for
6 Medicare Advantage and pull those in. That's
7 almost 40 percent of the --

8 MEMBER JOYNT: Right.

9 DR. DRYE: Right. So that -- we're
10 working on that.

11 MEMBER JOYNT: Yes, I know. Speaking
12 to that converted on the data issue.

13 But with the under-65s MedPAC has
14 shown, I think, pretty convincingly in the MA
15 data that disability is a bigger driver of core
16 outcomes than dual status. And if you're looking
17 at really the vulnerable population, preventing
18 admissions, running a good ACO and saving money,
19 that may be where you need to go. If you feel
20 methodologically that group can't be included
21 because they just are so different, it may be
22 helpful to know why that's the case, because I'm

1 not sure that excluding the 65 and under from all
2 fee-for-service measures is a good long-term
3 rule.

4 DR. DRYE: I agree with you. I mean,
5 I think it's just another -- it requires further
6 work and evaluation. I think we will be going in
7 that direction.

8 CO-CHAIR BULGER: Larry?

9 MEMBER GLANCE: Do you have any
10 concerns of the potential for unintended
11 consequences with this measure? It may be that
12 too few admissions is a bad thing for people with
13 heart failure and may lead to excess mortality.
14 This is a little bit new for us in terms of
15 quality measures. But in obstetrics, for example
16 with C-sections, driving the C-section rate down
17 too low may be a bad thing. There may be more of
18 a kind of a U-shaped curve. And rewarding the
19 hospitals with -- the ACOs with the fewest
20 hospital admissions may not actually be the right
21 way to go here. I don't know if you've thought
22 about that.

1 DR. DRYE: Yes. And again, I think
2 we're flipping back -- between talking about
3 heart failure to really talking about all three
4 of these measures. Just realizing we're talking
5 about -- so if we're not confusing you.

6 They're part of a broad set of ACO
7 measures. So I'm just looking at the measures
8 that are changing next year -- well, for this
9 year, 2016-2017 that include multiple domains of
10 care including patients' experience of care, so
11 the CAHPS surveys. And I think that's really
12 critical. And then we have to be looking at a
13 broad set of outcomes when we use these measures
14 so that we're understanding health outcomes,
15 patients' experience, as well as cost.

16 It's a question that applies to the
17 ACO Program or any shared savings program
18 overall. Are we creating incentives to provide
19 too little care? And I think we have to be
20 vigilant about that. We tried to build tracking
21 of some of those effects into what we're doing
22 with CMS, but I think more broadly CMS is looking

1 at that as well. And some of the other measures
2 in the ACO set cover those things, but not
3 perfectly.

4 CO-CHAIR BULGER: Karen?

5 MEMBER JOYNT: Yes, just a quick
6 response to that. The quality measures in an ACO
7 have so very little impact on the money they save
8 compared to the actual money they save that you
9 could argue that being in an ACO makes you want
10 to cut admissions much, much more than this
11 measure does. I've certainly heard it said
12 convincingly by some health economists that
13 having admission and readmission measures in an
14 ACO is completely redundant. You already have
15 very strong incentives in place to cut
16 admissions. That's where your dollars are.

17 It's a separate question, but it does
18 a bit beg the question of evaluating a measure
19 for its use within a program versus evaluating
20 the measure for being methodologically sound for
21 the population to which it's applied, which I
22 think it is. The use I think is actually bigger

1 and more complex question even than just this
2 measure.

3 CO-CHAIR BULGER: Any other questions,
4 comments from the Committee on reliability?

5 (No response.)

6 CO-CHAIR BULGER: Anyone on the phone?

7 (No response.)

8 CO-CHAIR BULGER: Okay. So we will
9 vote on reliability.

10 MS. HERRING: Voting is now open for
11 reliability for Measure 2886. Your choices are
12 one, high; two, moderate; three, low; or four,
13 insufficient.

14 (Voting.)

15 MS. HERRING: I believe we're looking
16 for 20 votes this time around, so if everyone
17 could just vote one more time?

18 (Voting.)

19 MS. HERRING: The results are 2 high,
20 18 moderate, 0 low, 0 insufficient, so 10 percent
21 high, 90 percent moderate.

22 CO-CHAIR BULGER: Okay. Validity?

1 MEMBER BRUCE HALL: Obviously the
2 discussion of reliability ranged on a variety of
3 issues including some modeling issues, but in
4 terms of just reminding the Committee about some
5 of the details of the measure that we've heard,
6 this is a standardized risk ratio where the
7 predicted and the expected are used to create a
8 ratio that's then multiplied by the grand mean.

9 The methodology uses two years of data
10 prior to the beginning of the performance period
11 to define the diagnosis. The diagnosis of heart
12 failure is defined by either one, inpatient, or
13 two, outpatient codes in those prior to years.
14 In the first year preceding about 90 percent of
15 the patients are identified and in the second
16 year preceding about 10 percent of additional
17 patients are identified. And rheumatic failure
18 was included as per expert advice. This is
19 depicted in the figure 1 by the developers.

20 I did note that the program on the
21 whole seems to be fee-for-service data-dependent,
22 but I think we've already covered that in the

1 last few minutes.

2 In comparison to the two years used to
3 define the diagnosis, one year of data is used to
4 risk-adjust the diagnosis, and that seems
5 appropriate. And then the performance period is
6 one year beginning on the beginning of the
7 calendar year.

8 As a note, about 114 of the MSSP ACOs
9 were included in the diagnosis, and as I noted
10 earlier, about 61 of them were rated as no
11 different than average with 37 being rated
12 better, and 16 were so. About half of all the
13 participants at the measure level are being rated
14 as either better or worse and then two-thirds of
15 those are being rated better and one-third worse.

16 For that 114 MSSP population there
17 were roughly 120,000 patients. And so going back
18 to Karen and some of John's comments earlier,
19 we're probably looking at a mean patients of
20 about 1,000 per ranging down to a couple hundred
21 in terms of minimum necessary for future
22 considerations.

1 The developers did consider SES
2 factors. As we've heard both this morning and in
3 more detail yesterday, they examined both the
4 ACS-based AHRQ Index and dual-eligibility status.
5 And I will say that while the developers
6 continued to feel that the effect was small, and
7 I support that, still from some perspectives
8 there does seem to be a substantial effect. So
9 for instance, if you just compare the top and
10 bottom quartile risk by either of these, there
11 does seem to be an effect.

12 So for instance, if you just look at
13 the SES Index version, the fourth quartile has
14 about a 25 percent admission risk while the first
15 quartile has just a 7 percent admission risk.
16 And if you go to dual-eligibility status instead,
17 it's 24 percent for the worst quartile versus 3
18 percent for the best quartile.

19 So obviously those are crude figures,
20 but I'm still concerned that there might be a
21 substantial effect from some perspectives,
22 understanding that at present the decision is not

1 to adjust further for gender, race, resources,
2 behaviors or other aspects of the conceptual
3 model that we want the ACO to be responsible for.
4 We want the ACO responsible for encouraging good
5 behaviors and so on and so forth.

6 And so I think it's conceptually sound
7 that these things are not currently adjusted, but
8 I do wonder whether some perspectives are showing
9 us a pretty substantial effect.

10 In terms of other modeling decisions,
11 any days in the hospital are subtracted from the
12 out-of-hospital days risk. And then if a patient
13 starts the year in inpatient and dies, they're
14 totally excluded from the model because they
15 don't contribute to any outpatient days of risk.

16 The variable selection for the model
17 was driven by AIC, Akaike Information Criterion.
18 That seems to be a very sound approach, the way
19 the developers applied. And in terms of fit,
20 about 12.2 percent of the variance is explained
21 by the risk-adjustment model, which in terms of
22 medical practitioners might not seem a lot to us,

1 but in terms of economists it's actually a
2 substantial amount of variance to explain.
3 Otherwise, the fit criteria appeared to be good
4 as portrayed in figures 5 and 9 through 11. And
5 the quartiles of risk at the end seem to be well
6 estimated and fit pretty well.

7 I also had noted that under the
8 current paradigm ACS can be entering measurement
9 at different points of maturity, but I felt that
10 that was very reasonable, because if ACOs, quote,
11 "need to catch up," then this is the way to show
12 them that they need to catch up. While at the
13 same time, as Liz and the developers mentioned,
14 the risk-adjustment scheme, because of the way
15 the risk-adjustment is determined off the prior
16 year's data, it does blunt that a new ACO is
17 going to look horrible. It does blunt that, but
18 it still I think preserves the ability to show an
19 ACO that they have catching up to do.

20 So those were the concerns and issues
21 I raised in reviewing. I think each is
22 appropriately handled by the developers.

1 CO-CHAIR BULGER: Karen?

2 MEMBER JOYNT: That was very thorough.

3 I only have a few things to add. One just kind
4 of, I think in MSSP there's a hold-harmless where
5 you get a year of reporting. I believe that any
6 new measure everyone gets a free year.

7 DR. DRYE: Yes, two years of --

8 MEMBER JOYNT: Oh, two years?

9 DR. DRYE: -- pay-for-reporting and
10 performance score doesn't matter.

11 MEMBER JOYNT: Oh, I thought there was
12 only one. Anyway, so you do have an opportunity
13 to see your performance before you're paid on it
14 for these, but I had one question about the
15 comorbidities, and I think this is more important
16 for an admission measure than a readmission
17 measure because you're trying to look at
18 aggregate risk.

19 My understanding is that a lot of
20 comorbidities in the fee-for-service population,
21 much more so than MA, will fall out because
22 things like quadriplegia are actually not

1 terribly stable in the Medicare fee-for-service
2 data. I don't know if this is totally like an
3 old wives' tale, but that because in Medicare
4 Advantage comorbidities can be picked up by a set
5 of not just claims-based ascertainment, whereas
6 in fee-for-service there is only claims-based
7 ascertainment that chronic disease that should
8 not vary over time does vary a lot in claims.

9 And so I've heard it argued that for
10 better ascertainment of chronic disease that a
11 two-year look-back is favorable to one, but I'd
12 just be curious if you did any looking to see for
13 this type of stuff whether things actually -- it
14 made a difference how far you looked back for
15 chronic risk-assessment.

16 DR. DRYE: Yes, I mean, I think in
17 this setting, and I just want to give a shout-out
18 to our analysts, we're using so much data. We're
19 looking at all the outpatient data over two
20 years. And I don't think that we're losing
21 things. We did look at -- we did think about
22 going back three years, which is more burdensome

1 given the tremendous volume of data you have to
2 process to get these risk factors for these very
3 large cohorts. And we looked at -- for example,
4 we were particularly focused on dementia and
5 looking back, and it made a very small marginal
6 difference there.

7 But I would say the one area we were
8 the most concerned that we would not be fully
9 capturing risk factors is dementia and mental
10 health because they're often just not recorded by
11 providers, raised by patients. So it's not going
12 to be perfect, but I think we have a really broad
13 sweep and a chance -- we were able to pull those
14 from both inpatient and outpatient claims over a
15 long period of time.

16 CO-CHAIR BULGER: Paul?

17 MEMBER HEIDENREICH: Just one thing.
18 Since the SES was brought up -- and I suppose
19 that goes to usability potentially more, but I
20 feel there's a much stronger case for using SES
21 than with the measures presented yesterday
22 looking at the dual-eligible. And you have an

1 eightfold difference between quartile one and
2 quartile four being in the worse than national
3 rate of 24 versus 3 percent. I realize it's
4 relatively small numbers, but I can't believe
5 that that is all due to quality differences that
6 we need to pay attention to.

7 And again, I think it's -- I'm not sure
8 we're the ones to make these decisions. It would
9 be nice if this came from a higher level. But I
10 think this is clearly different from yesterday's
11 data where the differences were a lot smaller.

12 DR. SPATZ: Right. So I think we
13 struggled a lot looking at our data and how ACOs
14 perform in the different quartiles of proportions
15 of low-SES patients. There is a trend, and as
16 you point out there are more ACOs who are poor-
17 performing ACOs in that group that are caring for
18 a lot of low-SES patients. So that trend does
19 exist.

20 We also saw a lot of heterogeneity,
21 which actually the heterogeneity increased. The
22 data that we submitted were from 2012. The 2013

1 data show that even more ACOs that are caring for
2 a lot of these patients are performing well.

3 When we think about is it fair to
4 compare ACOs that are caring for different
5 proportions of low-SES patients, no matter how
6 you feel about it, when we look at our risk-
7 adjustment models, we don't really see a big
8 difference. So it does pose a challenge for
9 risk-adjustment, because if we want to
10 meaningfully consider the challenges of ACOs that
11 are caring for these patients, the risk-
12 adjustment models don't end up helping them.
13 They're pretty bland.

14 DR. DRYE: I would just add, going
15 back to the conceptual model, if you want to pull
16 that back up, which is in 2b4.3 of the testing
17 form, there are many factors in the admission
18 context that we're dealing with that probably
19 aren't as relevant even in a hospital setting
20 like resources in the community, transportation,
21 the physical environment, health behavior norms,
22 the conversations that we've had the ACO Program

1 going back to is it a policy? It's a policy
2 methods question, really.

3 We know from what we're learning about
4 ACOs that a lot of them are creatively trying to
5 mitigate these factors. CMS is actively setting
6 up a program to investigate how can ACOs partner
7 and other providers partner with conversation
8 public health and social services to mitigate
9 these factors. So even though we know that trend
10 is there, the main two reasons we're recommending
11 against adjusting one is there are many, many
12 good performers with a lot of low-SES patients.
13 So we feel like that should set the benchmark.

14 The benchmark for these ACOs caring
15 for low-SES patients is good performance, and
16 that's established. So we have 30 to 40 percent
17 of these fourth quartile doing really well, doing
18 better than the national average. We want that
19 to be visible. And other ACOs are succeeding in
20 effectively caring for these populations, we want
21 that to be really visible in the measure.

22 And then it's not as high stakes as in

1 the hospital setting if there's two years of pre-
2 pay-for-performance. And it's one of many
3 measures in a domain. And also, you can offset
4 any reduction in your shared savings portion
5 allocated by improvement. So there are factors
6 that mitigate. It's programmatic. We are
7 evaluating in the context of this particular
8 Medicare Shared Savings Program and on balance it
9 seems most important to reveal these differences
10 and learn from them rather than to adjust.

11 CO-CHAIR BULGER: And I think the
12 other thing you said though is you haven't
13 necessarily said that SDS doesn't play a role in
14 this. What you said is that your risk models
15 don't speak to it. So there may be other things
16 that down the road you could adjust for which
17 would level out the data, but when you went --
18 the risk model you were using didn't fix it.

19 DR. DRYE: Well, we used the AHRQ SES
20 Index and dual-eligibility, and those made very
21 little difference. But as you can see on this
22 conceptual model, there are many, many kinds of

1 -- like we could adjust for health behaviors in
2 the community and lots of other things that we
3 know are related to admission risk at the
4 population level. But we're working to try to
5 understand how those factors affect rates and
6 what this -- where providers are succeeding
7 working to lower admission rates in spite of
8 those factors.

9 So we want the measure to be revealing
10 success there. I mean, over time I think,
11 depending on how providers do, you could revisit
12 the balance of that decision, that that's what
13 we're recommending at the outset of these
14 measures.

15 CO-CHAIR TRAVIS: Wes?

16 MEMBER FIELDS: Yes, a question that's
17 partly about validity and partly about structure,
18 so a bit of a relapse, I guess, but I'm wanting
19 to understand. The analogy is a little bit like
20 very large hospitals versus critical access
21 hospitals. So are you not going to distinguish
22 between categories of ACOs?

1 For example, to me there would be a
2 big difference between -- even if they had a
3 substantial claims-based or 1,000 patients
4 they're taking care of, to me an ACO that's
5 community-oriented that doesn't have a hospital
6 partner and is highly reliant on community
7 resources for all the things that Medicare
8 doesn't pay for to keep folks out of the hospital
9 -- to me that's a very different model than a
10 large scale ACO piggybacking on a well-funded
11 multi-specialty group that has other access to
12 capital.

13 So the short question is, are you
14 distinguishing between categories of ACOs or are
15 you -- you're going to report on one pool of ACOs
16 even though they have very different attributes?

17 DR. DRYE: Correct. So I think this
18 is just going to be an area of learning for the
19 field is further -- and with great questions
20 about what types of ACOs are really doing well in
21 these measures? But the ACO measure set CMS uses
22 applies across the Shared Savings Program ACOs,

1 which, Karen mentioned, they don't have that much
2 of a return on their investment or that much
3 risk, and also the Pioneer and evolving next
4 generation ACOs that are highly, highly varied in
5 how they're structured. But we use one measure
6 set.

7 CO-CHAIR BULGER: Yes, I think the
8 other thing that comes up with that; validity I'm
9 thinking about, is that comparison group is a
10 self-selected comparison group, so it's not as if
11 you -- the other measures that we're looking at,
12 they looked at every hospital in the country or
13 every -- I mean, this is a group that decided
14 they wanted to do this and is a big piece of
15 the --

16 DR. DRYE: Yes, that's a critical
17 point. I want to clarify. You mentioned it
18 before, but it's -- we actually -- we run the
19 numbers against all fee-for-service providers,
20 not just providers in ACOs, because we do not
21 want the comparison to be just within ACOs. So
22 we use hierarchical modeling like we do in a

1 hospital. We have so many cases that we get this
2 great spread of performance, but the comparator
3 is the admission rate among all fee-for-service
4 providers. So in the analysis we have 20-plus
5 million patients and then we calculate the scores
6 just for the ACOs.

7 And so, you see on average -- because
8 at the outset we didn't know what we were going
9 to see, but we wanted to be able to see on
10 average are these ACOs -- how they compare to the
11 broad group of fee-for-service providers. We
12 don't take it as a given, but they're better.
13 But they did turn out to be, you know, have lower
14 risk-adjusted rates. And that's how the program
15 calculates it. When they use it in -- they keep
16 all those other fee-for-service providers in the
17 score calculation.

18 CO-CHAIR BULGER: Leslie?

19 MEMBER LESLIE HALL: I had a question
20 about the admission data. Did you do this on
21 ICD-9 or ICD-10 data, or both?

22 DR. DRYE: That is a very alive issue.

1 So the first performance measurement year is
2 2015, which has one quarter of ICD-10 data. So
3 we have specified the measures in both ICD-9 and
4 ICD-10. And we will be continuing to test the
5 ICD-10 specifications as more data rolls in
6 working with CMS and RTI, which is the CMS
7 contractor that's actually crunching the numbers
8 to produce the measure scores.

9 MEMBER LESLIE HALL: Were the gaps
10 materially different between ICD-10 outcomes
11 reported and ICD-9?

12 DR. DRYE: I don't think we know. We
13 haven't seen that ICD-10 data yet. We'll be
14 looking at it later this summer. What CMS is
15 working to do is really look for -- looking
16 across those four quarters. So if the fourth
17 quarter, October to December of 2015, is coded
18 ICD-10, then that data will be part of what's
19 used to calculate the measure score. So doing
20 quality checks to make sure that it looks like it
21 should look. But it's a transition that we'll
22 just -- we'll be testing through into the next

1 couple of years, I think.

2 As Karen Dorsey didn't say yesterday
3 to you, but she was reminding me and said it's a
4 couple of years before we're really, really
5 confident about ICD-10 data. It's a big focus of
6 our efforts right now to ensure the measures
7 continue to be valid as we go through the
8 transition. I'm not sure that was reassuring,
9 but that's where we are.

10 CO-CHAIR BULGER: Kathy?

11 MEMBER AUGER: I have a methods
12 question. So because the identification of the
13 CHF population relies on two years of claims data
14 and then your comorbidities rely on one year of
15 claims data, if you're 65 and just coming into
16 it, there's a good chunk of that population that
17 just doesn't have claims data because they
18 weren't in Medicare before. So I assume that
19 those are at high risk for misclassification,
20 that they may actually have CHF and you just
21 can't recognize it.

22 What about also the patients who were

1 previously in Medicare because they were
2 disabled? Are those previous claims like when
3 from they were 64 used, or how does -- does this
4 measure effectively -- a measure of patients that
5 are 67 and older, so where they all have two
6 years of claims?

7 DR. SPATZ: And, Elizabeth, feel free
8 to jump. We used two years of data because we
9 wanted to capture the healthy heart failure
10 population. So we require two claims-based
11 encounters with heart failure, if those claims
12 are in the outpatient setting, only one with a
13 principal discharge diagnosis from the hospital.
14 However, we only require that people in the
15 cohort have one year of prior data. That
16 captures the majority of our cohort.

17 And we also thought that we needed one
18 year of data to adequately risk-adjust for this
19 population. Where to draw time zero was a
20 question of when we start to hold providers
21 accountable. And kind of consistent with prior
22 measures we used the one-year time point.

1 With regards to your question of -- we
2 are capturing the incoming population of people
3 who are 65 -- is that correct? Do you want to --

4 DR. DRYE: Yes, it is a limitation in
5 that if they were not enrolled as a dual-
6 eligible, we won't capture them. If they were,
7 we have their data and we will capture them in
8 that first year of enrollment.

9 CO-CHAIR BULGER: Okay. Bruce?

10 MEMBER BRUCE HALL: I was just going
11 to reiterate, add a comment back to the SES
12 conversation again as pointed out by Liz and as
13 asked previously by Karen. And that is that we
14 are talking about a population where the payment
15 policy, the penalty is already in place, so we're
16 talking about designing a measure, as Liz said,
17 to shed light on what's happening. Even if ACOs
18 are advantaged or disadvantaged by their
19 population they're under the payment penalty, so
20 to speak, regardless already. And so, I think as
21 I was reviewing the measure I felt it was a
22 little bit of additional justification to take

1 the approach of wanting to shed light where there
2 are issues.

3 CO-CHAIR BULGER: Other comments on
4 validity? On the phone?

5 MEMBER BRIGGS: No.

6 CO-CHAIR BULGER: Keith?

7 MEMBER LIND: I'm sorry. I didn't
8 understand your comment, Bruce, about what
9 penalty we're talking about.

10 MEMBER BRUCE HALL: Well, by
11 definition they're under financial constraint.
12 As an ACO they have risk already.

13 MEMBER LIND: But not the one-sided
14 risk.

15 MEMBER BRUCE HALL: Okay. Fair
16 enough.

17 MEMBER LIND: The Medicare Shared
18 Savings is one-sided only.

19 MEMBER BRUCE HALL: Yes, fair enough.

20 MEMBER LIND: There's only a half a
21 dozen or a dozen that have two-sided risk, I
22 think.

1 MEMBER BRUCE HALL: Right. Fair
2 enough. Good comment. Under ultimate state,
3 yes.

4 MEMBER LIND: And just to clarify the
5 -- I don't know how relevant this is, but the
6 readmission penalties I believe are waived for
7 two-sided risk ACOs, not for the one-sided risk.

8 CO-CHAIR BULGER: They are not for the
9 one-sided risk, I know that.

10 MEMBER ROBINSON: And I guess to tack
11 onto that comment, moving forward with the APMs
12 in the future under MACRA would be two-sided
13 risks.

14 CO-CHAIR BULGER: Maybe.

15 MEMBER ROBINSON: Okay.

16 MEMBER HEIDENREICH: Just a quick --
17 I strongly agree we do need to shed light on
18 this, however, a performance measure means ready
19 for public reporting and labeling ACOs as
20 delivering bad care. And I think that's where
21 I'm struggling.

22 CO-CHAIR BULGER: Okay. So we're

1 going to vote on validity.

2 MS. O'ROURKE: Sure. Before we vote,
3 I did want to just make sure everyone is aware
4 that per the validity algorithm moderate is the
5 highest level this measure would be able to get
6 to due to face validity. So that is why you
7 don't have high as a voting option.

8 DR. DRYE: Sorry. I just want to
9 clarify one thing about the labeling, because the
10 data we provided, the analysis we provided for
11 this application classifies ACOs categorically
12 into better, worse or no different. We have a
13 lot of statistical significance and we have so
14 many cases, but that's not the approach the ACO
15 program is using. They're actually just creating
16 a scale of -- a range of scores and setting a
17 benchmark and a threshold. So they don't propose
18 and they won't be labeling ACOs as better or
19 worse.

20 So for both the better and the worse
21 they may just be marginally -- we have small
22 confidence intervals because we have so much

1 sample size. They may just be slightly above or
2 below the national mean. But that's not going to
3 be visible in public reporting as CMS is carrying
4 it out.

5 CO-CHAIR BULGER: But it could be.

6 DR. DRYE: If they move to this kind
7 of categorical approach, they could. That's not
8 what they do in the ACO Program though. We used
9 it --

10 CO-CHAIR BULGER: No, I understand
11 but --

12 DR. DRYE: Yes.

13 MEMBER HEIDENREICH: That's my point.
14 We're not judging how CMS is going to use this.
15 We're going to say for anyone out there this is a
16 way to report the quality of ACOs. And that's
17 the concern. I agree CMS is doing it potentially
18 the right way, but I'm not sure everyone will.

19 CO-CHAIR BULGER: Okay.

20 MS. HERRING: Voting is now open for
21 validity for Measure 2886. Your choices are one
22 moderate, two low, three insufficient. And I

1 believe we're looking for 20 votes. Oh, there we
2 go.

3 The results are 14 moderate, 6 low, 0
4 insufficient, so 70 percent moderate, 30 low.

5 MS. WATT: All right. We'll go to
6 use, which we've talked about a lot already.

7 Karen?

8 MEMBER JOYNT: Would it be appropriate
9 to bring up the PQIs now? So there are competing
10 -- I shouldn't use that term. There are other
11 measures that look at admissions, the AHRQ
12 Prevention Quality Indicators. They're obviously
13 different. The big difference is that those are
14 only risk-adjusted for age and gender category,
15 which is because they were developed for use at a
16 large geographic area. They're now being used --
17 I don't understand the whole endorsement thing.
18 They're now being used for physicians, which is a
19 not very large geographic area. And I believe
20 they're in the ACO Program also, again not risk-
21 adjusted.

22 My understanding is that AHRQ is

1 considering what to do with those measures and if
2 they should be risk-adjusted, but they are very
3 similar and overlap. The age range is not quite
4 the same. They do include the under-65s in
5 those, which you can decide whether or not you
6 think that's good or bad. I guess COPD/asthma
7 has different cutoffs. They're different.
8 There's a lot of them and they have acute and
9 chronic composites. They look at a very similar
10 thing, which is admissions to the hospital. In
11 their case for heart failure or for urinary tract
12 infection or for pneumonia.

13 So they're selected based on why you
14 were admitted, given that you are theoretically
15 eligible. All three measures, to my
16 understanding, are admitted for anything, given
17 that your outpatient diagnosis has classified you
18 for something. I don't know if we're supposed to
19 consider that now, but they are very similar
20 measures.

21 MEMBER BRUCE HALL: John, and we're on
22 feasibility, right? Use is next?

1 MEMBER JOYNT: Oh, sorry. He said
2 usability. It's very feasible.

3 MEMBER BRUCE HALL: No, all comments
4 still pertinent when we vote.

5 CO-CHAIR BULGER: Any comments on
6 feasibility? All right.

7 MS. HERRING: Voting is now open for
8 feasibility for Measure 2886. Your choices are
9 one high, two moderate, three low, or four
10 insufficient.

11 And we're just waiting on three more.

12 The results are 12 high, 7 moderate,
13 0 low, 0 insufficient, so we're at 63 percent
14 high, 37 percent moderate.

15 MR. AMIN: So the typical way that we
16 handle the related and competing conversation is
17 typically after the measure has been endorsed. I
18 think there is a reasonable question, so, Karen,
19 in terms of the use and usability I guess the
20 question sort of is this a use and usability
21 question or this truly sort of a related un-
22 competing measures question that you're raising?

1 I mean, it obviously could be both and
2 we can welcome response from the developers here
3 on the relationship between the two measures.
4 And I believe CMS is on the line as well since
5 they're at least the co-steward, I believe, of
6 the other PQI measure. So I would welcome that
7 feedback as well. I'm just trying to understand
8 where to center this conversation.

9 MEMBER JOYNT: It's probably more of
10 a competing measures, unless you think that one
11 is better for usability per se. But I guess I
12 was thinking about it as sort of an
13 implementation, which I guess is different than
14 usability.

15 DR. DRYE: And I'm just going to
16 disclose that I'm a small part of AHRQ's contract
17 to maintain the quality indicators, which include
18 those measures by Stanford University who leads
19 that effort.

20 So they overlap. Let me just
21 highlight the differences. You pointed out some
22 of them, Karen. So the outcome -- the ones that

1 are relevant here, and I'll just -- yes, we'll
2 talk about CHF's. So there is one and it's used
3 in the ACO Program now and for the 2016-2017
4 measure set. The outcome is just heart failure
5 admission, so it's a narrow outcome. We look at
6 admission for any acute unplanned cause. So as
7 Erica pointed out, we look at three times as many
8 admissions trying to capture things like
9 admissions for pneumonia or other causes that can
10 be reduced in this vulnerable population by
11 better quality of care.

12 The modeling is really different.
13 It's a single-level model, logistic model just
14 adjusted for age and sex. They were designed as
15 area indicators, so it's just a very -- one thing
16 that the ACO Program did is they narrowed the
17 population. They didn't just take AHRQ's quality
18 indicator. They narrowed the eligible population
19 so the denominator for the measure just to
20 patients with heart failure.

21 So that measure does overlap with our
22 measure and it's different than our measure. It

1 gives slightly different information. That was a
2 programmatic decision. In the ACO Program
3 there's also the AHRQ PQI adapted for the program
4 for COPD.

5 CO-CHAIR BULGER: Any other comments
6 around usability and use we haven't already
7 talked about? Okay. On the phone, Frank?

8 All right. We'll vote.

9 MS. HERRING: Voting is now open for
10 usability and use for Measure 2886. Your choices
11 are one high, two moderate, three low, or four
12 insufficient.

13 Just waiting on one more.

14 CO-CHAIR BULGER: Still need one more?

15 MS. HERRING: Yes.

16 CO-CHAIR BULGER: All right.

17 Everybody want to click again?

18 MS. SHAHAB: Tom, can you please send
19 me your vote?

20 MEMBER SMITH: I sent it once. I'll
21 send it again.

22 MS. O'ROURKE: Tom, we're voting on

1 usability and use right now.

2 MEMBER SMITH: Yes, I sent it twice.
3 It looks like the chat room's not working. Do
4 you want me just to tell you or text you? Does
5 it matter?

6 MS. O'ROURKE: You can tell us.

7 MEMBER SMITH: It's between zero and
8 two.

9 CO-CHAIR BULGER: Okay. Thanks.

10 MS. HERRING: And the results are 5
11 high, 14 moderate, 1 low, 0 insufficient, so 25
12 percent high, 70 percent moderate, 5 percent low.

13 CO-CHAIR BULGER: Any other comments
14 on this one? All right. Let's vote.

15 MS. HERRING: We're now voting on
16 overall suitability for endorsement for Measure
17 2886. Your choices are one yes, two no. And
18 we're looking for 20 votes.

19 MS. SHAHAB: Tom, do you mind just
20 emailing me your vote?

21 MEMBER SMITH: Yes, this is a yes for
22 me, too.

1 MS. SHAHAB: Okay. Thank you.

2 MEMBER SMITH: Is it, Zehra?

3 MS. SHAHAB: This is Zehra, yes.

4 MEMBER SMITH: Zehra. All right.

5 I'll try sending you an email. See if you get
6 it.

7 MS. HERRING: The results are 19 yes,
8 one no. Ninety-five percent yes, five percent
9 no.

10 MR. AMIN: So before we move on to the
11 next measure, let's handle this related and
12 competing measures issue.

13 So as I sort of described yesterday,
14 the way that we'll handle this is we will ask for
15 the -- I'll ask the Committee whether or not
16 based on this discussion that we've had whether
17 we believe that this measure is related or
18 competing to another measure in the portfolio.
19 If there's any one particular -- all I'm looking
20 for is one hand to say we should have that
21 conversation.

22 We need to pull both measures and have

1 a more robust conversation about both measures
2 and the differences in the specifications. So we
3 will likely have that conversation during our
4 post-comment call and have a discussion about the
5 two measures informed about both measure
6 specifications and have a discussion around the
7 level of harmonization. And if we need to, if
8 they do classify as competing measures,
9 potentially have a discussion around best in
10 class.

11 So with that, I'll just ask for one
12 hand to say that if we need to have that
13 conversation based on what we've heard today.

14 MEMBER JOYNT: Yes, I think we need to
15 have that conversation.

16 MR. AMIN: Okay. So then we'll flag
17 that for a future conversation. So again, just
18 for the record that is for this measure along
19 with the AHRQ PQI measure. Do we have the
20 measure number, quickly? That's all right. So,
21 and it's an AHRQ PQI measure for CHF.

22 MEMBER BRUCE HALL: Measure No. 0277.

1 MR. AMIN: Thank you, Bruce.

2 CO-CHAIR TRAVIS: Okay. Well, thank
3 you all for that great conversation. I do
4 imagine that a lot of the conversation that we
5 just had would also be applicable to the diabetes
6 measure, which is 2887, Risk-Standardized Acute
7 Admission Rates for Patients with Diabetes.

8 However, we want to be sure that, one,
9 if there are any particular issues related to
10 diabetes that perhaps we did not cover and
11 congestive heart failure, because they're
12 different, let's be sure and focus on that.

13 And if there is still some lack of
14 clarity or some concern around some of the issues
15 we discussed already, we do want to be sure that
16 we circle back to those. But hopefully we can
17 move through this one a little bit faster since
18 we've had a conversation on the underlying
19 methodology that was for congestive heart
20 failure.

21 So our discussants for this particular
22 measure are Kathy, John and Keith, but before we

1 do that I wanted to see if the measure developers
2 wanted to say something particular related to the
3 diabetes measure to kind of ground us in this
4 particular issue.

5 DR. DRYE: Just a couple quick
6 comments. I don't know if --

7 Kasia Lipska, are you on the phone?
8 She's our expert endocrinologist who led this
9 measure, but she's traveling to a conference
10 today.

11 We have a lot more cases in this
12 measure, so that's just a note. There's more of
13 a range in the illness burden of the patients in
14 this measure. As a result, our risk-adjustment
15 does even more to distinguish among them. And
16 then we use a Diabetes Severity Index variable to
17 help us with that. That's validated in claims
18 data. So otherwise, I don't think there's
19 anything fundamentally different about the
20 measure.

21 MS. SHAHAB: Elizabeth, I did want to
22 let you know that Kasia is on the phone and she

1 has an open line.

2 DR. DRYE: Kasia, did you want to add
3 anything? We can't hear you.

4 DR. LIPSKA: Can you hear me now?

5 DR. DRYE: Yes. Go ahead.

6 DR. LIPSKA: So I am driving and it's
7 very busy, so I'm going to have a hard time
8 contributing, but I've been listening.

9 I think that the things that I wanted
10 to highlight about the diabetes measure are that
11 patients with diabetes are obviously also at high
12 risk of admission. That risk is lower than the
13 risk for admission for patients with heart
14 failure and multiple chronic conditions, as
15 Elizabeth already mentioned.

16 And one thing you'll notice when we
17 present the measure is that the model that is
18 higher than it is for MCCs and for heart failure.
19 It's about 0.22. And that may have to do with
20 the fact that there is a variation in the
21 population at risk for hospital admissions.
22 There are patients who are healthy patients with

1 diabetes and then there are those who have a
2 advanced disease and are very vulnerable to
3 hospital admission. And our risk model appears
4 to allow us to discriminate between these
5 populations.

6 CO-CHAIR TRAVIS: So are we ready to
7 move on, Elizabeth?

8 DR. DRYE: Yes.

9 CO-CHAIR TRAVIS: Okay. All right.
10 Well, let's move on to evidence. And I'll go to
11 Kathy first to see if you have anything that
12 you'd like to share with the group. And then
13 we'll go to Keith and then John.

14 MEMBER AUGER: I think that this
15 measure is very similar to the heart failure
16 measure. They have the same conceptual model of
17 how improving care for chronic conditions such as
18 diabetes might prevent hospital admissions.

19 CO-CHAIR TRAVIS: Keith, anything to
20 add?

21 MEMBER LIND: No, I agree.

22 CO-CHAIR TRAVIS: John, anything to

1 add?

2 CO-CHAIR BULGER: No.

3 CO-CHAIR TRAVIS: Okay. All right.

4 Any questions or discussion from the Committee?

5 Seeing none, we'll go to vote.

6 MS. HERRING: Voting is now open for
7 evidence for Measure 2887. Your choices are one
8 yes, two no.

9 And the results are 19 yes, 0 no, so
10 100 percent yes.

11 CO-CHAIR TRAVIS: Okay. Thank you.

12 Our next criterion is opportunity for
13 improvement or gap.

14 Keith, anything you'd like to mention?

15 MEMBER LIND: Yes, there is clearly
16 room for improvement here. And it's similar. I
17 guess the gap is narrower than it was for heart
18 failure. So 45 percent no difference, 40 percent
19 had better than national, and 16 percent worse
20 than national. Definitely room for improvement.
21 So I mean, I would -- that's enough for --

22 CO-CHAIR TRAVIS: Okay. Thank you,

1 Keith.

2 Kathy, anything to add?

3 MEMBER AUGER: Just note that there
4 are disparities that they talk about as well. In
5 terms of the AHRQ SES Index and as well as the
6 dual-eligible you see differences in performance,
7 which also speaks to gap.

8 CO-CHAIR TRAVIS: Thank you. John,
9 any additional information?

10 CO-CHAIR BULGER: No, I would agree
11 with what they just said. I mean, I think with
12 many of the other measures we look at generally
13 there's a lot more people that are in the middle
14 and lot less on the tails, whereas in these
15 measures there were -- the fact that such a --
16 that I guess it was 40 percent, almost 40 percent
17 were better than the national rate is pretty --
18 is a lot with what we're used to looking at. But
19 there's clearly a large gap between high and low
20 on this.

21 DR. DRYE: Yes, I can just add that
22 the number of admissions is just lower also to

1 begin with, so I think that affects the variation
2 that we're seeing. It's a median. The national
3 crude rate is 41.4 per 100 person-years and in
4 ACOs it's 39.6, so -- compared to heart failure,
5 which is 85 nationally and MCCs at 72. So
6 there's not quite as much of a room for absolute
7 range of number for admissions for person-year.

8 CO-CHAIR TRAVIS: Thank you for that.

9 Okay. Any questions or comments from
10 the Committee about performance gap?

11 Okay. We're ready to vote.

12 MS. HERRING: Voting is now open for
13 performance gap for Measure 2887. Your choices
14 are one high, two moderate, three low, or four
15 insufficient. We're looking for 20 votes.

16 The results are 7 high, 13 moderate,
17 0 low, 0 insufficient, so 35 percent high, 65
18 percent moderate.

19 CO-CHAIR TRAVIS: Great. Now we'll
20 move onto to reliability. And, Kathy?

21 MEMBER AUGER: Sure. So they also did
22 the split-half correlation, and the ICC of that

1 was 0.89. So there was a high degree of
2 reliability.

3 CO-CHAIR TRAVIS: Anything to add,
4 Keith?

5 MEMBER LIND: I would just reiterate
6 my point about looking at other areas,
7 particularly for diabetes outside of inpatient
8 admissions and reiterate Wes' point about
9 mortality. I mean, as we discussed yesterday, if
10 you're not in the sample, it may be that you're
11 dead, which is a significant outcome. That's a
12 bad outcome.

13 And the fact that there's a parallel
14 measure -- I understand there's a different
15 measure for mortality, but we talked about this
16 yesterday. So sometimes it could skew the way
17 this measure looks. Even though you have another
18 measure, it's difficult to put them side by side
19 for an individual institution and see how they --
20 is there an ACO mortality measure?

21 DR. DRYE: No, not exactly. So there
22 are a set of measures around diabetes care, but

1 patients who die, they're only the -- I mean, our
2 denominator only includes patients that are
3 alive, so it's different in the sense that we use
4 person-years. So we don't count the time after
5 which something had happened to them. But the
6 ACO measure set does not include a mortality
7 measure per se. It includes specific composite
8 around achieving diabetes care. And it's a good
9 point.

10 MEMBER LIND: Yes, I guess that makes
11 it that much more important. I think the days of
12 acute care that they used yesterday used a --
13 well, you use a year, so if you use person-years,
14 if you block -- if mortality reduces the number
15 of person-years available -- I don't know, I
16 shouldn't try to figure out how to do it, but --

17 DR. DRYE: Yes, it's if you die within
18 a year, you -- so if you were only alive through
19 February, you would just contribute 2/12ths of a
20 person-year. You contribute a fraction of a
21 person-year to the denominator. So we don't
22 count that period as being exposed. That's

1 different. That's consistent with EDAC. It's
2 different than the hospital readmission measures.

3 But the hospital readmission measures,
4 as you point out, are reported with a mortality
5 measure. We don't have the same thing in the ACO
6 measure set.

7 CO-CHAIR TRAVIS: John?

8 CO-CHAIR BULGER: I don't have
9 anything to add to what was already said.

10 CO-CHAIR TRAVIS: Okay. Any other
11 questions or comments from the Committee on
12 reliability?

13 All right. Well, I think we're ready
14 to go for a vote.

15 MS. HERRING: Voting is now open for
16 reliability for Measure 2887. Your choices are
17 one high, two moderate, three low, four
18 insufficient. And we're looking for 19 votes.

19 The results are 2 high, 17 moderate,
20 0 low, 0 insufficient, so 11 percent high, 89
21 percent moderate.

22 CO-CHAIR TRAVIS: Okay. Now, we'll

1 move to validity. Keith, any comments?

2 MEMBER LIND: I mean, they did pretty
3 strong validity testing and used -- I think they
4 used three different methods, right, and scored
5 pretty high on those. I don't know if anybody
6 else had any other comments on this.

7 CO-CHAIR TRAVIS: Kathy?

8 MEMBER LIND: They decided not to
9 include the SDS factors.

10 CO-CHAIR TRAVIS: Thank you, Keith.
11 I'm sorry.

12 Kathy, anything?

13 MEMBER AUGER: Yes, overall this model
14 fit better than the previous model with R-squared
15 of about 22 percent exclaimed. I will comment
16 that when you look at the models with and without
17 the sociodemographic factors, it looks like
18 there's a little bit more movement than there was
19 in the heart failure ones, but still for the same
20 conceptual reasons. And because the performance
21 of -- there are some high-performing ACOs even in
22 the high-percentage share of the poor ACOs --

1 that they still argued to not include them.

2 I think the one question that I had
3 for the developers is so this, like the other
4 measure, is about planned -- is excluding planned
5 admissions. And I was looking at the planned
6 admission. It looks like debridement of wounds
7 is considered a planned admission, which
8 conceptually for a diabetes measure it seems like
9 wound prevention would be a big thing that you
10 want physicians to focus on. So I was curious as
11 to why that was considered planned and then
12 therefore excluded.

13 DR. DRYE: Yes, great question. So
14 the algorithm that we used to identify planned
15 admissions we adapted from what we used in the
16 readmission measures, because when we developed
17 them initially, we were thinking about planned
18 admissions broadly, not just readmissions.

19 And we did make a couple of
20 modifications. We started with the version 3 of
21 the algorithm. So for example, we pulled out --
22 we don't count as planned amputations. But

1 around debridement there was -- I don't know the
2 specifics off the top of my head. I can get them
3 for you.

4 We did a validation of the algorithm.
5 And if you're admitted for an acute condition
6 like sepsis and wound infection is the cause,
7 it's not called planned. If you're admitted for
8 anything acute as a primary diagnosis and the
9 procedure of wound debridement occurs, it will
10 not be called planned. But if you don't have any
11 acute diagnosis and you're admitted for wound
12 debridement, when we went and developed an
13 algorithm that was found to be most often just
14 routine care, which can be good diabetes care.

15 It's not going to classify these
16 perfectly as planned or unplanned, but the
17 balance was towards those being planned. But we
18 did go through for this measure and just review
19 in this context whether we were striking the
20 right balance. And we made some adjustments.
21 I'm sure it's not perfect.

22 MEMBER AUGER: I will just kind of

1 echo that, because I was on a committee where we
2 did chart reviews of these cases. And so, when
3 it wasn't associated with an acute diagnosis like
4 cellulitis or acute osteomyelitis, all of these
5 other wound care procedures were planned follow-
6 up procedures, so staged procedures for wound
7 care that we felt were part of quality care and
8 not necessarily should we be including them in
9 this measure. We shouldn't necessarily be dis-
10 incentivizing that care.

11 DR. DRYE: That makes sense. Thank
12 you.

13 CO-CHAIR TRAVIS: John, anything else?

14 CO-CHAIR BULGER: No. I mean, it
15 still is a little bit of a question in my head
16 when almost 40 percent, I think it's 38.5
17 percent, end up better than the national average.
18 How valid the measure is just from a face
19 validity standpoint, it just seems like -- and
20 again, I think that's partly because the ACOs
21 you're looking at are a self-selected group and
22 honestly you don't put yourself in a program

1 unless you think you can do okay. So I think
2 that's part of it, but it's a little bit of a
3 concern.

4 DR. DRYE: Yes, and I'm definitely
5 learning from this experience that when we put
6 these results in the application, we were very
7 cognizant of how many outliers there are. Like
8 in the more recent data we ran with the AHRQ SES
9 testing update where we had 220 ACOs from the
10 2013, there's even more outliers. The reason is
11 we have such high -- so if you think of the
12 national average just like a point, a line, it's
13 just the crude rate over all the diabetes
14 patients who are in fee-for-service. What was
15 the number of unplanned admissions?

16 And so, if that's sitting at 41 and
17 you have very small confidence intervals around
18 our risk-adjusted estimates -- and we have such
19 high volume that we have a nice distribution of
20 risk-adjustment estimates, so we don't have
21 shrinkage or anything like that happening because
22 we have such volumes. It could be that many of

1 these are just barely over the line in one way or
2 the other, and some are way over the line, so
3 that on a more informative -- or it might --
4 there is a distribution of the measure scores.

5 We converted it into a categories
6 because that's how CMS traditionally has reported
7 for consumer interpretation the hospital measure
8 results in this setting. And actually CMS isn't
9 using these categories, and I'm not convinced it
10 would be the right way to report these results
11 because if you're given the statistical power we
12 have, just being like a tiny bit lower than the
13 national crude rate really is probably not
14 meaningful.

15 So I just want to caveat that that's
16 one way to report the measure score. It has its
17 down sides. I don't know if others --

18 CO-CHAIR BULGER: Well, and as you
19 said, that's not the way they're using it right
20 now. So you chose to report it that way for us
21 because that's just the traditional way it's been
22 done.

1 DR. DRYE: Well, and the irony is that
2 a limitation of our models in the hospital
3 settings is we don't identify very many
4 statistically significant outliers because of the
5 approach to modeling and the small sample sizes.
6 So, and CMS likes to use this very high
7 confidence level of 95 percent, which you
8 wouldn't necessarily need to use for reporting
9 the way you might in a research setting where
10 you're rejecting a hypothesis or something.

11 So we were like, great, we have so
12 many outliers, but as we've been thinking about
13 it more, it maybe conveys more sort of better and
14 worse that we really should be conveying. We
15 just have so much data that we are probably -- it
16 may not be the best way to present the results.

17 DR. SPATZ: Because of the self-
18 selection bias we anticipated that potentially
19 all 100 percent could be performing better than
20 the national rate and kind of looked at the data
21 a little bit differently at the other end, which
22 is to say, wow, we were surprised to find that

1 there were ACOs that were worse than the national
2 rate given that they were the earliest of
3 adopters.

4 CO-CHAIR TRAVIS: Okay. Paula?

5 MEMBER MINTON-FOLTZ: Sorry if this
6 was covered already, but are we talking about
7 attributed, designated or both for ACOs?

8 DR. DRYE: I think you're asking how
9 our patients attributed to the ACOs. So we were
10 lucky to be able to use CMS' ACO assignment file,
11 which was post-all of that work, to assign our
12 patients and our data to ACOs, but that file used
13 the policy in place at the time for the Medicare
14 Shared Savings Program and also the Pioneer ACOs.

15 In the MSSP it's post -- it's
16 attributed based on where they're getting the
17 majority of their care. And for this particular
18 analysis it used criteria that have since been
19 revised a little bit.

20 CO-CHAIR TRAVIS: Okay. Any other
21 questions or comments about validity?

22 (No response.)

1 CO-CHAIR TRAVIS: Okay. I think we're
2 ready for a vote.

3 MS. HERRING: Voting is now open for
4 validity on Measure 2887. Your choices are one,
5 moderate; two, low; or three, insufficient.
6 We're looking for 20 votes.

7 (Voting.)

8 MS. HERRING: The results are 17
9 moderate, 3 low, 0 insufficient, so 85 percent
10 moderate, 15 percent low.

11 CO-CHAIR TRAVIS: Okay. Now we'll
12 move to feasibility.

13 Kathy, any thoughts on feasibility?

14 MEMBER AUGER; It's very similar to
15 the other.

16 CO-CHAIR TRAVIS: Thank you. Keith,
17 any additional comments?

18 (No response.)

19 CO-CHAIR TRAVIS: John?

20 CO-CHAIR BULGER: No.

21 CO-CHAIR TRAVIS: Okay. Any comments
22 or questions from the Committee?

1 (No response.)

2 CO-CHAIR TRAVIS: Okay. Ready for a
3 vote.

4 MS. HERRING: Voting is now open for
5 feasibility for Measure 2887. Your choices are
6 one, high; two, moderate; three, low; or four,
7 insufficient. Again, we're looking for 20 votes.

8 (Voting.)

9 MS. HERRING: The results are 15 high,
10 5 moderate, 0 low, 0 insufficient, so 75 percent
11 high, 25 percent moderate.

12 CO-CHAIR TRAVIS: Okay. Now we'll go
13 to use and usability.

14 Keith, any comments?

15 MEMBER LIND: It's not currently in
16 use, but it's planned for use and seems usable
17 and understandable.

18 CO-CHAIR TRAVIS: Thank you. Kathy,
19 any additional comments?

20 (No response.)

21 CO-CHAIR TRAVIS: None? Okay.

22 John?

1 CO-CHAIR BULGER: Yes, I just can't
2 help myself. I think the only thing that's
3 ironic is the comment you just -- and we're
4 talking about use in the -- that you made the
5 comment that the difficulty -- because CMS
6 requires 5/95 for reporting, which is true, and
7 they require 49/50 for payment. I mean, the O/E
8 ratio is the difference between the 49th
9 percentile and the 50th percentile. You become
10 -- it changes your payment on -- not on this
11 measure, but on a bunch of the other measures,
12 whereas for reporting they require 5/95 to say
13 that you're better than the national average or
14 worse than the national -- my soap box. Sorry.

15 CO-CHAIR TRAVIS: Thank you for your
16 soap box. But it is a recurring theme, so it is
17 part of our thought process.

18 Okay. Any other comments or questions
19 about use and usability?

20 (No response.)

21 CO-CHAIR TRAVIS: Okay. We're ready
22 for a vote.

1 MS. HERRING: Voting is now open for
2 usability and use for Measure 2887. Your choices
3 are one, high; two, moderate; three, low; four,
4 insufficient. We're looking for 20 votes.

5 (Voting.)

6 MS. HERRING: The results are 5 high,
7 14 moderate, 1 low, 0 insufficient, so 25 percent
8 high, 70 percent moderate, 5 percent low.

9 CO-CHAIR TRAVIS: Okay. So now we're
10 to the point where we will be voting on overall
11 suitability for endorsement. Are there any final
12 comments or questions from the Committee? Wes?

13 MEMBER FIELDS: Yes, I've been
14 struggling with this for about the last 10, 15
15 minutes, and this will probably disturb Taroon
16 because I really feel like our last question
17 should include utility. And so, I'm a little
18 troubled by the utility of this.

19 I understand the decisions you made.
20 They're defensible from a methodological
21 approach, but I have to believe the most
22 important measure for these very important

1 populations for an ACO is per-member per month
2 cost and the impact on shared savings.

3 My bias is that I'm an acute care
4 provider, but I see tons and tons of people,
5 especially in the category of diabetes, and also
6 renal disease, although it's not one of your
7 measures, who come from accountable care
8 entities, and some of them do a much better job
9 than others in terms of managing things.

10 So for example, for me the difference
11 between a scheduled debridement or a scheduled
12 amputation and an unscheduled one is moot. And I
13 don't think it matters that much to the patient
14 who has their foot cut off either.

15 And so, I'm just troubled a little bit
16 by what seems like an arbitrary focus on acute
17 care services when what we should all be striving
18 for is the best outcomes for this population in
19 which all costs matters and all interventions
20 matter.

21 CO-CHAIR TRAVIS: Any comments?

22 DR. DRYE: No, I mean, I think you're

1 raising valid points. What we were trying to do
2 was capture an underlying quality domain of care
3 coordination and care efficacy. We weren't
4 really focused here on resource use per se, so we
5 tried to walk that line and we didn't want to
6 generate adverse consequences like discouraging
7 routine care.

8 So I think that the difference -- I
9 think the supplements, the broader numbers that
10 ACO had on their savings -- and their biggest
11 costs are hospital costs for sure, but here we're
12 trying to get down in all three of these measures
13 to reflecting the quality of care. And that was
14 the design. Is it perfect? No. And those are
15 some of the things that we really struggled with.
16 But it isn't a resource use measure. That would
17 have been done very differently. So it's risk-
18 adjusted. It's pulling out things that we think
19 aren't related to quality. It's not perfect.

20 MEMBER FIELDS: In a consensus-driven
21 organization like NQF a reasonable compromise
22 would probably be to consider all admissions.

1 DR. SPATZ: Yes, I will say with the
2 three measures in parallel we had a lot of
3 stakeholder input, and this particularly came up
4 in the multiple chronic conditions, which we'll
5 hear about next. But we had a lot of pushback by
6 some people to say hospitalizations for these
7 very difficult patients are not all bad, even
8 some of the acute ones that we don't classify.

9 It provides an opportunity to
10 reconfigure resources. Sometimes a break for
11 families, we heard. People were afraid that we
12 might dis-incentivize placing an ICD or
13 appropriately caring for them the amount of
14 duration needed because those things -- and those
15 things are high-quality care.

16 So we didn't just kind of
17 automatically assume that all -- just don't --
18 let's just cut the line at acute admissions, but
19 we did hear very loud and clear from a large
20 stakeholder group that we're not looking to
21 reduce all admissions and that some of these are
22 indicators of quality. And that kind of caused

1 us to -- especially with the diabetes measure,
2 the amputations, because these are outcomes that
3 we really care about, that we really want to
4 avoid.

5 We want to avoid end-stage renal
6 disease. We want to avoid amputations. But we
7 also want to incentivize good care for people
8 whose diseases have been manifesting for the last
9 20, 30 years and at this point we're not going to
10 prevent them from going on dialysis, but we can
11 change the way that that's done and improve their
12 outcomes in all.

13 So we tried to walk that line, but
14 you're right, I mean, there's not like a clear
15 bright line between what should count and what
16 shouldn't count.

17 MEMBER FIELDS: Well there is in your
18 measure.

19 DR. SPATZ: There is, right. We had
20 to draw a bright line, but clinically I think we
21 can all come up with cases that don't fit that
22 bill.

1 CO-CHAIR TRAVIS: Paul?

2 MEMBER HEIDENREICH: I would just say
3 there's a lot of acute care that's good quality,
4 too. So you're theoretically providing a
5 disincentive to admit someone with chest pain in
6 the emergency room, depending on their -- so I
7 don't think it's a fine line that bad quality is
8 acute and planned is good.

9 CO-CHAIR TRAVIS: John?

10 CO-CHAIR BULGER: Yes, I do hear what
11 you're saying, and I think probably you're right,
12 when you talk to -- get TPs together and they
13 talk about they're worried about people
14 withholding care because of this. But to me the
15 balance to that in these measures is, as we have
16 talked about, the end-all be-all for the ACO is
17 total cost of care.

18 So to me these measures are balancing
19 the ACO withholding all care, because that's the
20 way you could really win in an ACO is not spend
21 any money. And this measure is looking -- so
22 looking at all admissions with this measure would

1 be the complete balance to what the ACO is after
2 if they were in a perverse environment, which
3 would be not providing care. So looking at all
4 admissions. I don't think looking at all
5 admissions in this group is going to make people
6 not admit someone for a reason, that they have a
7 reason not to admit them, which is because it's
8 going to be a cost to their ACO.

9 CO-CHAIR TRAVIS: Karen?

10 MEMBER JOYNT: Yes, I have to
11 respectfully disagree that I don't think this
12 measure balances the risk of not doing anything.
13 If anything, it makes it worse because it just
14 puts more -- puts not only on your cost side, but
15 also on your quality side not to do anything. In
16 theory the ACO measures like diabetes control and
17 other things where you're measuring LDL, those
18 should incent you to do more to make people
19 better, but there isn't -- to the point raised
20 earlier, there isn't an offsetting -- like
21 keeping people alive and out of the hospital in a
22 way that is in keeping with their goals and not

1 in doing too little that exists currently. Maybe
2 that's a place for future measure development is
3 some sort of offset to some of the risks we worry
4 about, thinking back to capitation and things
5 like that.

6 CO-CHAIR TRAVIS: Helen?

7 DR. BURSTIN: I was actually going to
8 raise the point about balancing measures as a
9 concept we've talked a lot about as you look at
10 some of these more population-oriented measures.
11 And in fact, this also relates to a potential
12 competing measure discussion. But there are also
13 AHRQ Prevention Quality Indicators, specifically
14 in the diabetes space, that get at long-term
15 complications admission rate, short-term
16 complications admission rate, the lower extremity
17 amputation rate among patients with diabetes, as
18 well as the uncontrolled diabetes admission rate.

19 So in some ways those -- but they're
20 not part of this program, which is a separate
21 issue, but I think it is a question as we come
22 back and look at competing measures. If some of

1 those measures are out there, one consideration
2 would be how do you then factor in concerns about
3 measures that they push the bubble in one
4 direction about having some way of understanding
5 if there are balancing measures that give the
6 full picture? And obviously something much more
7 aligned with what we tend to do at the MAP
8 tables, but I think this is obviously -- raises a
9 potential concern for this measure.

10 CO-CHAIR TRAVIS: And I'll just
11 comment on that as well, because as you were
12 talking of course the whole MAP conversation came
13 to my mind about looking at the programmatic
14 portfolio and having this rich discussion about
15 what are the drivers in an ACO? And the
16 financial driver is critical and is key to that.

17 So I think it's very good conversation
18 to be sure the MAP understands that our concerns
19 were around do we have some measures in the
20 portfolio for the ACO Program that are balancing
21 measures to be sure that care is not being
22 withheld. Because the financial incentive is to,

1 quote/unquote, "not spend the money," which could
2 mean not provide the care.

3 So I do think that it causes us to
4 have to look at this program a little -- I mean,
5 an ACO-type measure; not program, but ACO
6 measure, a little bit differently than we might
7 in a fee-for-service-type environment where the
8 financial incentive traditionally has been to do
9 more.

10 So I think let's find a way; and Erin
11 and I were talking about this earlier today, to
12 be sure that this kind of a conversation we're
13 having gets not just on our side, on the
14 endorsement side, but migrates into any
15 discussion that goes on at the MAP side. Because
16 I think this has been an important aspect of what
17 we're evaluating and struggling with, quite
18 frankly, relative to these measures.

19 Leslie?

20 MEMBER LESLIE HALL: I just wanted to
21 comment. I don't think we want to end up with
22 whack-a-mole for measures, and it feels like that

1 when you're trying to juxtapose all of these
2 things. And it's worth discussion further.

3 CO-CHAIR TRAVIS: No, I agree. I
4 mean, we looked at the portfolio earlier that's
5 in this Committee's, and we went through it
6 rather rapidly. There may be some time that it
7 makes sense for us to have not an in-depth, but
8 at least a little bit -- maybe a different way of
9 picturing it so that we can understand what kind
10 of measures are in here. Because I think you
11 bring up a really good point, I mean, just
12 continuously having more and thinking about how
13 they're related. And I think it's an issue that
14 we're beginning to see.

15 So thank you, Leslie, for bringing
16 that up.

17 Yes?

18 DR. DRYE: I think this is really
19 interesting and I think our communities' view is
20 evolving on this somewhat. So I would encourage
21 you to think about it across actually the
22 readmission -- this is the Readmissions

1 Admissions Committee, but across the readmission
2 measures as well. It was really in the context
3 of the readmission measures that we had a lot of
4 discussion at NQF and elsewhere around how to
5 evaluate admissions and should we be looking at
6 only related admissions -- and I'm sure you guys
7 are doing all this -- only related admissions
8 that are directly related? Now, you had your
9 hip/knee replacement. Did you come back with an
10 infection or a DVT? Or should we look more
11 broadly?

12 And we really evolved as a community
13 towards taking a very patient-centered view
14 saying we want to look at all admissions that
15 could be related and then risk -- we don't think
16 it's going to be zero, and we risk-adjust for
17 differences that will take care of the unrelated
18 things like you walked across the street and got
19 hit by a car. Hopefully that wasn't because you
20 were over-medicated. We don't know if it's
21 related or not, but we try to get a lot of that
22 noise out of the way and hold onto that broad

1 set. But we didn't go all the way to counting
2 everything because there was a strong view among
3 many stakeholders that many admissions aren't
4 providing a quality signal.

5 So we evolve. We approach these
6 admission measures starting really where the
7 debate was at the time, which is we're trying to
8 capture admissions related to quality as broadly
9 viewed in the setting of primary care, chronic
10 disease management from the patient's
11 perspective. And an admission for a hip
12 replacement in that context, if you happen to be
13 a patient with a diagnosis of diabetes, is not a
14 quality signal.

15 So it's those concerns and that
16 context and those discussions over a number of
17 measures, not just these that kind of led us away
18 from saying, well, an admission is good or bad.
19 We're trying to craft a measure to reflect
20 quality of care, not to count admissions. And
21 I'm hearing maybe we haven't struck the right
22 balance. There are other measures that do it

1 differently that are essentially focused on more
2 narrow highly-related things for narrower cohorts
3 depictions.

4 So it's a great discussion. I mean,
5 I'm agreeing with you, but I think it's broad
6 beyond these measures.

7 CO-CHAIR TRAVIS: Yes, Carol?

8 MEMBER RAPHAEL: In line with that;
9 and this is just for the future, I think one of
10 the issues I can relate to in home healthcare is
11 you get a discharge for someone who's had a hip
12 replacement and you in and the person has out-of-
13 control hypertension, they have diabetes that's
14 not well managed, they have extraordinary pain
15 from arthritis and they're depressed. And you go
16 back to the physician, the orthopedic surgeon who
17 says it's not my job. You've got to go elsewhere
18 to deal with all the rest of that.

19 And what you're trying to do is get
20 the best outcomes for someone who has multiple
21 chronic conditions at the same time that you're
22 trying to prevent the readmission for some

1 infection or decline having to do with the hip
2 replacement. And you're working in two domains.
3 The first one is measured; the second is not
4 measured, and it's much more complicated. But to
5 me that is part of how you have to think about
6 people who have multiple chronic conditions.

7 CO-CHAIR TRAVIS: Thank you, Carol.

8 Wes?

9 MEMBER FIELDS: Yes, I want to go back
10 to something Karen raised earlier. And for me I
11 bow down to primary care-sensitive conditions,
12 but I think the reality is that for things like
13 diabetes or renal failure -- you talked yourself
14 about sort of inheriting the healthy 65-year-old
15 with a fasting blood sugar of 130, where you
16 actually have an opportunity to prevent
17 comorbidity over a period of time.

18 But the reality is that the people at
19 the other end of the rainbow treating a very
20 advanced disease is the likelihood that they're
21 even able to get through the door of a standard
22 lower-tier medical home is low. And they in fact

1 have a very different set of providers.
2 Hopefully the ACO is enlightened enough that
3 they're well-integrated, but that's not always
4 the case. And a lot of what you're struggling to
5 measure is when it's not.

6 But I think the reality is that the
7 more complex or advanced these diseases are,
8 especially the MCC patient, the more likely
9 they're in a different orbit between acute care
10 facilities and post-acute care. And that's one
11 of the reasons I think it's a mistake not to
12 measure all bed days, because they all matter.
13 They matter to the patient. They matter to CMS.
14 They matter to providers.

15 So I think some of the distinctions
16 you made about whether care was scheduled was not
17 ultimately are arbitrary and don't reflect
18 anything that's worth measuring.

19 CO-CHAIR TRAVIS: Okay. Any other
20 comments? Anybody including the developers want
21 to say anything before we finish?

22 (No response.)

1 CO-CHAIR TRAVIS: Okay. So we're
2 ready for the vote.

3 MS. HERRING: Voting is now open for
4 overall suitability for endorsement for Measure
5 2887. Your choices are one, yes; two, no. And
6 we're looking for 20 votes.

7 (Voting.)

8 MS. HERRING: The results are 18 yes,
9 2 now, so 90 percent yes, 10 percent no. Thank
10 you.

11 CO-CHAIR TRAVIS: All right. Well,
12 thank you. I'm going to turn it back over to
13 John.

14 MR. AMIN: Before we move onto the
15 next measure, Cristie, if it's okay, based on our
16 prior conversation it appears that we'll probably
17 need to have also a conversation around related
18 and competing measures for this measure as it
19 relates to 0272, the Diabetes Short-Term
20 Complications Admission Rate, the PQI 01, along
21 with 0724, the Diabetes Long-Term Complications
22 Admission Rate, PQI 03, and then 0638,

1 Uncontrolled Diabetes Admission Rate, PQI 14.

2 Is there anyone -- it sounds like
3 there's agreements about that, so we will flag
4 that for follow-up for conversation with the
5 Committee.

6 And so, I'll turn it back over to
7 John.

8 CO-CHAIR BULGER: Okay. Thank you.

9 And I did want to say to -- I got discombobulated
10 in the point I was trying to make there. And to
11 Karen and Helen's point and to somewhat what was
12 just said, I think the universe of ACOs is very
13 heterogeneous in the way it sits right now with
14 the shared savings and essentially comparing
15 yourself to yourself, at least in the old method,
16 now realizing that the new rule that came out in
17 the last couple of days changes that a little
18 bit. It still offers the availability for people
19 to -- and I hate to use the word "game," but you
20 can go into a system where there's a very large
21 Medicare cost beneficiary, kind of a McAllen
22 place, and there's money to be made essentially.

1 So coming up with measures -- and I
2 agree completely that these measures don't
3 necessarily do it, but coming up with measures,
4 as Helen talked about, that are able to check
5 that to some extent I think is extremely
6 important for us to do.

7 So the next measure is 2888, Risk-
8 Standardized Acute Admission Rates for Patients
9 with Multiple Chronic Conditions. And again, it
10 is much like the two we've just talked about, but
11 somewhat different. Frank, Mae and Steve are the
12 discussants. And we'll start with the developer.

13 DR. DRYE: Okay. I'll try to cover
14 quickly. You guys have given us thorough
15 discussion.

16 So this was a fun to measure to work
17 on. It was a privilege to work on it because as
18 you know there are very few measures for patients
19 with multiple chronic conditions. So I just
20 wanted to highlight how we put together the
21 cohort for this measure, otherwise, its
22 properties aren't that different from the two

1 other measures.

2 We started by looking at frameworks on
3 what do we mean by patients with multiple chronic
4 conditions including NQF's, and NQF's MCC
5 framework defines MCC patients as having two or
6 more concurrent chronic conditions that act
7 together to significantly increase the complexity
8 of management that affect functional roles,
9 health outcomes, compromise life expectancy or
10 hinder self-management.

11 So we started there. Sought expert
12 input including from Mary Tinetti at Yale and
13 Cynthia Boyd at Hopkins and tried to really --
14 looked at the frameworks that are coming out of
15 the geriatrics expertise and defined a list of
16 chronic conditions consistent with those
17 definitions and then empirically looked at how
18 they were acting together to contribute to risk.

19 And we settled on -- we developed an
20 approach and gave two versions of it put out in
21 public comment using eight fairly broadly defined
22 groups of chronic conditions. We said we could

1 define our cohort using two or more of these or a
2 more restrictive narrow cohort would require
3 three or more of these conditions, which was
4 consistent with at least one of the clinically-
5 driven frameworks.

6 And it was just really interesting to
7 get expert input and public comment. And in the
8 big picture we ended up defining this cohort as
9 patients with two or more of eight chronic
10 conditions. They're listed -- or I can list them
11 for you quickly. Ischemic heart disease or
12 history of MI, Alzheimer's disease and related
13 disorders of senile dementia, chronic kidney
14 disease, chronic obstructive pulmonary disease,
15 depression, atrial fibrillation, diabetes, heart
16 failure and stroke. Sorry, we pulled out -- we
17 didn't use diabetes. I mentioned that before.
18 And we also looked at non-traumatic joint
19 disorders or arthritis, which is an important
20 chronic condition, but it doesn't contribute much
21 in our analyses to admission risk.

22 So when we put this out in public

1 comment, some of what we got back was just
2 acknowledgment from primary care providers and
3 internists that they felt like our two-plus or
4 two or more chronic conditions cutoff was as good
5 one. That represented about 25 percent of
6 Medicare fee-for-service patients with any
7 chronic condition. And that just kind of -- it
8 was consistent with their clinical experience,
9 that they felt about a quarter of their patients
10 with chronic conditions really fit these
11 framework definitions of multiple chronic
12 conditions. That left us with a pretty big
13 cohort nationally of 4.9 million patients. And
14 within ACO it was about 240,000 patients.

15 There's no one way to do this, but I
16 think we've drawn a line systematically with
17 expert input. And I'm happy to answer questions
18 about how we came to this particular group of
19 patients.

20 CO-CHAIR BULGER: Okay. Thank you.

21 So, Frank, you want to --

22 MEMBER BRIGGS: Yes. So as mentioned,

1 all the previous discussion I think is relevant.
2 These are patients, again unplanned admissions
3 with two of those chronic conditions listed
4 representing a number of Medicare fee-for-service
5 populations.

6 The strategies for improvement are
7 basically the same for interaction with the ACOs:
8 building better social networks, better chronic
9 care management and those things. What the
10 developers have started to touch upon was that
11 list of eight. Unsure really at this point how
12 the eight came about as well as the interaction
13 between the eight. So do the eight all interact
14 equally? So does someone with AMI carry the same
15 risk as AMI, Alzheimer's, Alzheimer's, AFib, that
16 type of interaction between the two? But other
17 than that I think that the measure itself is very
18 similar to the previously discussed.

19 CO-CHAIR BULGER: Okay. Mae?

20 MEMBER CENTENO: Nothing to add.

21 Thank you.

22 CO-CHAIR BULGER: And, Steve?

1 (No response.)

2 MS. O'ROURKE: He's not here.

3 CO-CHAIR BULGER: He's not here?

4 MS. O'ROURKE: No Steve.

5 CO-CHAIR BULGER: Helen, go ahead.

6 MEMBER CHEN: Hi. It's just more of
7 an editorial comment. I just wanted to thank you
8 for including these conditions in your model. As
9 a geriatrician we struggle with all the time in
10 terms of the concept of multi-morbidity. And
11 these eight conditions are actually pretty
12 strongly associated with this bigger concept of
13 frailty, and I really wish -- actually that's
14 what I would like to see, is a measure for
15 determining how we can help people to manage the
16 concept of frailty in terms of readmissions,
17 because I don't know that there's any really good
18 way of getting at that from claims data, but
19 that's really what we're mostly interested in in
20 terms of this population that is so at high risk
21 for readmission, or just admissions to begin
22 with.

1 I do think that it is striking that
2 most of these conditions do risk-adjust from --
3 in terms -- from the CMS HCC kind of risk-
4 adjustment, except for I believe dementia is no
5 longer on the list. So just an editorial
6 comment.

7 DR. DRYE: Thank you.

8 CO-CHAIR BULGER: Any other comments?

9 (No response.)

10 CO-CHAIR BULGER: Okay. So we'll vote
11 on evidence.

12 MS. HERRING: Voting is now open for
13 evidence for Measure No. 2888. Your choices are
14 one, yes; two, no.

15 (Voting.)

16 MS. HERRING: The results are 20 yes,
17 0 no, so 100 percent yes.

18 CO-CHAIR BULGER: Okay. Thank you.
19 And just a quick -- we're close on time. We're
20 not horrible. So just try to keep comments on
21 this measure. And if we don't have anything new
22 from the previous two -- the other thing is we

1 had a break built in. I think we're not going to
2 take the break, but people have been getting up
3 and taking their own break. Encourage you to do
4 that. Sitting is the new smoking, so --

5 (Laughter.)

6 CO-CHAIR BULGER: -- get up and move
7 around, if you get a chance.

8 So next we have gap, and I'll start
9 with Mae.

10 MEMBER CENTENO: Yes, so for this
11 measure the gap that was -- so the average, the
12 national risk-standardized acute admission rate
13 for fee-for-service is 71.9. For the ACO it's
14 about 69.3. And the range is anywhere from 62 to
15 76, so there's quite a gap with this one.

16 Forty-seven ACOs or forty-one point
17 two percent were better than national rate. And
18 then there is a subset of 45 ACOs that are no
19 different than national, but about 19.3 percent
20 have lower than national. So there's room for
21 improvement.

22 CO-CHAIR BULGER: Okay. Frank, any --

1 MEMBER BRIGGS: Just to point out that
2 they did look at SES adjustments similar to the
3 other ones. They found little difference when
4 you risk-adjust with or without the adjustment.
5 And the recommendation was not to adjust for the
6 modifiable factors.

7 CO-CHAIR BULGER: Okay. Any other
8 comments from the Committee?

9 (No response.)

10 CO-CHAIR BULGER: All right. We'll
11 vote on the gap.

12 MS. HERRING: Voting is now open for
13 performance gap for Measure 2888. Your choices
14 are one, high; two, moderate; three, low; four,
15 insufficient.

16 (Voting.)

17 MS. HERRING: The results are 4 high,
18 16 moderate, 0 low, 0 insufficient, so 20 percent
19 high, 80 percent moderate.

20 CO-CHAIR BULGER: Okay. Thank you.

21 Reliability. Frank?

22 MEMBER BRIGGS: So this is going to be

1 driven from the administrative claims similar to
2 the others. They did do reliability testing.
3 They used the MEDPAR data as well as the AHRQ SES
4 Index. They did tests and retests with the
5 split-half methodology. I want to say the
6 intraclass correlation coefficient there came out
7 to be a 0.84, which suggests that it was high. I
8 think that's it.

9 CO-CHAIR TRAVIS: Okay. Mae?

10 MEMBER CENTENO: Nothing to add.

11 CO-CHAIR BULGER: Okay. Anything from
12 the Committee? Paul?

13 MEMBER HEIDENREICH: Oh, wait. Sorry.
14 I want to talk about validity.

15 CO-CHAIR BULGER: All right. Anything
16 on reliability?

17 (No response.)

18 CO-CHAIR BULGER: Okay.

19 MS. HERRING: Voting is now open for
20 reliability for Measure 2888. Your choices are
21 one, high; two, moderate; three, low; four,
22 insufficient.

1 (Voting.)

2 MS. HERRING: The results are 3 high,
3 17 moderate, 0 low, 0 insufficient, so 15 percent
4 high, 85 percent moderate.

5 CO-CHAIR BULGER: All right. So we're
6 at validity. Mae?

7 MEMBER CENTENO: So the developers
8 performed face validity and also used the risk
9 model diagnostics with an R-square of 0.123, so
10 really not as great as diabetes, but close to
11 what they found in heart failure. They also did
12 conceptual modeling of the SES and for reasons
13 already mentioned earlier decided to exclude
14 those.

15 CO-CHAIR BULGER: All right. Frank?

16 MEMBER BRIGGS: Nothing to add.

17 CO-CHAIR BULGER: All right. Anything
18 from the Committee? Larry?

19 MEMBER GLANCE: This is just kind of
20 a general comment; and we touched upon this a
21 little bit earlier, but we're going to be making
22 the transition from ICD-9 to ICD-10 codes. It's

1 a massive transition. We're not going to have
2 any idea about data reliability at all for
3 several years, and really a huge number of
4 models, most of the models in fact in the
5 portfolio models of measures that we have we're
6 really not going to know anything about their
7 model performance.

8 In general, and maybe this is more for
9 NQF, what is the plan? Are we going to go back
10 and reevaluate every single model based on really
11 a very new methodology?

12 DR. BURSTIN: Yes, so I'm happy to
13 quickly respond to that. We don't have the
14 person in the room who does this, but my
15 understanding is our current approach has been
16 that anybody who has claims-based measures;
17 actually Yale probably knows this better than
18 anyone, has a snip of ICD-9 and ICD-10 during
19 this transition. And again, you're absolutely
20 right, we don't know how this is all going to
21 play out, but at least the thinking is to
22 prospectively ensure that that information is

1 available as that transition begins to happen.

2 MS. MUNTHALI: In addition to that
3 they have to submit the plan for converting over
4 to ICD-10, and it's by 2019.

5 DR. DRYE: Yes, I would just add I
6 think it's a great issue to think about with NQF
7 actually, because what we're doing now is for
8 CMS, with CMS we're thinking about how to do the
9 most robust testing possible because some of
10 these measures are already in public reporting,
11 including these.

12 So we will look at the consistency of
13 the risk variables, the relationships of those in
14 terms of their frequency, the relationship of
15 those variables to the outcome, what do they look
16 like in -- do they have the same binary
17 relationship? What does the overall model look
18 like? But that isn't really even enough. We're
19 right now still developing our testing plan to
20 really be able to confirm the models that are
21 working in that ICD-10 data.

22 And I think it's a great issue for --

1 I don't know that it -- I don't know what context
2 you guys would be involved, but it's a major
3 focus of our work right now.

4 CO-CHAIR BULGER: Paul?

5 MEMBER HEIDENREICH: For heart failure
6 and diabetes there was that nice analysis of the
7 SES by quartile and for different -- and how they
8 were labeled as outliers, but I didn't see it for
9 this. Were the results similar or was -- any
10 notable differences?

11 DR. DRYE: Yes, we put the updated
12 analysis in the memo that we sent last week, and
13 there's some analysis in the original report.
14 It's pretty similar in that in the -- when you
15 use the AHRQ SES Index and nine-digit ZIP code,
16 you have in the quartile of ACOs with the -- of
17 the 220 ACOs, so 55 ACOs with the most low-SES
18 patients, 33 percent are statistically better
19 than the national rate, 31 percent are worse.
20 And that distribution is skewed. There are more
21 who fall into the worst category than in that
22 quartile with the fewest low-SES patients where

1 11 percent are worse.

2 So you do see -- I'm going to hand
3 this down to you so you can look at it because
4 it's hard to just -- at least for me, to listen
5 to these quartile results without looking at
6 them. But you do see the same in that there are
7 a lot of -- the 25 percent in the -- I mean,
8 sorry, as I said, 32 percent of the ACOs with the
9 most low-SES patients do very, very well.

10 So that again, we're advocating for
11 leaving that visible and having that be the
12 benchmark and having those ACOs, which in ACOs is
13 a little more collaborative than in the hospital
14 setting, really being the drivers of change and
15 innovation for those ones that are still
16 struggling. But I'm going to hand this down to
17 you so you can see. And let me know if you have
18 questions.

19 CO-CHAIR BULGER: Okay. Any other
20 comments on -- Leslie?

21 MEMBER LESLIE HALL: So building back
22 on the ICD-10 question, when you're doing that

1 analysis doesn't the whole nature of whether
2 something is planned or unplanned -- isn't that
3 impacted by ICD-10 versus ICD-9, so just that are
4 just that basic? And so, how do you then
5 reconcile that? It seems quite difficult.

6 DR. DRYE: I mean, I think it would be
7 -- again, I'm looking at Helen because we have
8 formal testing plans. I know other CMS measure
9 developers do as well. And we haven't really
10 publically shared them. I wouldn't mind sharing
11 the outline, but we go through a whole series of
12 steps to make sure that the -- first we code
13 everything in ICD-10, meaning that we look at --
14 we use GEM's crosswalk, we get expert input, we
15 make sure that we have the right ICD-10 codes
16 that we think people are going to code.

17 But I think to Larry's point, it's not
18 clear that people are going to use ICD-10 codes
19 exactly how we expect them to. Sometimes a
20 single code is replaced by a double code. And so
21 we're going to be not assuming that those same
22 codes will be used as -- those new codes will be

1 used as expected or per coding guidance. We're
2 going to be looking to see are we seeing the same
3 patterns of comorbidities? Are we seeing
4 correspondence in the way these risk variables
5 behave?

6 Beyond that, I mean, I think we would
7 be happy to share strategies on that, how we're
8 going to be doing this testing going forward, but
9 it's kind of a longer conversation.

10 What would you suggest, Helen?

11 DR. BURSTIN: Yes, I think it's a
12 longer conversation. We do regularly convene all
13 the measure developers, and it might be a good
14 topic for an upcoming webinar of all the
15 developers to get a sense of where they are in
16 their plans and maybe share and learn what each
17 of them is doing. I know this has been a big
18 issue for AHRQ certainly on all the AHRQ PSIs,
19 PQIs, etcetera.

20 CO-CHAIR BULGER: o Any other
21 comments?

22 (No response.)

1 CO-CHAIR BULGER:

2 MS. WATT: All right. So we're going
3 to vote on validity. Remember this one the
4 highest you can do is moderate.

5 MS. HERRING: Voting is now open for
6 validity for Measure 2888. Your choices are one,
7 moderate; two, low; three, insufficient.

8 (Voting.)

9 MS. HERRING: The results are 16
10 moderate, 4 low, 0 insufficient, so 80 percent
11 moderate, 20 percent low.

12 CO-CHAIR BULGER: Okay. So
13 feasibility. We'll start with Frank.

14 MEMBER BRIGGS: Yes, so similar to all
15 the other measures we discussed this data will be
16 coming primarily from electronic claims, so your
17 admission, discharge and information from the
18 billing and your ICD-9 coding. So apart the ICD-
19 10 conversion it's all currently there and
20 spelled out.

21 CO-CHAIR BULGER: Okay. Mae?

22 MEMBER CENTENO: Nothing to add.

1 Thank you.

2 CO-CHAIR BULGER: All right. Any
3 comments from the group?

4 (No response.)

5 CO-CHAIR BULGER: Okay. We'll vote.

6 MS. HERRING: Voting is now open for
7 feasibility for Measure 2888. Your choices are
8 one, high; two, moderate; three, low; four,
9 insufficient.

10 (Voting.)

11 MS. HERRING: The results are 12 high,
12 8 moderate, 0 low, 0 insufficient, so 60 percent
13 high, 40 percent moderate.

14 CO-CHAIR BULGER: All right. And
15 we're on use. Mae?

16 MEMBER CENTENO: Oh, on use, as
17 already mentioned, this is already used in some
18 of the Medicare Shared Savings with potential use
19 for pay-for-performance beginning 2017.

20 CO-CHAIR BULGER: Frank, any comments?

21 MEMBER BRIGGS: Nothing to add.

22 CO-CHAIR BULGER: All right. Anything

1 from the Committee on use?

2 (No response.)

3 CO-CHAIR BULGER: Okay. We'll vote.

4 MS. HERRING: Voting is now open on
5 usability and use for Measure 2888. Your choices
6 are one, high; two, moderate; three, low; four,
7 insufficient.

8 (Voting.)

9 MS. HERRING: The results are 4 high,
10 16 moderate, 0 low, 0 insufficient, so 20 percent
11 high, 80 percent moderate.

12 CO-CHAIR BULGER: Okay. And last any
13 further comments from anybody on the overall
14 suitability?

15 (No response.)

16 CO-CHAIR BULGER: All right. Seeing
17 none, we'll go to vote.

18 MS. HERRING: Voting is now open on
19 overall suitability endorsement for Measure 2888.
20 Your choices are one, yes; two, no.

21 (Voting.)

22 MS. HERRING: The results are 20 yes,

1 0 no, so 100 percent yes. Thank you.

2 CO-CHAIR BULGER: Great. Thank you.

3 I want to thank the developers for sitting
4 through that marathon and helping us with that
5 and for the measure.

6 DR. DRYE: Thank you.

7 CO-CHAIR TRAVIS: And I'll turn it
8 over to Cristie.

9 CO-CHAIR TRAVIS: Yes, and my thanks
10 as well. And it's kind of nice, we're going to
11 actually change topic area and think about
12 psychiatric care. We have a large variety of
13 measures that we consider in this standing
14 committee. So we're going to be looking at
15 Measure 2860, which is 30-Day All-Cause Unplanned
16 Readmission Following Psychiatric Hospitalization
17 in an Psychiatric Hospital.

18 And we will start off -- once we
19 switch out our developers, we'll start off with
20 some comments from the developers. And our
21 discussants are Frank, Keith -- and is Tom on the
22 phone today?

1 PARTICIPANT: He is.

2 CO-CHAIR TRAVIS: Okay. Great.

3 MEMBER SMITH: You bet I am. I've
4 been waiting three years for a psychiatry
5 measure.

6 (Laughter.)

7 CO-CHAIR TRAVIS: Well, I'm sorry you
8 had to wait until the second day for this
9 measure, but I'm glad you're there, Tom.

10 So we will start with the developers
11 making some opening comments.

12 MR. CAMPBELL: Sure. Hello, and I'm
13 happy to hear about the enthusiasm for behavioral
14 health. My name is Kyle Campbell. I'm Vice-
15 President of Pharmacy and Quality Measurement at
16 the Health Services Advisory Group, and I'm
17 joined by my colleague Dr. Almut Winterstein from
18 the University of Florida, and we've led the
19 development of this measure for CMS. We've
20 collaborated for the past several years on
21 quality measures for national CMS reporting
22 programs and have a number of measures in the

1 portfolio that are endorsed.

2 So for your consideration today is a
3 30-day all-cause unplanned readmission measure.
4 And this measure was developed for use in the
5 Inpatient Psychiatric Facility Quality Reporting
6 Program, which is a pay-for-reporting program,
7 not a pay-for-performance program. And the
8 facility-level measure estimates an unplanned 30-
9 day risk-standardized readmission rate for the
10 adult Medicare fee-for-service population. In
11 this case this measure does include patients 18
12 years of age and older because a large number of
13 those patients that are in our population are
14 eligible for Medicare for the other reasons that
15 were talked about before.

16 The measure includes patients with a
17 principal discharge diagnosis of psychiatric
18 disorder or dementia or Alzheimer's disease and a
19 few key points about the importance of the
20 measure that I want to bring forward.

21 First of all, readmissions following
22 psychiatric hospitalization have been identified

1 as a key gap by national stakeholders, including
2 the MAP, and this measure has been conditionally
3 supported by the MAP for the IPFQR.

4 The second thing is that data suggests
5 ample room for improvement with this measure. So
6 the measure rates for the IPF setting are higher
7 than what we see in the acute care setting with
8 risk-standardized readmission rates of 21 percent
9 versus 15 percent. And we also see more
10 variation in performance, which we would expect
11 given the fact that in the acute care setting
12 we've been working on readmission reduction for
13 quite a while, but in the behavioral setting we
14 have not.

15 As you know, readmissions are costly
16 and an undesirable outcome for patients and
17 caregivers and we identified ample evidence with
18 regard to the fact that providers could influence
19 measure rates through the adoption of
20 interventions. To that end, we anticipate that a
21 key benefit of measure implementation will be
22 innovation and interventions to address

1 integration of behavioral and physical care.

2 This is particularly important for
3 this population which has very early mortality
4 compared to the general population principally
5 from treatable chronic disease and infectious
6 disease. And in one-on-one patient caregiver
7 interviews which we've conducted throughout our
8 measure development process and focus groups we
9 heard loud and clear that care coordination is
10 one of the key gaps in this particular
11 population, and the handoff between the discharge
12 and the outpatient care is extremely important.

13 Finally, the majority of public
14 comments received from stakeholders support this
15 measure and felt it addressed an important topic.
16 In terms of the specifications, they are
17 harmonized to the extent possible with the CMS
18 readmission measures used in other settings and
19 those that were presented to you from Yale-CORE.

20 Our expert panel carefully considered
21 appropriate inclusion and exclusion criteria that
22 were clinically and empirically determined. And

1 like the other readmission measures this uses the
2 planned readmission algorithm to excluded planned
3 readmissions from the outcome.

4 In terms of the measure testing, I
5 just wanted to let you know that it was very
6 comprehensive. So we obtained the entire
7 National Administrative Claims data set from 2011
8 to 2014 for measure testing, and that measure
9 score reliability was tested in both split sample
10 and bootstrapping with intraclass correlations
11 found to be moderate to substantial.

12 For our validity we established the
13 use of diagnosis and procedure codes that are
14 used for billing and that have been validated by
15 other CMS readmission measures. We did a
16 comprehensive risk factor assessment and modeled
17 development including specifically defining
18 psychiatric comorbidity diagnosis grouping based
19 on clinical input and empirical analyses. And we
20 also conducted empirical model validation and a
21 systematic evaluation of face validity by a
22 multi-disciplinary TEP.

1 The risk-adjustment model includes
2 age, gender, principal discharge diagnosis,
3 comorbidities present during the admission or the
4 12 months prior and psychiatric-specific risk
5 factors.

6 Analysis of SDS risk factors was also
7 very comprehensive. We looked at 22 different
8 variables. We did a lot of work to geocode-
9 specific data sets to our data, including at the
10 nine-digit ZIP code level. And unfortunately, as
11 you see these variables did not improve model
12 discrimination. For that reason and several
13 others that I assume we'll discuss, these
14 variables were not included in the final risk
15 model.

16 The final model has a c-statistic of
17 0.66 indicating adequate discrimination, which is
18 comparable to risk-adjusted readmission measures
19 used in the other CMS programs.

20 So in summary, we believe the measure
21 represents a really important outcome for
22 patients with psychiatric disorders and this will

1 help to support innovation and care coordination
2 in the integration of behavioral health for a
3 very vulnerable patient population. And we'd
4 greatly appreciate your consideration of this
5 measure and we look forward to your comments and
6 questions. Thank you.

7 CO-CHAIR TRAVIS: Thank you.

8 Okay. We'll start with looking at
9 evidence. And, Frank, do you have any comments
10 regarding evidence?

11 MEMBER BRIGGS: Yes, but first I need
12 to at least disclose that I previously worked
13 with both Kyle and Almut on a technical expert
14 panel for CMS around adverse events in the
15 hospital, completely unrelated to this measure
16 topic. I wanted to at least point that out so
17 that everybody on the Committee level was aware.

18 In terms of evidence, as described,
19 this measure is looking at unplanned all-cause
20 readmissions to the inpatient facility. I did
21 have one question regarding the numerator
22 statement which is described as unplanned

1 readmission to an inpatient or a short-stay acute
2 care hospital following discharge. The developer
3 further distinguished that. They are looking at
4 days between days 3 and 30 really to I think
5 account for those transfer stations between
6 hospitals and interrupted stays. But my question
7 is really around the short stay being included in
8 the numerator statement, but it is not in the
9 denominator statement.

10 In terms of evidence and support, I
11 think very similar to other measures that we've
12 discussed today a lot of the same type of
13 interventions can be put in place around
14 intensive care management and connecting patients
15 to services out into the community.

16 CO-CHAIR TRAVIS: Thank you.

17 MEMBER BRIGGS: Thank you.

18 CO-CHAIR TRAVIS: Thanks, Frank.

19 Keith, anything to add?

20 MEMBER LIND: Nothing to add. I think
21 they covered it.

22 CO-CHAIR TRAVIS: Thank you.

1 And, Tom, anything to add?

2 MEMBER SMITH: Yes. No, I agree with
3 the developer's comments. I think I'm the lone
4 psychiatrist on the panel here, so I really have
5 been waiting for a psychiatry measure for a long
6 time, and I'm glad to see it.

7 And the developers are right, we just
8 -- the field has not turned its attention to
9 admissions and readmissions and care coordination
10 issues in behavioral health to the extent it has
11 in general med/surg. So I think this measure is
12 sorely needed, and I'm very happy to see it.
13 The opportunity is huge. We don't have much data
14 on readmissions, but we are seeing now is that
15 they're high and perhaps higher than in general
16 med/surg.

17 In connections with aftercare, rates
18 of connection with aftercare following discharge
19 from inpatient mental health are very low. In
20 the Medicaid Program it's upwards of -- close to
21 50 percent of the people don't connect at all in
22 the first month following discharge with

1 aftercare. So we need to focus more on care
2 coordination. The opportunity is there. And
3 there is a lot of evidence suggesting that care
4 coordination interventions and discharge planning
5 practices can significantly impact on aftercare
6 connectivity and readmission rates.

7 CO-CHAIR TRAVIS: Thank you, Tom.

8 I would like to see if the developers
9 mind to answer Frank's question since he raised
10 it a moment ago relative to the inclusion of
11 short-stay acute care.

12 DR. WINTERSTEIN: Yes, this was
13 actually a double-whammy question, because
14 there's two components that Frank brought up.
15 One is to incorporate acute care hospitals in the
16 numerator and then whether they should be
17 incorporated into the denominator. So I start
18 with the latter.

19 This measure was specifically focused
20 on the IPF environment. If we had included
21 patients who were the index admissions where the
22 index admission was in the acute care hospital,

1 that would probably go into a different measure
2 framework within CMS; for example, into IQR. And
3 our charge was specifically to develop something
4 for the IPF, so that's the major reason. But we
5 did comment in our reports that there certainly
6 is a need for patients who would be admitted with
7 a principal diagnosis of mental health disorders
8 in the acute care environment, and it would
9 certainly make sense to expand this measure into
10 this environment, which of course we did not
11 test.

12 With respect to the numerator
13 statement we did include readmissions into the
14 acute care environment for two reasons: One is
15 of course there may be admissions with a
16 principal mental disorder because patients'
17 comorbidities are too complex to allow
18 readmission into an IPF.

19 The second is though that we
20 specifically focused on an all-cause readmission
21 measure. So what that means is that we are also
22 looking at patients who might be readmitted for

1 non-mental principal diagnosis, and these would
2 have of course pretty much exclusively occurred
3 in the acute care environment.

4 CO-CHAIR TRAVIS: Okay. Thank you
5 very much.

6 Pam?

7 MEMBER ROBERTS: So I just had a
8 couple questions. One, so does this include the
9 5150 people that are forced readmissions or the
10 involuntary readmissions? So, because there
11 could be an access issue when there's only so
12 many in the state. And so then they could be
13 penalized for taking these people and it becomes
14 an access issue because there's nowhere else for
15 these people to go. So was 5150-type patients
16 included?

17 DR. WINTERSTEIN: Yes, they are
18 included. The claims are not particularly
19 specific with respect to the legal status of
20 patients where the patients were -- there is an
21 admission source variable that looks what whether
22 somebody was admitted from court or from prison,

1 but the TEP as well as our work group felt -- or
2 found out that this is really not reliable enough
3 to make that distinction.

4 MEMBER ROBERTS: So then what happens
5 with the facilities that do take these patients?
6 Like for example, in California there's only 20
7 psychiatric places that will even -- throughout
8 the state. So these people are taking and giving
9 access to these people, but they could be
10 penalized because they have these patients there.
11 I know there's no way on the claims to notify
12 that, but it puts -- I mean, because we have an
13 access issue. Especially in the State of
14 California it becomes a huge issue. And now if
15 we're not going to be able to -- people are going
16 to be concerned about readmissions, I get
17 concerned.

18 CO-CHAIR TRAVIS: Thank you, Pam.

19 Leslie?

20 MEMBER LESLIE HALL: In your
21 conditions do you include substance abuse? Is
22 that part of the primary conditions?

1 DR. WINTERSTEIN:

2 (No response.)

3 MEMBER LESLIE HALL: And so back to
4 Pam's question of access and just what's
5 available 24 hours versus not. So you have many
6 patients presenting into the emergency room,
7 stabilized and transmitted at hours of operation.
8 How does that get impacted or accounted for in
9 this?

10 DR. WINTERSTEIN: Principal diagnosis
11 as the major reason for admission in the IPF
12 environment was actually surprisingly low.
13 Comorbidity extremely high, but the principal
14 diagnosis is fairly equally shared between
15 psychoses, major depression, bipolar disorder and
16 dementia, Alzheimer's disease.

17 CO-CHAIR TRAVIS: Thank you.

18 Derek?

19 MEMBER ROBINSON: Thank you. I was
20 just seeking some clarity. So when you state in
21 IPF, that does not include a locked unit in a
22 short acute care hospital? That would be purely

1 a stand-alone inpatient psychiatric hospital?

2 MR. CAMPBELL: No, there is actually
3 both. So there's stand-alone units, of which I
4 think there's about 50 in our data set, and then
5 there are 1,700 total. And the remaining are
6 units within acute care facilities.

7 MEMBER ROBINSON: Okay. All right.
8 So what you have in your numerator is referenced
9 to like a medical admission?

10 MR. CAMPBELL: Correct. Yes, as Almut
11 mentioned, it's all-cause, so --

12 MEMBER ROBINSON: Okay.

13 MR. CAMPBELL: But in the denominator
14 it's strictly related to IPF. And IPF is a
15 payment designation, so those units within acute
16 care facilities bill under IPF.

17 MEMBER ROBINSON: Okay. Great. Thank
18 you.

19 CO-CHAIR TRAVIS: Paul?

20 MEMBER HEIDENREICH: Yes, I know
21 theoretically we only need a rationale, which I
22 have to say I think is at too low of a bar for

1 NQF for these things, but even though we only
2 need a rationale, in terms of actually randomized
3 trials, it seems the best data is for intensive
4 case management, as was summarized by the
5 Cochrane Review. But how much control do the
6 facilities have over starting and implementing
7 intensive case management, which it seems like
8 that would be more of a system that included the
9 outpatients?

10 MR. CAMPBELL: Yes, that's a good
11 question. Karen, are you available to answer?

12 (No response.)

13 MR. CAMPBELL: Perhaps on mute?

14 DR. PACE: Yes, this is Karen. Can
15 you hear me?

16 CO-CHAIR TRAVIS: Yes.

17 MR. CAMPBELL: Yes.

18 DR. PACE: Okay. So the idea is not
19 so much that the IPF would necessarily be
20 initiating the intensive case management on an
21 outpatient basis, but that would be one type of
22 aftercare to connect patients to if they exist.

1 So I think the observation about
2 what's available for these psychiatric patients
3 afterwards is a good one, and the incentive of
4 this measure, as most of the hospital readmission
5 measures, is to facilitate the working between
6 the inpatient facility and outpatient services
7 and trying to connect patients to those if they
8 exist.

9 But you're right that there's no
10 extensive research specifically targeted to IPF
11 facilities, but a lot of the concepts apply
12 equally well to care coordination and
13 facilitating appropriate follow up and services
14 after discharge.

15 CO-CHAIR TRAVIS: Thank you.

16 MS. SHAHAB: Cristie, Tom Smith did
17 you want to make a comment as well.

18 CO-CHAIR BULGER: Hey, Tom?

19 MEMBER SMITH: Yes, a couple of
20 comments. I think many hospitals or inpatient
21 psychiatric facilities are also large parts of
22 agencies that do provide aftercare care

1 coordination, but I don't think that's the point.

2 I think the point is that the onus
3 really is on the inpatient clinical team to
4 identify the individuals who need the various
5 levels of intensive care coordination to ensure
6 follow up. And that I think is a key element of
7 quality that's on the inpatient team. So I think
8 it's very important to note that.

9 And I had a question for the
10 developers as well. In terms of the readmission;
11 I couldn't find too much data, or maybe it's
12 there and I couldn't see it, but what percentage
13 of the readmissions were to inpatient psychiatric
14 facility versus general med/surg units?

15 CO-CHAIR TRAVIS: I think they're
16 looking for it, Tom. They're busy looking.

17 MEMBER SMITH: I have a bunch of other
18 questions that are really validity-related. We
19 haven't voted on evidence yet. I think the
20 evidence is very strong. There are other
21 questions. I don't know how much people want to
22 get into them now versus wait.

1 CO-CHAIR TRAVIS: We will wait, if
2 that's okay, because we need to kind of focus on
3 the evidence. And then we'll vote and then we'll
4 kind of move down the line. But I think they are
5 looking for an answer to your question. Is that
6 something that you need right now, or can they
7 come back with it in a few minutes when they find
8 it?

9 MEMBER SMITH: No, it doesn't have any
10 bearing on the evidence.

11 CO-CHAIR TRAVIS: Okay. Thank you.
12 Well, they will continue to look.

13 Are there any other comments or
14 questions around the evidence?

15 (No response.)

16 CO-CHAIR TRAVIS: Okay. If not, I
17 think we'll go to the vote.

18 MS. HERRING: Voting is now open for
19 evidence for 2860. Your choices are one, yes;
20 two, no. And I believe we're looking for 18
21 votes, if I'm counting correctly.

22 (Voting.)

1 MS. HERRING: Never mind. Nineteen.
2 And we have 18 votes for yes, one for no, so 95
3 percent yes, 5 percent no.

4 CO-CHAIR TRAVIS: Okay. You all let
5 me know when you're ready. Are you ready?

6 MR. CAMPBELL: So, yes, just to make
7 a comment that 75 percent of the readmissions are
8 psychiatric and 25 percent of the readmissions
9 are for medical.

10 CO-CHAIR TRAVIS: Okay. Thank you.

11 Tom, hopefully you heard that.

12 MEMBER SMITH: Yes, thanks.

13 CO-CHAIR TRAVIS: Sure. Now we're
14 going to go to the performance gap or the
15 opportunity for improvement. And we will start,
16 Tom, how about with you?

17 MEMBER SMITH: Sure. I think from the
18 data they present for the overall population the
19 mean 30-day readmit was 21, around 21 percent,
20 minimum 12 percent, max closer to 31 percent, and
21 the 10th and 90th percentiles were 17 to 24
22 percent. Then in comparison to national readmit

1 rates they did have -- 8 percent of the hospitals
2 were -- performed better, and 13 percent
3 performed at the low end. So I think there's a
4 significant gap there in opportunity.

5 CO-CHAIR TRAVIS: Thank you.

6 Frank, any additional comments?

7 MEMBER BRIGGS: Nothing to add.

8 CO-CHAIR TRAVIS: Keith?

9 (No response.)

10 CO-CHAIR TRAVIS: Okay. Any questions
11 or comments from the group around the opportunity
12 for improvement or gap? Yes?

13 MEMBER ROBERTS: So I still wonder if
14 at the high readmission rates, especially if 75
15 percent of them are for psychiatric, if it's not
16 an issue of some of our failing behavioral health
17 issues for access versus if it's a quality. It
18 just concerns me.

19 MEMBER SMITH: I think the developers
20 can speak to that. They did look at regional
21 measures of access and actually found; I'm trying
22 to -- off the top of my head, higher rates of

1 readmission in the areas where there was greater
2 access. It's a complicated set of circumstances.

3 I think one issue is access, the idea
4 that if there are not enough providers out there
5 that people will have higher readmission rates,
6 but we often see the opposite. In areas where
7 there are more providers, you see greater use of
8 services. It's due to a couple things perhaps.
9 One is migration. People with especially serious
10 mental illness tend to migrate and are more
11 likely to live in areas where there are
12 providers.

13 The other is the opposite. And one of
14 our concerns for access is in areas where there
15 is not access to services, you see a lot of
16 trans-institutionalization or service use.
17 People are ending up in prisons, in jails and
18 homeless settings. And so, readmission rates
19 actually might go down in these rural areas.

20 So it's a very, very complicated
21 conceptual and real landscape and I don't think
22 it would be fair to say that we should not pursue

1 a measure like this just because we know there
2 are significant access issues. But I'm speaking
3 -- I'm interested in the developer's response.

4 CO-CHAIR TRAVIS: Yes, please.

5 DR. WINTERSTEIN: This is indeed a
6 really complicated issue, and the observation is
7 correct that in more urban areas there's actually
8 more readmissions. And that could be a
9 consequence of more complex issues, perhaps
10 substance use disorder, but it could also be a
11 consequence of more access which would
12 essentially look like it's a quality issue, even
13 though it's not. And we can address this as
14 well. And we have done a lot of analysis to
15 this.

16 We actually looked at access in
17 various ways. We looked at RUCA designation. We
18 geocoded patients. We used the HRSA health
19 shortage area designations which produce county-
20 level estimates of health shortage areas broken
21 down by access to medical versus psychiatric
22 care. And then we also created our own access

1 measures within the Medicare environment where we
2 geocoded patients, basically produced a 20-mile
3 radius circle around them, counted the number of
4 providers that were in that circle and created
5 ratios of that.

6 So basically the number of patients we
7 had, Medicare-eligible patients with psychiatric
8 disorders in that circle versus -- and then in
9 ratio toward the number of providers that were
10 there. And we did this with respect to non-
11 prescribing mental health care providers, so
12 essentially psychologists as well as
13 psychiatrists, IPFs. We even looked at
14 pharmacists and PCPs. None of them were
15 particularly predictive of readmissions, so the
16 access issue didn't really bubble up to the
17 surface as being the major explanation.

18 Now that said, access means very
19 different things, right? There may be providers
20 around me and I still may not see them. And I
21 think that is another layer that it's I think
22 much harder to get to, so we know for example

1 from the literature that living alone will
2 increase my risk for readmission because there's
3 not that direct support network around me which
4 might actually encourage me to see a physician
5 and to get help. And that may not be there.
6 So there's different layers of access that we
7 certainly don't all capture in this particular
8 measure.

9 The other thing I think that we need
10 to be aware of is that this measure is built for
11 Medicare patients. We are not looking at the
12 homeless patients with no insurance. So I think
13 the global population of IPF patients is
14 certainly more diverse than what we have here in
15 front of us in the Medicare population.

16 CO-CHAIR TRAVIS: Thank you.

17 Leslie?

18 MEMBER LESLIE HALL: Is it possible
19 that at hospitals there's -- that is accepting
20 more patients for readmission as the safety net
21 hospital that these measures can potentially
22 identify where dumping is happening,

1 inappropriate movement of patients to a facility?

2 That's one question.

3 And then we wouldn't want to have a
4 hospital that is accepting these patients to be
5 penalized because they are the community provider
6 of these services when they're acting as that
7 main hospital readmit versus the originating
8 hospital, so the medical facility.

9 DR. WINTERSTEIN: Not completely. So
10 when you say hospitals who would accept those
11 patients versus those who don't --

12 (Simultaneous speaking.)

13 MEMBER LESLIE HALL: I'm in a rural
14 community and in our state there's only a few
15 hospitals that generally accept the patient in
16 the emergency room, I mean, whether it's a
17 cultural bias or a medical bias or an access
18 bias. And so they will see a disproportionate
19 share of any mental health patients or patients
20 who are being readmitted and don't have access to
21 the inpatient psychiatric facility but are coming
22 into the emergency room of the medical facility

1 just for access issues.

2 And they're the only ones accepting
3 those patients. They will have a
4 disproportionate number of patients simply
5 because of who they are and how they accept it.
6 The faith-based hospitals are very -- would that
7 unfairly penalize them on one hand, and on the
8 other hand would it also identify where we have a
9 problem of hospitals that aren't fairly sharing
10 that population?

11 DR. WINTERSTEIN: Yes.

12 MR. CAMPBELL: Maybe just one thing to
13 clarify to start. The readmission penalty is
14 assigned to the facility that initially accepts
15 the patient, right? So in the cohort the first
16 facility would be the facility that would get
17 counted for the readmission.

18 MEMBER LESLIE HALL: Unless that
19 readmission is now for a medical primary purpose.

20 MR. CAMPBELL: Right. Well, all-cause
21 readmissions are in our measure, but acute care
22 hospitals are not in the denominator of the

1 measure, so the initial admission --

2 MEMBER LESLIE HALL: Oh, that's back
3 to your point?

4 MR. CAMPBELL: Yes, the initial
5 admission has to be an IPF in the cohort.

6 DR. WINTERSTEIN: But perhaps to
7 elaborate on this a little bit more, the
8 denominator are really the IPFs, and these are
9 certainly -- the largest proportion are inpatient
10 psychiatric units that get paid under the IPF
11 model. And certainly those inpatient units have
12 the more complex patients, because if you have
13 the choice between a freestanding IPF where the
14 requirement for medical care is limited to a
15 psychiatrist versus a hospital that's imbedded in
16 an acute care facility, the patients who go in
17 the acute care facility imbedded IPF are more
18 likely to have more complex medical problems,
19 which of course is incorporated in this measure.
20 So we use the same risk-adjustment methodology
21 with respect to all medical comorbidities that
22 all the other readmission measures are using.

1 CO-CHAIR TRAVIS: Pam?

2 MEMBER ROBERTS: You mentioned that
3 you included Medicare only, and that included the
4 chronically disabled patients that are on
5 Medicare, is that correct?

6 DR. WINTERSTEIN: Yes, and that's in
7 fact the larger proportion. So this is a very
8 different population than what we usually like to
9 think about when we think about Medicare. So the
10 largest proportion is below 65 years of age
11 because they qualify because of disability.

12 MEMBER ROBERTS: Right. Thank you.

13 CO-CHAIR TRAVIS: Okay. Paula?

14 MEMBER MINTON-FOLTZ: Have you also
15 looked at process performance gap in say like the
16 Joint Commission HBIPS data that would seek to --
17 they were processes that would seek to create
18 maintenance so patients wouldn't have to be
19 readmitted.

20 MR. CAMPBELL: Yes, so there are HBIPS
21 measures slated for reporting in the IPFQR
22 specifically, and also measures of care

1 coordination as process measures. So those will
2 be in the data set for -- they'll be reported.

3 CO-CHAIR TRAVIS: Okay. Any other
4 comments or questions around performance gap?

5 MEMBER MINTON-FOLTZ: I was just --

6 CO-CHAIR TRAVIS: Sorry.

7 MEMBER MINTON-FOLTZ: To follow up on
8 your -- was there a performance gap in those
9 measures? You said they're included, but did you
10 see a gap?

11 MR. CAMPBELL: I believe there was,
12 but I don't have the data specific to the testing
13 of those measures and the population. I don't
14 believe they've been reported yet.

15 CO-CHAIR TRAVIS: Thank you. Okay.
16 Seeing no other comments or questions at this
17 time, we'll go on and take a vote on performance
18 gap.

19 MS. HERRING: Voting is now open for
20 performance gap for Measure 2860. Your choices
21 are one, high; two, moderate; three, low; four,
22 insufficient.

1 (Voting.)

2 MS. HERRING: The results are 8 high,
3 10 moderate, 1 low, 0 insufficient, so 42 percent
4 high, 53 percent moderate, 5 percent low.

5 CO-CHAIR TRAVIS: Okay. Thank you.

6 Now we're going to move on to reliability.

7 And, Keith, anything that you want to
8 bring up?

9 MEMBER LIND: Not really. I think the
10 developers actually covered this pretty well.
11 They did use the two methods, split the sample in
12 half and bootstrapping. And for splitting the
13 sample the correlation coefficient was 0.6, which
14 they called moderate. And for bootstrapping,
15 0.78, which they thought was a substantial level
16 of agreement.

17 CO-CHAIR TRAVIS: Thank you. Tom, any
18 additional comments on reliability?

19 MEMBER SMITH: No, nothing to add.

20 CO-CHAIR TRAVIS: And, Frank?

21 MEMBER BRIGGS: Nothing to add. Thank
22 you.

1 CO-CHAIR TRAVIS: Thank you. Any
2 comments or questions from the Committee on
3 reliability?

4 (No response.)

5 CO-CHAIR TRAVIS: Okay. I think we'll
6 go to the vote.

7 MS. HERRING: Voting is now open for
8 reliability for Measure 2860. Your choices are
9 one, high; two, moderate; three, low; four,
10 insufficient.

11 (Voting.)

12 MS. HERRING: We have 3 high, 16
13 moderate, 0 low, 0 insufficient, so we have 16
14 percent high, 84 percent moderate.

15 CO-CHAIR TRAVIS: Great. Okay. We'll
16 go to validity.

17 Frank, any comments you want to make
18 on validity?

19 MEMBER BRIGGS: Yes. So for validity
20 they did face validation with their TEP, across
21 their TEP of 17 members. The median rating was
22 seven, which they described as agreement.

1 Looking at agreement versus non-agreement, it was
2 a 60/40 split, so 60 percent had the rating of 7
3 or 9, which they said was agreement, neutral at 6
4 votes, and disagreement was 1 vote.

5 In terms of threats to validity
6 looking at the patients that were excluded, the
7 majority of the patients that were excluded came
8 from transfers or interrupted stops. I suspect
9 that's the patients who may have been transferred
10 from one unit to a medical or vice-versa. That
11 accounted for 7.2 percent.

12 And then they addressed the discharge
13 against medical advice, which was 1.2 percent of
14 their sample at 9,000 patients leaving against
15 medical advice.

16 The did look at SDS adjustment.
17 Ultimately did not include it in their
18 recommendation. And I think that's it.

19 CO-CHAIR TRAVIS: Okay. Thank you so
20 much.

21 Tom, any comments on validity?

22 MEMBER SMITH: Sure. I have a couple.

1 Yes, they did a fairly comprehensive SDS
2 analysis. As in with previous measures the
3 variables just didn't hold up in the end, so they
4 ended up proposing not including them. I don't
5 know whether to be surprised or not. I guess I'm
6 not surprised given the complex interrelations
7 between behavioral healths and SDS, but the
8 effect size -- or the odds ratios were washed out
9 when controlled for clinical variables.

10 I have questions about a couple of
11 things. The interrupted stays and the age issue.
12 As regards the interrupted stays, because of the
13 CMS billing procedures they're not able to count
14 any readmissions that took place on the day of or
15 day one, day two following discharge. And I
16 don't know any other way around that. I don't
17 know Medicare claims as well as I know Medicaid,
18 but from my understanding there's no away around
19 that. But I do worry as a threat to validity
20 that this excludes a fair number of people who
21 are discharged from an inpatient psychiatric
22 facility and then readmitted a day or two later.

1 A lot of people are in fact readmitted.

2 One common example is to include
3 people who are still acutely suicidal and get
4 home and it's another crisis and they have to go
5 back, or people who have unstable housing
6 environments and they just don't connect with the
7 aftercare housing arrangement. And they're back
8 the next day or on day two.

9 There's a lot of such people, the
10 Medicare claims however just simply don't allow
11 for a meaningful way of capturing them. And I'd
12 like to hear the developers -- if there's any
13 further thoughts or ways they think this might be
14 addressed in the future.

15 I also have a question I just -- my
16 second issue is about the age, in the 65 and
17 older population versus the younger. The measure
18 does group all individuals aged 18 and up. Out
19 there in the clinical world there tends to be a
20 distinction between geriatric psychiatry programs
21 versus general adult psychiatry programs. And it
22 varies around the country depending on access and

1 geography, but a lot of clinician experts would
2 say that geriatric psychiatry is somewhat
3 different from adult psychiatry. You see much
4 higher rates of course of dementia disorders in
5 that elderly population. And I think that was
6 born out in the data.

7 I think the developers discussed this
8 with your expert panel and you did a series of
9 cohort analyses breaking out by dementia and by
10 age and you found that the models were not as
11 robust. The c-statistics were actually lower
12 when we stratified your cohorts and broke out
13 your models. And so I understand that. I guess
14 the best model from a statistical perspective is
15 to include all age groups, but from a clinical
16 perspective I think a lot of providers would say
17 that the geriatric psych population is some ways
18 fundamentally different from the younger
19 population. So I wonder if you have any other
20 thoughts about that.

21 MR. CAMPBELL: So just the first issue
22 with regard to the interrupted stays. So that is

1 a situation that's unique to the inpatient
2 psychiatric facility billing. And we worked very
3 closely with the CMS payment folks to even
4 understand that and how the claims were
5 collapsed. So we were unable to count those in
6 the data, but it's definitely something that as
7 we move forward could definitely be something
8 that we would work on in the future.

9 And then I'll defer to Almut on the
10 second question you had.

11 DR. WINTERSTEIN: There's one thing to
12 add about the transfers. One thing is that all
13 the readmission measures remove the first day
14 post-discharge from the readmission time frame
15 because of the transfers. So the people we lose
16 in addition because of this weird readmission
17 model is really just one day. That would be that
18 day two because this still is the issue that
19 those readmissions would still be reimbursed
20 under the same original claim. So there's not
21 two claims that get generated.

22 The other part in terms of losing a

1 good proportion because of that, this is actually
2 -- I think we have in our report a histogram that
3 shows the number of readmissions over the 30-day
4 time frame, and that looks quite different from
5 the acute care readmission frame work where there
6 is a much steeper decline in the readmission
7 rates over the 30-day period.

8 In our case I wouldn't say it's flat,
9 but the decline is much, much slower. And we
10 actually followed this through 90 days. And you
11 see we have here an average readmission rate of
12 about 22 percent. If you go to 90 days, we have
13 50 percent. So there is a consistent readmission
14 that goes across the entire time span. If you
15 wait six months, it still increases quite a bit.
16 So it's not that we are losing a whole lot
17 proportionally of all the readmissions if we are
18 dropping that additional day.

19 With respect to age, we did two things
20 actually. One was that we did do, as you
21 mentioned, stratifications by age and created
22 separate risk-adjustment models for different age

1 groups. We also stratified by different types of
2 diagnosis, specifically Alzheimer/dementia
3 patients versus the more streamlined mental
4 health disorders. So cognitive disorders was
5 versus mental health disorders basically. And as
6 you said, the c-statistics were actually lower
7 than combining everything, which of course
8 relates to just getting more explanatory power
9 from the larger sample.

10 The other thing that we did; and
11 that's probably a little bit more of an unusual
12 way that you may not see in previous readmissions
13 measures, we actually we did a multinomial model
14 where we were not predicting readmission versus
15 not, but we actually predicted readmission for a
16 major -- with a principal diagnosis for a mental
17 health disorder versus a physical disorder just
18 to also touch more on patients who might have
19 more multimorbid issues, which would be obviously
20 more in the older population.

21 And this modeling approach, which is
22 way more complex and took about two weeks or so

1 to run on a very high-speed server, still didn't
2 really add a whole lot. And my explanation to
3 this is that by capturing the multimorbidities --
4 which I think we did fairly well, in particular
5 because we didn't use the typical classifications
6 that are used for the mental disorder. We broke
7 them further down to really get enough
8 granularity. I think we captured the age issues
9 primarily really with the clinical conditions so
10 well that it didn't really require anything in
11 addition.

12 MR. CAMPBELL: And one additional
13 comment, if I could make, related to the
14 readmission patterns, which I think is really
15 important for this population, is that one-third
16 of the population is readmitted more than one
17 time, and five percent of the population is
18 readmitted five or more times. So within this
19 population readmissions are a significant issue.

20 CO-CHAIR TRAVIS: Thank you for that.

21 Keith, have I give you a chance to say
22 anything?

1 MEMBER LIND: You did.

2 CO-CHAIR TRAVIS: Okay. You're fine?

3 (No response.)

4 CO-CHAIR TRAVIS: Okay. That sounds
5 good.

6 So I know Bruce had his card up early,
7 so if you'd like to make a comment?

8 MEMBER BRUCE HALL: Yes, two comments
9 on validity or model choices, or maybe bordering
10 into use, but the first is with respect to the
11 expert panel face validity query, 7 out of 17 of
12 your preferentially selected experts weren't
13 impressed with face validity. They were either
14 neutral or negative. That's a little more than
15 you would expect I think in a preferentially
16 selected group of experts, so that raised a flag
17 for me.

18 The other issue I wanted to ask about
19 is why you're setting the performance here at 24
20 months. I know the standard in your material
21 said that you did it for stability or power, but
22 I'm not sure that we actually know enough about

1 what the institutional grades will look like to
2 know that you need two years for performance.
3 Certainly you could always use two years of data
4 for derivation, but do you really need two years
5 of data for performance?

6 Because I think probably most of us in
7 the room in our normal lives we don't like
8 measures that stretch on for extended periods.
9 They became quite hard to interpret and make use
10 of and drive improvement off of.

11 So I don't think we considered any
12 other measure during our two days that was longer
13 than a year and I was wondering why that decision
14 was made. So those were the two queries I had.

15 MR. CAMPBELL: Those are two are
16 really good questions, and maybe start with the
17 latter question and then go to the former.

18 So one of our goals here was -- again
19 this program is a pay-for-reporting program and
20 not a pay-for-performance program like the other
21 readmission reduction program. And we wanted to
22 have as many IPF facilities that would meet that

1 minimum threshold of 25 cases, which has been the
2 standard for the CMS measures. So by using the
3 two-year time frame and accumulating those cases,
4 we get about 96 percent of the IP units in the
5 country that could be reported using the measure.
6 So that's the rationale for that.

7 As far as the face validity vote from
8 the panel, some of our neutral panel members were
9 just that they felt that they didn't have enough
10 expertise to assess this particular measure. And
11 then we also had some concern about the measure
12 being all-cause versus psychiatric readmissions.
13 And we wrestled with that quite a bit, but we
14 think that we're taking a very patient-centered
15 approach and that all readmissions are very
16 intrusive to patients and burdensome and
17 burdensome to facilities.

18 And we also think it's very difficult
19 to tease out the rationale for why a patient gets
20 readmitted, so for example one of the most common
21 -- or one of the more common readmission reasons
22 was adverse drug events. So those adverse drug

1 events for psychotropic drug poisoning show up in
2 the data. So we just didn't feel that it made
3 sense to separate those things out.

4 So I think that's reflective of what
5 you're seeing in the vote, but the folks that did
6 support it supported it very strongly. And in
7 our public comment period when we took the
8 measure out for public comment, 83 percent of
9 stakeholders supported the measure as you see it.

10 CO-CHAIR TRAVIS: Thank you.

11 Pam?

12 MEMBER ROBERTS: Just a quick
13 question. Did you look at the readmissions by
14 freestanding versus unit? And if so, was there a
15 difference?

16 MR. CAMPBELL: We did, and there were
17 no meaningful differences between the two.

18 CO-CHAIR TRAVIS: Kathy, is that your
19 card?

20 MEMBER AUGER: So this question may be
21 reflective of my ignorance as a pediatrician, so
22 I'm sorry. You mentioned earlier that the

1 majority of the patients in this measure are in
2 that 18 to 64 range, but my question really is
3 what percentage of people with significant mental
4 illness end up on Medicare in the first place?
5 So how much does this type of measure reflect the
6 vast -- like how hospitals will perform with the
7 majority of their patients as opposed to just the
8 Medicare, if that makes sense.

9 MR. CAMPBELL: I think that's a really
10 good question and one I think we may have to get
11 back to you on, because we only have data on the
12 Medicare population, from the fee-for-service
13 population for these.

14 MEMBER AUGER: And but do you have any
15 sense of what percentage of people with
16 significant mental illness would have Medicare?
17 Is it --

18 (Simultaneous speaking.)

19 MEMBER SMITH: It's Tom. I'm echoing.
20 I could jump in.

21 CO-CHAIR TRAVIS: Okay.

22 MEMBER SMITH: It varies from state,

1 but if you look at state-level populations of
2 individuals with serious mental illness, and you
3 see the majority of them will be on Medicaid, the
4 number that are duals, like it varies from state
5 to state, but I think on the low end it's 15 to
6 20 percent. And then I think it goes up from
7 there. Might be 30 to 40 percent. I can't
8 exactly remember, but it's on that order. It's a
9 significant sub-population.

10 CO-CHAIR TRAVIS: Thank you. Okay.
11 Wes?

12 MEMBER FIELDS: Yes, it was actually
13 a very good question, because in order for
14 somebody with a chronic behavioral illness to
15 become Medicare-eligible they probably have to
16 have become unstable. Schizophrenia is the
17 classic sort of benchmark. Bipolar disorder is
18 very similar.

19 But the reason I wanted to speak to
20 this is that it's great that you have a pay-for-
21 performance measure, but in terms of community
22 needs and crises in terms of access to behavioral

1 health services, this is the wrong piece of the
2 pie. Because the real issue are young adults and
3 late adolescents who are becoming unstable before
4 they're diagnosis or before they're actually
5 stabilized in an inpatient setting. Classically
6 the first time they get admitted either they're
7 insured by their parents or they're young adults
8 without coverage at all, depending on where they
9 live, state by state.

10 As Tom suggested, there's wide
11 variation between states, partly with the
12 Obamacare effect, about whether or not they get
13 Medicaid benefits, but really the meter starts
14 for when they become Medicare-eligible, when they
15 have a significant psychiatric disorder that
16 results in their permanent disability. So
17 classically these patients become impaired,
18 disabled. It persists long enough for them to
19 wind up with Social Security benefits that are
20 more or less tied to Medicaid.

21 But the Medicare benefit is sort of
22 like the last thing that happens to them in terms

1 of coverage and benefits, so it's great that
2 you're looking at persons greater than 18 years
3 old with Medicare, but the real systemic problem
4 of access are people who are not yet Medicare-
5 eligible and often not yet Medicaid-eligible who
6 are at great risk in the community in emergency
7 departments where they can hang around for days
8 at a time.

9 So I guess I'm speaking in favor of
10 future measures, but I'm sure you both know, as
11 Tom knows, that the real issue here are people
12 that have very unstable behavioral health
13 problems who have not been sick long enough to
14 become Medicare-eligible.

15 MR. CAMPBELL: Thank you. Thank you
16 for those comments. And the only one thing I
17 would clarify is it's pay-for-reporting, not pay-
18 for-performance. So in this case we're not
19 looking at performance. But thank you.

20 DR. WINTERSTEIN: But he's happy to
21 say it again.

22 (Laughter.)

1 DR. WINTERSTEIN: I mean, there is
2 research that even shows that mental health
3 disorders also correlate with the ability to seek
4 insurance, so Medicaid for example -- well
5 Medicare as well, but both require us to sign up
6 for it. And I am paranoid and I don't want to
7 deal with the system, I may very well have no
8 insurance. So the problem is way more complex,
9 for sure.

10 CO-CHAIR TRAVIS: Thank you Okay.
11 Last call for any questions or comments on
12 validity.

13 (No response.)

14 CO-CHAIR TRAVIS: Okay. Let's go to
15 a vote.

16 MS. HERRING: Voting is now open for
17 validity for Measure 2860. Your choices are one,
18 moderate; two, low; three, insufficient.

19 (Voting.)

20 MS. HERRING: The results are 16
21 moderate, 4 low, 0 insufficient, so 80 percent,
22 20 percent low.

1 CO-CHAIR TRAVIS: Okay. Now we're at
2 feasibility.

3 Tom, any issues relative to
4 feasibility?

5 MEMBER SMITH: No, I think the
6 developers described it well. These are claims-
7 based and all the elements have been -- may of
8 the elements for the risk modeling have been
9 validated, so I think they're quite feasible.

10 CO-CHAIR TRAVIS: Thank you.

11 Keith, any other comments?

12 MEMBER LIND: No, I agree.

13 CO-CHAIR TRAVIS: Agreed? Okay.
14 Frank?

15 MEMBER BRIGGS: No, I agree.

16 CO-CHAIR TRAVIS: Okay. Thank you.
17 Any other questions or comments from the
18 Committee on feasibility?

19 (No response.)

20 CO-CHAIR TRAVIS: Okay. Let's go to
21 a vote.

22 MS. HERRING: Voting is open for

1 feasibility on Measure 2860. Your choices are
2 one, high; two, moderate; three, low; four,
3 insufficient.

4 (Voting.)

5 MS. HERRING: Just waiting on -- oh,
6 never mind. The results are 12 high, 8 moderate,
7 0 low, 0 insufficient, so 60 percent high, 40
8 percent moderate.

9 CO-CHAIR TRAVIS: Okay. And our last
10 category other than overall, we'll look at use
11 and usability.

12 Frank, any comments?

13 MEMBER BRIGGS: Although the program
14 is not currently publicly reported, it has been
15 submitted for inclusion in the CMS Inpatient
16 Facility Quality Reporting Program.

17 CO-CHAIR TRAVIS: Keith, anything to
18 add?

19 No audible response.)

20 CO-CHAIR TRAVIS: Tom?

21 MEMBER SMITH: No, I think it's a very
22 important measure. We don't have anything like

1 it. We've got very little in behavioral health.
2 As you can see, there's a lot of validity issues,
3 a lot of conceptual issues that have to be sorted
4 out, but we need these measures. Especially as
5 pay-for-reporting I think there's going to be a
6 lot of interest and a lot of potential use.

7 CO-CHAIR TRAVIS: Thank you, Tom.

8 Paul?

9 MEMBER HEIDENREICH: In terms of
10 potential unintended consequences is there any
11 other outcome measure for this group such as
12 mortality or suicide? Because I think especially
13 if we're talking about for young people, I know
14 within the VA we have the issue of not being able
15 to track them and losing them to follow up, and
16 then they end up incarcerated or dead. And I
17 think that's probably less of an issue for the
18 Medicare population, but I'm just curious, is
19 there any other part? Like MI, heart failure,
20 pneumonia we have a mortality measure.

21 MR. CAMPBELL: No, currently there
22 aren't any mortality measures for this

1 population.

2 CO-CHAIR TRAVIS: Any other questions,
3 comments or others on use and usability?

4 (No response.)

5 CO-CHAIR TRAVIS: Okay. We'll go to
6 the vote.

7 MS. HERRING: Voting is now open for
8 usability and use on Measure 2860. Your choices
9 are one, high; two, moderate; three, low; four,
10 insufficient.

11 (Voting.)

12 MS. HERRING: And the votes are 6
13 high, 13 moderate, 1 low, 0 insufficient, so 30
14 percent high, 60 percent moderate, 5 percent low.

15 CO-CHAIR TRAVIS: Okay. Any comments
16 before we vote on overall suitability?

17 Yes, Carol?

18 MEMBER RAPHAEL: I just wanted to echo
19 what Paul said, because to me I'm very much in
20 favor of moving ahead. I think this is really
21 important directionally, but I don't think this
22 is classic kind of transition. I can remember

1 that for the 30 percent of referrals we got with
2 a psych diagnosis, 30 percent of those referrals
3 we could not connect with the person. And it was
4 a combination of not being able to find the
5 person, being able to find the person, but the
6 person not wanting to engage and distrusting, a
7 variety of factors. But I just think that as we
8 think this through we should be cognizant that
9 just there's an engagement that's really, really
10 important with this population. It isn't just a
11 treatment, an intervention.

12 CO-CHAIR TRAVIS: Thank you, Carol.

13 Any other -- Paula, is your card still
14 up for a comment?

15 (No response.)

16 CO-CHAIR TRAVIS: Okay. Any others?

17 (No response.)

18 CO-CHAIR TRAVIS: Okay. Well, we'll
19 go on and vote on overall suitability for
20 endorsement.

21 MS. HERRING: Voting is now open for
22 overall suitability for endorsement for Measure

1 2860. Your choices are one, yes; two, no.

2 (Voting.)

3 MS. HERRING: The results are 19 yes,
4 one no, so 95 percent yes, 5 percent no. Thank
5 you.

6 CO-CHAIR TRAVIS: Okay. Thank you
7 very much for that. We are going to go to a time
8 of public comment. And I will first open it up
9 to those in the room. Any public comment in the
10 room?

11 (No response.)

12 CO-CHAIR TRAVIS: Okay. Seeing none.
13 Operator, could you please open up the lines for
14 public comment?

15 OPERATOR: Yes, ma'am. At this time
16 if you'd like to make a comment, please press
17 star then the number one.

18 (No response.)

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

21 CO-CHAIR TRAVIS: Okay. Thank you,
22 operator.

1 I'm looking at -- are we going to
2 continue or do we go?

3 MS. O'ROURKE: So lunch is ready and
4 we haven't had a break yet, so why don't we take
5 a 15-minute break and then come back for a
6 working lunch to discuss our next measure? So
7 we'll see you back here shortly before 1:00.

8 CO-CHAIR TRAVIS: Okay. Thank you,
9 all.

10 (Whereupon, the above-entitled matter
11 went off the record at 12:40 p.m. and resumed at
12 1:00 p.m.)

13 MR. AMIN: All right, if everyone can
14 find their way back to the table, we're going to
15 get started here. Thank you.

16 CO-CHAIR BULGER: So the first measure
17 here after lunch is 2884, 30-Day Unplanned
18 Readmissions for Cancer Patients from the Seattle
19 Cancer Care Alliance and the Alliance of
20 Dedicated Cancer Centers. Thanks for being here.

21 So as we have in the past, we'll start
22 with the developers. Thank you.

1 MS. JAGELS: Good afternoon, and thank
2 you for having us. I'm Barb Jagels. I'm Vice
3 President of Quality, Safety, and Value at the
4 Seattle Cancer Care Alliance. Joining me this
5 afternoon in person is Terry Fisher, our project
6 manager based at MD Anderson. On the phone with
7 us today we have Susan White at the James-Ohio
8 State who served as our statistician; Denise
9 Morse, a program manager who greatly assisted
10 with the development of this measure based at
11 City of Hope.

12 So it is with a great deal of
13 professed anxiety and humility that I sit with
14 you today. It's been a very sobering experience
15 to hear you all this morning and have the
16 opportunity to sit with you and see how this work
17 is actually done.

18 We came last year to the MAP where we
19 presented our measure, received the feedback and
20 went back and obviously sustained a great deal of
21 further testing and learning. So I sit with you
22 today having seen our Yale colleagues in action

1 this morning and recognizing that our measure
2 looks very distinct and different, so I look
3 forward to learning from your input and wisdom
4 this afternoon.

5 So I'll start briefly by describing,
6 of course, that we are a unique group in that
7 we're 11 PPS-exempt cancer centers. What we were
8 finding three years ago is that all-cause
9 readmission measure wasn't working well for our
10 cancer purposes. Naturally, you'd observe that
11 cancer patients enter and exit the hospital
12 regularly, sometimes for intentional, appropriate
13 reasons, think chemotherapy and surgery;
14 sometimes for foreseeable and avoidable reasons,
15 think chemotherapy and nausea.

16 So as we started to look at our own
17 data and collaborate across our centers, we asked
18 ourselves the question could a group of team
19 spirited, quality improvement minded hospitals
20 work together to share our data, compare our
21 claims, clean up our coding, and most importantly
22 understand where we have opportunities to better

1 serve our patients, specifically related to
2 foreseeable and avoidable cancer treatment
3 related symptoms?

4 So I'm delighted to tell you that we
5 think we've made great progress and if we have
6 time or interest this afternoon, Denise and I can
7 share with you specific narrative examples where
8 we've used this data to actually improve our
9 patients' experience of cancer, but I know that's
10 not our intent this afternoon. We're here to
11 explain to you how we did our testing and have
12 you give us input on how we might proceeding.

13 So with that, I'll open it up for
14 questions.

15 CO-CHAIR BULGER: Okay, so we'll start
16 with -- as we have, with the evidence. And we'll
17 start with Helen.

18 MEMBER CHEN: Thank you, this is
19 actually an interesting measure and as they
20 mentioned, it's a very narrow focus. And I would
21 just ask a question as to whether it's
22 appropriately named. It's a measure that looks

1 at cancer patients cared for specifically at
2 PCHs. So I don't know if we want to be more
3 specific because I don't -- that was just my
4 first question. But in terms of the evidence
5 that was provided by the developers, they did
6 cite some relevant literature regarding the
7 importance of condition-specific or disease-
8 specific measures for quality that were above and
9 beyond the typical evidence that we've seen to
10 date regarding the ability of facilities to
11 intervene on readmissions through general quality
12 improvement measures. So there is some evidence
13 implemented.

14 CO-CHAIR BULGER: Keith.

15 MEMBER LIND: It seems like an
16 important measure. I agree that it's important,
17 but I defer to your comments. I agree.

18 CO-CHAIR BULGER: Cristie.

19 CO-CHAIR TRAVIS: No, nothing to add.
20 Thank you.

21 CO-CHAIR BULGER: Okay, so I think
22 we'll come back to that. But I think we'll vote

1 on the evidence standpoint so it's yes or no.

2 MS. HERRING: Voting is now open for
3 evidence on measure 2884. Your choices are 1,
4 yes; 2, no.

5 (Voting.)

6 MS. HERRING: And it's 17, yes; 0, no.
7 So 100 percent yes.

8 CO-CHAIR BULGER: Okay, great. So go
9 to the gap.

10 MEMBER CHEN: So in terms of the
11 performance gap, the developers report
12 interestingly that the performance on readmission
13 rate for various groups of hospitals, the first
14 group being the ADCC and then a second group, the
15 Coalition for Quality Improvement which is
16 actually, there's an overlap between those two
17 groups, as well as some additional data from the
18 bigger UHC group, larger group of 100 hospitals.

19 And the rates of readmission that were
20 reported in the alpha group, there's two
21 different time periods, was 13 to 13.4 percent.
22 And in the beta group which was a year later, was

1 14.5 to 15.8 percent. Interestingly enough, in
2 the validations that they report on readmission
3 rates, unadjusted readmission rates for six
4 hospitals in the ADCC group and there does appear
5 to be some degree of variability in performance.
6 And the rates for those hospitals were, let's see
7 -- I don't have it. There's a range, 10.9 to, I
8 believe, 15.7. I may be misquoting, but there is
9 a performance gap.

10 MR. AMIN: Helen, would you mind just
11 moving your microphone closer to you. There's
12 construction over here to the right. It's making
13 it difficult to hear.

14 MEMBER CHEN: Sure, sorry.

15 MR. AMIN: Thank you.

16 CO-CHAIR BULGER: Keith.

17 MEMBER LIND: Nothing to add.

18 CO-CHAIR BULGER: Okay, anything from
19 the committee on the performance gap?

20 MEMBER CHEN: Did you want me to talk
21 about disparities here too, as well?

22 CO-CHAIR BULGER: Say that one more

1 time?

2 MEMBER CHEN: I'm sorry, should I talk
3 about disparities here as well? Okay, so they
4 did take a look at adding some SDS factors to
5 their risk model and they were, of course,
6 limited by data points that were available on
7 electronic claims data. Race and gender were
8 considered as risk adjusters, but were not felt
9 to be significant.

10 Interestingly enough, they decided on
11 payer class as a marker for SES and the payer
12 class lumping -- I'm not a lumpers, but they
13 appear to be lumpers. And it was basically
14 Medicaid, charity care, and no insurance.

15 And I'm wondering from a committee
16 perspective we really feel that that's a valid
17 delineation of SES as a marker, although in the
18 patients who had the SES composite factor, versus
19 who didn't, there actually was a higher
20 readmission rate. I don't know if the developers
21 want to speak to that.

22 My sort of anecdotal experience of

1 regional cancer center care is that some
2 proportion of the uninsured are actually people
3 who are private pay who have come to a regional
4 center, but looking at your overall statistics,
5 it looks like that was only about 3, 3.5 percent
6 of the total.

7 MS. JAGELS: Susan, can you take that
8 one?

9 DR. WHITE: Sure, So I guess we are
10 lumpers. I never thought of it that way. So
11 yes, you're correct. Depending on which of the
12 -- there's a small number of centers and
13 depending on which ones they are, some of them
14 have more or less international pull, which would
15 end up -- be out-of-pocket payers mostly.

16 And so what we're trying to do is come
17 up with obviously a proxy that would not have
18 such small -- that had a reasonable number of
19 observations so that we could really assess the
20 it versus sort of as a proxy. It would be better
21 if we had some geographic indicators or something
22 else perhaps, but we tried to do the best we

1 could with what we had available and we did see a
2 difference. So I felt as though sort of lumping
3 them together might dampen out the cash-paying
4 patients that we might see in the traditional
5 self-pay for this particular type facility.

6 CO-CHAIR BULGER: Wes.

7 MEMBER FIELDS: Real quick, I think
8 you'd be doing Medicaid beneficiaries a real
9 favor if they suffer from cancer by looking at
10 that as a separate category from the no-pay,
11 self-pay patient, especially if you've got
12 international patients at major New York type
13 centers. My experience in multiple hospitals
14 over a long period of time is that Medicaid
15 beneficiaries have delays in getting staging
16 done. They may or may not get primary surgery
17 done. They may or may not get chemo, but I think
18 you're very likely to see substantially higher
19 readmit rates that are unscheduled because of the
20 gaps in their community care and so you'd be
21 doing them a real favor if you could separately
22 track that from the self-pay patient.

1 MS. JAGELS: I think that's good
2 advice.

3 Susan, anything you'd add in response?

4 DR. WHITE: No. I think that we can
5 certainly adjust and look at it that way.

6 CO-CHAIR BULGER: Cristie?

7 CO-CHAIR TRAVIS: I want to take us
8 back just for a moment to be sure that I kind of
9 understand the construct of the measures so that
10 I can think about the performance gap.

11 When I read this, it looks like it's
12 readmissions back to the same hospital. And I
13 guess the only thing that -- I don't know it's
14 the only thing, I shouldn't have said it that
15 way. I guess one of the things that would
16 concern me about that is that there could be
17 potentially admissions to another hospital for
18 cancer care, thinking that some people may be
19 traveling quite a distance to go to one of your
20 11 hospitals. And so this measure doesn't really
21 capture that. And so I think -- and it's not the
22 traditional way we've been looking at readmission

1 measures over in the general acute care hospital
2 setting, so just trying to figure out perhaps who
3 is not being captured, but also thinking about
4 the construct from the beginning in terms of why
5 it was set up that way.

6 MS. JAGELS: That's a really great
7 question and indeed, we've had copious amounts of
8 internal debate about the data we don't have. So
9 we don't have CMS data, nor do we have anything
10 that looks proximate to an all-payer database.
11 What we have is our own each individual's
12 hospital claims data.

13 So indeed, we did not set out to test
14 the hypothesis that we were failing to coordinate
15 care beyond our hospitals. You're absolutely
16 right. And many of our patients do come and go
17 within our regions, or even nationally, so we
18 recognize that there are some circumstances in
19 which this measure doesn't tell us all that we
20 need to know about whether we're successfully
21 managing those patients outside the hospital
22 settings outside of our index hospital area.

1 Instead, what we've really focused on
2 is given the patients we can find and given the
3 patients who are going in and out of the hospital
4 regularly, what sorts of clinical circumstances
5 are we seeing? So as an example, I can't tell
6 you in Seattle who goes back to Wenatchee and
7 gets -- in Central Washington -- who gets
8 admitted there. I can tell you that we draw a
9 lot of patients from Central Washington to
10 Seattle for leukemia and lymphoma care. And I
11 can see why they're going in and out of the
12 hospital particularly for foreseeable and
13 preventable reasons.

14 So this measure has limitations. I
15 think it's useful for our academic cancer
16 centers. It allows us to compare. And I think
17 fairly rigorously so to understand what the
18 circumstances are and is helping us actually
19 develop triggers. It doesn't help us broadly in
20 the care coordination issue.

21 CO-CHAIR TRAVIS: Well, thank you and
22 I think especially since this measure has been

1 looked at by the MAP. And if I'm remembering
2 correctly and that it's coming here for
3 endorsement, I think that this distinction and
4 this difference than most readmission measures is
5 an important piece for us to be sure that it gets
6 translated as it goes through any other related
7 processes here at NQF. So thank you for that.

8 CO-CHAIR BULGER: Helen?

9 MEMBER CHEN: I just wanted to add
10 that maybe changing -- sorry to harp on this --
11 the name of the measure might help that because
12 it's not really a general measure of care of
13 cancer patients. It's really patients who are
14 cared for at those PCH hospitals during their
15 index hospitalization. Just a thought.

16 CO-CHAIR BULGER: Any other -- Leslie.

17 MEMBER LESLIE HALL: So is it a very
18 high percentage of patients who have diarrhea,
19 nausea, dehydration during care that there's
20 often a readmission or an observation or
21 something? Is it a high percentage that makes
22 this difficult to track as a result of these

1 distances that we talked about earlier of
2 patients traveling, not going to travel four
3 hours if they're in the middle of dehydration and
4 diarrhea. They're going. And yet, is it
5 prevalent? Is it really common?

6 MS. JAGELS: About 13 to 15 percent of
7 the time, according to our findings. What we
8 were really trying to set out to establish is
9 that there was so much white noise in the all-
10 cause readmission that we couldn't see the
11 underlying patterns. There were so many patients
12 intentionally going back into the hospital for
13 scheduled surgery or for scheduled chemotherapy
14 that when we went looking for the things that
15 they ostensibly shouldn't or less ideally be
16 admitted to the hospital for, we couldn't find
17 them. So once we excluded those intentions, then
18 indeed -- there were three: nausea, vomiting,
19 diarrhea, gastrointestinal side effects, pain,
20 and septicemia.

21 So now septicemia is a little trickier
22 to consider foreseeable and avoidable except in

1 the circumstance of high-intensity chemotherapy
2 or other treatment. Nausea, vomiting, diarrhea,
3 and pain eminently foreseeable and avoidable. We
4 want to do a better job of getting ahead of those
5 circumstances and preventing those admissions.
6 So it was less around the travel dynamic and more
7 around we're doing things that we know will cause
8 these side effects. Let's develop mitigation
9 strategies to once again more successfully
10 deliver that therapy outside the hospital
11 setting.

12 CO-CHAIR BULGER: Wes.

13 MEMBER FIELDS: Yes, real quick. I'd
14 be a little bit concerned if the index is an
15 admission to the hospital that this may not be a
16 sensitive at 30 days as it would be with a longer
17 period of time trailing the index alternately if
18 the index could be a schedule infusion or a chemo
19 session. I think you'd be in better shape.
20 Because my sense of this, and I've been on both
21 sides of this as a caregiver, that a lot of these
22 things happen further downstream than 30 days

1 from the index.

2 MS. JAGELS: I think you're right.

3 Denise, do you want to speak to that?

4 MS. MORSE: I believe what we've seen
5 within the data is that our average time to
6 readmission tends to hover between 10 and 12 days
7 for the medical oncology population and when we
8 get to the hematology it can out a little bit
9 further, closer to 20 days. That's where they
10 all tend to cluster. That's including up to 90
11 days of readmissions.

12 MS. JAGELS: I think we did most of
13 them. Thank you, Denise.

14 CO-CHAIR BULGER: Karen.

15 MEMBER JOYNT: I'm not sure if this is
16 veering into the validity, but it does seem like
17 it would be helpful to know of the different
18 hospital readmissions what the pattern of those
19 is. There's been prior work in pediatrics and in
20 heart failure demonstrating that there may be
21 specific types of hospitals for which those non-
22 same site readmissions are more prevalent and if

1 you're going to use it as a -- I totally
2 understand for quality improvement, feedback to
3 the same hospital what's your readmission rate
4 that that may not be a big deal if you're
5 comparing hospitals to each other and you're
6 missing 20 percent for one hospital, 5 percent
7 for another, and 40 for another, it becomes a
8 pretty invalid comparator. So if you had data
9 that could test that at least in some subset and
10 then reassure us, that would be helpful.

11 MS. JAGELS: I agree. Susan, anything
12 you'd add?

13 DR. WHITE: No, other than at the time
14 of development we certainly didn't have the data
15 to be able to do that. And it did obviously
16 exist. I mean our friends at Yale have it. We
17 didn't have a data set to be able to measure
18 that. It's a great idea and I totally understand
19 that it's an uneven playing field if you compare
20 -- different centers have different referral
21 patterns, you know, and so -- agree. If we're
22 able to obtain the data, that's something we can

1 address.

2 CO-CHAIR BULGER: Other comments?

3 Okay. So we will vote on the performance gap.

4 MS. HERRING: Voting is now open for
5 performance gap on Measure 2884. Your choices
6 are 1, high, 2, moderate, 3, low, 4,
7 insufficient.

8 (Voting.)

9 MS. HERRING: The results are one
10 high, 16 moderate, zero low, one insufficient.
11 So 6 percent high, 89 percent moderate, 6 percent
12 insufficient.

13 CO-CHAIR BULGER: Okay, reliability.
14 And we'll start with Keith.

15 MEMBER LIND: So the reliability
16 testing, they did a sample chart review and they
17 checked for -- at the facility level, they found
18 a range of agreement of .08 to 1. The average
19 was .77, which sounds pretty good, but I just
20 wondered what happened. I wondered, too -- I
21 mean you do go through potential sources of
22 differences in definition of the planned versus

1 unplanned, but it just sounds like one of the
2 hospitals was way off the chart in that.

3 MS. JAGELS: We would agree. Susan?

4 DR. WHITE: I can help with that. So
5 one of the pieces of the logic in the numerator
6 is looking at whether it's an emergent, elective,
7 or urgent admission. And we did have one
8 facility that had a different pattern in how they
9 coded that particular data element when
10 submitting their claims.

11 And we were able to sort of break it
12 apart, so both of those facilities, the one that
13 was at 8 percent and the one that was -- just shy
14 of 43, both had similar but different ways of
15 determining that urgent/emergent versus elective
16 admission.

17 So we were able to trace it back to
18 that one particular data element. So have a
19 little bit of a reliability issue in that that
20 data element isn't typically used as a payment
21 indicator and so it's difficult sometimes to
22 leverage some of those for secondary use. So

1 that was really the source of that variation.

2 MEMBER LIND: So the developer gives
3 it a reliability low, but I guess the question is
4 whether -- if you've gotten these other -- how
5 are these hospitals, the one or two -- on the
6 same page?

7 MS. O'ROURKE: So just to jump in to
8 clarify, the preliminary reading is staff.

9 MEMBER LIND: Oh, staff.

10 MS. O'ROURKE: So that's from NQF
11 staff and --

12 MEMBER LIND: Oh, okay. All right. So
13 the staff gives it to them.

14 MS. O'ROURKE: -- it's not non-binding.
15 It's just where -- as we saw the information
16 using our reliability algorithm, where we would
17 come out, but it's to the committee to make that
18 determination. But just to clarify, that's staff
19 opinion, not the developers.

20 MEMBER LIND: So I'm --

21 DR. WHITE: Yes, I didn't think we
22 tagged it low. Thank you.

1 MEMBER LIND: I'm not quite sure how
2 to deal with that myself. I mean, one outlier,
3 the question is are you able to get them in line
4 and get everybody on the same page, and do we
5 have to consider the way they present it or the
6 way they might be able to fix it? I'm not sure
7 what the answer is.

8 DR. WHITE: Yes, I think that's a
9 really good question. So I think given that, you
10 know, we have a fairly captive audience of 11
11 hospitals, I think we can get alignment and get
12 everybody reporting in a reliable way.

13 We didn't -- we obviously left those
14 in there because if this measure were to go more
15 broad, I think there might be more noise because
16 of that one particular data element. And so we
17 may want to think about a different proxy or some
18 other way of detecting -- you know like for
19 emergent admission, maybe we'd look for an ED ref
20 code or something, some other way, if this
21 measure were to go more broad.

22 I think for the PCHs, though, we can

1 get everybody on the same page. I happen to be
2 at the center that has the 43 percent and I know
3 we've already tightened that up. So I think it's
4 manageable mainly because we have such a small
5 number of providers. Is that helpful?

6 MS. JAGELS: Yes. Thank you, Susan.

7 CO-CHAIR BULGER: Paul?

8 MEMBER HEIDENREICH: So just to be
9 clear, so for what we're considering is a measure
10 for 11 hospitals, or are we considering a measure
11 beyond 11 hospitals? Are those 11 going to -- is
12 that clear in the measure specification if that's
13 the case?

14 MS. JAGELS: So -- correct. This is
15 a measure we put forward to be incorporated into
16 our PPS-Exempt Cancer Hospital Reporting Quality
17 Program administered by CMS by virtue of the ACA.
18 We eleven centers by virtue of our exemption are
19 required to undergo our own quality reporting, so
20 pending your decision today, we'd be submitting
21 this to CMS for consideration for the MUC List
22 for next year.

1 So it'd be just us for now with
2 obviously the potential down the road with
3 additional testing and expansion, I suppose.

4 CO-CHAIR BULGER: So this -- it's a
5 carved-out program that CMS has for these cancer
6 centers, correct?

7 MS. JAGELS: Yes.

8 CO-CHAIR BULGER: Yet, it's a CMS
9 program, which means for CMS to use the measure
10 it needs to be NQF approved. Is that --

11 MS. JAGELS: That's correct.

12 MEMBER HEIDENREICH: They don't have
13 to have NQF endorsement. I think they'd like to
14 have it, right? But it's not required.

15 MS. JAGELS: They really like to have
16 it, they told us.

17 CO-CHAIR BULGER: But that's why you
18 brought it was because ideally --

19 MS. JAGELS: It was at their
20 encouragement.

21 CO-CHAIR BULGER: -- you'd like to
22 have an endorsement of the measure and it's this

1 carved-out set of -- okay. Helen?

2 MEMBER CHEN: I had a question to
3 clarify the numerator definition, especially
4 regarding the exclusions.

5 The first question, it was interesting
6 that you use the UB-04 as the designation for
7 unplanned hospitalizations. And I don't know
8 that much about UBs and whether or not there's
9 some sort of national error rate published about
10 completion of that. That's my first question.

11 Second question is one of your major
12 exclusions is progression of disease. What
13 you're defining as a diagnosis and you gave a
14 code set of metastatic disease, and I guess the
15 question is, is that in a new diagnosis of
16 metastatic disease on the subsequent readmission,
17 and what happens if there was already an
18 admitting diagnosis of metastatic disease on the
19 index? How would you then judge whether the
20 person had progression?

21 MS. JAGELS: That's a great question.
22 I'd just like to point out that our first

1 excursion into proof of concept for this measure
2 was ensuring amongst ourselves that we could find
3 our cancer patients. As you can appreciate, most
4 of our hospitals have patients in them other than
5 cancer patients, so that was one of the proxies
6 we put forth.

7 Susan, can you explain in more
8 detailed fashion? I hope you're still there.

9 DR. WHITE: Which part of the
10 question? I'm sorry.

11 MS. JAGELS: First the UB question, and
12 then second, the metastatic and codes associated.

13 DR. WHITE: Oh, yes. So the clinical
14 folks involved in the measure were really looking
15 at the metastatic and if it were a new diagnosis
16 of metastatic, it would exclude them from the
17 numerator as we've written the measure.

18 Using the UB, I'm not familiar with
19 any literature on those particular data elements.
20 I can tell you, and probably most people who are
21 experiencing using the UB billing data for
22 secondary uses, that we generally consider

1 variables that are sort of payment determinant to
2 be more reliable than those that are not involved
3 in determining a payment.

4 So we also -- we want to make sure
5 we're careful on how we use variables that are on
6 the UB and are there for more tracking than for
7 payment.

8 So I think this is a learning
9 experience. I think we thought that would be a
10 pretty solid variable, and we thought going a
11 priori that we would have an issue with the
12 difference between urgent and emergent and that's
13 why we sort of put those two categories together.
14 Although I think certainly the majority of our
15 facilities were all coding in the same way and
16 looking at or at least reporting that variable in
17 the same way.

18 But I'm not aware of any literature
19 nor was able to find any after we found this
20 issue. It might be a good study to do.

21 CO-CHAIR BULGER: Other questions?

22 Paul?

1 MEMBER HEIDENREICH: Just quickly, is
2 the reliability a must pass? And so, judging
3 from -- obviously staff is not the final word,
4 but they gave it a low and if this committee
5 voted low, that's the end of it, right?

6 CO-CHAIR BULGER: Helen, do you still
7 have a -- yes.

8 Any other thoughts on reliability?
9 You know, I do want -- because I think it's
10 validity, but I think it's part of this whole
11 issue of same hospital. I think probably it has
12 to impact reliability a lot as well and given the
13 fact that there's going to be differences and
14 there could be shifts based on -- you know
15 because a lot of it is market share, too.

16 So I mean if you're in a situation
17 where there's a lot of other options, you know,
18 say like an urban area, you may have a lot of
19 non-same hospital readmissions versus a rural
20 area and that could change over time. So if you
21 have a hospital closure or things like that, it's
22 going to change that ratio which would inherently

1 change the reliability for that place, but
2 because hopefully everybody else is compared for
3 every place.

4 MS. JAGELS: That's a really good
5 point. What we tend to find, and it's difficult
6 to measure, is that cancer patients while
7 undergoing treatment tend to go to the hospital
8 that their physician recommends. So assuming
9 that they're within the same city, we didn't
10 look, because we obviously didn't have access to
11 that data, but our impressions are clinically
12 that it's a closed system.

13 Most of our patients stay at the
14 hospital where either they'll get a portion of
15 their treatment in the in-patient setting or
16 where their oncologist has admitting privileges.
17 So I agree, we don't know what we don't know.
18 But I do believe that most of us -- most of our
19 hospitals tend to see the patients going in and
20 out of the same index hospital for the purpose of
21 their cancer treatment.

22 CO-CHAIR TRAVIS: I, too, don't know

1 whether I'm in reliability or validity. But I
2 guess just as a matter of clarification, have you
3 all -- have your set of hospitals been getting at
4 all the readmission measure feedback from
5 Medicare, from CMS?

6 You know, I know you were saying this
7 is to kind of address the unique aspects of
8 cancer care, but have you been getting that
9 information so that you know whether or not
10 patients are being admitted to other hospitals
11 more broadly?

12 MS. MORSE: Yes.

13 MS. JAGELS: Yes and no. Denise, you
14 want to take that one? Go ahead.

15 MS. MORSE: Yes, absolutely. We
16 received the CMS dry run report from -- that is
17 posted on QualityNet, that is the readmissions
18 all-cause dry run that they do produce for us and
19 they just do not submit that back.

20 We actually did, as part of the
21 initial alpha testing for this measure, compare
22 some of our results we identified from our dry

1 run to see how much we are seeing of that
2 readmission to the same hospital and readmissions
3 to different hospitals.

4 And we actually do not see as much
5 readmissions to other hospitals. To echo what
6 she was saying, we tend to see our patients come
7 back to our own hospital. And so I only see a
8 difference of about 3 percent when I look at
9 readmissions to my center versus readmissions to
10 all centers.

11 CO-CHAIR TRAVIS: Thank you.

12 CO-CHAIR BULGER: That's an absolute
13 3 percent or a relative 3 percent?

14 MS. MORSE: An absolute 3 percent.

15 CO-CHAIR BULGER: Any other questions
16 on reliability before we vote? Okay, and then
17 this -- like the last bunch we've done, moderate
18 is the best you could do.

19 Sorry, Keith.

20 MEMBER LIND: So that -- I don't think
21 that 3 percent was in the documentation. But I
22 think that speaks, to me at least, that says a

1 lot about how much of this -- these numbers are
2 going to change if you add in the other facility
3 readmissions.

4 I mean I was imagining from your
5 comments, Karen, that it could be, I don't know,
6 20 percent.

7 CO-CHAIR BULGER: Yes the only question
8 I would have on the 3 percent if we want to go
9 down that road is is that consistent across
10 hospitals or is that the average, and some
11 hospitals it's 20 percent and some hospitals
12 it's, you know --

13 MEMBER JOYNT: And 3 absolute percent
14 in readmission rate --

15 CO-CHAIR BULGER: That's a big deal.

16 MEMBER JOYNT: -- on a base of 15
17 percent is huge. Three absolute percent in the
18 number of people coming to your -- right? I
19 didn't totally understand what the 3 percent was.

20 MEMBER LIND: So that's like 20 percent
21 of the readmission rate, is that what you're
22 saying?

1 MS. JAGELS: Denise, can you answer
2 that?

3 MS. MORSE: Yes, so this is for one
4 time period and so we're looking at the all cause
5 for -- honestly for my center the rate is 29
6 percent back to my center and it is 32 to all
7 centers. So when looking at the all cause, we
8 look at very large numbers for the cancer
9 population because of the nature of cancer.

10 MEMBER LIND: And can you shed any
11 light on the rate for other institutions than
12 your own? Because that, obviously, is a concern.

13 MS. JAGELS: In Seattle it looks
14 similar to the City of Hope numbers.

15 Susan, have you seen other absolute or
16 modified rates for others?

17 DR. WHITE: No, I have not looked at
18 that.

19 CO-CHAIR BULGER: You know, I asked
20 too because I know just looking in our own -- in
21 our system, and again, it's not cancer, it's all
22 of them, but in the seven hospitals -- and we

1 track both because we track one with Premiere and
2 we get the all cause from CMS, you know some
3 hospitals it's 2 percent absolute difference, and
4 again, it's on a 15, 16 percent Medicare. And
5 some hospitals it's 5 or 6 percent.

6 But it depends. A lot of it is market
7 share based and you know, some of them --
8 everybody comes back to the same hospital and
9 others there's a hospital right down the street
10 and wherever EMS happens to take them when
11 they're really sick, that's where they go. So it
12 depends on the -- which is why this is so
13 variable which is -- to me, gives me a lot of
14 concerns about both reliability and validity.

15 CO-CHAIR TRAVIS: Can I ask just one
16 other clarifying question? Do you continuously
17 get that data or was that just a one time that
18 your hospitals got the dry run from CMS? Or do
19 you get it every quarter, annually?

20 MS. JAGELS: Denise?

21 MS. MORSE: Yes. We do get that -- I
22 believe it's annually that we receive that

1 report. We did not for a while and then we
2 started receiving it again, so I think there's
3 some variability in terms of whether we are
4 included or excluded from their dry run set.

5 CO-CHAIR TRAVIS: So there is some
6 information available on that, I guess, because
7 the way that it was described was that there's
8 not any information on where your patients go.

9 I know it's set up differently -- I
10 mean there's a different construct, but it does
11 seem like there's some information that gives you
12 a feel for if they're going other than to your
13 hospital.

14 MS. JAGELS: You're correct. A more
15 nuanced answer on my part would be in measure
16 development, we were using the UHC hospital
17 claims data. The distinctions between that data
18 set and what CMS provides us for our Medicare
19 patients, we try not to mix them up --

20 CO-CHAIR TRAVIS: And I do appreciate
21 that. Thank you. I understood a methodological
22 kind of difference, but there's at least some

1 information that's out there.

2 MS. JAGELS: Absolutely true. Thank
3 you.

4 CO-CHAIR TRAVIS: Thank you.

5 CO-CHAIR BULGER: Okay, any other
6 questions or comments on this? Karen, go ahead.

7 Yes and I think this will be -- this
8 is obviously, as we said, that this is -- if this
9 is low, we stop. So I mean, as much discussion
10 as we want to have.

11 MEMBER JOYNT: Yes, this may or may
12 not be germane to the current thing, but I was
13 just trying to find any other sources of data.

14 So in the Massachusetts hospitals, the
15 range of readmissions to other hospitals by
16 region, so metro Boston, 43 percent are to
17 another region, and the places where people don't
18 travel as far to get to care, it's between 7 and
19 10 percent are to another hospital.

20 So if your hospitals are similar
21 types, you may have a narrow range. If they're
22 not, you may have a huge range. It just seems to

1 me like this is a testable issue. Not easy to
2 test, but either using Medicare data or an all-
3 payer claims data or a sub-sample or something.

4 I don't have a feel for how big of an
5 issue we're talking about. If your hospitals are
6 very uniform, maybe the difference between them
7 or the calculation of performance with or without
8 is the same, in which case this is a non-issue.

9 MS. JAGELS: That's why today has been
10 a huge learning experience. Obviously we didn't
11 set out on a quest to avail ourselves to large
12 sum ResDAC-type data. The question we were
13 asking ourselves is for our hospitals, for our
14 patients, in our claims data, could we
15 successfully identify opportunities to better
16 manage these patients outside the hospital?

17 So you're right, it -- once again,
18 it's a grand assessment of where the patients are
19 being readmitted and why. To other hospitals,
20 this measure wouldn't be sensitive enough to
21 detect that.

22 But we do believe for the purposes

1 that we set out to establish, could we, from a
2 quality improvement perspective, find our
3 patients, identify them, understand the frequency
4 with which they're entering and exiting the
5 hospital, for foreseeable and avoidable reasons?
6 We think we did a decent job.

7 MEMBER JOYNT: Is the measure used to
8 compare hospitals or only for individual
9 hospitals to do their own quality improvement
10 activities?

11 MS. JAGELS: So we are sharing our
12 data across settings, but currently only using it
13 for internal quality improvement. City of Hope,
14 Seattle, and the James are robustly reporting by
15 service line and by provider so that once again
16 at the clinical decision making level, we can
17 improve our performance.

18 But it's not a benchmark, nor are
19 there targets, nor are we asking CMS to set those
20 for us.

21 CO-CHAIR BULGER: Okay. Leslie.

22 MEMBER LESLIE HALL: So I think this

1 is a conundrum we'll have at any time we get
2 presented a very specialized group of patients
3 with a strong desire to use quality to improve
4 your organization. I think it's fair to say that
5 this is a learning effort as much as anything
6 else. And I really support that idea. This is a
7 group of patients that have opportunities to
8 prevent readmissions and to participate and
9 engage in those discussions, decisions, and
10 they're very active patients.

11 So I think that we should consider
12 this a learning effort and an eye-opening effort
13 and maybe request, as a result, if this measure
14 goes through, reporting back in a more frequent
15 cadence to see if that measure has -- either had
16 the unintended consequence that have been pointed
17 out here, or actually been beneficial to quality
18 improvement efforts. And that way that might
19 mitigate some of the ongoing concern about both
20 the narrowness of this approach and the
21 unintended consequences of the other facilities
22 that may be impacted.

1 CO-CHAIR BULGER: Taroon, you want to

2 --

3 MR. AMIN: So on this issue of use, I
4 think we need to clarify a little bit in terms of
5 what the role of this committee is in terms of
6 the endorsement process.

7 The endorsement process is intended to
8 identify national performance standards for the
9 purposes of quality improvement and
10 accountability applications which would include
11 public reporting. So we will need to address
12 this question again if we get use and usability
13 in terms of, you know, making sure that this
14 measure is capable of doing both of those things.

15 And I'm not suggesting that it is or
16 isn't. That's part of the committee's
17 deliberations and it's not necessarily under the
18 domain of reliability, but I understand there's
19 concerns among the committee that they want to
20 get all the concerns out before we vote on
21 reliability. I just needed to clarify that
22 specific point because it's important to

1 understand what the committee is voting on.

2 CO-CHAIR BULGER: Okay. Paul?

3 MEMBER HEIDENREICH: That was
4 basically my point. I think there are definitely
5 measures that are very important for quality
6 improvement, but they're not yet at the level for
7 public reporting and so, you know, we don't --
8 there's many measures we would potentially not
9 even consider that are very important for
10 communities and hospitals to use.

11 CO-CHAIR BULGER: Okay. Keith.

12 MEMBER LIND: Maybe the developers can
13 clarify this, but my understanding is that these
14 hospitals tend to specialize in different
15 conditions. So to some extent the comparability,
16 you wouldn't expect their readmission rates to be
17 identical and the comparisons might or might not
18 be valid. There's some overlap, as I understand
19 it, but my understanding is that there is also --
20 they're reputationally specialized in different
21 areas.

22 MS. JAGELS: I would agree, and in a

1 moment I'll let Denise speak directly to that.
2 For instance, in Seattle and in Los Angeles, we
3 attract many patients for the purpose of
4 treatment for leukemia and lymphoma and bone
5 marrow transplant. Naturally, the treatment
6 trajectory for those particular modalities is in
7 many cases highly intense, so we see patterns of
8 patients entering and exiting the hospital that
9 look different for patients undergoing colorectal
10 or breast cancer therapy.

11 Denise?

12 MS. MORSE: Yes, that is absolutely
13 correct. Our two sites tend to be the highest
14 overall percentage of hematologic cases compared
15 to other sites. And some sites within the PCHQR
16 program do not treat or perform bone marrow
17 transplants, as well, which is a huge
18 differentiator. So even -- correct, within our
19 group there are differences.

20 DR. WHITE: This is Susan, just for a
21 second. We did make some effort to try to adjust
22 for that in looking at -- in our risk adjustment

1 methodology, looking at solid tumor surgery and
2 presence or absence of BMT -- bone marrow
3 transplant status.

4 We at the James are also a pretty
5 heavy hem-onc hospital and we have some
6 predictive modeling that we do internally for
7 readmissions and have found that that's a pretty
8 good proxy for that mix. It's better than
9 traditional comorbidity sometimes in predicting
10 our readmission rates.

11 So not that it's a perfect model, but
12 we did try to address some of that in our risk
13 adjustments.

14 CO-CHAIR BULGER: Karen? All right.
15 Any other questions, comments?

16 All right, so we're going to vote.
17 Remember 1 is moderate. The highest you can get
18 is moderate.

19 MS. HERRING: Voting is now open for
20 reliability for Measure 2884. One, moderate, 2
21 low, 3 insufficient.

22 (Voting.)

1 MS. HERRING: The results are 5
2 moderate, 13 low, 1 insufficient. Just 26
3 percent moderate, 68 percent low, 5 percent
4 insufficient. This measure does not pass and we
5 will conclude voting on this measure.

6 MR. AMIN: So before we move on, I
7 think it might be helpful just to summarize a
8 little bit of the feedback for the developers
9 because although we had to stop discussion at the
10 point of reliability, the conversation spanned
11 just reliability. So I think one of the -- just
12 to -- I'll do a very abbreviated version of what
13 I heard.

14 Related to the reliability testing, I
15 think was what triggered some of the questions
16 related to the .8 in terms of inter-rater
17 reliability conversations about the underlying
18 data element.

19 There was validity conversations
20 related to readmissions to other facilities, and
21 then I think there was probably some conversation
22 around use and usability, which again related to

1 the validity question.

2 If there are any other sort of high
3 level feedback elements, I'm sure the measure
4 developers would welcome that.

5 CO-CHAIR BULGER: Yes, I mean the
6 comment I would make is that, you know you made
7 the comment you don't know what you don't know.
8 And I think some of that you need to know before
9 it would go through under the endorsement
10 process.

11 So some of the stuff I think you can
12 say, you know, you don't know what you don't
13 know, but I think some of that it would be very
14 beneficial. So, for example, this issue around
15 what are the -- what is the difference between
16 same hospital and even if you did a sample or you
17 found some way to -- across your hospitals to
18 understand what the spread was, knowing that
19 information I think would be very helpful to the
20 committee going forward.

21 And it doesn't necessarily -- you
22 could know what the spread was and that spread

1 turns out to be equivalent, as Karen said, which
2 would give you that, that you could absolutely
3 say that was the case. But I think that would be
4 very helpful to know.

5 Bruce?

6 MEMBER BRUCE HALL: Taroon, I think
7 there was one other comment early on which might
8 have got lost and that was that the title itself
9 doesn't really reflect the fact that this is
10 actually urgent emergent readmission and using
11 the word unplanned actually I think draws too
12 many parallels to the CMS unplanned algorithms
13 which are not involved here.

14 I would, at the same time, suggest or
15 ask whether this committee is permitted to sort
16 of give this developer group an endorsement of
17 some kind saying we think this is incredibly
18 important work and we'd love to express to your
19 constituents that the work should continue,
20 right? And that might even help them get their
21 work done. It might help them with local support
22 and everything. So I just put that out on the

1 table.

2 MR. AMIN: We would certainly reflect
3 that in the feedback to the developers in our
4 materials. There's obviously a lot of great work
5 that was done here by the developers and it's
6 moving us significantly further in terms of
7 measuring this important outcome for a population
8 -- for this important care population.

9 So we'll definitely reflect that in
10 the materials.

11 CO-CHAIR BULGER: Wes.

12 MEMBER FIELDS: Yes, I just want to
13 support what Bruce suggested, whether it's
14 official or it's just friendly. I actually gave
15 you a moderate vote, but I think the discomfort
16 of people that didn't centers on the fact that
17 most of the measures we look at are more
18 universal, all community hospitals, all ACOs, et
19 cetera.

20 And I think what we all recognize is
21 that you're essentially providing quaternary
22 types of services that are regional in nature so

1 it's fundamentally different. But I think what
2 we'd all probably like to see more is that even
3 if you're quaternary in structure admission, you
4 still interact in a number of ways not just with
5 your patients, but with other providers.

6 And I think knowing what your
7 readmission rate is to all facilities is worth
8 knowing, even if it's not a truly significant
9 number. Because I think where this quality
10 movement is going overall is that we expect to
11 have more and more special -- highly specialized
12 procedures be regionalized, but we're getting to
13 a place where the flow of patients back and forth
14 for those highly specialized services is getting
15 to be a pretty big deal.

16 So knowing when they bounce and where
17 they bounce is important even -- and it's not
18 because we disbelieve what your data shows, but
19 in order to understand the best fit and the best
20 outcomes in terms of authorizing readmissions, I
21 think you really need to know what that
22 interaction is with admissions away from your own

1 quaternary center really is.

2 CO-CHAIR BULGER: Okay, any other
3 comments from the committee?

4 So thank you. I think we all just
5 said -- I think you heard that the committee is
6 very supportive of what you're doing and
7 hopefully that continues. And I think we would
8 be thrilled to see it come back at a future time.

9 MS. JAGELS: Well, I'd like to express
10 my gratitude. Believe me, as I sat through the
11 morning and had an increasingly urgent sense of
12 unsettlement I thought okay, I can feel it
13 coming. So I think your advice is very genuinely
14 offered and I really appreciate the opportunity
15 to even bring a measure of this stature before
16 you. So thank you for your time.

17 CO-CHAIR BULGER: Thank you.

18 All right, so the next one is 0171
19 which is Acute Care Hospitalization During the
20 First 60 Days of Home Health, it's a CMS measure.
21 And the discussants are Helen, Paulette and Pam,
22 and we'll start with the developers. Thanks for

1 coming.

2 MS. KEANE: So first of all, thank you
3 for allowing us to present these measures and to
4 answer any questions that you may have about
5 these two measures. Again, it's 0171, Acute Care
6 Hospitalization During the First 60 Days of Home
7 Health, as well as Measure 0173, Emergency
8 Department Use Without Hospitalization During the
9 First 60 Days of Home Health.

10 Helping me present today, I have my
11 colleagues. I have Dr. Jennifer Riggs, a nurse
12 researcher at Abt Associates. I have Dr. Stephen
13 McKean, who is our analytical lead for all home
14 health claims based measures. And I also believe
15 I have on the phone our measure steward, two
16 representatives from CMS. And also I'll just
17 offer Jennifer and I have both seen patients in
18 home health as nurses in the past.

19 So both measures are currently
20 endorsed and they're also outcome measure with
21 the data source of administrative claims. These
22 measures are for home health. Both measures are

1 currently used in the accountability reporting
2 programs for CMS. For publicly reporting, these
3 measures are reported on Home Health Compare.
4 Measure 0171, what I'll refer to as ACH Measure,
5 is used in the Quality of Care Patient Star
6 Ratings program.

7 The home health acute hospitalization,
8 or ACH Measure, and the Emergency Department Use
9 Without Hospitalization Measure, or ED, are
10 harmonized with the rehospitalization measures
11 which are NQF numbers 2505 and 2380. And with
12 CMS's hospital-wide, all cause, unplanned
13 readmission measure, which is NQF 1789, and the
14 definition of unplanned hospitalizations.

15 They do differ from other post-acute
16 care hospital readmission measures, however, in
17 the definition of eligible post-acute stays and
18 the risk adjustment approach and by measuring
19 emergency department use as an outcome.

20 The differences arise due to the
21 unique nature of home health care as a post-acute
22 setting. The ACH and ED Use Measures were

1 initially developed and later leveraged to
2 construct the rehospitalization measures by
3 further restricting the ACH and ED Use Measures'
4 eligible population by requiring prior proximal
5 in-patient hospital stay within five days from
6 the start of home health.

7 Finally, both pairs of measures are
8 risk adjusted using patient level predicted
9 probabilities calculated from multinomial
10 logistic regression.

11 Risk factors that are accounted for in
12 both pairs of measures include demographics and
13 health status as measured by both the CMS
14 hierarchical condition categories, HCCs, found on
15 claims in the previous six months, the
16 rehospitalization measures leverage the prior
17 proximal in-patient hospital claim to obtain the
18 patient's diagnosis related group or DRG, and
19 also risk adjust for the activities of daily
20 living fields on the OASIS, or Outcomes and
21 Assessment Information Set assessment of the
22 initial home health stay.

1 The risk-adjusted rates for the ACH
2 and ED use measures are publicly reported, as I
3 previously stated. However, due to a large
4 number of relatively small home health agencies
5 treating previously hospitalized patients, the
6 measure developer determined that reporting home
7 health agencies' risk-adjusted rates could lead
8 to misleading conclusions since small home health
9 agencies' risk-adjusted rates tend to be
10 unstable.

11 Therefore, the risk-adjusted rates for
12 the home health rehospitalization measures are
13 publicly reported as categorizations, for
14 instance, better than expected, same as expected,
15 worse than expected.

16 While the acute-care hospitalization
17 and Emergency Department Use Without
18 Hospitalization Measures differ from other post-
19 acute care measures in some regards, these
20 differences arise from the unique nature of home
21 care as well as a desire for harmonization across
22 all of our home health quality measures.

1 The only thing I also want to call
2 out, as there were no major changes in these two
3 measures since they were previously endorsed in
4 2012, we have had two minor changes that were
5 made to the measures. First, the title of the
6 measures were changed to improve the clarity.
7 Previously, they just said acute care
8 hospitalization or emergency department
9 utilization. The first 60 days of home health
10 has been added to clarify that, which I'm quite
11 happy we did after the previous presentation.

12 Secondly, there's been a recalibration
13 of the risk adjustment model coefficients using
14 data from January 1st, 2013 through to December
15 31st, 2013.

16 So I don't know if either of you want
17 to add anything.

18 MEMBER CHEN: So as the developers
19 mentioned, this is a maintenance discussion and
20 this measure has already been in use in the
21 community for public reporting.

22 In terms of evidence, the evidence

1 that's mostly provided in this measure is really
2 around readmissions. There's a mention of some
3 more recent work at the -- from QIOs about
4 community-based interventions that also prevent
5 acute care hospital utilization. To be honest, I
6 couldn't get into that study, but I did look at
7 the Jane Brock, Joanne Lynn JAMA paper from 2013
8 and they did show an ability for home care
9 agencies and communities to actually intervene on
10 all admissions, not just readmissions. So the
11 evidence does exist out there for this.

12 CO-CHAIR BULGER: Vote on the evidence.

13 MS. HERRING: Voting is now open for
14 evidence for Measure 0171. Your choices are 1
15 yes, 2 no.

16 (Voting.)

17 MS. HERRING: The results are 18 yes,
18 0 no. So 100 percent yes.

19 CO-CHAIR BULGER: Gap?

20 MEMBER CHEN: In terms of the
21 performance gap, the developers reported new data
22 from 2011 to 2014 regarding performance rates.

1 For 2014, the interquartile range was 12.7 to
2 16.8 percent. And also in the validation set the
3 difference between the 10th and 98th percentile
4 was 11.3 to 22.9 for those agencies with at least
5 20 stays. So there is a performance gap.

6 In terms of SDS, they did report on a
7 conceptual rationale. They did look at some of
8 the measures and as discussed in other measures
9 previously, they recommended not including SDS in
10 the model.

11 CO-CHAIR BULGER: Great. Thank you.

12 Pam?

13 MEMBER ROBERTS: I think the only
14 thing to add is that they did note variations
15 across facilities.

16 CO-CHAIR BULGER: Okay. Any thoughts
17 from the committee? All right, we'll vote on the
18 performance gap.

19 MS. HERRING: Voting is now open for
20 performance gap. For measure 0171, your choices
21 are 1, high; 2, moderate; 3, low; 4,
22 insufficient.

1 (Voting.)

2 MS. HERRING: The results are 3, high;
3 15, moderate; 0, low; 0, insufficient; so 17
4 percent, high; 83 percent, moderate.

5 CO-CHAIR BULGER: Okay, reliability.
6 Pam, do you want to --

7 MEMBER ROBERTS: They did do
8 reliability tests, as I mentioned, using the
9 beta-binomial. They did it at the patient level
10 and the reliability score was greater than .871
11 and at least 50 percent of the agencies had a
12 reliability score of .77. So they had some good
13 reliability.

14 CO-CHAIR BULGER: Okay, Helen? All
15 right. Anything from the committee on
16 reliability? Seeing none, let's vote.

17 MS. HERRING: Voting is now open for
18 reliability for measure 0171. Your choices are
19 1, high; 2, moderate; 3, low; 4, insufficient.

20 (Voting.)

21 MS. HERRING: The results are 2, high;
22 16, moderate, 0, low; 0, insufficient. So 11

1 percent, high; 89 percent, moderate.

2 CO-CHAIR BULGER: Excellent.

3 Validity, or excuse me, yes, validity. Helen?

4 MEMBER CHEN: Data element validity
5 was not tested because CMS audits the sample for
6 accuracy of claims and the claims are very
7 accurate. They did perform a random split sample
8 of the agencies with at least 20 stays with 80
9 percent of the facilities in the development
10 group and 20 percent in the verification group.
11 And the c-statistic was actually 0.693 in both
12 samples and the cross-validation at the 10th and
13 the 90th percentiles for predicted probabilities
14 was 8 and 31 percent in both.

15 CO-CHAIR BULGER: Anybody from the
16 committee with comments? Karen?

17 MEMBER JOYNT: I just have a question.
18 So I know you guys have two measures and they're
19 sort of related to each other. It looked like
20 there's a beta in this measure for whether or not
21 you've had an ER visit. Is that right or did I
22 misread that? I'm trying to understand how the

1 two measures work together that the revisit
2 versus the rehospitalization. Did I understand
3 that that event distributes here?

4 DR. MCKEAN: Right, so there's a
5 multinomial logit model, it's both measures,
6 basically, for the two different outcomes. So
7 you would have different parameters estimates
8 predicting the -- you would have two sets of
9 parameter estimates. One set of parameter
10 estimates would predict whether or not you have
11 the ED use without the hospitalization and then
12 the other set of parameter estimates would
13 predict if you had the acute hospitalization.
14 But it's one multinomial logit model predicting
15 the two outcomes.

16 MEMBER JOYNT: So whether or not you
17 have a -- is there actually a term in the
18 hospitalization model that says whether or not
19 you had an ED visit? Or did I just misunderstand
20 what that said?

21 DR. MCKEAN: So the parameter estimate
22 in the risk-adjustment model would have.

1 MEMBER JOYNT: Okay.

2 DR. MCKEAN: There might be a
3 parameter estimate in the risk-adjustment model,
4 but I would say if you had previous ER visits, I
5 could pull up --

6 (Simultaneous speaking.)

7 MEMBER JOYNT: Oh, I see. It's not
8 about -- it's not because the model is linked,
9 that it's actually built that way. It's whether
10 or not you had a prior ED visit.

11 DR. MCKEAN: Right.

12 MEMBER JOYNT: Is the thing that
13 informs this model. Okay. I was thinking about
14 this is a bit of a usability question, also a
15 validity question, but it's a little hard to get
16 your head around how to think about -- is it good
17 if you have low readmission rate, but a high ED
18 use rate and --

19 DR. MCKEAN: The goal would be to have
20 a low for both of them and that could be
21 possible. And that is possible.

22 MEMBER CHEN: Just as a point of

1 clarification, this all acute care
2 hospitalization and not just readmissions? Yes.

3 CO-CHAIR BULGER: Okay.

4 MEMBER AUGER: Sorry to follow up on
5 that, but it is one model for both measures, is
6 that correct?

7 DR. MCKEAN: Right, that is correct.

8 CO-CHAIR BULGER: Bruce.

9 MEMBER BRUCE HALL: I was trying to
10 get my head around perhaps a related issue and I
11 don't know whether necessarily it's validity or
12 use, but as an unintended consequence, if a
13 facility just uses home health for everything,
14 they're going to look great, right? Okay.

15 CO-CHAIR BULGER: Other questions?
16 Karen.

17 MEMBER JOYNT: This is another related
18 issue that I think relates to both validity and
19 maybe unintended consequences which is you also
20 have to be accepted into home health, so whether
21 or not home health is available and whether or
22 not you're accepted and whether or not you sort

1 of make traces between where you're sent. It
2 just makes me a little bit nervous that the
3 selection into an exposure is very different here
4 than it is in many of the other settings we look
5 at. I don't know that I actually have a prior
6 and what to do about it or how it might influence
7 things, but the selection feels important to me
8 in judging how well you can really tell patients
9 that are in home health agency versus another
10 given that it's a little bit like that sort of
11 selection bias of treatment assignment that we
12 always worry about in observational data.

13 MS. KEANE: So I will offer that there
14 is patient choice to select which sites they go
15 to, so if a patient is making a choice to go to
16 home health, they're making a choice to go to
17 home health. Beyond that, I think this is a home
18 health measure.

19 CO-CHAIR BULGER: Carol.

20 MEMBER RAPHAEL: I have to respond to
21 that. I mean yes, there is choice in the
22 regulations, but in reality, one of the major

1 issues is that many people land in nursing homes
2 because it's a Friday afternoon and there's an
3 available bed and the hospital wants to discharge
4 someone who's medically ready to discharge. And
5 before they know what hit them, they're in the
6 nursing home. So I really think that is an issue
7 that we should be cognizant of. And people who
8 land in home care often don't really have a
9 choice. I mean yes, they're given a list, but
10 they ask what is your recommendation? And they
11 often will go with the recommendation of whoever
12 the hospital kind of has preferred provider
13 relationships with. I don't know how that plays
14 out in terms of selection, but that's how it
15 operates in the world that we inhabit for better
16 or for worse.

17 CO-CHAIR BULGER: Other questions or
18 comments? I just would say that's evolving a
19 lot, too, with the narrow networks, you know, the
20 previous ACO discussion and as networks narrow,
21 the choice -- again, there's still choice, but
22 you're given -- the list has narrowed certainly.

1 Keith?

2 MEMBER LIND: So the agencies also
3 have a choice.

4 MEMBER RAPHAEL: That's what I was
5 talking about.

6 MEMBER LIND: That's what I thought
7 you were talking about. So it's not just the
8 patient. The agencies have a lot more
9 flexibility about whether or not to accept a
10 patient than a hospital does when they're
11 deciding to admit an unplanned admission.
12 There's no EMTALA for health agencies. So I
13 don't know how you deal with that. You can
14 adjust for clinical and patient characteristics,
15 but there's an inherent selection bias in that
16 measure. But I mean it's already approved, but I
17 wanted to mention that.

18 CO-CHAIR BULGER: Any other comments?
19 Pam.

20 MEMBER ROBERTS: I think you're
21 starting to see though in some of the markets, at
22 least in urban markets when you have quaternary

1 hospitals, they are really working with home
2 health agencies that can handle those level of
3 patients. And you're starting to see much more
4 coordination of care starting to happen. So I
5 think there could be some good byproducts of this
6 that are starting to happen I guess over time.
7 We'll see more, but at least I can say for urban
8 markets you start to see that.

9 CO-CHAIR BULGER: Anything else?

10 Okay.

11 MS. HERRING: Voting is now open for
12 validity for measure 0174. Your choices are 1,
13 high; 2, moderate; 3, low; 4, insufficient.

14 (Voting.)

15 MS. HERRING: The results are 1 high;
16 17 moderate, 1 low, zero insufficient. So 5
17 percent high, 89 percent moderate, 5 percent low.

18 CO-CHAIR BULGER: Okay. Feasibility.
19 Helen?

20 MEMBER CHEN: It's basically claims
21 data. That's fine. Not much to say.

22 CO-CHAIR BULGER: Any other comments?

1 Okay, we'll vote on feasibility.

2 MS. HERRING: Voting is now open for
3 feasibility for measure 0171. Your choices are
4 1, high; 2, moderate; 3, low; 4, insufficient.

5 (Voting.)

6 MS. SHAHAB: Tom, can you submit your
7 vote, please?

8 MEMBER SMITH: I texted you a 1.

9 (Laughter.)

10 MS. HERRING: Thank you. And the
11 results are 16 high; 3 moderate; 0 low; 0
12 insufficient. So it's 84 percent high; 16
13 percent moderate.

14 CO-CHAIR BULGER: Use, Pam. Do you
15 have any comments on use?

16 MEMBER ROBERTS: I mean they're
17 starting to show some risk-adjusted performance.
18 It's very slight at the agency level. And it's
19 been stable across the population level.

20 CO-CHAIR BULGER: Helen.

21 MEMBER CHEN: It's being used.

22 CO-CHAIR BULGER: Any comments from

1 the group? All right. Oh, Cristie.

2 CO-CHAIR TRAVIS: Any expectation that
3 we'd see more change than perhaps we're seeing
4 with this measure? Are there any particular
5 relevant issues that we need to see? If I'm
6 reading this correctly it's stayed about the
7 same, even though it is being used. I guess I
8 was hoping that we would see an improvement over
9 time. So just any thoughts you have about that,
10 I would appreciate it.

11 DR. RIGGS: I think one of the things
12 that's holding us back a little bit is that
13 there's not a great deal of research that's home
14 health care specific. And so we're not
15 necessarily -- we don't necessarily have the
16 evidence that we need to take us to the next
17 level. However, as we speak, there's an awful
18 lot of activity going on really trying to
19 identify what best practices are that really will
20 move the needle in these areas. And so I think
21 over the next five years, we may, in fact, start
22 to see an additional step forward in terms of

1 reducing these rates. I agree. I see exactly
2 what you see. We're kind of plateaued here, but
3 I think we're just moving a little bit slowly
4 because of the nature of the care setting.

5 CO-CHAIR TRAVIS: Thank you.

6 CO-CHAIR BULGER: Okay, any comments?
7 Paula.

8 MEMBER MINTON-FOLZ: Do you see much
9 of your readmissions from patients who really did
10 not want to go into a skilled nursing and now
11 need to and that three-day rule? Is that part of
12 that you have to have -- or is that just
13 Washington where it's a three-day rule before you
14 -- oh, okay.

15 Well, if a patient needs to go into a
16 SNF from home, they need to have a prior three
17 days of acute care hospitalization. Do you see
18 the impact of that affecting your readmission
19 rates? Do you see patients often going from home
20 to hospital to SNF? Or are they often going
21 home, hospital, back home? Is that clear?

22 MEMBER FIELDS: Paula, I think I can

1 answer the question for you even though I don't
2 know their data. But I think you're talking
3 about a different subset because the ones you're
4 worried about and it's a legitimate concern is
5 the patient that doesn't meet criteria for
6 admission for three days of in-patient service is
7 not well enough or stable enough to be
8 independent at home. Therefore, it gets referred
9 to home health services that prove to be
10 inadequate. But that won't show up in their data
11 because they don't have that index admission.

12 CO-CHAIR BULGER: Other questions?

13 Okay, we'll vote on usability, use.

14 MS. HERRING: Voting is now open for
15 usability and use for measure 0101. Your choices
16 are 1, high; 2, moderate; 3, low; 4,
17 insufficient.

18 (Voting.)

19 MS. HERRING: The results are 3 high,
20 16 moderate, 0 low, 0 insufficient. So 16
21 percent high, 84 percent moderate.

22 CO-CHAIR BULGER: Okay, that brings us

1 to the final question, the overall suitability.

2 Any further -- Pam, Helen, anybody from the

3 committee? Okay.

4 MS. HERRING: Voting is now open for

5 overall suitability for endorsement for measure

6 0171. Your choices are 1, yes; 2, no.

7 (Voting.)

8 MS. HERRING: The results are 19 yes,

9 0 no. So 100 percent yes. Thank you.

10 CO-CHAIR TRAVIS: Okay, well, we're

11 ahead of schedule which is great and we're going

12 to come to our last measure now which is 0173,

13 Emergency Department Use Without Hospitalization

14 During the First 60 Days of Home Health.

15 Are there any additional comments that

16 you all wanted to make? Okay. The developers

17 have already made their comments earlier. We've

18 got Wes, Carol, and John as our lead discussants.

19 So Carol, would you like to go first?

20 MEMBER RAPHAEL: I just wanted to make

21 a kind of overall comment which is I know this

22 has already been endorsed in the past and it's

1 being used for public reporting. But I did have
2 to say and maybe this is in line with a point
3 that was made earlier, I thought the research
4 base for this was very thin. There was one study
5 that really kind of was the buttressing study.
6 And there's very little evidence of what can make
7 a difference in regard to really preventing
8 unnecessary emergency department visits.

9 The only things that I have seen and
10 it's still very early stage references to
11 telehealth, but I don't think we know enough yet.
12 Access to primary care, which is really tough
13 because you get patients who don't have a primary
14 care physician, a primary relationship. And then
15 even if they do and they call, the primary care
16 physician is not available. And then all of the
17 things that we thought made a difference like
18 medication, reconciliation, a lot of kind of
19 front-loading, follow-up visits, patient
20 education, and activation and all of that good
21 stuff, falls prevention, makes no difference
22 whatsoever.

1 So when you put this all together, I
2 have to say I felt like I was standing on kind of
3 sand rather than stone. And so that really did
4 concern me in terms of thinking about how do get
5 improvement here and where are we headed with
6 this? But I don't know, Wes, what your reaction
7 --

8 MEMBER FIELDS: Yes, I want to
9 disclose tow conflicts. One is my group now
10 offers a telemedicine service and the other is
11 that since this is a maintenance measure that I
12 probably can't kill, I think I'd rather catch my
13 plane. But that being said, that being said, you
14 know, the developers have actually given the best
15 reason for this to be maintained. And it
16 essentially functions as a tracking measure for
17 the interaction between condition at hospital
18 discharge, condition at referral to home health
19 services, and the likelihood that they'll bounce
20 back to the emergency department. So we all want
21 to prevent preventable readmissions, and I think
22 that since this is kind of an area that's more

1 dynamic in the marketplace, as you say, rather
2 than pure research, I think we need to continue
3 to follow this, but that's probably it's only
4 reason to exist, including your statistical
5 model.

6 But I do think we spent a fair amount
7 of time yesterday talking about Medicare
8 patients' condition on discharge from acute care
9 being significant, a significant issue in terms
10 of their ability to provide self-care or to be
11 stable for community-based care with home health.
12 And I think that's the only reason that this is
13 worth continuing to follow because there is no
14 science here. And even the one reference that
15 you have is really about frequent visitors to the
16 emergency department which is a really -- that's
17 a different population.

18 But I do think we should support it,
19 because I think we need to do our best to make
20 sure that people being discharged from acute care
21 are in sustainable health statuses in the
22 community.

1 CO-CHAIR TRAVIS: John, anything else?

2 CO-CHAIR BULGER: I feel the same way,
3 but I won't belabor -- I think you're both
4 exactly right.

5 CO-CHAIR TRAVIS: This is a
6 maintenance measure and the developers have
7 indicated that the underlying evidence has not
8 changed, but I want to get a read from the
9 committee as to whether we want to kind of vote
10 on the evidence criterion? You know, I'm just
11 kind of hearing both sides of the issue here and
12 I just want to be sure I'm clear on what our next
13 steps should be.

14 MEMBER FIELDS: Well, I think you
15 should consider that the sponsor of the measure
16 is CMS and that this is a moving target. I think
17 we should probably move on from here and to
18 support the measure's renewal.

19 CO-CHAIR TRAVIS: Pam.

20 MEMBER ROBERTS: I think that we're
21 going to need to watch this measure over time and
22 we should support it now because especially with

1 all the bundling payments and the changing
2 payment models, this could become a very
3 important measure if people start using the ED or
4 if we can if we can really keep them out.

5 CO-CHAIR TRAVIS: Okay, well, not
6 seeing anybody say we should vote on it, oh, I'm
7 sorry. Kathy, I didn't see your card.

8 MEMBER AUGER: The only other
9 evidence, sort of type statement I would make is
10 that it seems like sometimes home health care
11 referrals to ED is not seen as a bad thing. It's
12 actually seen as a good thing that the home
13 health care agency or home health care nurse was
14 in the home and recognized a problem early and
15 was able to get them to the appropriate level of
16 care. So that's just the other part of me. And
17 it ties up, perhaps, this multinomial model that
18 they're going to the ED, but not getting
19 readmitted, so that may not be a bad thing.
20 That's the only --

21 CO-CHAIR BULGER: And I think it's
22 good that you track it, too, for the reasons that

1 were mentioned because I think you're going to
2 see -- if you think of a curve of -- as opposed
3 to acute space is one that everybody is looking
4 at because if you look at where the variation is
5 in Medicare it's in that post-acute space after
6 hospitalization. If you want to save money and
7 you're an ACO, after not getting them in the
8 hospital in the first place, where they go is
9 important.

10 So this kind of curve with -- after
11 hospitalization with say LTAC on the far left
12 being the most expensive, and then in-patient
13 rehab and then SNF and then home health, people
14 are going to start trying to shift that curve to
15 the right. So you're going to see sicker and
16 sicker patients, if you will, going to home
17 health.

18 So I think this notion is well said of
19 having this to track because you'll be able to
20 pick up these things and Pam mentioned it, too,
21 and so did Carol. I think it's important to have
22 it as a tracking device to be able to -- it's

1 almost maybe a canary in a coal mine to see if
2 things are starting to go wrong with that whole
3 process.

4 CO-CHAIR TRAVIS: Well, I think based
5 on this discussion and the advice of Taroon, it
6 probably would be best for us to go on the record
7 of voting relative to evidence. And this a must-
8 pass criterion.

9 MS. HERRING: Voting is now open for
10 evidence for measure 0173. Your choices are 1,
11 yes; 2, no.

12 (Voting.)

13 MS. HERRING: So the results are 17
14 yes, 1 no, so 94 percent yes, 6 percent no.

15 CO-CHAIR TRAVIS: Okay, thank you.
16 We'll go to performance gap, and Carol, you want
17 to start us out there? Can you put on your
18 microphone? Thank you.

19 MEMBER RAPHAEL: I don't think there
20 was anything that was noteworthy. We're not
21 making progress. I think that was said before
22 and we have a gap to close here. I don't think

1 there's anything more to add.

2 MEMBER FIELDS: No, that's actually a
3 little bit alarming. The results look the same
4 and I think we'd all like to see them get better.
5 And I think we all support CMS' intent with this
6 measure. But the reality is it's not happening
7 yet.

8 CO-CHAIR TRAVIS: John, anything to
9 add?

10 CO-CHAIR BULGER: I don't other than
11 to say is there some idea as to why that's the
12 case? Is there anything in the -- any thoughts?

13 MEMBER RAPHAEL: The only point that
14 was made and I don't know if you can comment on
15 it, we said anecdotally, there seems to be
16 evidence that -- and this is a line drawn with
17 where you were headed -- that the patients now in
18 home health are older, more women who are living
19 alone tend to be sicker. That would be the case
20 --

21 CO-CHAIR BULGER: That was one of my
22 -- you made it. It is getting better. But the

1 patient population is getting sicker and those
2 two things are equaling each other out so that
3 you end up staying the same.

4 DR. BURSTIN: But that's the data you
5 should have.

6 MEMBER RAPHAEL: Helen, it was
7 mentioned it was anecdotal evidence.

8 DR. BURSTIN: I am just saying that
9 you would think that they would have the data to,
10 in fact, look to whether the population has
11 shifted in terms of age, number of comorbidities,
12 etcetera. If they have the whole system.

13 DR. MCKEAN: Just pulling up, we have
14 numbers that show the distribution of the age
15 groups by year, so from 2011 to 2014. And it
16 does look like the biggest group which is the 75-
17 to 84-year-olds, that stays relatively constant,
18 around 35 percent over time. So it doesn't look
19 like the distribution of ages is dramatically
20 changing over time. So that might not
21 necessarily be what's driving this.

22 MEMBER FIELDS: Can you tell us if --

1 DR. MCKEAN: There could be other
2 comorbidity and distribution --

3 MEMBER FIELDS: So there's no data for
4 comorbidity or MCC proxies.

5 DR. MCKEAN: We could look at that
6 over time.

7 MEMBER FIELDS: Well, I think that's
8 kind of what we're suggesting.

9 DR. MCKEAN: All I have right now in
10 front of me is distribution by age, sex, race.

11 CO-CHAIR TRAVIS: Any other
12 conversation on performance gap? Time to vote.

13 MS. HERRING: Voting is now open on
14 performance gap for measure 0173. Your choices
15 are 1, high; 2, moderate; 3, low; 4,
16 insufficient.

17 (Voting.)

18 MS. HERRING: The results are 4 high,
19 13 moderate, 0 low, 0 insufficient. So 24
20 percent high, 76 percent moderate.

21 CO-CHAIR TRAVIS: Okay, now we'll move
22 to reliability. Wes, any comments on

1 reliability? Carol, John? Does anybody on the
2 committee have any questions or comments on the
3 reliability testing? Okay, we can go to vote.

4 MS. HERRING: Voting is now open on
5 reliability for measure 0173. You can choose 1,
6 high; 2, moderate; 3, low; or 4, insufficient.

7 (Voting.)

8 MS. HERRING: The results are 0 high,
9 17 moderate, 0 low, 0 insufficient; so 100
10 percent moderate.

11 CO-CHAIR TRAVIS: Validity. Wes,
12 anything?

13 MEMBER FIELDS: I think we've beat up
14 validity pretty well. But I really do think that
15 this is a companion to the readmission piece and
16 as long as your model doesn't change, I think we
17 need to continue to track this. But I'm hoping
18 to hear that our real concern is for the
19 population you serve and whether it's changing or
20 becoming more unstable at the time of referral to
21 home health. So if there's ways to enhance the
22 model, I mean, what do they call it? The

1 continuity of care document, the electronic
2 document following the patient? Yes, that should
3 be a rich source of information for you to know
4 what the health status of the patient is at the
5 time of their discharge from the hospital. And
6 it's pretty much of an electronic standard. So
7 you probably have to reengineer that or rebuild
8 it. But I think even if you can look at the
9 parallel problems of the MCC population or rather
10 high-risk, high-cost populations other than age,
11 I think we'd all like to know what's happening in
12 terms of the likelihood that they're referred to
13 home health and the likelihood of them being
14 referred back to the emergency department or even
15 needing to be readmitted.

16 CO-CHAIR TRAVIS: Anything, John?
17 Carol said no already. Okay, any other
18 questions? Ready to vote.

19 MS. HERRING: Voting is now open for
20 validity for measure 0173. Your choices are 1,
21 high; 2, moderate; 3, low; 4, insufficient.

22 (Voting.)

1 MS. HERRING: Results are 1 high, 16
2 moderate, 0 low, 0 insufficient; so 6 percent
3 high; 94 percent moderate.

4 CO-CHAIR TRAVIS: Okay, feasibility.
5 Carol, any comments?

6 MEMBER RAPHAEL: I think it's
7 feasible. It's based on claims.

8 CO-CHAIR TRAVIS: Wes is nodding his
9 head. Okay, John, anything extra? Okay. We're
10 ready -- I don't see any other cards, so we're
11 ready to vote.

12 MS. HERRING: Voting is open for
13 feasibility for measure 0173. Your choices are
14 1, high; 2, moderate; 3, low; 4, insufficient.

15 (Voting.)

16 MS. HERRING: I think we're just
17 waiting on one more. Okay. We have 14 high, 2
18 moderate, 0 low, 0 insufficient; so 88 percent
19 high, 13 percent moderate.

20 CO-CHAIR TRAVIS: Okay, use and
21 usability. Carol, Wes, John, any comments you
22 want to make?

1 MEMBER RAPHAEL: Well, I think as was
2 said, it's already being used for home health
3 compare.

4 CO-CHAIR TRAVIS: Okay, seeing no
5 other discussion, we'll go to vote.

6 MS. HERRING: Voting is now open for
7 usability and use on measure 0173. Your choices
8 are 1, high; 2, moderate; 3, low; 4,
9 insufficient.

10 (Voting.)

11 MS. HERRING: The results are 7 high,
12 9 moderate, 0 low, 0 insufficient; so 44 percent
13 high, 56 percent moderate.

14 CO-CHAIR TRAVIS: Any final comments
15 before we vote on overall suitability for
16 endorsement? Okay. Thank you. We'll go to vote.

17 MS. HERRING: Voting is now open for
18 the overall suitability for endorsement for
19 measure 0173. Your choices are 1, yes; 2, no.

20 (Voting.)

21 MS. HERRING: The results are 16 yes,
22 0 no; so 100 percent yes. This concludes voting

1 for today. Thank you very much.

2 MR. AMIN: So just a quick thing
3 before we move on from this measure. We did
4 identify that it's related to 2505, the emergency
5 department use without hospital readmission in
6 the first 30 days of home health.

7 Just a quick reminder this committee
8 reviewed that measure and this measure in terms
9 of related and competing. The developers offered
10 a rationale in terms of why both measures are
11 needed and this committee agreed with that
12 rationale as we review 2505. So it doesn't
13 appear that we need to have an additional
14 conversation about competing measures discussion
15 unless anyone feels otherwise.

16 MEMBER FIELDS: Taroon, actually,
17 remind me why we need both 2505 and this one?
18 What is the rationale?

19 MR. AMIN: The developers contended
20 that there are differences in justifying the two
21 separate measures; patient admission to an
22 emergency room without hospitalization during 60

1 days following the start of home health; and 2505
2 evaluates admission to emergency room within 30
3 days of starting home health for patients who are
4 recently discharged from an in-patient setting.

5 So I believe the idea was that 0173 assesses the
6 efficacy of clinical care for all patients and so
7 I just want to confirm that with the developers.
8 Was that sufficient?

9 MEMBER FIELDS: Does 2505 not -- does
10 2505 not include an index referral after an in-
11 patient stay? Is that the difference? One is
12 referral from the community and one is a post-
13 discharge thing? Is that the difference?

14 MEMBER RAPHAEL: From what I
15 understand, that is the difference. The first
16 one is 60 days post-discharge from an in-patient
17 setting. The second is voted ED from the
18 community and you are not --

19 MR. AMIN: Okay, thank you.

20 DR. LEVITT: This is Alan Levitt from
21 CMS. The 2505 is ER use after hospital
22 discharge. It's a readmission measure. It's 30

1 days and it harmonizes with the hospital-wide
2 readmission measure. It includes only hospital
3 discharged patients who go into home health.

4 The measure that we're talking about
5 now is a hospitalization measure during the
6 entire home health episode for all home health
7 patients. I don't know the exact number, but
8 probably 50 percent of the home health admissions
9 are hospital -- come from the hospital. The
10 other 50 percent come from the community. So
11 it's a much larger group of patients that we're
12 talking about. And it's over the home health
13 episode of care which is that's where 60 days
14 come from.

15 MR. AMIN: So the only other question
16 I have for the committee in terms of relating and
17 competing, we identified two measures during this
18 morning discussion related to admission rates for
19 heart failure and diabetes.

20 Paul, you had mentioned yesterday that
21 there were other measures that you wanted to
22 raise related to this related and competing

1 measure as it relates, I believe, to --

2 MS. SHAHAB: Between the access days
3 and the readmission rates.

4 MR. AMIN: And I wanted to know if
5 that was still a question, obviously not for
6 right now, but if that needed to be raised for an
7 additional conversation during our next
8 conference call.

9 MEMBER HEIDENREICH: I think it should
10 be touched on briefly in one of the calls.

11 MR. AMIN: Okay. Thank you.

12 CO-CHAIR TRAVIS: So we're going to
13 open it up now for public comment. Is there any
14 in the room? Seeing none in the room, Operator,
15 will you see if there's any public comment on the
16 phone, please?

17 OPERATOR: At this time, if you'd like
18 to make a comment, please press star and the
19 number 1. There are no public comments at this
20 time.

21 CO-CHAIR TRAVIS: Thank you. Well,
22 thank all of you for your time. Before we let

1 you go, however, we're going to have Zehra kind
2 of walk us through what the next steps are.

3 MS. SHAHAB: Thank you, Cristie. So
4 on the next slide you'll see a few dates. The
5 first one is the post-meeting follow-up call
6 which is coming up really quickly, June 21st and
7 that's from 2 to 4 p.m. After this, we will --
8 after today's meeting, staff is going to be
9 writing the draft report and we will have that
10 draft report posted for public and member comment
11 for 30 days from August 1st to August 30th. And
12 then we will have a post-draft report call with
13 you all, the committee, October 5th. And then
14 the draft report will be posted for NQF member
15 vote October 11th through 31st. And then we plan
16 on going to the CSAC in November of this year and
17 that's also when we will go for endorsement of
18 the Board.

19 And finally, our appeals will be
20 December 2nd through January 2nd, a 30-day
21 appeals periods. And with that I want to thank
22 all of the measure developers for their

1 incredible work. I know many of them are not
2 here right now, but we want to thank you
3 especially for all of the innovative work you've
4 been doing with the SDS trial, responding to all
5 of the committee feedback and the concern. And
6 thank you for taking the time over these past two
7 days for being with us and to answer all of the
8 questions.

9 Second, I wanted to thank all of you
10 committee members for such rich discussions and
11 all of the work you all have done since there has
12 been an extra load of work on your plates for
13 this project and I can't thank you enough for
14 making this project and all of our meetings
15 together so enjoyable.

16 You're definitely my favorite
17 committee hands down. I'm not sure if I'm
18 allowed to say that, but I don't think I've ever
19 said that before. This is the first time.

20 DR. BURSTIN: And you may have
21 contributed to her decision to try to go to
22 medical school, so there you go.

1 MS. SHAHAB: A very special thank you
2 to all of our chairs, Cristie, John, and Bruce,
3 and especially Bruce, who offered to help when
4 John had a conflict on the first day and then I
5 want to see if any of my staff or the chairs or
6 any or all of you have anything to say. Taroon,
7 Erin?

8 MR. AMIN: No, just thank you.

9 MS. O'ROURKE: Just to echo Zehra's
10 thanks. She put it very eloquently. So thank
11 you all and thank you to our developers and
12 especially to our chairs.

13 DR. BURSTIN: Thanks. It's been a
14 tough slog, but we couldn't imagine doing it with
15 anybody else. So thank you.

16 CO-CHAIR TRAVIS: Or anybody else
17 doing it. Thank you all very much.

18 MR. AMIN: Safe travels.

19 CO-CHAIR TRAVIS: This concludes the
20 meeting.

21 (Whereupon, the above-entitled matter
22 went off the record at 2:40 p.m.)

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This is to certify that the foregoing transcript


In the matter of: All-Cause Admissions and
Readmissions Standing Committee

Before: NQF

Date: 06-09-16

Place: Washington, DC

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