NATIONAL QUALITY FORUM

Moderator: Kim Patterson
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10:39 am CT

Matthew Pickering: So good morning. I do see some folks dialing in to the meeting this morning. This is Matt at NQF. I'm just letting everyone know, we will be starting about maybe a minute or so after 9:00 am as we give some folks a little bit of time to dial-in. Thank you.

Sheila Roman: Hello?

Matthew Pickering: Hi, good morning. This is Matt at NQF.

Sheila Roman: Hi, this is Sheila Roman. I can't get in through the link. I get a - I'll tell you exactly what message I get.

Matthew Pickering: Well, good morning Sheila. Thanks for joining us.

Sheila Roman: You're welcome.

Matthew Pickering: And we see if we can try to resolve your issue.

Sheila Roman: Yes. I changed the phone number that was on there, because I want to keep my cell phone open for the day. But even before that, I thought that was fixed. It would not let me in. What I get is either the conference phone number or access code are incorrect.

Woman 1: Okay. We can email you Sheila. Will that be all right?

Sheila Roman: So you're going to email me another link?

Woman 1: Yes. We're going to email you another link.

Matthew Pickering: So I also have - (Poonam), I also have (Casey). (Casey), I'm sorry, I don't know how to pronounce your last name, (Perrotti) is also experiencing the same issue. Can you also send her an email of that?

Woman 1: Okay.

Sheila Roman: Okay. So I guess I should wait for your email and then follow the directions in the email?

Woman 1: Okay, yes. I'll just - I'm going to re-forward you the calendar invite.

Sheila Roman: Okay. So I'm looking for an email from you with an invitation.

Woman 1: Yes, it's going to be the calendar invite. I'm just going to forward it again from the readmissions account. You should be able to see it momentarily as well as (Casey).

Sheila Roman: Okay, thank you. Should I hang up or do I want to be on the line?

Matthew Pickering: Maybe if you want to hang on the line Sheila until you get the link just to make sure that we - you're able to get it.

Sheila Roman: Okay.

Matthew Pickering: Thank you. And I will say good morning to those who are dialing in and joining us. It is 8:59 here on the Eastern side. We're going to get started here in a little bit, maybe about a minute or so after 9:00 am.

And it is 9:00 am. I will say if you are not speaking or on the line, could you put yourself on mute just to prevent any background and we'd greatly appreciate it. We're going to get started here in about another minute just to allow some folks to dial-in and can be with us this morning. We'll just get started here in another minute, thank you.

Woman 1: Hi Sheila, did you receive the calendar invitation?

Matthew Pickering: Hello?

Lisa Freeman: Hi. Is there a question for that or we're just going to (unintelligible)?

Matthew Pickering: So - yes - I'm sorry, who is speaking?

Lisa Freeman: I'm sorry. This is Lisa Freeman.

Matthew Pickering: Hi Lisa. Yes, it just a question and there was another standing committee member that was having some difficulties joining in. So we were just asking if she was on the line.

Lisa Freeman: Okay, very good.

Matthew Pickering: Yes. But with that and good morning to you Lisa, we will go ahead and get started and we'll have to see if we can get that standing committee member situated on the platform.

Very much appreciate your time this morning and good morning to everyone who is on the line thus far and welcome to the All-Cause Admissions and Readmissions Spring 2020 Measure Review Cycle.

My name is Matthew Pickering. I'm the Senior Director here working with this team and overseeing this portfolio. And we very much thank you all for your time and participation today.

We do have a very long meeting ahead of us. There are two different type of cycle components or things that we'll be discussing today. One is obviously reviewing the spring 2020 measures or the measures that are coming through for spring 2020 evaluation. And in the afternoon, we have a post comment discussion for our fall 2019 measure and the work that happened in fall 2019.

For those of you that have seen some communications come through your inbox or across your inbox regarding why we're doing this is because during the COVID-19 pandemic and what's going on currently, we recognize that stakeholders, their priority's shift and has shifted to address the issues that are currently going on and not having necessarily the time to really thoughtfully or potentially even at all to respond to our fall 2019 meeting the measure, the liberations that happened, et cetera.

So NQF extended its post comment period to 60 days. That's ending where we are today to where we have now that post comment meeting discussion

happening during this meeting as oppose to a separate meeting that would close out fall 2019.

So those items, those post comment memo as you may have seen come through last week - late last week will be discussed this afternoon with regards to the fall 2019 Measure 3495.

The other measures for spring, spring 2020, what will be happening and what we'll be starting with today. So there are five measures that we'll be going through today.

But again, we just wanted to welcome you very much for your time. This is an all-day meeting. We recognize that maybe difficult for folks and we really do appreciate your time and we'll try to keep things focused as well as keep things moving forward as we go through our call today.

I do want to recognize our two co-chairs, one will not be joining until about 9:30, John Bulger, but I did want to recognize Cristie Travis and maybe give her an opportunity to give some welcoming remarks.

Cristie, are you with us? Are you able to welcome the committee?

Cristie Travis: Yes, I'll be glad to. Can you hear me?

Matthew Pickering: Yes.

Cristie Travis: Okay. Well, thank you all for being with us today. As Matt said, we have a very long day in front of us, but a very important day. And I thank you all for the preparation that you went through in advance of this meeting. I look forward to our discussions and to being able to do what we need to do relative

to these measures as well as the 2019 post comment period. So thank you Matt.

Matthew Pickering: And thank you Cristie. And like I said, John Bulger will be joining us here a little bit later this morning. So we'll allow him to also provide a welcome once he is able to join us.

Before we introduce the team, just a few housekeeping items here. We do have the CenturyLink platform which allows you to visually look at this presentation. You also have the slide decks available to you and as we walk through the deck.

If you have difficulties, we've heard a couple of folks having some difficulties logging into the platform, please message through the chat box and that will be very helpful and our team can definitely work with you and send you link or try to see what maybe the issue as we go through. But you should also be able to have the slides available to you through the calendar invite as well.

But if you're having difficulties with the link, please message through the chat box or we can definitely follow up with you. Or if you are having some difficulties, please feel free to speak up and we can try to get that taken care. Is anybody having difficulties with the platform?

Sheila Roman: Yes, this is Sheila Roman and I've got two further emails with links from you and I can't get in on either of them.

Matthew Pickering: Okay. So we'll definitely try to follow up with you Sheila.

Sheila Roman: So I can't get to a chat box.

Matthew Pickering: You can't. Right, exactly. But I'm glad you're able to get on the line. So we'll continue to work with you outside of the platform on this as we proceed. Has anybody else having some difficulties?

Chloe Slocum: This is Chloe Slocum. I'm having some difficulty.

Matthew Pickering: Also logging into the platform?

Chloe Slocum: Yes.

Matthew Pickering: Okay. So Chloe as well, thank you. And if you both can just hang on the line as we proceed and you should have the slides available to you, it's going to be the same slide deck. It's attached to the calendar invite. It will be the slides that we'll go through the meeting today. So right now we're just on slide 3. Hopefully we can get the issue resolved.

Has anyone else having difficulties with the platform? Okay, well thank you folks.

Dheeraj Mahajan: And Matt, it's Dheeraj. And the question of (unintelligible). Is that test question on that – because there is already a question up there, right, the poll question.

Matthew Pickering: No, it's not a test question, right. So there is another link, it's a poll everywhere link and we'll get to that later on today. So Raj, thank you. There is a poll everywhere link. That's a separate link. That's what we'll be using for voting. There will be a question up there. It's a test question, but we're not going to be using that right now. We were just trying to see if anyone can - is having difficulties getting in the CenturyLink platform.

So I will keep moving and Sheila and Chloe, we'll try to get that resolved for you as well. But please hang on the line. Again, we're on slide 3 of the slides.

We ask that you please mute your lines if you're not speaking just to minimize any background noise that maybe happening. If you're somewhat noisy, we will definitely be muting you. But we ask that if you're not speaking to please keep yourself on mute.

And please do not put this call on hold as well, sometimes it also gives back some hold music. And as we go through today, we ask that you use the raise your hand feature. There is a lot of jumping in, people kind of jumping in over top of each other. That can happen.

So we want to use the raise hand feature through the chat platform as we go through today if you have any questions or you like to bring anything to the committee's attention for discussion. So just use that raise hand feature as we move forward and we'll keep an eye and monitor that and recognize you for those parts of discussion.

And also if you're having any difficulties or if you want to bring something to our attention, please also use the chat feature within the web platform as well. There is a chat box you can message the entire group or just individually.

Okay. So I just wanted to give a few moments just for the team to recognize themselves and just for - give some introductions. So my name is Matthew Pickering, again I'm the Senior Director here at NQF working on this portfolio and with this great team. And also, again, thank you all very much for your time today. Oroma?

Oroma Igwe: Good morning. My name is Oroma Igwe and the Project Manager.

Matthew Pickering: Thanks Oroma. Funmilayo?

Funmilayo Idaomi: Good morning. My name is Funmilayo Idaomi and I'm the Project Analyst.

Matthew Pickering: Okay, thank you. And Poonam?

Poonam Bal: Hi everyone. This is Poonam Bal. I'm a Director helping on this project cloud.

Matthew Pickering: Thank you Poonam. And Taroon?

Taroon Amin: Good morning. Taroon Amin, I'm the Consultant for NQF.

Matthew Pickering: Great, thank you. And so we all again very much appreciate your time this morning for this busy day and leading up to this event.

So what we're going to be talking about today, here is just an agenda focusing on really just the spring 2020 - obviously before we adjourn, there is going to be the post comment for fall 2019 discussion that we will be having for Measure 3495. Again, that's in the (report) occurring at the latter part of the day.

So we're first going to do some introductions and disclosures of interest. You have been receiving a series of emails from us to fill out some disclosures of interest so that we can identify any potential conflicts that you may have leading up to this meeting. So we will be going through and our Acting Vice President Apryl Clark will be doing that with you all.

And then we will go into the measures under review as well as discuss some overview of the evaluation process. During that time, we'll also be doing a voting test. And so there is a link that's - a different link from the CenturyLink platform, but it's a poll everywhere link that's within the calendar invite and you may have also received one early this morning to be at the top of your inbox. It is the voting link that we will be using today, so please feel free to start accessing that once that time comes.

We also will be discussing Profile Inter-Unit Reliability and we have members here, one of the developers will be discussing the Profile Inter-Unit Reliability. And the reason being is that we have four measures this cycle and some of you may have noticed this that are using an Inter-Unit Reliability test and also a profile Inter-Unit Reliability test.

So we have the developer on the call this morning to present both of these methods, also some of their limitations and gain any dialogue from you all as well as answer any questions you may have as you approach your voting to be a little bit more consistent with that approach, because again there're four measures that have both of these methods coming through this cycle. So we'll touch on that in a little bit.

And then we'll dive into the measures. And so we'll go through all of the measures that we will be reviewing for spring 2020. We will open it up for NQF member and public comments and then we will have some next steps regarding those measures themselves.

And then we will switch to the post comment discussion as well as hear any responses from the developer based on the comments we have received, as well as get any dialogue and discussion from you all as well and the developer

will be on the call to answer any questions. And then we will also have the public comment and next steps for that measure and then we will adjourn the call.

Any questions from the committee before we go into introductions and disclosures of interest?

And I just want to check Sheila and Chloe, are you able - were you able to access the web platform?

Sheila Roman: No. I haven't received any other - you know, this is Sheila. And I haven't received any other instructions.

Matthew Pickering: Okay. We'll get that followed up. And then Chloe? Yes.

Chloe Slocum: I can access the slides from the - sorry, this is Chloe. I can access from email and I can access poll everywhere, so I'm following along with those right now.

Matthew Pickering: Okay.

Sheila Roman: Yes, me too.

Matthew Pickering: Okay, thank you Sheila.

Woman 1: Hi Chloe and Sheila, we just sent you an email - we were going to send you another email again. We just sent you an email.

Matthew Pickering: Okay.

((Crosstalk))

Matthew Pickering: Yes, thank you both very much. Sorry for the inconvenience. I would say, if it's still not working, we may have to just reserve to the slides. Right now we're on slide 6, introductions and disclosures of interest and then we'll go into slide 7 and we'll go through that list accordingly. Apologies for that inconvenience with that. But thank you very much for following on with the slides. Hopefully the email works.

Okay. Apryl, I'm going to turn it over to you and we'll do introductions and disclosures of interest.

Apryl Clark: Great, thanks. And just to echo Matt's comments about thanking everyone for being here, it's a very busy day, we really appreciate that.

Before I jump into introductions and disclosures, I wanted to do an introduction of a new member of our NQF team. So Sheri Winsper has joined us as the new Senior Vice President for Quality Measurement. Sheri is a registered nurse who's had a number of positions in quality measurement, quality improvement and patient safety. So she had a long history of quality information and overseeing quality programs. So she is a great addition to NQF.

Sheri comes to us from the Dallas State Texas Health Resources where she served as Vice President and Chief Quality Officer and was responsible for their system wide management of clinical quality improvement.

So Sheri has joined us last week, so this is her second week and she's probably been on a couple of different evaluation meetings, but we really wanted to make sure that she had a chance to say hello to our readmissions

and standing committee. So I'm going to turn it over to her to see if she wants to say a few words.

Sheri Winsper: Thank you Apryl and it's so nice to meet all of you virtually over the phone. I really appreciate everyone coming and spending the time today. I know this is going to be a long day, but it's a really important day for measuring readmissions and coming to some great decisions on how we should do that.

I'm excited to join you all and partner with you going forward as part of NQF. I'm excited to be able to continue the great work that you all are doing. Thank you for spending the time as well, looking at the materials ahead of time and have a great day. Apryl?

Apryl Clark: Thanks Sheri. So now we'll move into our introductions and disclosures of interest. So as Matt mentioned, you received two disclosure of interest forms from us, one is our email disclosure and the other is a disclosure specific to the measures we are reviewing this cycle. In those forms, we asked you a number of questions about your professional activities. Today, we'll ask you to orally disclose any information you provided on either of those forms that you believe is relevant to this committee. We are especially interested in grants, research or consulting relating to the committee's work.

Just a few reminders. You stood on this group as an individual. You do not represent the interest of your employer or anyone who may have nominated you for this committee. We are interested in your disclosures of both paid and unpaid activities that are relevant to the work in front of you.

Finally, just because you disclose, it does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

So I am going to start with our co-chairs and I'll call your name. Please state your name, who you're with and if you have anything to disclose. I apologize in advance if I mispronounce your name and I believe we are missing a couple of people who have not submitted their disclosures. So when I call your name, I might (unintelligible) that we're missing something.

So I'll start with our co-chairs. I know John is actually not able to join us. So we'll do his disclosure once he is able to join. So we'll (write) to Cristie Travis.

Cristie Travis: Hi there. I'm Cristie Travis and I'm the CEO of the Memphis Business Group on Health and I have nothing to disclose.

Apryl Clark: Great. If you are not speaking, it will be great if you could just put yourself on mute to help prevent some of the background noise. Frank Briggs? Mae Centeno? Helen Chen?

Helen Chen: Good morning. This is Helen Chen. I'm the Chief Medical Officer of Hebrew Senior Life which is a multi-side integrated senior healthcare and senior living company. I'm Geriatrician Internist and Hospice and Palliative Care Physician by training.

I also serve on the board of the Beth Israel Lahey Health Performance Network which is an ACO. And I'm the Division of Geriatrics and Gerontology in Beth Israel Deaconess Medical Center, Harvard Medical School. And I have nothing to disclose.

Apryl Clark: Great. Edward Davidson?

Edward Davidson: Hi. This is Ed Davidson. I'm partnered Insight Therapeutics, a firm that conducts research in long-term care setting. I'm on the board of directors of the National Transitions of Care Coalition and I'm a faculty at Eastern Virginia Medical School in the Department of Geriatrics. And I have nothing to disclose.

Apryl Clark: Great. Richard James Dom Dera?

Richard James Dom Dera: Hi. This is James Dom Dera. I'm a Family Physician. I'm the Population Health Medical Director of NewHealth Collaborative, the Accountable Care Organization of Summa Health in Akron, Ohio. I also sit on an editorial advisory board for American Academy of Family Physicians. And I have nothing to disclose.

Apryl Clark: Great. Paula Milton Foltz? Brian Foy?

Brian Foy: Good morning. My name is Brian Foy. I run Product Development at Q-Centrix. Q-Centrix is a company that helps hospitals manage and report quality data. I have nothing to disclose.

Apryl Clark: Great. Lisa Freeman?

Lisa Freeman: Yes. I'm Lisa Freeman. I'm the Executive Director at the Connecticut Center for Patient Safety. We're a nonprofit in Connecticut and we basically represent the patient perspective and voice in patient safety issues, but in all of healthcare as much as the city involved. And I'm just very honored to be part of this committee all these really (nice amount) of people. And I have nothing to disclose.

Apryl Clark: Great Lisa. Faith Green?

Faith Green: Hi. Faith Green of Humana and I have nothing to disclose.

Apryl Clark: Okay. I think we are missing one of your disclosures. So I am going to ask the team to follow up, because we do need to have the final disclosure. So I'll ask our team to kind of follow up with you directly right now.

Faith Green: Okay, I've sent a few, but I'll send it again. Thank you.

Apryl Clark: Thank you, thank you for your patience. Leslie Kelly Hall? Michelle Lin? Kenneth McConnochie? Dheeraj Mahajan? Zeyno Nixon? Sorry, go for it.

Dheeraj Mahajan: No problem. It takes a couple of seconds to unmute yourself. Raj Mahajan, Internist Geriatrician here at Chicago and no disclosures.

Apryl Clark: Great. Zeyno Nixon? Amy O'Linn?

Amy O'Linn: Good morning. Amy O'Linn. I'm an Internist Hospitalist for the Cleveland Clinic and I'm the Physician Lead for Enterprise Remission Reduction of the clinic. I have nothing to disclose. Thanks for having me.

Apryl Clark: All right Amy. I do think we are missing one of your disclosures. So I am going to ask the team just to follow up directly with you to get that.

Amy O'Linn: Sounds good, thanks.

Apryl Clark: No problem. Gaither Pennington? Carole Pulaski? Pamela Roberts?

Pamela Roberts: This is Pam Roberts. I'm from Cedars Sinai, the Executive Director of Physical Medicine Rehab. And I have no disclosures.

Apryl Clark: Great. Sheila Roman?

Sheila Roman: Hi everybody. Good morning. I'm an Independent Health Consultant and also Endocrinologist Internist and part-time faculty member at the Johns Hopkins Medical Institutions in Baltimore.

I formally was Senior Medical Officer at Center for Medicare and Medicaid Services and work both on the quality and payment side of the house. And previous to that, I spent 20 years in academic medicine at Mount Sinai School of Medicine in New York City where I directed the diabetes clinic and also ran quality measurement for the system.

Apryl Clark: Great and do you - go ahead.

Sheila Roman: I have no conflicts of interest to disclose.

Apryl Clark: Okay. (What we will do), I'm not sure that we have both of your disclosures. So again, I'll have the team directly follow up with you on that.

Sheila Roman: All right, thanks.

Apryl Clark: Teri Sholder? Yes, no problem. Teri Sholder? Chloe Slocum?

Chloe Slocum: Hi. This is Chloe Slocum. I'm the Associate Director of Quality at Spaulding Rehabilitation Network which is part of Mass General Brigham. And also, I'm a faculty at Harvard Medical School. I have no conflicts of interest to disclose.

Apryl Clark: Is there anybody that I called - may have joined late, but I haven't called that need to state their disclosure?

Michelle Lin: This is Michelle Lin. Can you hear me?

Apryl Clark: Yes.

Michelle Lin: Yes. I am Director of Performance Improvement at Mount Sinai and I Chair the Clinical Emergency Data Registry. I don't have any disclosures.

Apryl Clark: Great. Anybody else that I missed? Great, well thank you very much. I'd like to let you know that if you believe that you might have a conflict of interest at any time during the meeting, please speak up. You may do so in real time during this web meeting or you can send a message via chat to your chairs or to any one on the NQF staff.

If you believe that a fellow committee member may have a conflict of interest or behaving in a wise manner, you may point this out during the meeting, send the message to your chairs or to the NQF staff. Do you have any questions or anything you like to discuss based on the disclosures made today?

Thank you. I'd also just remind you that NQF is a non-participant organization, out of mutual respect for each other we kindly encourage that we make an effort to reframe for making comments (unintelligible) or humor relating to for example, race, gender, politics or topics that are otherwise maybe considered inappropriate during the meeting. While we encourage discussions that are open, constructive and collaborative, let's all be mindful of how our language in the (community) maybe perceived by others.

With that, I will turn it back over to the team. Thank you.

Matthew Pickering: Thanks Apryl. This is Matt again. So thank you all very much for being on the call today providing your disclosures of interest. Again, we are still missing John which we'll just check in as it gets closer to 9:30.

However, I do see that we have - even with John on the call, we have 14 members. So in order to have quorum based on our committee numbers, we need to have 15. So unfortunately, we do not have quorum today, but that's okay.

So the next steps with not having quorum is that we will continue with the discussion, we will continue with the dialogue and answer - and the developer will be on the call to answer any questions you may have regarding the measures.

After the meeting is done, we will then send out a survey to the entire committee and the survey is just for voting. It will be going through each measure and we'll ask your votes based on if you're on this call a dialogue that's happened.

Or if those who're unable to attend the call, they will now have the survey and the recording. The recording will also be sent out to the committee for them to listen in and review and then also provide their input not for the survey.

So again, with John joining later on this morning, we have 14 and we need to have 15 for quorum. So we will not be voting during the call today, we will just be discussing. And so what we will do is that we will go through the process of each criterion. There will be a discussion and presentation by the lead discussant. There will be a discussion of the measure and answer any questions that the committee may have.

However, once that discussion is seized, the questions are answered, we will then move on to the next criterion, we will not vote at the end of that criterion. Again, the vote will happen after the meeting is - has adjourned.

Okay. Any questions? Okay. We'll proceed forward and we'll just check one more time as well just before we do any sort of - as we do the voting test, we may just do the voting test just to also confirm. But we'll move forward and we'll get to the voting test and we will confirm once more.

Okay, all right. And thank you Brian, I see your note. You're going to drop off in about five, but returning in a little bit and we'll announce when you were joined, so thank you. I know that people have to sort of jump in and out and we're trying to monitor that.

So I will say as well that if you are planning to leave for a little while, please send a note through the chat box as we can monitor that. We understand this is a whole day meeting and people are busy and some people have notified us in advance about this. But please if you are going to drop off to go to something else, let us know and let us know when you plan on rejoining as well.

Okay, so going in to the measures under review for spring 2020. So there are five measures that came through this cycle, three measures are maintenance measures and two are new measures. And so just keeping that in mind especially when you're looking at the evaluation criteria, new measures don't necessarily have the must-pass or they don't have the must-pass for the used component of the measure evaluation criteria whereas maintenance measures do have the must-pass on use.

There're also different considerations when you're looking at maintenance and new measures again for certain aspects of the reliability and validity testing. Maintenance measure is looking more towards the more empirical type of testing as oppose to something like case validity for example.

So keeping all of this in mind as we've explained in our orientation, some of you are familiar with this and also what the - when our measure evaluation criteria look at. But there are three maintenance measures, 1463, 2496, 2539 and the two new measures are 3565 and 3566, all looking at facility level analysis. 3565, 3566, 1463 and 2496 specifically look at dialysis facilities and some of which we'll be getting a little bit more into depth here as we proceed.

All five of these measures went to our Scientific Methods Panel. So again, our Scientific Methods Panel or SMP is consisting of researchers and methodologists that look at the reliability and the validity approaches that have been used.

They really look to make sure that the methodologies and testing approaches are sound although they are not prescriptive in that approach in evaluation and they also really provide any input or feedback to the standing committee for our consideration and determination or your consideration and determination.

There will be a series of measures that will require a question around whether or not to determine to hold the SMP review, whether you agree with their pass or not pass review. And there are some measures as well this cycle that have a consensus not reached from the Scientific Methods Panel on reliability. So those measures don't require a consideration of whether or not the standing community wants to withhold the vote, but rather there will be a vote of the standing committee on that consensus not reached.

And the reason being is largely around just trying to get the standing committee's inputs on reliability and/or validity depending on what that consensus not reaches for that criterion. So if all five measures went through the SMP and we will be reviewing all five measures with this cycle.

So again, SMP just provides that methodological expertise or methodologic expertise and really providing inputs to the standing committee on whether or not the approaches are sound. And really leading the standing committee to evaluate those and make - take that into consideration as well as either a poll there and agree with the standing committee's review of the measure for reliability validity or if they wish to actually revote on those criteria and provide their own vote on reliability and/or validity.

So certain measures also do not pass reliability and validity from the SMP. There are instances where the approach or the methods used are really just need to be redone completely and it does not pass. In those instances, the standing committee can pull the measure for discussion, but it's not eligible for revote, because the methods need to really be reassessed, reevaluated and the measure needs to be resubmitted for those types of considerations.

However, there are instances where the - either validity and reliability of the SMP feels it doesn't pass, but there needs more - there can be more input provided by the standing committee. So if the standing committee chooses to pull the measure and that measure is eligible for a revote that can be done. And that is the case for Measure 2496 specifically.

So I'm on slide 12. So for 2496, one of these measures did not pass the SMP and did not pass specifically on validity. The panel really had concerns regarding adequacy of the correlations. So the approach that was taken was sufficient.

It was just the standing committee question how good the correlations were within the validity score testing. And so the standing committee had pulled the measure for a discussion, the standing committee asked to pull the measure for discussion, in this case, it also can be - that vote on validity can be reconsidered and a revote can happen from the standing committee.

Again, the approach to this and the methods used for validity were found that it was just that the SMP questions the adequacy of the correlations and felt that the standing committee is better suited to answer those questions. And thus it was pulled and thus it's up for discussion and eligible for a revote for 2496.

We also had a Renal Technical Expert Panel to provide input to the standing committee. And so on our current standing committee, we do not have any renal expertise currently represented. We have four measures looking at dialysis facility level of accountability. And so we wanted to provide an extra layer of review based on the validity and also just the clinical relevance of these four measures specifically, 1463, 2496, 3565 and 3566.

So we at NQF convened a technical expert panel which was made up of committee members from our renal standing committee to provide their inputs and reviews of the measure and their inputs on again the clinical relevance and aspects of validity if you're thinking about the inclusion and exclusion criteria, also elements of risk adjustment. Those inputs were added as summaries into the PAs if you've reviewed those and saw the Renal Technical Expert Panel's summaries were in there.

We also provided the full input and information in the standing committee Web site as well for your review. So again, the inputs from the SMP and the

inputs from the Renal Technical Expert Panel are all provided to allow you to make your review and vote of these measures.

I'm going to turn it over to my colleague Oroma. But before I do, does anybody have any questions? Okay. So I'm going to turn it over to Oroma. She is going to walk through the overview of evaluation process. Oroma?

Oroma Igwe: Thank you Matt. Again, good morning everyone and thank you for your time today. So let me start by explaining and reiterating the role of the standing committee during today's meeting.

As you all know, your service here is very beneficial and it contributes to the overall voting body of the NQF multi-stakeholder membership. And as the standing committee and you work closely with NQF staffs in the organization at large to achieve the goals of the portfolio in this project (unintelligible).

Today's meeting will allow you to evaluate each criteria and vote on the measure overall (unintelligible) form, so we'll be voting offline. But there are five criteria that drive this evaluation of each measure and you will be voting on that.

In the process, we are making recommendations regarding overall endorsement on the measures and on behalf of NQF membership and you are voting directly on measures within the All-Cause Admissions & Readmissions portfolio.

The rules for today's meeting. Today we ask that you come prepared to discuss and subsequently vote on the measures that we are reviewing today. We ask that you remain engaged in the discussion without any distraction and

at any point in which you are not able to stay on the call, please either notify us on the chat or live on the call.

We really encourage you all to stay focus on the criteria at hand. As we go through each criteria there will be an opportunity to talk specifically on that criteria and then reserve any comments related to a different criteria when that time comes. Please keep your comments concise and focused as we try to adhere to the agenda for today's call and allow everyone to contribute their feedback.

So a bit of procedure on the discussion and voting today. When we begin reviewing each measure, we're going to allow the developer to give a three to five-minute introduction. From that point, the co-chair will facilitate the entire discussion, but the lead discussant will step in to begin the committee discussion for each criteria. So that lead discussant will begin by explaining a bit of background on that criteria and the information related to that criteria.

Emphasizing any information that might be new, any data that's new to the measure or any information that was particularly significant and consequential during the measure evaluation, the pre-evaluation process. At that point, the lead discussant will then allow the current standing committee to add their feedback to the measure itself in that criterion.

Now, throughout the discussion the developers will have the ability to respond to questions that may arise. So standing committee, if you have a question that you feel you want answered prior to making a final conformation on decision, the developers are able to step in and answer any questions that cannot be answered by the standing committee themselves.

After the full discussion, we'll then proceed to vote. However, let me (unintelligible) today we don't have quorum, so we won't vote on the criterion on the call today. However, when you receive the offline survey, you will proceed with the voting offline. So what it does, is it - we'll wrap up the conversation and we'll especially move on to the next criterion.

Okay, so a reminder that there are five criterions that drive the evaluation of each measure and we'll go a bit more in depth on the next slide. But you have your importance to measure and report with sub-criterions being the evidence and performance gap.

As you see here, this is a must-pass criteria. So it's a bit different here, because we're not voting live. So normally if we vote on this criterion and it does not pass then we would (unintelligible). But how does this apply to the offline voting? Well, essentially when you receive the offline survey, you will be voting independently and you won't have any awareness of whether or not the measure is passing. So you will essentially move through the criterion voting independently and when we got all of the results, we will then determine whether or not the measure pass unimportant to measure and report or not.

So this is something you may not necessarily have to worry about in the call live today. But we're just going to remind of the must-pass criterion as well as all of the criterion at large.

Scientific acceptability has (two) criterion, reliability and validity, also must-pass and vote must-pass. If one fails, that measure fails.

Moving on to feasibility and usability and use, feasibility is not a must-pass criteria. Usability and use however is a must-pass for maintenance measures,

so not for new measures, but for maintenance measures. And then the comparison to related or competing measures, discussions what we will have, we will not necessarily hold a vote on this today, just the discussion.

Okay. I will hand it over to my colleague Funmilayo to go a bit more in depth here on voting on endorsement criteria.

Funmilayo Idaomi: Yes, this is Funmilayo Idaomi now. So as we know, currently we do not have quorum, so we will not be voting live. However, the votes that we'll be taking after this discussion will include the importance to measure and report and this is a vote on evidence which is must-pass criterion as well as performance gap which is also must-pass. The vote on rationale is for composite measures only.

Scientific acceptability of measure properties is another criterion we will be voting on. And so another must-pass vote on the liability and a must-pass vote on validity. And a vote on quality construct, but only for composite measures. It will also be - you will also be voting on feasibility, usability and use. So for use, this is a must-pass for maintenance measures and just usability as well.

So moving on, the related and competing discussion will be held at the post comment web meeting and that will be on September 24. And please note, this post comment web meeting is not to be confused with the fall 2019 post comment web meeting that we're having today. This will be the post comment web meeting for spring 2020 measures, so that will be on September 24 from 1:00 pm to 3:00 pm. And again, this will be reiterated at the end when we discuss next steps.

So we'll also be voting on the overall suitability for endorsement and just some procedural note. If a measure fails on one of the must-pass criteria, there will be no further discussion or voting. Well, as we know, we're not voting live, so there won't actually be any discussion.

The survey will be sent out shortly after this call. But anyways, if we were, there will be no further discussion or voting on the subsequent criteria for that measure, so the committee discussion moves to the next measure. And in the case that consensus is not reached, the discussion would continue with the next measure criterion.

So just some things to note when it comes to quorum and voting. Please let us know if you need a miss part of the meeting. Please don't be shy to glad and just reach out in that chat box and say that you need to step off, whether it'd just be for five minutes, no matter how small, please let us know as we must have quorum to vote even though we know that we don't have quorum right now, but still we're still keeping track of how many are on the call during each of the different parts of our discussion today.

So in general, you - as you know, we must have quorum to vote for discussion, though discussion may occur as we are doing today without quorum.

So in the case of today where we do not have quorum, well, in general at any part of the meeting live voting would stop if we did and we certainly did not. And we would - currently what we're going to do is send out a survey link to complete voting. Please note that the votes must be submitted within 48 hours of receiving the survey link from us. So just note that you'll have two days to complete that survey. So if you had any questions or concerns, please be sure (to let) know us, but note that the deadline is today.

If a committee member leaves the meeting and the quorum is still present, the committee would continue his vote on the measures, however, as we note today, we currently have not reached quorum. So in general, the committee member who left the meeting would not have the opportunity to vote on the missed measures. So I'd like to open the floor for any question or concerns.

Cristie Travis: Hi. This is Cristie, just a clarification. When we will be sending out the link to the recording? Because this is an all-day meeting and if people who aren't here want to be able to listen to the recording before they vote, I hope that will be - that link will be sent out more than 48 hours in advance if you understand what I'm saying. Like in other words, before you send out the survey, voting survey, give us a little time to review the recording.

Matthew Pickering: Yes. Hi Cristie, this is Matt. Thank you for that question. Yes, the recording and the survey link will be sent together. So you will have the recording to listen to for those who are not on the call as well as the survey link. Thank you for that question and I hope that's helpful Cristie.

Cristie Travis: Well, it's not really addressing my concern. I mean this is a five or six - I mean this is like an eight-hour meeting and if we only get 48 hours to complete, you know, the voting survey, that doesn't give us much time - I mean this is just almost like we'd have to dedicate all that time just to get us - and I guess I'm trying to think it might be nice to have the recording a little bit more in advance and then sort of send out the survey link.

Matthew Pickering: Right, so a great suggestion Cristie. I think we can definitely look at our timelines and give more time for the standing committee members to listen to recording as well as take the survey as oppose to 48 hours, so yes.

Cristie Travis: Thanks.

Matthew Pickering: We can definitely give more time. Yes, thank you Cristie. And I did want to mention, so I've seen some folks sort of maybe one or two people possibly come dial-in. So we are going to do a voting test. But before we do, I just want to see who has joined the call that maybe wasn't on at the very beginning when we did disclosures of interest.

Leslie Kelly Hall: This is Leslie Kelly Hall from Engaging Patient Strategy and I have no disclosures. And I delayed.

Matthew Pickering: Well, thank you Leslie very much for joining. And Leslie, I believe we also may need some disclosures of interest forms from you. So our team is going to send out those forms to you here shortly. If you could - there is - if you could fill those out and send them back or at least the PDF back and there is another one that's online, just quickly to allow us to see…

((Crosstalk))

Leslie Kelly Hall: So I'll…

Matthew Pickering: You did the online last week? Okay great.

Leslie Kelly Hall: Yes.

Matthew Pickering: Sorry, you did the online last week you said?

Leslie Kelly Hall: Yes, I did.

Matthew Pickering: Okay. So then there is - we were probably still missing the measure specific DOI from you and our team will follow up - that's a PDF you can easily just populate and send back.

Leslie Kelly Hall: Okay. I'll do it right now.

Matthew Pickering: I very much appreciate that. Thank you, Leslie. Anyone else? Has John joined the call? Has anyone else joined the call? Okay. So we'll go ahead and do the voting test. But before I do, I'll see if there is any more questions and see if anyone needs any clarification. Any other questions at this point?

Okay. Funmilayo, I think we can move to voting test. So there was another link within the calendar invite and also there was - it was also sent out earlier this morning. It's a poll everywhere link. You should be able to click that link and open it up and there should be a question around a - or I should just say, a test yes or no.

And Funmilayo, are you able to open that up for folks?

Funmilayo Idaomi: Hi yes. The voting has been now voting. So we're currently taking votes right now.

Matthew Pickering: Okay. If everyone has been going - yes.

Leslie Kelly Hall: Hi, this is Leslie. Sorry, I had a - I did have a trouble getting in. So you should know, if you press the call me link on the webinar, it does not work and tells you that the meeting number is incorrect. So you have to only press the web link and then go online audio once you're in, but the call me feature doesn't work. So that might contribute to why people are not, because the message comes back and says this meeting is invalid.

Matthew Pickering: Great. So you were saying the - if you do the call me and join, that allows you to get on the platform and join the call?

Leslie Kelly Hall: No, just the opposite. That does not work. It tells you the meeting is invalid.

Matthew Pickering: That does not work?

Leslie Kelly Hall: And if you then just click on the web link which isn't just obvious then it comes up with the meeting and then asks you to join by computer, so that's fine. But it does come up for me, but that's contributing to the issue.

Woman 1: Yes. That took me a couple of minutes to figure out too.

Matthew Pickering: Thank you. Sheila, maybe that's also a problem that you are experiencing.

Sheila Roman: Yes, I'm on…

Matthew Pickering: Okay.

Sheila Roman: I'm on. I figured that out.

Matthew Pickering: Great, thank you. Okay, everyone can go into the poll everywhere link and go ahead and vote and Funmilayo, how many do we have?

Funmilayo Idaomi: Currently we have 12 votes.

Matthew Pickering: 12 votes? So without John, we have 14, I counted 14 individuals on the call unless Brian, I think he's also possibly dropped off. Yes, he is not going to be back on until seven more minutes.

Sheila Roman: Yes, I just voted.

Matthew Pickering: Okay. And how many you have now Funmilayo?

Funmilayo Idaomi: I currently have 13 votes.

Matthew Pickering: Okay. So Brian Foy will be back on at seven, so he was on - to begin, he was at - not seven, in seven minutes, so that's one. And then John, are you on the line? Okay. So John and Brian make 15, so that means we would have quorum going into the voting.

In this case, we will proceed with voting. Again, noting everything that Funmilayo has mentioned previously. If we do lose quorum, we will have to stop the voting where we are and follow up with the survey link.

We strongly, strongly stress that if you need to walk away, if you need to go to another meeting quickly then come back, please let us know in the chat box. We can try to work around that potentially through breaks and a lunch. So please, please, if you are leaving or if you step away, again we're right at 15 with John and Brian. Brian will be back on in about six minutes and John is still attending the call later. It will bring us to quorum at 15.

And Funmilayo, are you still at 13?

Funmilayo Idaomi: Yes, I'm still at 13.

Matthew Pickering: Okay. So we will proceed with voting when John and Brian come on. We also need to ensure that we have your disclosures of interest for those of you that we had said that we did not have those. So we will be monitoring those

on our end and follow up as we get to the next steps here with consideration of candidate measures.

I'm going to proceed to our next item on the agenda which we have presentation from one of our measured developers here around reliability testing.

So I have Dr. Jack Kalbfleisch from the Kidney Epidemiology and Cost Center from the - at the University of Michigan who is going to be presenting here with the standing committee as well as other members from the University of Michigan, Kidney Epidemiology and Cost Center who will be on the call as well.

Again, four measures this cycle came through with a Profile Inter-Unit Reliability method which is a fairly new method of reliability testing that they used within the measures submitted this cycle.

So on slide 26, you see those four measures as well as the Inter-Unit Reliability results in the PIUR, that's Profile Inter-Unit Reliability results. So we have 1463, 2496, 3565 and 3566. All four of these measures were for the dialysis facility. So these were the four kidney focused measures or renal focused measures holding dialysis facilities accountable for hospitalizations, readmissions, ED visits and ED visits occurring within 30 days after hospital discharge.

What you see on the far right are two columns, the Inter-Unit Reliability result which is that method that is used to determine differences or used to reliably detect differences in the normal distribution if you will of those accountable entities. And then on the right is this Profile Inter-Unit Reliability which is really just designed to really detect the most extreme cases of or outliers of the

distribution to determine how reliable the measure is for detecting those. And Dr. Kalbfleisch will be going through that later here in the next couple of slides.

I will say that two of these measures, again all five including these four went through our Scientific Methods Panel, all right. So two of these measures had consensus not reached from the Scientific Methods Panel due to the reliability testing results for IUR and PIUR. All these - all four of these measures presented both reliability statistics, that's how we see them listed here, all right.

So it's on the same scale, but two of these measures, 2496 and 3566, had the consensus not reached from the SMP whereas 1463 and 3565 passed the SMP and the reason being is because 2496 and 3566, you can see that the IUR is fairly low. You're seeing it's less than 0.5, whereas the PIUR even though it's hovering around 0.5, it really was questionable for the SMP as whether or not - how to determine whether or not it was reliable or this measure had sufficient reliability based on these two methods.

So they decided to bring this to a consensus not reached and it's up to the standing committee to determine whether or not they wish to pass on this reliability criterion.

And so that's why we decided to bring Dr. Kalbfleisch and his team as well to present this methodology to you all. As you approach your voting, as you approach this method - this reliability criterion, understand that there are these two different statistics, the IUR and PIUR and just try to be more consistent in your approach with this especially when you're looking at 2496 and 3566, because there was a consensus not reached by the SMP whereas 1463 and

3565, the SMP felt it would pass. Again, because the PIUR has sufficient liability and/or the IUR did.

So with that, I'm going to turn it over to Dr. Kalbfleisch who will go through the next couple of slides and then we'll open it up for some questions as well as some facilitation by Cristie.

And I just want to check once more, John, have you able - were you able to join the call, John Bulger? Okay. We'll check in a little bit later. All right, so Dr. Kalbfleisch, I'm so sorry to keep stumbling over that even though that Jennifer has sent me a recording, I was listening it till this morning. Are you on the call sir?

Dr. Jack Kalbfleisch: Yes, I'm here.

Matthew Pickering: Okay. I'm just going to flip to the next slide, whenever you like to proceed, I'll just flip to the next slide accordingly. So we are on slide 27.

Dr. Jack Kalbfleisch: Okay. There were updated versions of this slide, but - okay. So I might expand on things a bit as we go through here.

Yes, so the Inter-Unit Reliability I guess, it's been a traditional measure of reliability that's been used for quality measures. And as you know, the quality measure can be described - this variation can be described as the sum of two components, one, which is the - within provider variation, just the fact that you replicate the data you wouldn't get exact to the same measure. There is going to be variation from time-to-time within providers.

And the other is to between provider variation to the extent which the measure varies between providers. So we can get to total variation as to sum of those

two and the IUR simply looks at the variation between providers compared to the total variation. So it's the proportion variation in the measure score that can be attributed to the between provider variation.

And I guess it's important to realize that the variation between providers and will be due to more than one thing and it's not necessarily due to quality of care. And I think that's something that gets lost sometimes. But the variation for example can also be due to variation in the factors that - in patient level factors that occur between providers.

So it could be due to quality of care, but more generally there are things that we don't measure very well and they're risk adjusted and that can also influence between provider variance. So such things for example as diet or genetic factors or the fact that some - that extra (unintelligible) of comorbidities can vary between providers, so all of these could - or socioeconomic factors, all of these can vary substantially between providers and would contribute for the between provider variation. So while it's - so that variation, it could be due to quality in part, but it's also probably due to some of these unmeasured confounders.

The statement that's commonly referred to with respect to the IUR is the technical report by Adams is (RAN Technical Report) which discuss the IUR in a very nice piece of (report), but it may quite clear that the assumption was basically that the variation between providers is entirely due to quality of care. And I think this is a very strong assumption and something that should be kept in mind in assessing reliability.

There is a subsequent paper actually that I had with colleagues at Michigan which ask the question, when - is the IUR a measure of reliability and basically it says that there is difference between the two if the measure is

entirely due to quality of care or entirely due to unmeasured confounders or a mixture of the two. So I think that's one point that I want to make that I think is quite important with respect to IUR and that is the source of the between provider variation, it's not always just quality.

The other point about IUR is that it doesn't really measure - it doesn't - it's not very sensitive to outliers that is if there're outliers in the tail of the distribution so that you got some substantial portion, perhaps 5% of providers that are out of the center of the distribution that was somewhat extreme, the IUR is - well, it can be quite small and yet still have those providers present. And at least where the patients involved in those providers, there is an important quality issue in that case and the IUR does not pick that up.

Let's go to the next slide. So that was really the - it was really the lack of sensitivity to outliers, so that is to think about the PIUR, the Profile IUR. And so we think about sort of the supplementary measure to the IUR and it's one that's arranged to be more sensitive to extreme values or outlying values of the measure.

So the idea here is that we're going to assess the measure by its probability of identifying the same providers as extreme on the data are replicated. So the idea here is that if you repeat the data which of course we have to, but we did a conceptual experiment that if we repeated the data that we would like to see that the same providers were identified is being outlying in the two situations. And so we try and assess the measures reliable to using that idea.

And in fact, in the NQF guidelines with respect to reliability, reliability is to find in terms of this progress we're identifying providers as extreme. So the idea here is what we do, we can't of course replicate the data, but what we do is we do sample splitting and so we split each provider's data, patients into

two groups, Group A and Group B and we assess whether the same outlier - with outliers are going to be flagged as - in Group A and in Group B and compare the two to see the degree to which we got a (green light).

So the PIUR basically is using that sample studying and then puts the measure basically on the same scale as the IUR. The PIUR is going to depend on the method of flagging, so if we use the empirical null method as we do or when you use random effects or fixed effects, all of those could give slightly - could give different measures of PIUR. And also the extent to how you describe outliers whether it's 5% or 10% for example. So the degree of (rigor that everyone) puts in, in describing outliers.

So the PIUR really emphasizes the tail of the distribution rather than the center of the distribution where the IUR replaces more emphasis there. The PIUR as well will be large and the IUR is smaller than measure maybe most too so for identifying providers with large (unintelligible).

So the PIUR and the useful addition to the characterization of the liability, because it does have this notion of looking at the tails and that's something that missed in the IUR and it can indicate the usefulness of a measure for identifying these extreme facilities, I guess it's worth noting that measure that something like medium to large PIURs still providers the ranking of all the facilities and ranks in particular, facilities in the center of the distribution, but it probably indicates the most attention should be paid to the tails of the distribution rather than center so that the ranking is more dependable in the tail, so I think that's the source really of the PIUR.

But it's important to note I think also that with any quality measure, if you look at the center in the distribution, that's - the variation there is going to be heavily influenced by any unmeasured confounders which invariably are

present. So in general, I think one needs to worry a bit about ranking in center of the distribution, PIUR falls into the rank (unintelligible) fails.

So I think that really was the motivation for it and we feel that it's a good supplement to the IUR. So thank you very much for the opportunity to put this presentation Matt and I'm happy for any questions.

Cristie Travis: Okay. Well, Matt, I guess it's my turn. This is Cristie.

Matthew Pickering: Actually Cristie, I just wanted to double-check. John, are you on the call? Sorry Cristie, John Bulger? I thought he had joined.

Cristie Travis: Maybe his line…

Matthew Pickering: I do see his - John, are you on mute? I do see your name here. Okay. Cristie, I think we'll proceed. We'll see if we can get John on here. The - sorry Cristie, go right ahead.

Cristie Travis: No, that's okay. I was just stepping in since I didn't think he was on. So we do want to open this up to our committee discussion and question so that we can enter into our measure review with a clear understanding of the difference between IUR and PIUR. And as Matt mentioned earlier so that we can also be consistent in how we consider both these reliability testing methodologies between the measures that we are considering.

So I will open up to see if any other committee members have questions and we'll move forward.

Matthew Pickering: And this is Matt again. I do have a question in the chat box. And I will say it again, if you do have a question, please raise your hand. I do have a

question from Helen Chen. Is there a level at which PIUR is considered significant?

Dr. Jack Kalbfleisch: I think this might be IUR really is sort of the gradient which I don't - I mean I think let's commonly due to some (unintelligible) should have an IUR, perhaps 0.5 or better and I guess something similar to that would apply for the PIUR. So I don't think there is any, really strong cutoff as to where you can say that things - the business are reliable (unintelligible) less or unreliable, I think it's more a gradient for both measures really.

Cristie Travis: Do you have any other questions in the chat box Matt?

Matthew Pickering: Not in the chat box. I do see Leslie Kelly Hall has her hand raised. Leslie?

Leslie Kelly Hall: Yes, thank you so much. So we have been struggling so much with social determinants than wondering how that fits in. Are you been including with your confounders social determinants or other patient specific issues and accommodating that under risk factors? Is that one of the reasons is this being implemented?

Dr. Jack Kalbfleisch: I guess my comments on that really were that one has to be careful in interpreting between provider variation, but it's not entirely due to quality of care in most instances, but there are other variables that we can't measure very well and subsequently we can't adjust for. So for example, we don't have - don't really have information on diet and we don't have very good information on socioeconomic factors or on - and measuring comorbidities for example that that varies between providers, between the kind of patients that they have or in fact the degree to which the - there is access to hospitals or other sources of - the source is basically we have comorbidities.

And so all of these things also contribute to differences between providers, so if patients and different providers have different genetic makeup or different diets that's also is affecting the - that's affecting outcomes, that will be reflected also in variation between providers.

And so really just the point that what you see in the IUR, what you're measuring there is between provider variation and that's partly due to quality, but it's certainly not holding to quality. I think that's the point that I should make (unintelligible).

Cristie Travis: It seems these point - it's not about that. I'm talking about the differences for a long time. In many of the times it's been associated with the patient - differences in the patients and the socioeconomic factors and others. With the genesis that this change because of - or I guess what was the genesis of this approach?

Dr. Jack Kalbfleisch: So it really was the fact that the IUR is not very sensitive to outliers. So that you can have - in other words the IUR basically was developed in a normal distribution with a random effect for providers and random error. And within that distribution if you have - if everything follows that distribution except say 5% or 10% of the providers that are extreme that won't be reflected very strongly in the IUR.

And yet those providers that are extreme are really quite important and the fact it seems to me in a quality review, one really wants to be able to identify that was in the measure which is able to do that is kind of useful.

So the IUR doesn't reflect that. It really was we're looking for something that does reflect those extreme providers and that really was the motivation for the PIUR.

Cristie Travis: Thank you.

Dr. Jack Kalbfleisch: Yes. You're welcome. Yes, thank you.

Matthew Pickering: So Cristie, I have a couple more questions or at least a question from Amy O'Linn, but I also see Cristie, you have your hand raised and Sheila Roman. So maybe I'll address Amy's first. So Amy has a couple of questions. Is PIUR just a new and superior way of measuring quality? And are there other organizations using this that you know of?

Dr. Jack Kalbfleisch: Yes. So it's relatively new. And in fact, it's in the paper from 2019 that's (unintelligible) in biometrics and we've been experimenting it for a while. But I don't think it's in NYUs. It's - really it was motivated by the fact that we had measures that had relatively low IUR and nonetheless seem quite useful in identifying providers that were extreme where we really wanted to pay attention to really what was going on. And so that we - really we're looking for a way of measuring that.

I'm thinking about this reidentifying the same provider as the notion of IUR, as a notion of reliability whether it's to the PIUR. So that really was the motivation that led to this and I hope other providers - other measured developers will found a useful technique as well. But no, it's not in combined (new shift).

Matthew Pickering: Okay. And I see Cristie, you have your hand raised?

Cristie Travis: Yes. I really was trying to follow up on an earlier question from Leslie. It seems that in the validity testing that you would in your risk adjustment try to take into account as many of the other factors that maybe impacting the IUR as possible as you were having that discussion.

I mean - so when we get to validity, I mean it seems to me that it will be important to understand what other factors such as (FDS) which my understanding that there was some testing done around that with some of these measures. So I just want to be sure I'm thinking about it correctly. Some of the ones that are confounding maybe able to be handled by the risk adjustment methodology, is that correct?

Dr. Jack Kalbfleisch: Yes, that's correct. And certainly that is important to do risk adjustment and if you didn't do it, of course you would have many more unmeasured confounders that will be affecting the - between provider variation. So the primary reason actually for risk adjustment is to try and take out variables that are correlated with facilities in consequent (vary) between facilities and consequently effect the between provider variation.

And I guess the point is really that - and I think this is true basically in any observational type study that there always will be some variables that we can't measure very well and that will affect the outcome. So there almost always are these unmeasured confounders in an observational study and this I think is no exception.

And so for example, things like diet, we have basically no information on patient diet which varies across the country in various - between providers or socioeconomic status, so what we can measure some things. And I guess there is a question as to what extent one wants to adjust their socioeconomic status.

But we really don't have very strong measures of a patient - socioeconomic stages available so that there are these variations that certainly vary between providers and that are basically measured confounders and the fact that between provider variation. So it's still very important to adjust to what you can, but I think it's also to recognize that one can't adjust for everything.

Cristie Travis: Thank you.

Matthew Pickering: And Sheila?

Sheila Roman: Yes. The question I have is - does the PIUR has the same issue with unmeasured confounders that the IUR does? I would assume that both do. Is that a correct assumption?

Dr. Jack Kalbfleisch: Yes, that's correct. Yes, there're all - they're measuring sort of between provider variation in both cases and I think in both cases it's important to remember that the fund measure confounders are potentially there and can affect the interpretation of these things. There are unmeasured components…

((Crosstalk))

Sheila Roman: So the reason…

Dr. Jack Kalbfleisch: …of course. Sorry, go ahead.

Sheila Roman: That's okay. So the reason the PIUR has a value which is more acceptable is because of its focus on the tails?

Dr. Jack Kalbfleisch: Yes. I'm not saying that it's more acceptable, but that it's - it has a different focus and yes, focuses on the tails. And so that you can have a situation where you have a measure been in the population under consideration has a reasonable percentage of individual - providers basically that are quite extreme and nonetheless get a fairly small IUR which would suggest that the measure is not reliable. And yet the measure is quite reliable for identifying these providers where there is potential for real problems with patient treatment.

And so the PIUR is designed to try and identify both and to make a measure which can identify those and one that want to look at. So it's supplementary to the IUR. It's not replacing the IUR.

Sheila Roman: Thank you.

Dr. Jack Kalbfleisch: Yes.

Cristie Travis: Any other questions Matt?

Matthew Pickering: Yes. There was one in the chat box again from Amy. And it's obviously - let me see if I can try to read this off as a question Amy. So PIUR equals the inter-provider reliability over the total variance of reliability. Its total variance reliability which includes inter and inter-provider variability?

Dr. Jack Kalbfleisch: Yes. So that is the idea of the IUR that says let's looking at the total variation and the measure and then seeing what proportion of that is due to the providers is - and to the extent which the effects of the providers are varying, the proportion of variability that's due to that between provider variation.

And of course if that's very high then it says almost all the variation in the measure is reflected and variation between providers and variation within providers is relatively much smaller or if it's very low, it says that almost all the variation is within providers and very little is between providers and that's really the motivation for that as the measure of reliability.

So - and certainly, it's quite useful in that respect and my comment about unmeasured confounders is just that that's something to keep in mind in interpreting any measure of reliability, but that's always something that's potentially there and with risk adjustment, it's important for that reason.

But the PIUR on the other hand is not really tied to the measures of variation, it's rather looking at the chances you would reidentify the same providers (that's the) extreme in a replication of the data and that was if you did this, if you in another universe looked at the same providers and in the same situation that you would get different measures, of course in that case, but to the extent in which you would still identify the same providers is being extreme and that's really what we're trying to measure in the PIUR. So it's concentrating more on the tails and less on - just on the variation of the measure.

I'm not sure if that answers the question, but I think the two have a - sort of have complementary focus as long as (unintelligible) just with the variation overall and a lot of that's coming from the center of the distribution and the others looking at the tail. And the two are - both are useful.

Matthew Pickering: And so Jack, Amy says thanks, makes sense to that. And I do have one - another question. I realize we are eating into the break, everyone on the agenda is following on the agenda. We put this together break here just in case if we need to go into the - go into it with this discussion. So we will sort

of just burn through the break just to make sure that everyone gets their questions heard. So we'll try to wrap this up around 10:30.

But there is another item in here again from Lisa just wanting some clarity on social determinants health or they will be included in risk adjustment or are they being considered here with IUR, PIUR? And how is this measure really - how will the measures be used? How are they expected to be used? And I feel that the social determinants health should be thoughtfully considered, but not for all purposes.

So I think the first piece - and as also in terms of health included in risk adjustment are considered here with IUR, PIUR and then the second really being around how will these measures - how - what's the - how are the measures expected to be used?

Dr. Jack Kalbfleisch: Okay. So in the first case with socioeconomic factors, the question is to whether or not you adjust with them. I think is in fair measures is probably policy issue and I think there is two sides to that. One is certainly (unintelligible) with the variation I think between providers is probably unavoidable and do some variation with socioeconomic factors may not be usually managed by providers. And to that extent there may be a reason to adjust for those to some extent.

On the other hand, I think the argument has been that you shouldn't adjust for socioeconomic status, because you're giving a pass to providers who are perhaps giving less than optimal care to people with more socioeconomic status. So I think there're sort of two sides to that point and I doesn't really want to comment on that. It really was if you decided you should adjust for socioeconomic status and you need to acknowledge that we don't really

measure it very well. And - so that will be unconfounded - it will be unmeasured confounders with respect to that variable.

The other question about how to interpret them or what's used to make of them, I think both IUR and PIUR are important. If you see if there are no outliers in the distribution underlying the IUR is confirmed to by the data then the PIUR and the IUR will be same.

And so if the PIUR differs quite (unintelligible) different from the IUR, it says that whatever the value of the IUR, the PIUR is much larger than that it says that there are these outliers, extreme values that the measure is being used - is useful to identify them. So to some degree the difference between the two tells you about the existence of extreme values so the heaviness of the tail, basically the distribution (unintelligible).

So the two of them together are useful, but the difference is large and it says that there are - the measure is useful for again to find these outlying values or extreme values in the distribution.

Matthew Pickering: Thanks Jack. Another question, this is from James. So the implied use of any quality data or measurement to identify and - is to identify and correct poor performers, the "tails". A PIUR allows for this focus on these, correct?

Dr. Jack Kalbfleisch: Yes, that's right. That's a good part of the idea is that it's trying to identify when the measure is useful to take up the most extreme cases, the cases perhaps which are most egregious with respect to quality of care. But again, we still have the unmeasured confounders is still important to assess the reasons for the extreme.

Matthew Pickering: Okay. I don't see any other hands raised or any other questions in the chat box Cristie. And I will just mention once again, please feel free to raise your hand and we will definitely call in you if you want to ask a question, we'll definitely do that. So thank you.

I don't see any other hands raised or questions.

Cristie Travis: Great. Well, is it time - then I want to thank - I do want to thank Jack for coming and helping us better understand the PIUR and the IUR and their connection and how they are different in terms of distinguishing differences between providers. So thank you so much.

I'm sure as we get into the measures themselves, we may - we did some of these issues. But thank you for being with us and taking the time to help us this morning.

Dr. Jack Kalbfleisch: Thanks for the opportunity.

Cristie Travis: Thank you Jack. So I guess Matt, are we ready to move into the first measure at this point?

Matthew Pickering: Yes, great. I'm just going to check, John, are you on the line?

John Bulger: I am.

Matthew Pickering: Great. Thanks John. And John, would you mind sharing who you are, your organization and if you have any disclosures of interest?

John Bulger: Yes, John Bulger. I'm the Chief Medical Officer at Geisinger Health Plan and I don't have any disclosures other than working for Geisinger Health.

Matthew Pickering: Great, thanks John. And I'm just going to ask Brian Foy. I think that you messaged that you were back, but can you confirm verbally that you were back?

Brian Foy: I'm back.

Matthew Pickering: Okay. So that means we have 15, we have quorum. And I believe I'm trying to double-check on our DOIs. So I think we have Leslie received your DOI, okay. Sorry, just confirming with the team.

Okay, so Cristie and - hi, Zeyno, are you on the line?

Zeyno Nixon: Yes, I am.

Matthew Pickering: Hi Zeyno. Welcome…

Zeyno Nixon: Sorry, I was able to reach - it took me…

Matthew Pickering: It's okay.

Zeyno Nixon: Thank you.

Matthew Pickering: Okay. Are you - so you're able to join okay, that's great. Zeyno, would you mind saying your name, your organization and if you have any conflicts of interest or disclosures of interest as well?

Zeyno Nixon: Of course, good morning. Zeyno Nixon and I work for Washington Health Care Authority and I have no disclosure.

Matthew Pickering: Okay, great. Thanks Zeyno. Okay, so that means we're at 16 now. Again, as we go through the consideration of candidate measures, we'll go through each criterion. There will be some discussion and then there will be vote. I will say that if you again have to leave the meeting, please let us know so that we can keep track of that and the quorum numbers.

Again, we are at quorum, so we will be proceeding with voting during the call. If we do lose quorum in any time, we will seize the voting, we can continue with discussion, but we will have to follow up where we left off with the survey.

So I think John, you have this first measure.

Cristie Travis: No, I do.

Matthew Pickering: No? Cristie, I'm sorry, that's right, because John was - yes, I'm sorry. Cristie, you have this (unintelligible). So I will go ahead and turn it over to you.

Cristie Travis: Okay, that's great. For some reason, I keep getting kicked off the web. So I'm trying to pull up my slides. Can you tell me what slide number we're on?

Matthew Pickering: Yes. It's going to be slide 33. It's Measure 1463.

Cristie Travis: Okay. Sorry about that. I don't know why it keep kicking me off. But we are going to be now looking at Measure 1463: Standardized Hospitalization Ratio for Dialysis Facilities. The measure developer is UM Kidney Epidemiology and Cost Center and CMS.

One thing I will point out is this is a maintenance measure and there are certain aspects of the review criteria that are emphasized for maintenance measures. So we will be focusing on that as we go through each of the criterion to be sure we know which one maintenance paid special attention to. They're all important, but there are some special attention.

You can see the brief description of the measure here. The SHR, the Standardized Hospitalization Ratio is defined to be the ratio of the number of hospital admissions that occur from Medicare end-stage renal diseases dialysis patients treated at a particular facility to the number of hospitalizations that will be expected given the characteristics of the facility's patients and the national norm is calculated as a ratio, but it can be expressed as a rate. And as Matt mentioned at the beginning of the meeting, this was reviewed by a renal technical expert panel.

So I'm going to ask - I need different (unintelligible), sorry. I'm going to ask Helen who, you know, is our lead discussion, no, I'm sorry…

((Crosstalk))

Cristie Travis: …I'm really sorry. I got all discombobulated, thank you. Yes, I have so many pages I have to look at one time, I will get it. I usually work better at - about my second measure.

But yes, we want to go to the developers and we do have about three to five minutes and we will also have an opportunity to ask some questions. So I will turn it to the developer.

(Claudia Dahlerus): Hi good morning. This is (Claudia Dahlerus) from the University of Michigan. So thank you for the opportunity to introduce the proposed updates to the Standardized Hospitalization Ratio.

The SHR received initial NQF endorsement in 2011 and again in 2016. The SHR is an all-cause measure. So the original test that developed the measure in 2006 did discuss and consider a cost specific measure focused on dialysis related conditions.

However, the test felt it was difficult to achieve consensus on specific cost that should be covered. More broadly, there is not clear consensus on what really accounts as in ESRD dialysis related versus non-related admission. For these reasons, the SHR remains an all-cause measure.

The original SHR was modified in 2016 to include adjustment for a comprehensive list of prevalent comorbidities that were recommended by a subsequent TEP in 2015. These conditions account for potential risk of hospital admission. In this way, the measure attempts to address concerns about facilities being held responsible for hospitalization related causes outside of their control.

On average, dialysis patients are admitted to the hospital nearly twice a year and spend an average of 11.2 days in the hospital per year while hospitalizations account for just about 33% of total Medicare expenditures. Hospitalization rates among dialysis patients have declined around 15% between 2007 and 2016. This trend has generally stabilized suggesting that dialysis providers have been somewhat successful in reducing unnecessary hospitalizations.

An all-cause measure provides an opportunity to encourage facilities then to design interventions that can help mitigate against unnecessary admissions. Since the last maintenance review in 2016, we just wanted to highlight some important revisions that were made to the SHR.

As part of our comprehensive maintenance for the measure, we identified a potentially important bias related to Medicare Advantage patients. Medicare Advantage patient acute hospitalizations have always been included in the SHR as part of the definition of the eligible Medicare patient population for the measure.

That is active Medicare coverage is determined using combination of criteria and defined a minimum of paid claims for dialysis services and/or the presence of a Medicare inpatient claim during eligibility period.

Moreover, both inpatient and outpatient claims have been the source of prevalent comorbidity adjustment for SHR since 2016, yet outpatient claims are not available for Medicare Advantage patients. As a result then our approach introduced potential bias in two ways that is only patients with an eligible hospitalization were included in the SHR and prevalent comorbidity risk adjustment was incomplete and that outpatient claims are not available for Medicare Advantage patients. Together, these can affect results for dialysis facilities with either very low or high-MA patient populations. In order to mitigate this bias, we made the following revisions.

First, we include all time at risk for MA patients to help eliminate bias-related to the definition of active Medicare coverage. Next, since MA coverage was associated with substantially lower hospitalization risk once we added the additional time at risk, we also include an indicator in the model for the proportion of patient months with Medicare Advantage coverage.

And third, we limit ascertainment of claims-based prevalent comorbidities for risk adjustment to inpatient claims sources and use all available inpatient claims and the prior 365 days for both fee-for-service and Medicare Advantage patients.

While we agree that limiting comorbidity ascertainment to inpatient claims results in a less comprehensive set of comorbidities, we think our methodology helps protect against potential bias in determining comorbidity burden due to differences in the fee-for-service and Medicare claim availability.

You said inpatient claims also reflects more current conditions that are more likely to be predictive of post-validation risk. And while prevalent comorbidities based on inpatient claims only results in fewer comorbidities for each patient, the use of only inpatient claims results in generally similar numbers and types of comorbidities for both MA and other Medicare patients.

In addition, the use of inpatient claims only for risk adjustment and SHR harmonizes with other admissions, readmission metrics that are actively NQF endorsed, which includes the all-cause hospital readmission measure. Collectively, we think these revisions improve the SHR and its utility and public reporting of dialysis facility quality. Thank you.

Cristie Travis: Okay, thank you so much and I apologize (Claudia) for the little mishap on the process. But thank you for that.

(Claudia): No worries.

Cristie Travis: And we are now going to go into our criterion review and remember we're going to discuss each criterion separately and then we will vote on that and then we will move to the next one. And to help us do a comprehensive review, I want to thank (Helen Chen) the committee member and is our lead discussant on this measure. So, Helen, if you will start with the evidence criteria.

Helen Chen: Sure.

Cristie Travis: And if we will also start with the sub criterion that we will be voting on and that will be helpful to us the evidence of criterion under the importance to measure. And then after that we'll move the gap. But let's try to keep our focus on evidence at this point. So, Helen, would you like to start off? Thank you.

Helen Chen: Thanks Cristie and thank you to the staff for providing us with a very nice framework for the discussion. So, as you just heard evidence, new evidence was reported for the maintenance of this measure indicating that hospitalization rates have improved.

And that there are also a number of studies that have targeted effective interventions that can improve hospitalization rates including communication, improved infection control, dialysis effectiveness, and also data from the comprehensive ESRD program focused on care coordination.

So, there are things dialysis facilities can do to reduce hospitalizations. The new evidence built on prior evidence presented previously and was preliminarily rated by the staff as passing. The comments from committee members were generally supportive of the evidence that's presented.

I don't know if we need to spend a huge amount of time discussing this, but I would have to comment on that so...

Cristie Travis: Great, thank you very much, Helen. Do any committee members have any questions related to evidence that they would like to ask or any comment? And (Matt), has anybody raised their hand or put anything into the chat box?

(Matt): So no, Cristie, I don't see anyone raising their hand or any questions in the chat box.

Cristie Travis: Okay. Well, that's great. And we're seeing as there are none. I think it, do we move on to voting now?

(Matt): Yes, that's correct. So, we'll move on to voting. Okay.

Cristie Travis: Now, we're off writing our Poll Everywhere, Matt?

(Matt): That is correct. So, the Poll Everywhere link, everyone if you could go back into that and just…

(Amy Olin): I have a question.

(Matt): Oh, yes, who is this?

(Amy Olin): Oh, sorry, (Amy Olin), Cristie I didn't realize when to chime in. So, is the proposed modifications for 1463 is a message permission thing that we will be limiting the information for inpatient only because of Medicare Advantage patients have inpatient only charges in the Medicare traditional has inpatient office?

So, we modify only to the inpatient charges? The inpatient charges I mean.

Helen Chen: So, this is (Helen Chen). So, let me if I could speak to that, and perhaps the developers can clarify as well. My understanding of this is because for the MA and will get to that under the reliability and validity. But because the outpatient claims are not available for most MA patients that was very difficult to look at their comorbidities based on outpatient claims.

So, in order to make this fair, they are looking only at inpatient claims to do the adjustment for comorbidities for both fee-for-service and Medicare Advantage.

(Amy Olin): Awesome, I understand that then. Thank you.

Cristie Travis: Thank you Helen.

Helen Chen: I'm not seeing anything on Poll Everywhere. Is it open?

Cristie Travis: Yes, me either.

(Matt): We are just confirming as well that we need to ensure that we have all the DUIs. I believe that we have all of the measures-specific disclosures of interests. However, we are confirming with the annual disclosures of interests. Again, for those folks that we had not received those yet, we wouldn't be able to accept your votes. So, we're just confirming that at this point.

Sheila Roman: This is Sheila Roman. I wasn't sent another document. If someone could send it to me, I'll fill it out right now.

(Matt): Okay.

Sheila Roman: I didn't get one I know, but I figured that whatever I saw that on Friday counted, that's what I figured. I mean, that's wrong, send me a link.

(Matt): So, Sheila, and you said (Amy), is (that Amy)?

Sheila Roman: Yes.

(Matt): Okay.

Faith Green: I didn't need them. I went back in and filling out the link. This is Faith but I'm almost finished.

(Matt): Oh, great. Who was that?

Faith Green: Faith Green.

(Matt): Oh, Faith, thank you so much Faith. Yes, that I believe you're one individual that we needed. So, while we're doing that, I know that we would need to vote on evidence and we still have quorum. So, thank you very much for attending to those issues and working with our staff on the back end.

Sheila will see what's going on with the link to you. But may I suggest Cristie and others that we don't vote on this obviously, but we continue on with the dialogue and move to performance gap and then we can circle back and vote on evidence. And if we get to the performance gap, we can do the same.

Cristie Travis: All right, great suggestion. I was just going to make it messed up, so let's plan to do that. So Helen, can you tee up performance gap for us?

Helen Chen: Great. So, there is a reported gap in performance, they did look back four years from 2015 to 2018 and reported the data regarding the variation and performance. For 2018, the FHR vary from 0 to 3.55 with a mean value of 0.99 and a standard deviation of 0.25, so there is a gap.

This is also where some of the discussion regarding FDS disparities comes in. So, the developers did actually report data and which demonstrated some performance gaps based on gender, race, employment status, and dual eligibility. The preliminary rate which we'll talk about more later because it's a lot of that left the risk-adjustment model later, the preliminary rating was designated as moderate by the staff.

And your comments, the committee comments generally agree that there was a demonstrable performance gap although some people thought it was low as opposed to moderate or high.

Cristie Travis: Great, thank you. Thank you, Helen. Are there any questions or comments from committee members? And (Matt), you know, I can't see the chat or raising hands. So, if anybody has chatted or raised their hands, could you please call on them?

(Matt): Yes, I don't see anyone with their hand raised nor do I see a question in the chat box.

Cristie Travis: Okay. As a suggestion, please keep in mind how you will vote on these as we move forward, but I think we probably should go on and move forward. Do you agree Matt?

(Matt): Yes or maybe we may need to take - how about we do this with a group mine taking a 10-minute break. We want to make sure that we are getting those disclosures of interests so that we can start voting. So, with the group be - okay, I suggest we make like a 10-minute break and we can come back here towards right around let's make it 11:00 am Eastern.

We'll just take a 10-minute break. That way people can sort of get up, move around, go to the restroom and we'll come back at 11:00 am Eastern and that meanwhile, we'll work with those folks and we need those annual DUIs from.

Cristie Travis: Okay, thank you so much Matt.

Woman: Thank you.

(Matt): Yes, thank you.

All right, I got to do the digital signature now.

Woman: (Joe) was that you?

(Joe): Yes.

Woman: Okay. All right, great. We are, yes, you're the, I think we're, this is April, I think we have you outstanding. So yes, if you can do that, that would be fantastic. We would really love it and then we can vote.

(Joe): Yes, yes. Now, I'm working on it.

Woman: All right, I appreciate that.

Sheila Roman: Can I ask a quick question? This is Sheila Roman.

Woman: Sure Sheila.

Sheila Roman: At the end there are two boxes. One that looks like it's your signature and then a bigger box.

Woman: Okay, let me see. Yes, maybe I'll ask the team if they can take a look. Are you asking which way you need to sign?

Sheila Roman: Yes.

Woman: Okay. (Unintelligible) have the form, I don't have the form. Can you help Sheila figure out where she needs to sign? Hey Sheila, I'm checking with our team now.

Sheila Roman: Okay, thank you. I think I've just lost everything.

(Matt): Okay, so it is 11 o'clock. We are still - Sheila I think we're still trying to get your annual DUI working. So, I think we're going to be messaging you separately. Sheila, are you still there?

Sheila Roman: Yes.

(Matt): And you're still having some issues with the link?

Sheila Roman: I filled out the link, but I need a PDF file in order to sign it.

(Matt): Okay, (Cindy Lyle), are you able to send her a PDF?

(Cindy Lyle): I'll look into it.

(Matt): Okay. So, Sheila we're going to try to send you a PDF of that so we can get your signature on it. I appreciate that but we have everyone else's. So, I know we're still good. I just want to double check. I think there was a message. Brian, you're on the line. Did you have to drop off at any particular point coming up? Brian Foy?

So, here's what I'd like to do at least I'd like to want to go back through the list just to make sure that we still have the same individuals coming on the call here. So, Cristie Travis, are you there?

Cristie Travis: Yes.

(Matt): Okay. Helen Chen?

Helen Chen: Yes.

(Matt): Edward Davidson? Edward Davidson? Okay. James Dom Dera?

James Dom Dera: Yes, I'm here.

(Matt): Thank you. Brian Foy? Lisa Freeman?

Lisa Freeman: Yes, I'm here.

(Matt): Faith Green?

Faith Green: I'm here.

(Matt): Thank you. (De Raj)? (Raj)?

(De Raj): I'm here.

(Matt): Thank you. (Amy Olin)?

(Amy Olin): I'm here. Amy is here, thanks.

(Matt): Thank you. Pamela Roberts?

Pamela Roberts: I'm here.

(Matt): Thank you. Sheila Roman, I heard you.

Sheila Roman: Yes.

(Matt): Michelle? Yes, thank you Sheila. Michelle Lin?

Michelle Lin: Here.

(Matt): Thank you. Chloe?

Chloe Slocum: Here.

(Matt): Thank you. ((John Bolger))?

((John Bolger)): Hello I'm here.

(Matt): Yes. Thank you. Leslie, Leslie Kelly Hall?

Leslie Kelly Hall: Here.

(Matt): Thank you. And Dana, Dana Nixon?

Dana Nixon: Here.

(Matt): Okay, I'm just circling back. Edward Davidson?

Edward Davidson: Here.

(Matt): Thank you. And Brian Foy? Okay, so I believe Brian had to hop off. Everyone, thank you. So, we are at 15, so we still have quorum. So, we are still able to proceed. However, we're still trying to work with Sheila on getting her PVS so she can vote. So, we're working on that.

So, may I propose then that we proceed where we left off and I believe we're still trying to work on with Sheila and her annual DUI. So, may we proceed Cristie on reliability and we can kind of continue with the discussion and we will have to go back once we get Sheila's DUI and vote on the measure.

So, but to keep the conversation going, just sort of remember where you were with the evidence and performance gap votes, and then we'll proceed with reliability. So, Cristie, I'll toss it back to you.

Cristie Travis: Okay. And (Matt), please correct me if I have a process fail here.

(Matt): Sure.

Cristie Travis: And, you know, because I'm going to ask Helen if she could summarize reliability for us. And we'll start with that and then we'll see if there are any questions.

Helen Chen: Okay, so just to refresh the definitions of the numerator of the number of inpatient hospitalizations for eligible patients at the dialysis facility over the expected hospitalizations based on patient characteristics of that facility and national norms.

So, there was a great deal of discussion from the SNP regarding IUR versus PIUR. And thank you so much to (Dr. Cal Flash) for that discussion. This morning I think I finally get it. And there was some discussion about what the standards were for PIUR regarding acceptable reliability.

So, basically the IUR and the PIUR reported for the last four years. So, the IUR range 0.53 to 0.59 which is not high but consistent with other NQF endorsed measures. And the PIUR was considered fairly high at 0.75 to 0.85. So, looking at intra-provider factors that create variability.

So, looking at the reliability testing for the four years from 2015 to 2018, the results were fairly consistent high PIUR for hospitalizations, which essentially demonstrate the ability to find outliers in particular.

There was some discussion regarding - the comment regarding patient characteristics, which again, we'll talk more about that moving on, especially regarding whether or not bias would be introduced for the MA patients either because of inability to capture comorbidities or because of lower hospitalization rates overall.

So, the bias could go either way as noted by the developer in the opening discussion. Your comments from the committee, there was one comment regarding the need to exclude potentially non-dialysis related hospitalizations. I think that was commented on earlier as well.

And I also wonder about this a little bit because, you know, how can you hold a dialysis unit accountable for chemotherapy or an elective orthopedic procedure. However, this has been the way it has been since the last endorsement and some discussion about stratifying by facility size.

The preliminary rating on the part of the staff regarding reliability with moderate.

Cristie Travis: Great, thank you Helen. Are there questions or comments from committee members around reliability?

(Matt): And so far, no hands are up. Oh, sorry.

Lisa Freeman: I'm sorry.

(Matt): Yes, yes, is that Lisa Freeman?

Lisa Freeman: It is.

(Matt): Okay, go right ahead.

Lisa Freeman: I'm not sure I understand the relevance of the size of the facility since we're trying to do quality and care assessments and a small facility should provide assisted care as a bigger one. So, why are they factoring that in or considering it?

Cristie Travis: It was a question. It was a comment from someone on the committee that we should consider it. There wasn't. Yes, it wasn't from the developer.

Lisa Freeman: Okay.

Cristie Travis: I will say that the scientific methods panel did so to the moderate on this particular, so from the scientific methods panel there it was a pass with a moderate finding. Any other questions or comments? I imagine we're not quite ready yet to vote (Matt), is that correct?

(Matt): That's correct, not just yet, so we'll have to proceed to validity.

Cristie Travis: Okay. And just to let you all know that what we will be voting on first for reliability will be whether or not we want to uphold the scientific methods panels, recommendation which was passed at a moderate level. So, that'll be the first vote that we take, it may be the last.

If we vote no on that then we will have a little bit more discussion and then our own vote, so let's move on to validity. And Helen, if you could summarize that for us. And by the way, I really appreciate all you've done to help us be prepared for this review. Thank you so much.

Helen Chen: You're so welcome. And it was really the staff, you know, the framework is terrific.

Cristie Travis: It is. I love it too. Thank you.

Helen Chen: So, in terms of validity, face of validity was assessed by the staff, concerns were raised about attribution and a facilities ability to intervene for potentially

non-dialysis related admissions although I'm sure we would have, you know, months of discussion about what's the dialysis-related admission.

There were also concerns raised about the risk assessment because of the MA issue and the lack of access to outpatient claims data. Validity was empirically assessed over four years comparing correlations for other measures of quality including mortality and transfusion events, readmission rates, effectiveness of dialysis and higher dialysis versus AV fistula usage.

And the spearman correlations were in the expected directions i.e. that's, you know, higher FHR was correlated with higher readmissions, higher mortality, et cetera. You can look at that on Page 9 if you'd like. So, the levels of correlation were minus 0.162, 0.47 and one of the SMP raters rated that as somewhat weak in his or her opinion.

The risk adjustment used 90 clinical grouping comorbidities. In addition, FCS and SDS factors were considered. And there was some small movements up and down using FCS, so 0.7% of facilities moved down as the FCS-SDS factors were included and 0.5% moved up.

The C-statistic for the risk-adjustment model was modest 0.621. But that's similar to other measures we've endorsed. So, here we go. So, race, Hispanic ethnicity, female sex were associated with lower hospitalizations, unemployment, and dual eligibility were associated with higher risk for hospitalization.

And interestingly enough, the ZIP code area deprivation codes showed no differences compared with national averages. But ultimately, these were removed because there was concern that the differences observed may not be related to quality differences within facilities.

And this is I think the same thing we've been struggling with for a while. And I think the SMP, I'm going to quote the SMP panel member number two, who I thought was fairly eloquent.

And he or she says, it is interesting and curious that after having developed a strong and clear conceptual rationale for including variables like race, ethnicity and area FCS model. And after having shown a clearly significant empirical association between those variables in the outcome, and having shown significant coefficients for these variables in the multivariable regression risk model, the developer has decided to leave them out of the final adjustment model on the old "Don't mask disparities argument."

So, I would like to hear from the committee about this because I remain concerned that we continue to have the same conversation about these factors or should be noted that gender remained in and comments from our group. There were concerns raised about the ability to demonstrate meaningfulness as 95% of the facilities scored as expected, relatively few scored below or better-than-expected.

And the recommendation regarding need for adjusting for planned admissions versus all-cause, there were some tech concerns about not excluding factors that are unrelated to dialysis and also concerns regarding, task concerns regarding removal of SDF factors. The preliminary rating, I believe, from the FMP and some staff was moderate.

Cristie Travis: Okay. Well, thank you Helen. I think you've teed up the question around, SDS that you would like to hear from the committee and I think that is an important opportunity. We will also give an opportunity to the developer to

respond as well. But let's start with the committee so that the developer has the benefit of understanding what our current thinking is.

So, does anybody want to start the discussion around SDS? And (Matt), you're going to have to help me out here.

(Matt): Yes. No questions in the chat box, question from Leslie Kelly Hall, hand raised. Yes Leslie.

Leslie Kelly Hall: So, I think we do have a discussion about social economic factors that we've talked about in this as to coming up would conflate two different ideas. The socio-economic factors are really geared towards a particular group and stuff is determined that over and over repeated social determinants of health do impact the quality of care.

So, this is how the patient presents the provider. All of the tests of the determinants, some impact their health, some not. And I do see often these two ideas. And interestingly enough is on my prejudices earlier, maybe through founding elements, whether it's coming from the provider or it's coming from the patient that's filling itself are very, very difficult to put into account.

But this piece of the population is so complex and so dependent upon the patient's ability to sustain themselves after that outpatient visit, like, it becomes more highlighted. So, that's just the general history of defining the question, why do we continue to have the same question over and over again and I could go to substantial reasons why. Are there others…

Cristie Travis: Are there others that would like to chime in? Helen, this is Cristie. Oh, I'm sorry (Matt).

(Matt): Yes, sorry Cristie. I just was going to say Lisa Freeman has her hand raised.

Cristie Travis: Okay, Lisa?

Lisa Freeman: Okay. Yes, you know, again and this come up over and over again, not just here, but almost everywhere this kind of discussion takes place. But I just think that when we include factors that are more or less patient dependent, it's important not to just wipe that off as a risk, you know, and adjust it.

I think we have to respond to it because if a particular facility is serving a particular population that includes a number of different challenges, we have to respond to the patient's needs. And that's a different way of thinking that I really believe has to become part of our health care system.

We have to get involved with patient preferences and patient needs and you know, why take care of somebody, why give them dialysis. If we can't control the factors that are making their needs for dialysis worse or more slower or whatever it might be more challenged.

So, you know, when this topic comes up, I do understand that using measures for reimbursement that may risk adjust while the facility is working on this. But I don't think that we can mix that with care and that's, you know, unfortunate because we have to either one set of measures but we have to qualify them for different things.

I'm not sure how to handle this because this is all really new to me and I'm just finally starting to understand it. But I would like to ask the committee to please really consider that, you know, we talk about numbers, but they're not

just numbers, they're people. And I think that it's really important to think of it that way.

Cristie Travis: Thank you Lisa. Any other hands raised or chat (Matt)?

(Matt): Yes, Sheila Roman has her hand raised.

Cristie Travis: Sheila?

Sheila Roman: Yes. Thank you. Thank you. I guess my thoughts are, this issue affects basically all the measures that we're talking about today. And I think that the developers have shown pretty clearly that the factors, you know, the things that they are factoring in as SDS don't really change the model.

But I think that really reflects the fact that we don't have the right factors for SDS and that the global factors that we use are probably less important than the patients directed factors, which we don't have the data for. So, my recommendation is a general recommendation that I think that some measures have to be qualified. The SDS is not included and why?

And I don't think that measures that are used for payment should be that these measures should not be used for payments because we know we're not risk-adjusting to the level we need to risk adjust from the point of view of SDS. So, I don't know if people would agree with that, but those are my thoughts.

Cristie Travis: You know, this question of use also comes up every time we review measures as well. And I would like to explore you know, how we as a committee (Matt) should be looking at this. Historically, we have not really been within our purview to think about how these measures may be used. That has not been part of our consideration.

So, I would like to see if we can get some clarification from NQF relative to how you should be thought of as we look at these criterion.

(Matt): Thanks Cristie. So, use itself is a criterion within our measure evaluation criterion use and usability. For use within accountability program within three years and public reported in six, especially for maintenance measures and the need to usability components really getting at the feedback that is received, if this measure is actually improving care over time.

So, I think that those aspects and components of use that are captured within our measure evaluation criteria. And Cristie, is that sort of getting to your question or are you wanting to go a little bit deeper than that?

Cristie Travis: No, thank you for that. I'd like to go a little bit deeper. I mean, that just says whether it is being used, not how it ought to be used. I mean, the, you know, I think the last comment was focusing on you know, even a recommendation that these measures should not be used for payment. That is not usually - if I am remembering correctly, it's something that we have considered in terms of how we vote on measures.

I think we may have made comments regarding preferences, but the use and usability is more is it being used it versus is it being used in a way that this committee thinks it ought to be used to understand the difference.

(Matt): I do. And, you know, unfortunately, the criteria that we have at NQF doesn't evaluate that piece of how it will be used or, you know, how it's intended to be used. And I think that's up to the committee to deliberate on.

And it's up to the committee to ask questions from the developer on those aspects of use and the intended use or purpose of use or as the criteria that we have for NQF aren't assessing is how it's intended to be used. So, I think there's a lot of discussion that the committee can have around that.

And then also, if the developer is able to provide any clarity or any information there, then that exactly is what can happen. Not to say that our evaluation criteria doesn't change, our evaluation criteria evolves over time. And I think there has been previous dialogue and conversation across all different types of committees around this piece.

So, I think there's always the potential for evaluation criteria to change and evolve, capture these types of elements but currently it does not. And I think there's definitely some dialogue that can happen between the committee around this. Any recommendations as well as Cristie, you've mentioned, we've done so in the past.

And any questions that maybe the developer can answer towards how or the intent of use and see if there's any reassurances or any of the questions that could be answered from the developer. It's a great question Cristie.

Cristie Travis: So, I would suggest that we table the use of discussion until we get to the use and usability criterion, would that be appropriate (Matt)?

(Matt): Yes, that's I would…

Cristie Travis: Kind of just focus on validity here.

(Matt): I would agree. Thank you Cristie. And I saw a couple hands raised and then a couple hands go down, so I think that makes sense.

Cristie Travis: Well, just to reassure everybody that we're not walking away from the discussion, but we are trying as (Matt) asked us to at the beginning to focus the discussion on the different criterion that we are here. And so, are there any other questions related specifically or comments related specifically to validity. And (Matt) do you see anything?

(Matt): No, I do not.

Cristie Travis: And I know you're paying attention to a lot of things. So, I apologize having to ask you to tell me that but I can't see it guys

(Matt): Yes. No, it's okay. Yes, I know, we're trying to promote you to this. So, I don't see any questions or hands raised. I do not. Thank you. Chloe, for letting us know. You need to step away from 12 to 1. So Chloe, we see that thank you. So, we do have everyone's PUIs now. So, thank you everyone for submitting that and working with the team.

So, if we could, I'd like to, if there's no other questions around validity, maybe we can go back to the evidence and starts voting for evidence and performance gap. And then we'll talk a little bit about what we'll do for reliability and validity with the SNP.

Cristie Travis: Okay, that sounds good. So, I guess we just need to refresh and the questions will show up. Is that the best way to do it?

(Matt): That's correct. So, (Cindy Lyle) are you - when you're ready, can you walk us through the when it's open for evidence?

Cristie Travis: Here we go.

(Cindy Lyle): Yes, it's, the evidence should be on the screen right now. The voting is being held. And so far, we have four results, but the voting is still open.

(Matt): Okay, so this is a separate link. Again, it's a Poll Everywhere link. It's the one that you all used for the test. So, please log into that and Pamela would you mind reading off the options for voting? What the responses options are? Are you there Pamela?

Pamela Roberts: I apologize. I was on mute. The options are: A, pass or B, do not pass. We currently have 14 votes.

(Matt): Okay. Has anybody not voted yet?

Pamela Roberts: Yes.

(Matt): Or does anybody have any…

Sheila Roman: I'm trying to get to the right. Here we go.

(Matt): Thanks, Sheila.

Sheila Roman: Okay. I should have voted.

Pamela Roberts: I'd like to confirm that we now have 15 votes.

(Matt): Okay. So, I think we can close and read off the responses. Pamela are you able to?

Pamela Roberts: I apologize. I was on mute again. It looks like we have unanimous vote for pass.

(Matt): So, 15 votes for pass, zero votes for no pass?

Pamela Roberts: Yes. Fifteen votes for pass and zero for do no pass.

(Matt): Okay. So, the measure pass is on evidence.

Pamela Roberts: Yes.

(Matt): Okay. So, moving on to performance gap.

Pamela Roberts: One moment please.

(Matt): Okay.

Pamela Roberts: The question for performance gap is now active.

(Matt): And then can you read off the responses and the criteria, the measure number?

Pamela Roberts: Yes. So, the options are: A, high; B, moderate; C, low; D, insufficient. Voting is now being held. We are at 11 votes so far. We now have all votes at 15. With 15 votes, we have four votes for high, 10 votes for moderates, one vote for low, zero votes for insufficient. So, this measure has passed on with 10 votes for moderate and four votes for high.

(Matt): Okay. The measure passes on for performance gap. And - okay. So, as we move to reliability, I was going to just say that now that we are voting since

the SNP passed on reliability. We will be asking the committee if they would like to uphold the vote for reliability for the SNP.

And so, that is the question where if the committee does choose to uphold it, we would have to have more than 60% of those voting, choose uphold the SNPs determination of passing for reliability.

If 60% or less or at least over 60% choose to not uphold the vote, then we would have to revote, the committee would have to provide their own vote for reliability. So, the first question you'll be asked is whether or not you choose to uphold the SNP vote.

If more than 50% choose to uphold, then it will move forward. If not, we would have to then discuss and revote. And we'll do the same thing for validity because the SNP pass it on validity. So, that will be the series of questions you will see. So, (Cindy Lyle), is it ready to go.

Pamela Roberts: Yes, currently the voting is open and it asks do you accept the scientific methods pedal rating for reliability?

(Matt): Do we have 15 votes?

Pamela Roberts: Okay, we have 15 votes and we have 15 votes for yes and zero votes for no.

(Matt): Okay. So, the measure then, you have accepted the scientific methods panel voting have passed. So, the measure passes on reliability.

Christie Travis: Okay. Now, on validity I wanted to be sure there weren't any other validity issues other than social determinants or social risk factors because that was the

only one, we really focused on and we wanted to be sure if there were any other issues that we raised them before we vote.

(Matt): Sure. We can open it back up for discussion.

Christie Travis: Please either chat or raise your hand and Matt will call on you if you have any other validity issues.

(Matt): Yes, Sheila?

Shelia Roman: I have no other issues except for the requests that when we identify, when SCS is included or not included in the risk adjustment. And can I ask you to maybe clarify that for me a little bit? Maybe just by a footnote, you know, just so that the frontline user, I think these measures in general are very complex and are not very transparent to the frontline user and I think that issue should be.

Christie Travis: Thank you, Sheila. (Matt), any thoughts around that? Can we include that in our thought, sort of, a report?

(Matt): Yes, we can definitely make mention of that issue in the summary report.

Christie Travis: Okay. Thank you. Any other raised to answer comments in the chat?

(Matt): No. No raised hands, no questions in the chat box.

Christie Travis: Okay, well does that mean we are ready to vote now?

(Matt): Yes, we are. We can proceed to voting. And Pamela, I'll turn it to you.

Pamela Roberts: Okay. So, now we will vote on the scientific acceptability of measure properties in the reliability for measure 1463.

(Matt): No. Pamela, we're going to be voting for, still validity will be the next question.

Pamela Roberts: Okay, got you.

(Matt): And again, standing committee members this will be the same way. You will be asking if you want to uphold the SNPs validity determination which they passed it.

Pamela Roberts: Okay. So, for the measure 1463, the question is, do you accept the scientific methods panel ratings for validity? Now, taking vote. We are now at 14 votes. All right, we just hit 15. So, we have 15 votes for yes, zero votes for no, and with that measure 1463 passes on validity.

Christie Travis: Great. Well, thank you everybody. And we do have two more criterion that we need to go through. And Helen would use summarize feasibility for that.

Helen Chen: There are no concerns regarding feasibility. It's all based on electronic claims data although some of the definitions are little complex. But nonetheless, it's been in use and should be highly feasible.

Christie Travis: Thank you, Helen. Any questions or comments from committee members, please chat or raise your hand on the platform.

(Matt): And no hand is raised, no questions in the chat box.

Christie Travis: All right. So, we do need to go to voting. It does look like it needs to be the next question.

Pamela Roberts: All right, for measure 1463 feasibility voting is now open. Data generated (unintelligible) electronic footage, data collection. The choices are: A, high; B, moderate; C, low; or D, insufficient. Voting is now open.

All right, we have 15 responses. For high, we have 12 votes. For moderate, we have three votes. For low, we have zero volts. For insufficient, we have zero volts. With 12 volts for high measure 1463 has passed for feasibility.

Christie Travis: Thank you. Okay, now we get to the use in usability criteria. We are going to do - use first. And this is a must pass, because this is a maintenance measure. Is that correct (Matt)?

(Matt): That's correct.

Christie Travis: And so, I'm going to turn it to Helen. And Helen, I think you usually follow what the staff gave us. So, you know, I do want to be sure that we know what we are supposed to be considering under use. And so, thank you for being sure that we include that in your summary.

Helen Chen: Okay, thanks. So, it's currently being used, as this is a maintenance measure. So, I didn't write down all the column. But specifically, it's being used for dialysis compare, and also ESRD equip. And I don't remember reading a lot about potential harms that were reported in the currently being used. And it is being publicly reported.

In terms of feedback, so stakeholder feedback was obtained. Feedback was related to a need for expanded risk adjustment. Concerns about attribution to

specific facilities. The need for cost specific as opposed to all-cause hospitalizations.

There are some concerns around how a dialysis unit could actually be held accountable for planned hospitalizations. However, in current use 95% of facilities perform as expected. So, just my interpretation of that is, I don't think it's been a significant issue in the current level of reporting. And the overall preliminary rating is moderate.

Christie Travis: Thank you, Helen. So, we did indicate that we were going to use this criterion to have a more in-depth discussion around the measures used as it is currently specified. And in terms of both the reliability and validity testing as well as the evidence in the gap.

So, this was the place that we could consider that, I guess that I would ask if you have any guidance on whether that discussion belongs underused or usability. And the only reason that I think it matters is, you know, whether, because use is particularly, use itself is a must pass.

(Matt): Right. So, and I'll just - and Helen, I think you read off a moderate culinary rating. I just - that was for usability for this piece, for use, the staff determined to be passed. And really the use aspect is getting to how and where it's used, is it using the accountability program? And is it within three years of initial endorsement? And how our evaluation criteria look at this.

And within six years, it's publicly reported or if this is not the case, the developer has a plan or rationale as to why that may not be used. Another aspect with use and usability is just looking at feedback as well.

So, feedback from the users that have the accountable entity or those who're both being held accountable to the measure for maintenance measures is definitely the case when it's actually being used. So, is there a way that the information is being collected, is being considered and potentially modifying the measures in some way? You know, this gets to, you know, both positive and negative types of inputs potentially.

For a new measure, the feedback aspect is where maybe in the development of this measure there has been a committee or a group or a technical expert panel of those individuals that we've held accountable to the measure to weigh in on aspects of the measure as it's being developed.

So that would be the criteria really, and how the frame of looking at this for use and usability would be different.

Christie Travis: Okay. So, any committee comments or questions relative to use, as Matt has described it?

(Matt): And I don't see any questions in the chat box or hands raised from the committee.

Christie Travis: I guess we can go to voting.

Poonam Roberts: Okay, for usability and use, votes are now activated, so…

(Matt): So, we are yes…

Poonam Roberts: The option are: A, for pass or B, no pass. And this is a reminder that we are voting on accountability/transparency use and accountability within three

years public reporting within six years or if (unintelligible) and feedback on the measure by those being measured or others.

Okay. I have 15 votes, we have 14 votes for A, pass and we have one vote for B, no pass. So, it's 14 votes for pass. Measure 1463 has passed on use.

Christie Travis: Thank you. Now, we'll move to usability. So, Helen, would you like to summarize usability for us?

Helen Chen: Thanks, Christie. I think as Matt noted, I sort of conflated the two things all in one bucket. So, there was - there have been some concerns regarding the complexity of some of the, you know, definitions of comorbidity and also some feedback from the stakeholders regarding how they can be held accountable for things outside of their control, specifically, non-dialysis-related again discussion about what that means hospitalization and a need for better risk adjustment.

Christie Travis: So, thank you, Helen. So, this is the section that looks like it's the best place for us to have our risk adjustment discussion that we started under validity. But really it was a usability question. And so, I certainly encourage people to share their thoughts around that as well as the other aspects of usability that Helen has pointed out as well.

So, anybody want to share their thoughts, either by chat or raising your hand. And Matt, let us know if anybody have done so.

(Matt): Not seeing any hands raised yet for, wait, I knew and it is Lisa Freeman.

Christie Travis: Lisa? Are you on mute, Lisa?

Lisa Freeman: Yes, of course. Thank you. With the comments that were made earlier, are they being noted with regard to this discussion or do they need to kind of be restated?

Christie Travis: I think from my preference, it would be good to maybe restate them so that we can be sure that we remember because we've done a lot of voting in between. And I think it would probably be best not to belabor it, maybe summarize it. But I do think it would be helpful.

Lisa Freeman: Okay, then I'll do a real quick restatement. And just that, you know, we have to be really, really careful that we are in essence putting the responsibility for complete patient care on facilities where they can, I mean, they are the coordinator of the healthcare.

If I understand it patients typically call their doctor there who sort of becomes their primary care doctor at a dialysis facility. And they are supposed to coordinate all the care, because it all kind of plays into the dialysis and the end-stage renal failure.

So, I think it's very important to hold them to a very high standard and not to give them a pass because the patients have comorbidity or because they can't control the socioeconomic status of the patient.

Frankly, if they can't control it, then they - because they are not going to really be a healthcare provider. They are going to be anti-sickness provides. So, I think we have to start getting people to look at this differently through the measures. Thank you.

Christie Travis: Thank you, Lisa. Others, Matt?

(Matt): No, no hands raised at the moment. No questions in the chat box. I do see Sheila. Sheila, your hands raised. Go ahead.

Sheila Roman: Yes. Just for the, you know, restatement for the record as Christy requested that, you know, I think that it would be useful to frontline providers to under - - since these measures are complex, I think most complex - most providers assume that risk adjustment includes the whole, you know, everything.

And when it doesn't include something as important as SCS, there needs to be a brief footnote with why not. You know, acknowledging that it wasn't included and why not.

And then I think there's the question of whether measures that the model cannot accommodate the SCS data that is available and show a difference when we know that there is a difference looking at more simple things, like, differences in length of stay between different, you know, racial groups, for instance, that we have to think about whether NQF wants to think further about what usability means. Because I think holding people under a risk situation in that instance is probably not fair to the provider.

Christie Travis: Thank you. I would like to ask and I can't remember and I apologize. I didn't write it down who brought up the question around payment. And if you wanted to make that statement again in this section about not using this measure for payments?

(Matt): Leslie, was that…

Christie Travis: That was Lisa.

(Matt): Lisa, I do have Leslie's hand raised as well. But Lisa, if you'd like to…

Lisa Freeman: Yes, and that's actually I had raised my hand also because I wanted to address that and to say that when it comes to payment, I think sometimes if, I'm losing the word but it's quite the opposite that I think sometimes when the risks are greater for a certain population that a dialysis facility is serving. That, in fact, perhaps their reimbursement needs to be a little bit higher because of the challenges that they have to address the health of their population of clients.

So, I think we have to be really aware and careful. And I get very concerned when measures are applied, are intended for care and quality rating. But they are applied to payment models.

And I just want to point out that we have to be careful in some way to communicate clearly the intent or the limitations of the data that's being given behind the measure.

Christie Travis: Thank you. Did she say Leslie had her hand raised?

(Matt): That's correct.

Christie Travis: Leslie?

Leslie Kelly Hall: Yes, and this is a general comment for, especially were there patients like these that are so much daily participating in their own care and survival? I think it'd be worthwhile for NQF to look at a special area that is a patient-centered measure review. So that when patients see a measure, they can understand what does this mean to me?

What questions should I ask of my provider to make sure that I get the best quality. So that we aren't simply depending upon a provider that also the true

partnership that especially this particular disease represents. And I think it will be overall as we go into more measures to make the meaningful and useful in patient to have that kind of education associated and as a mandate for you. Because the quality is only measured and use for payments.

And for a form of providers, we got an important partner. And that's the patient who should be co-producing health and quality. Thank you.

(Matt): This is Matt from NQF. Leslie, thank you for those comments. We definitely will take note of that. And I will say that NQF has done a lot to try to bring the patient into quality measurements and healthcare quality. But there's more work to be done. I would agree with you and thank you for those comments.

Christie Travis: Okay. Any other comments or hands raised, Matt?

(Matt): Just seeing here. Sheila has her hand raised again, Sheila?

Sheila Roman: I just wanted to thank the previous speakers for further elaborating and just make the point, again about payments that Christy has made. I really think that from a usability perspective that NQF has to think about usability and payment programs for just the reasons that were just very well-articulated that for payment programs, you need the front provider and the patient involved.

And it's very much more complex when you move into value-based purchasing.

Christie Travis: Thank you for that, Sheila. Any others, Matt or are we ready to vote?

(Matt): No other questions. Wait, Sheila does - Sheila is raising her hand again but I will say…

Sheila Roman: No.

(Matt): Oh, no Sheila you're not, okay.

Sheila Roman: No. I did it by mistake. I'm sorry. It's okay.

(Matt): Okay. I will say that (Amy Lynn) also just shared a comment that there are measures, the model cannot accommodate or understand at this date. And she also felt that putting this into a footnote would be helpful.

Christie Travis: Well, thank you, Amy. Appreciate that. Well, I think we are ready to move on to voting.

(Matt): Okay.

Poonam Roberts: Okay. For usability and use in this particular usability, we'd voting on improvements, progress demonstrated to new, credible, rationale and benefits outweigh evidence of unintended negative consequences to patients or population. So, the options are: A, high; B, moderate; C, low; or D, insufficient.

Okay. We now have 15 votes. We have three votes for high, 10 votes for moderate, one vote for low, and one vote for insufficient.

(Matt): So, I believe the measure passes on usability.

Poonam Roberts: Yes. So, this measure would pass on usability, yes.

(Matt): Great.

Christie Travis: Matt, could we go now to voting on the overall…

(Matt): We do.

Christie Travis: And then we'll cover related and competing on our follow-up call. Is that correct?

(Matt): On a follow-up call, yes. Correct.

Christie Travis: Okay, great. Okay. So, now we are going to vote on overall suitability for endorsement.

Poonam Roberts: Okay. So, for overall suitability for endorsement, we are asking whether the measure meets into a criteria for endorsement. Please note that this may not yet be a recommendation for endorsement. Final recommendation for endorsement may depend on assessment of any related and competing measures. Your options are: A, yes or B, no.

With 15 votes for yes and zero vote for no, this measure passes overall suitability for endorsement.

Christie Travis: Well, thank you, everybody. I would also like to especially thank Helen for helping us clearly look at each of these criterion. So, thank you for all of your preparation and work and leading us through that discussion.

So, at this point Matt, I'm trying to find my schedule, I know…

((Crosstalk))

(Matt): Yes.

Christie Travis: …behind.

(Matt): Well, yes, thanks Christy. Again, echoes a thanks as well to Helen. But at this point, we have been notified Chloe, you are actually breaking. You have to actually leave now from 12 to 1. So, maybe if we could, if the folks on the phone we could break for lunch now for that hour, because we have 15 if we continue for with Chloe not present, we don't have quorum.

So, maybe we break now for lunch for the hour and come back at 1:00 pm Eastern Time and then pick up where we left off.

Christie Travis: Okay, sounds good. Thank you, Matt.

(Matt): Okay, good. So, we'll reconvene at 1:00 pm Eastern and thank you all very much. We'll talk to you then.

Okay. So, I have - this is Matt from NQF. I have 1 o'clock Eastern on the clock. So, we are going to reconvene where we left off.

I will say that we do have some changes that we are going to be making for the afternoon. One of which is moving measure 3566 up to be the next measure, this is due to (Darlie) discussing (Michelle Lin) needing to drop off closer to 130 or 140. And so, we are moving that measure up 3566 will be our next measure for discussion.

So, if the measure developer is on the line, just wanting to see if that's okay. Is the measure developer on the line? Are you okay with us moving 3566 to be the next measure?

John Seagal: Yes, this is John Seagal from U-M (unintelligible) and that's fine, we can go ahead with that one.

(Matt): Great. Thank you. And I want to check, Michelle, are you on the line?

Michelle Lin: Yes, I sure did.

(Matt): Okay. So I'm going to go…

John Segal: We can go right after that. Well, the next one the 3565.

(Matt): Great, thank you. That's fine. So, either way then actually, Raj that could be fine, but you want to do 3565. Raj were you needing to leave also this afternoon?

(Raj): No, I just, you know, you can look the tabs when you are discussing in us when you are. So, that's a good time right after this, it would be a good time for me to be the lead discussant.

(Matt): Okay. Because we were thinking of picking up with 2496 and then finishing up with 3565 at the end. Would you be okay with that?

(Raj): Okay. Fine.

(Matt): Thanks, Raj. Okay, so, before we get started, I do want to go through a roll call once again, just to make sure we understand our numbers and where we

are. So, when I call your name just say present or not, or here or present or not here. So, Christy Travis?

Christie Travis: Here.

(Matt): Thank you. Helen Chen?

Helen Chen: Here.

(Matt): Edward Davidson?

Edward Davidson: Here.

(Matt): Thank you. James Dom Dera.

James Dom Dera: Here.

(Matt): Brian Foy? Okay. Lisa Freeman?

Lisa Freeman: I am here.

(Matt): Thank you. Faith Green?

Faith Green: I'm here.

(Matt): Thank you. And Raj.

(Raj): Yes.

(Matt): Yes. Thank you. (Amy Olin).

(Amy Olin): Here.

(Matt): Thank you. Pamela Roberts?

Pamela Roberts: Here.

(Matt): Thank you. (Sheila Roman)?

(Sheila Roman): Here.

(Matt): Thank you, Michelle Lin? Michelle, are you on mute?

Michelle Lin: Yes, sorry I'm on mute. I'm here.

(Matt): It's okay. Yes, thank you. Chloe Slocum?

Chloe Slocum: Here.

(Matt): Thank you. (John Bolger)?

(John Bolger): Hello, I'm here.

(Matt): Thanks, John. Leslie Kelly Hall? Leslie, are you there? Okay. And Dana Nixon

Dana Nixon: Here. Present.

(Matt): Thank you. Thank you very much. Just to double check, Brian or Leslie? Leslie, I see you're dialed in, are you on the call?

Okay. We didn't know that Brian was going to be coming back on here in a little bit. So, I think we can proceed and see where we are with either Leslie who looks like she's still on a call or Brian.

So, we are going to go again to measure 3566. And John, I believe that's your measure.

John Bulger: Yes.

(Matt): So, before I do, I'm going to turn it to…

John Bulger: Yes, so - go ahead.

(Matt): Sorry John, I'm going to turn it to Pamela, you have a brief announcement to make for the folks.

Pamela Roberts: Yes. Just regarding Poll Everywhere, we have one guest whose username is Guest 534 it's not their name. So, we have sent out an email to Brian as well Faith to try and identify who that guest is. So, if at your earliest convenience, you can reply to that email that would be great. Thanks so much, Matt.

(Matt): Great, thanks. And this is just to make sure that we are monitoring in case we lose quorum and we have to follow up with our survey. We just need to know that we're capturing you as the individual within the Poll Everywhere.

Okay. John, I'll turn it to you for 3566. Thank you.

John Bulger: All right, great. So, thanks everybody for sticking with us here. It's obviously, interesting doing this virtually. But thanks for this, doing and helping us with this important work.

So, 3566 is standardized ratio of emergency department encounters occurring within 30 days of hospital discharge for dialysis facilities. This comes to us from the U-M Kidney Epidemiology and Cost Center. This is a new manager. So, it's important for everyone as we go through this.

And you have in front of you on the screen a brief description of the measure. And I won't go into detail on that. But you can see it is the measure and what the numerators, denominators are, it is captured as a ratio but you can also be expressed as a rate. And I think it's important to know that this was reviewed as well by a Renal Technical Expert Panel as part of the process.

So, I'm going to kick it over to the developer, John Segal. And he's going to give us a short overview on the measure.

John Segal: Hi, this is John Segal, thanks. If it's okay, since I had intended to present a little bit of extra information for the other ED measure, I'm going to try and combine this in just one opening statements. And then I'll point out a couple of…

((Crosstalk))

Operator: The conferences has been unmuted.

John Segal: That's great. Okay. So, we appreciate the opportunity to introduce both of these emergency department measures today. These new quality measures

provide an opportunity to evaluate a frequently used and costly component of care for those with kidney failure that continues to go on monitored.

Dialysis patients visit the emergency department about six times more often than adults in the general population. And about half of all patients on dialysis have an ED encounter in their first year of treatment. Rates that have actually been increasing over the past decade. Many, but not all of these visits are for dialysis related complications, such as volume overload, hyperkalemia or vascular access-related issues.

So, these measures evaluate all-cause of ED use as opposed to only those that are directly attributable to dialysis facility care, because there's not really consensus on what specifically does or does not constitute a dialysis-related condition. Just the committee discussed earlier this morning, there's a large gray zone of diagnoses that may be impacted by dialysis facility care.

In addition, the Standardized Emergency Department ratio was designed to both complement and harmonize with the NQF-Endorsed Standard Hospitalization Ratio that also considers all-cause hospitalization, again, as we discussed earlier.

Unlike hospitalizations, however, with a dialysis facility is typically aware that a patient's been admitted. ED visits may go unnoticed by a dialysis facility if they don't interfere with the patient's treatment schedule. As a result, ED encounters are difficult for a dialysis facility to reliably track on their own accord, suggesting that these measures could be an important tool to both track outcomes, develop interventions and then evaluate changes over time.

There's an example, the comprehensive ESRD Care Model has demonstrated that dialysis facility staff and providers can impact the rate of ED utilization through targeted low-cost interventions such as evaluation of target weight and medication reconciliation.

These measures also capture observations days, which are not captured in a standardized hospitalization ratio. As hospitals expand, the use of observation stays, including both the length of time as well as the complexity of patients that qualify for these days. It's increasingly important that these encounters are also evaluated when considering unscheduled acute care.

Off note, urgent care visits are not included in these measures, since many of the issues handled by those during these are lower acuity and less likely to be attributable to dialysis facility care. Given the frequent contact that dialysis facility staff and providers have with patient maybe unique opportunity to coordinate care with other providers, educate patients about appropriate ED use and better manage dialysis care to avoid unnecessary ED use.

A couple of other comments about the Medicare Advantage patients are excluded from both of these measures. And the outpatient MA claims are not available limiting our ability to identify ED encounters for this patient population.

Similar to the standardized readmission ratio - sorry, never mind, I'm just going to wrap up the comments. I was trying to combine two different things together. But I think I've hit the highlights that we wanted to touch on. So, I appreciate your review of both of these measures. Thank you.

(Matt): Great. Thanks, John. And I'm going to go now to Michelle, as the lead discussion. And see, Michelle, do you want to just add any summary comments here at the beginning?

Michelle Lin: Sure. Yes. So, this is a measure that looks at ED visits within 4 to 30 days, after an inpatient discharge among dialysis patients. This specific measure is examining ED visits that result in discharge for all-causes.

Again, as mentioned by the developer, Medicare Advantage is excluded because they don't have access to outpatient claims for that population. And this is measured similar to other measures, we're discussing today as a risk-adjusted ratio but it can also be expressed as a rate.

I would say, you know, overall, there were some enthusiasm for the measure. I think there were some concerns that we'll get to later on with respect to reliability. But those are sort of the broad overall concepts that I gathered from the discussion.

(Matt): Okay, great. Thank you. And I want to note couple of things here as we start into this is, one, the Scientific Methods Panel vote was consensus not reached. So, we're going to, you know, work with that in mind.

The other thing is that I wanted everybody to realize is we did receive a pre-evaluation comment from Kidney Care Partners, and I'll repeat those. But there was specific comments around reliability and specifically due to the overall IUR and concerns about validity as well. But we'll see if those get weaved in as we're discussing reliability and validity. But I wanted everyone to realize those are there.

So, the first piece we're going to talk about is evidence and performance gap. Anything, Michelle's specifically around that you wanted to highlight?

Michelle Lin: Sure. I mean, I think some of the evidence we've already heard, you know, they're higher than average ED visits among dialysis patients. And there's little quality measures, currently examining those.

You know, there're some evidence that care coordination and medicine reconciliation can potentially reduce the likelihood of emergency department visits. There seems to be more evidence that readmissions are preventable as opposed to, you know, ED visits after admission. You know, so there is some evidence there. And so that was sort of the summary of both what the technical expert panel found and what some of the comments from this committee were?

(Matt): Great. Are there any questions, comments from committee members around evidence?

Woman: I have a question. I'm sorry, for not raising my hand. I'm sorry. May I ask a question? Okay.

(Matt): Absolutely.

Woman: Forgive me for not raising my hand on that thing (unintelligible). Basically, is there any evidence as to ED visits? And, you know, I think somebody, I think Michelle said that there was some evidence about it being a quality measure but helping - but didn't have any evidence on mortality or patient experience or do ED visits really hurt patients? I realize they might, I don't know. But was there any readmission perhaps are avoidable, perhaps ED visits aren't?

But it doesn't seem strong enough for what I'm hearing. And I must be missing something. Can you review, like, the evidence again, I'm sorry. The hard outcomes of how it hurt the patient to go to the ED for and patient-related (unintelligible) for patients?

Michelle Lin: I can comment and then if the developer would like to jump in, please feel free to fill in. But as I understand this is the utilization-based measure, you know, and the rationale was that ED visits are expensive and potentially lead to hospitalization. Although this measure is specifically focused on ED discharges, you know.

So, I wasn't aware of, sort of the patient hire component being factored in specifically to this measure. To my knowledge, mortality is not a component, although, you know, obviously, if you don't survive, you can't make it from ED visit.

So, I think it was more of an indicator of access to care outside of the ED, so that if dialysis facility is able to provide high quality, timely access to care that perhaps, an ED visit could be avoided.

Woman: That makes sense. Thank you.

(Matt): Thanks, Michelle. Does the developer have anything quick to add?

John Seagal: Sure. I'll just - I will acknowledge that there is less peer-reviewed literature that looks at ED outcomes after hospitalization then is typical for other measures. But we really look at this as the success or failure of coordinating post-discharge care.

And if the patient shows up in the emergency department immediately after hospitalization, particularly for things that were in the dialysis facilities control, like, reevaluating target weight, reconciling medications, helping arrange for follow-up visits those kinds of things are potentially preventable encounters.

And nobody likes being in the emergency department. And so, we do think that it has an impact on patient's overall quality of life that they end up having to go back to the hospital.

Woman: Thank you.

(Matt): And I just this is the highlight too for everybody that, you know, from a claims-based standpoint, if it is a readmission, there isn't an ED visit because it gets rolled into that and the ED visit isn't billed.

But, you know, this actually, you know, I think probably, it goes companion with readmission rates in this area too, is a big part of hospital level utilization. So it gives you that view if they're seen in the ED and discharged. So that's, I think one piece of it as well. Any other questions, comments around let's see Ed has his hand raised?

Edward Davidson: Yes, thanks. I was just wondering if there's any evidence about the duration of the emergency department visits. So for those that, you know, go beyond one day into a second day, you know, quarter going into that threshold of an observation. And is that different in terms of the severity and potential negative outcome compared to an encounter that is briefer?

Michelle Lin: I did not see anything about duration in my review and to echoes of recent comments but, you know, I believe this would include observation that results

in discharge. And so this is perhaps a way to counterbalance some hospitals that are, you know, placing patients in observation that instead of readmitting them within that 30-day post-discharge window.

Edward Davidson: Developer have a comment on that as well. I think that's absolutely true but do you…

John Seagal: Sure, that's correct. So, we do combine the emergency department counters as well as observation stays.

As you know since that's typically an administrative decision by the hospital. Some of the observation stays that we've documented can last days on hand as opposed to just, you know, less than 24-hour ED encounter or one that even expands past 24 hours. So, there's a range of length of stays, but they are all considered outpatient encounters. Thank you.

(Matt): Thank you. Lisa?

Lisa Freeman: Yes. So, I just wanted, again from a patient perspective, any ED visit is a horrible thing to happen. But I think in particular, people who are on dialysis, timing on things and all these disruptive routines that gets totally wrecked and broken in the ED make it even more critical. And I tend to suspect to that a vast majority of these ED visits and encounters after a discharge could be avoided if communication was improved.

So, I think a measure like this is very much supportive of the need for the patient-centered care. And it really brings to highlight the awareness of just how unnecessary – I mean it could bring to highlight if somebody, you know, is paying attention to it the way they should, the awareness of what's really involved.

And I mean, I've had experience, a family member was on dialysis. And so often an emergency visit could be avoided. After hospitalization, if communications had been better, if the dialysis center physician who was really taking service care was involved, more directly involved and had more information.

And likewise, it goes the other way too because when you're in the emergency department, there's such a chance for them not having all the necessary information. And again, in my relative situation incorrect tail was almost administered because of that. And so, I think that to measure this, it can highlight an awful lot of problems and not create solutions.

John Bulger: Great. Thank you. And I don't see any other hands up. Is that what you see, (Matt)?

(Matt): That's correct, John. I don't see any other hand nor any questions in the chat box.

John Bulger: Great. So, we'll go to voting on evidence, which is pass and fail, correct?

(Matt): It's correct.

John Bulger: All right.

Poonam Roberts: All right. For Measure 3566, we have important measure and report. So, we're voting on evidence for this outcome measures, the empirical data that demonstrates the relationship between the outcome in at least one, how it could be structured, process, intervention or service. If not available, wide variation and performance can be used as evidence. Assuming the data are

from a robust number of providers and results are not subject to systemic bias. The options are: A, pass and B, do not pass.

John Bulger: And while votes are being collected, just confirming, Leslie, you're on the call, correct? Leslie, are you there?

Leslie Kelly Hall: I am sorry, I was on the voting screen.

John Bulger: No worries.

Leslie Kelly Hall: And just to confirm though this was one of the measures that did not pass, what portion in that expert panel?

John Bulger: Yes, so just to confirm…

((Crosstalk))

John Bulger: Yes, go ahead. Go ahead Matt.

(Matt): You know, I was – yes, so just saying allegedly, it was a consensus not reached unreliability from Scientific Methods Panel?

Leslie Kelly Hall: Unreliability. Thank you.

John Bulger: Right. So, Leslie, I got you. And then, Brian Foy, have you returned?

Brian Foy: I'm on, yes.

John Bulger: Great. Thanks, Brian. Okay. So that means we have 16 on the call.

Leslie Kelly Hall: And so, now, the vote are at 16 votes in. So, for pass, we have 16 votes. For do not pass, we have zero votes. With 16 votes to pass, Measure 3566 has passed on evidence.

John Bulger: Great. So now, we're going to go to the gap in care and I think we already touched on this. But I just give - Michelle, do you have anything else to add?

Michelle Lin: Sure, yes. So now, the scores range from 0 to 3.52 among facilities with at least 60 presentations and I believe, 11 discharges. I have a mean with around 1.03. The standard deviation was 0.37, you know, there is a lot more variation at the tail.

And it was noted that predictors of higher scores, which is poor performance, where age, race, ethnicity and dual-eligible status. And there were some uncertainty as to whether or not this was actually a disparity based on quality or disparity based on the higher prevalence of comorbidities among patients with these risk factors.

John Bulger: Great. Thank you. Any questions at all from the committee? I don't see any, Bill, Leslie, great. Thank you.

Leslie Kelly Hall: So, I am concerned about the ambiguity around whether this is related to the patient's complexities for care and I'd like to hear how to help parse that out a little more.

(John): Great question. So it is developer have any comments around them?

(Matt): I guess I would just say that we noticed significant variation from issues like race, ethnicity, age. I'm not sure that in that's not uncommon you know this and other measures that we've worked on. Obviously, the question that has

come up earlier today is what all should be included in a risk adjustment model.

So, that's not the section we're talking about right now. But we just noticed that there's substantial variation. This has been recorded in the general literature for other populations in terms of ED encounters. So we find that dialysis patients have some of the same issues as patients from the general population with respect to those factors.

(John): Thank you. Other questions around the gap in care? I don't see any Matt we get on the - looks like I don't see anything in chat box. So let's go to voting on the Gap of Care. And that is a graduated one. So no matter what they are but high medium, high moderate low?

Woman: What are the importance to measure in terms of measure 3566 performance gap. The performance gap data and it's also for including the data demonstrated considerable variation or overall less than optimal performance across providers and or population groups, disparities and care.

The options are A. High, B. Moderate, C. Low or D. Insufficient. We are at 15 votes. Okay. We are now at 16 votes. We have seven votes for high, six votes for moderate, three votes for low and zero votes for insufficient. With seven votes for high and six votes for moderate this measure has passed on evidence performance gap.

(John): Okay. Great. Thank you. So now we move to reliability. And, you know, just to prefaces, this is the scientific methods panel vote was consensus not reached meaning they didn't get those enough votes to move forward, which means, you know, we'll discuss this and vote on ourselves, but you know, everybody should know that. That was the scientific methods panel vote. The

second piece is, as I said, in the beginning, there were was one commenter which was kidney care partners and their consensus around reliability and just rate it, the consensus that the measure is not reliable as specified due to overall IUR of 0.451 across all facilities and that the reliability for small facilities might be substantially lower than the overall IUR. So with that just a background, I'm going to kick it to Michelle to start the discussion.

(Michelle): What are we going to discuss the validity and then reliability or just you want to start with reliability?

(John): Michelle first. Yes. Well we use reliability, then validity.

(Matt): Right.

(John): Right Matt.

(Michelle): Okay.

(Matt): Right.

(Michelle): Great. So yeah, so that was sort of the consensus of you know, this is the one that did not reach consensus John mentioned, the specific comment you know from the Kidney Care Partners was that was in IUR of .45 across facilities, only 45% variation the score is attributed to between facility differences which is the signal whereas 55% is attributable to within facility differences, we just know it. And so therefore, by statistical convention this would be a poor degree of measure reliability. That was a specific concern.

(John): Great. Does the developer have any comment before we go to the committee for further comments?

(Matt): Well, I just would highlight Dr. (Unintelligible) discussion earlier this morning that with the PIUR that is higher, you feel that improves the reliability particularly as it relates to trying to identify outliers in terms of performance. So from our perspective, we think that, that the measure does have sufficient reliability to pick up those outlier facilities.

(John): Okay. Questions from the committee? Christy?

(Christy): Yes. Thank you, John. And well, I guess that you know, this is where, how the measure kits used or may also impact I mean, if it's used to identify outliers, then the PIUR scores. Although somewhat lower than maybe we would like it would probably be within you know, within the range of acceptability and but if it is used not just to identify outliers, it appears to be low.

So, this is where I think, you know, having a better understanding for perhaps how the results would be used, I think would be helpful. That may be a used discussion as we had earlier today.

But at least I think that's the quandary on that first measure, they were both of the IUR and PIUR were a higher than point five. Here, once slightly lower and then once only slightly higher.

And so to me, that's the dilemma. And I know and Matt, please correct me if I'm wrong, that we're trying to be sure that we're as consistent as possible and applying kind of the methodology around the IUR and PIUR you know to all these measures.

(Matt): Right. That's correct Christy. This IUR and PIUR used across all of the renal measures or the ones that with the dialysis facilities. And just to iterate on again, the SMP you saw the IUR and brought it to for discussion during in person during their all-day meeting. And so the PIUR being slightly higher than point five and made a determination that they were not really, they could not come to consensus on whether or not this measure has better liability moving forward (Unintelligible)

Okay. So that's why bringing it to you all around this and with the evidence that you have in front of you both the reliability, reliability but also thinking about any of this other aspect. Intended use has been something that come up as well. What's here in front of the committee to deliberate on to make a determination and your own votes on reliability. Jonathan Leslie has her hand raised. Leslie?

(John): Leslie. Sorry, I was talking and you didn't hear me because I was muted Leslie. Sorry.

Jonathan (Leslie): Sorry. Yes. So, if there's this kind of lack of consensus and lack of confidence on reliability that we just hear, then with that lack of competence, are there any other unintended consequences if a measure goes forward, that feels that there is lack of consensus on liability because we are doing that risk assessment to determine if there are unintended consequences.

(John): And before I asked the staff quick just and to be clear if, if, if a measure passes and is given the NQF endorsement, then the use is not restricted, at least at this current time. Is that correct, Matt?

(Matt): Correct. John.

(John): So, you know endorsement is endorsement, and that allows it to be used now. As part of the, the process of reviewing and, you know, regular reviews. The developers would have to come back and show, as we kind of saw in the first one reviewed but that was not a new measure that was a previously.

The used measure has to show what the how its use has affected care. And I think in that unintended consequences could come out of that. But I think we should all be clear is that if a measure is endorsed and we endorse it and it goes through the CSAC process and is endorsed, it's endorsed for use across the board and not in necessary and narrow.

So for example, in this measure, we couldn't say, well, it's endorsed for use to flag outliers, but it wouldn't be endorsed for us at the 50th percentile as we know some of the other you know, readmission measures, you know, cut at the 50th percentile and if you're 51st percentile, you're okay.

And if you're your 49th percentile, you know there might be a penalty. So I think it's important for all of us to keep that in our heads as we're thinking through this is that, I think it does become difficult to separate understanding what the numbers mean.

But it does become difficult to separate the IURs and the PIURs given the way the process works for us. Other questions, concerns from the committee about reliability? I don't see any hands. I don't see god.

(Matt): So sorry, John. This is Matt. And I think here I think what you know Leslie raised a good question. And I will iterate what John was saying about, you know, these maintenance measures that come in, you know, there's an aspect of our criteria within usability that starts to get to the unintended consequences and what the developer and or steward have noticed and how

they respond to potentially those unintended consequences. And maybe, I don't know if the developer has any comments on what Leslie was mentioning about use or intended use within any potential unintended consequences.

Even though that is measured, I believe it has a planned use for implementation, albeit it's not used now because of new measures. But does the developer have any comments regarding intended use or any unintended consequences potentially.

John Segal: Right. So this is John Segal again and, you know, ultimately, the decision would be up to CMS in terms of what if in any way they want to use the measure, so I can't specifically comment on how it is ultimately going to be used or if it's ultimately going to be used at all.

But clearly, similar to our other measures that's used in public reporting often, for many of those measures, it's reported as you know, as expected or better or worse than expected. So we try and really only highlight facilities that are at the extremes and not that are towards the center of the distribution.

And obviously, we have measures that are in the Quality Incentive Payment Program. So it's ultimately CMS would have the final call as the measure steward in terms of how it would be used if at all.

(John): Great. Thank you. Other questions, concerns from committee members. Okay. Seeing none, any good god.

Jack Kelso: This Jack Kelso so it’s time to make one additional comment, I guess which is, the question of I guess, using a measurement for example, at the 50th percentile and doing a discrimination there?

I think that's something that should be should be questioned actually, because it's because there's any unmeasured confounders in there is going to affect quite strongly the variation in the center of the distribution. And I don't really think there's any particular difference between one of the 55th percentile, not the 45th percentile. At least with most measures, I think.

The other thing I guess, with the, the things like the QIC that they equipped. There are several measures going together but they're being used in the Quality Payment Program. I think that's relatively fairly common.

And in that case, it's certainly the combination of the measures for the individuals that are being used for the score and that would tend to be more reliable than any particular measure. So in this case, I think when we want measure, to score this measure mainly towards the tails or in the center and it still could be used in such a program, I think subject to CMSs wishes.

(John): Yes. Thank you. I believe that was well said. Okay. I don't see any other hands raised. I don't see any comments, Matt. So I think we're ready to vote on reliability.

(Matt): Agreed.

(John): And you want to remind us as we vote, what the, what the thresholds are here, because this is a must pass?

(Matt): Right. So, for this thing that must pass, you have to have more than 60% in agreement. So we're looking at the majority that more than 60% represented within the moderate or high responses. Again, because this is a consensus not reached. We're not asking to uphold the SMP because SMP consensus not reached out. So we have to have more than 60% of the votes distributed

across the moderate or high or excuse me moderate and or high responses. Sorry. John go ahead.

(John): Correct. And that's, and that's what's the math on that? I'm sorry.

(Matt): Yeah it depends. Yeah and so…

(John): We have 16 voting.

(Matt): The number is we are, do we have still have 16? Michelle, are you?

(John): Well, let's vote. Let's vote. Let's see. I'm sure you guys have something that calculates it for you automatically. So let's just go. Sorry.

(Michelle): All right, voting is currently open. We have 11 votes so far. We're voting on measure 3566 for reliability. And this is reliability, meaning precise specification, as well as testing appropriate method and scope with adequate results. So options are A. High, B. Moderate, C. Low and D. Insufficient.

Our voting totally is at 15 currently. And now we have finally reached 60. So we have one vote for high 10 votes for moderates, four votes for low and one vote for insufficient with 10 votes for moderate and one vote for high. This measure has passed on the reliability.

(John): Okay. Thank you. So now we'll move on to validity. And we'll just go right to Michelle, we've read the other comments already.

(Michelle): Sure. So, with the section of validity this is reviewed for clinical relevance. You know, there are some concerns that attributing all visits, for all causes within 30 days of discharge to dialysis facilities. You know, it was for other

providers, although the comment was made previously that some dialysis providers are like primary care providers. And again, this is all diagnoses, not just a dialysis, the dialysis related easy to visits and then with respect to risk adjustment.

So we did note that there were differences by race and ethnicity and dual eligibility status. However, those were ultimately not included in the risk assessment for the measure, gender and comorbidities were included. So that was noted as one potential concern about validity even the discussion around SDS risk adjustment.

And then with respect to direct validity, this was compared to all of the other measures that was looked at for and for the most part, there was alignment with other measures such as, you know, mortality, transfusion events and hospitalization, as well as with measure 3565 wishes, all ED visits. There was in, there was in concordance with hypothesis score as we just showed, but the other ones were concorded.

(John): Great. Thank you. Any quick comments from the developer on validity?

(Matt): Nope, no comments. No, no specific questions?

(John): Great. Any questions, comments from committee members? I don't see any hands. And I don't see any comments. Just a reminder as we're going to vote so this in this case, the scientific methods panel did reach consensus. So our vote is to uphold the scientific method panel's findings. So it's a yes, no vote in this case. One more Look here. Any hands raised? No. Okay, we'll go to voting.

(Michelle): Okay. So for measure 3566. The question is whether we accept the scientific methods panel rating for validity. The options are yes or no. Voting is open. Okay. We are at 16 votes. 16 votes for yes and zero vote for no. So with 16 votes are yes. Measure 3566 has been decided that the committee agrees with the scientific methods panel's ratings for validity.

(John): Great. Thank you. So next is feasibility. Any comments on feasibility? Michelle?

(Matt): So, John, I believe Michelle had to drop off since this we are getting close to her time. So I'm just going to finish up, feasibility, use and visibility. So for feasibility, really no major concerns in here. The data sources is generated electronically from normal processes of care, such as administrative claims. We are looking at the comments from the committee. There were no concerns as well that came through the pre-evaluation comments for feasibility.

(John): Thank you, Matt. Any questions concerns right now from the committee members? I don't see any hands and I don't see any comments. So let's move to the vote count.

Woman: Okay. So, for feasibility of the measure 3566 we will be voting based on data generated during care. Electronic source, the data collection can be implemented in terms of the e-measure, feasibility, assessment of data, elements and logic. The options are A. High, B. Moderate, C. Low or D. Insufficient. I'm holding this option.

Okay. We now have 15 votes, eight votes for high, seven votes for moderate, zero votes for low and zero votes for insufficient. With seven votes from moderate and eight votes for high, measure 3566 has passed on feasibility.

(John): Great. Thank you. So now we will move to use and usability. Use first. Matt. Matt, you're muted.

(Matt): I am muted. Thanks. Thanks, John. So this is a new measure. So, again, for new measures we don't normally see these being used in accountability programs are publicly reported. There are some exceptions but, in this case, this measure is not currently used.

However, the developer does state that CMS will consider implementing this measure as a part of CMS dialysis facility public reporting program. This program provides information that can help dialysis patients and caregivers compare (Unintelligible)

(John): Is Matt breaking up for other people or is it just me?

Woman: No, me getting broken up.

(Matt): Oh, I'm sorry. Is this better? That's much better.

(John): Much better.

(John): Yeah. That's much better.

(Matt): Much Better.

(John): And I know what you said because I have the notes, but I'm not sure if everybody else heard that. So…

(Matt): Okay. So I'll go ahead and repeat myself. I apologize, everyone. So this again, this is a new measure. So this is something we don't know normally

expected to be used in the accountability programs or publicly reported. This is a new measure.

However, we do seek to see if the developer does mention anything about the rationale for use or plan to use. In this case, the developer does say that CMS does or will consider implementing this measure in CMSs dialysis facilities public reporting program.

So this program is used to hold dialysis facilities accountable, and also allows patients and caregivers to compare across but dialysis facilities. The developer also doesn't provide it information on feedback now. It's not necessarily here that we're looking for feedback.

We look here for feedback obviously on whether it how the measures being used and the feedback that the developer and or steward is receiving from dialysis facilities or the accountable entity in this case. But we also can see feedback from the development of the measure. So has there been those who work at dialysis facilities, they've been engaged in some way on technical expert panels, etcetera.

So there is no mention around that, within the feedback piece and developer does not provide information on that's for your usability a hold off on that one. So that so going through the standard committee pre-evaluation comments. Really no major concerns here, again, new measures not used yet. And then the same mentioned of the CMSs dialysis facility public reporting program, which is a plan to use. That's it for use.

(John): Great. Thank you, Matt. And we had some discussions around use here as we went through this and I think Michelle did a nice job of, of speaking about that and a couple of our commenters or committee members did a nice job. And I

think that notion, I think that came from the developer around the tail versus the middle, I think is a good comment to have on the record as we go through this. Are there other comments, questions from members of the committee? Seeing none, no comments? Nope. No hands raised. Let's go to voting.

Woman: Okay. So for measure 3566 for usability and use and specifically use, we're voting on accountability/transparency. So use an accountability within three years, public reporting within six years or if new a credible plan, feedback on measure by those being measured or others. The options are A. Pass or B. No Pass. Voting is open. Okay. We are at 15 votes. So we have 15 votes for pass and zero votes for no pass. So with 15 votes for pass measure 3566 has passed on use.

(John): Okay. Thank you. And next is usability. Matt, can I get a couple of comments that were specifics of usability?

(Matt): Right. Right. So, usability. So here we're looking again, if there's any sort of improvement over time, however, the measure is not currently use. However, there is, there is a section in here that does ask for some rationale to determine if there is will potentially be some improvement over time. The developer did not provide any of that information for us to make it make a decision internally on this. So the standing committee should discuss for a final rating as far as the usability component.

Again, it's not it's not used, so we're not seeing improvement over time. However, if the developer like to comment on any opportunity for improvement with the implementation and use of this measure that will help with the standing committee’s decision as the preliminary analysis because that information wasn't provided was a rating of insufficient.

(John): Yeah and I think this is, this is where the unintended consequences question that we had earlier, I think comes into play as well. So if you could, if you have any further comments about, you know, the usability, this potential unintended consequence where you see this potentially going?

John Segal: Sure. This is John Segal again. We obviously have the ability then to track rates of emergency department utilization, and by reporting this ratio to facilities that allows them to see how they compare to the national average. So we do you think that facilities can use this information just like these other standardized measures about their care to then implement care processes in the facility and then track those over time.

So we do think that, that this will give usable and actionable information. And I know that there had been some questions that it come up in terms of the percentage of facilities that were flagged as outside of the range of what's expected.

Remember, that's in comparison to the national average. And so, if rates are, these rates are undesirable, they still may be facilities may still be flagged as being as expected, even though those rates are particularly good. But we will be able to track these overtime to give people feedback.

And then facilities can see how they compare to other facilities across the board as they implement improvement processes. So I'm not sure if that addresses the concern or if there's other things that can comment on.

(John): No, I think that's a good start. Let's see if members of the committee have any other questions around this that have come up Christy. I see your hand raised?

(Christy): Yes. And this really just follows up on what you were just saying, I guess does the facilities get more detailed information? Will they see where they fall? If it's in the middle, you know, not on the tail or do you know?

(Matt): So typically for measures that are reported back to facilities, they would see where they fall in relationship to, to the national average and we provide confidence intervals so we can let them know, you know, where within a range, we think those results are.

We also for new measures, do a dry run period for measures that end up being implemented. So we without holding facilities accountable, they typically get to see their measure performance for trial period ahead of time and which also lets us solicit feedback on the measure, in terms of comments that that end users have as well as facilities that I can see how they're doing.

(Christy): Thank you. That's very helpful.

(John): Other questions, comments, concerns? I don't see other hands. I don't see any comments. So let's go to vote. Leslie.

(Leslie): I'm sorry. (Unintelligible) We talked earlier about facility differences and the differences of patients in a to critical access hospital and an acute care hospital. And so with that, those differences also considered into the lack of faith of reliability. Or was it says purely a problem the differences of the type of calculation they were doing?

(Matt): Yeah. I'm sorry, I'm sorry, I didn't quite I couldn't quite hear and understand all of the questions. Could you that again, please?

(Leslie): Yeah. It might not make sense so forgive me but, what I look at the differences between the critical access hospitals here in rural Idaho and acute care hospital in rural Idaho.

There's drastic differences and they are four hours apart in some places that the patient if they told go to that critical access hospital for that follow up care and then perhaps been transferred to the acute care hospital. I just wondered if the huge variations in facility treatment between that critical access hospital and acute care hospital contributed to the lack of faith in the reliability earlier. And or if that is those differences helped by this new calculation method?

(Matt): Well, we do adjust for, the we do adjust for characteristics of the discharging hospital. So if there are hospital differences in terms of discharge procedures, or things like that, you do try and account for that in the measure, because we understand that's are regional variations. It's not clear to me though how much that component alone is impacting the level of reliability but I think I understand what the point is there?

(Leslie): Thank you.

(John): Great. Thanks. Other questions, concerns? Okay. Let's go to a vote on this one.

(Matt): So, John, we may have less quorum here I know some people had to hop off at two, some we'll be back on in about 30 minutes. So at this point, I'm not even sure if, if we will, we would have quorum and I think we have somebody coming back on at three. So at this point, what we can do is allow those on the call to vote we wouldn't read off the responses, we allow those on the phone to vote.

We are able to identify that you've actually voted you as an individual we were able to identify you actually voted. And so the other criterion that would, we would still need to vote on from those who are not on the call, we would reach out to them directly to have them vote on those on those criteria.

So we still would allow you to put your vote in for this discussion, however, we would not read off the responses. And we would proceed until we would have quorum again. And then we would be able to read off the responses. So for those that had to drop off or those that for, yeah, for those who had to drop off, we will follow up with them directly with a survey to finish their voting for these criteria.

And the subsequent measures if they're still not on the call. So at this point, we are at the quorum number to read off any responses and so we will proceed and you can put your responses in and then we will follow up after the call for those who did not have we let you drop off.

Woman: Okay. So for measure 3566 for usability. We will be judging discussion based on improvements, (Unintelligible) administrated, if new credible rationale, add benefits, that outweigh evidence of unintended negative consequences for patient or population. The options are A. High, B. Moderate, C. Low and D. Insufficient. Voting is open.

(Matt): So the folks that had to drop off I believe were Pam Roberts. Pamela are you on? Right and we lost Michelle. And I believe Chloe had to drop off as well. Chloe, are you still on?

(Chloe): Yes, I'm still I'm sorry. I was muted.

(Matt): So you're still on. Has anybody not voted? Picked up, one. Anyone else not voted? Okay. So right now we're at 12 total. So we're not going to read off the responses, but we will close this poll. And again, follow up with those individuals that are not represented in these votes because we could see who's voted what, and follow up with them get their responses.

But we won't know at this point, any determination on pass or not pass on usability and most likely, it's going to be the same for the subsequent criteria moving forward and the question for this measure. So John, at this point, we're done with usability. We can turn it over to the overall vote.

Woman: Okay. So for measure 37…

(John): I'm sorry. Yeah, I was I was muted, sorry. So the last vote is for the overall package. And I don't think, and I don't think we need a preamble for that. I just would open it up and ask if any of the committee members have anything else, they wanted to add as part of this measure discussion, and then that will vote the same way we just did. And we just hold the, hold the detail. Okay.

(Matt): Correct. Right.

(John): All right. Any other questions? Concerns? I don't see any hands. I don't see any comments. So we will go to a vote.

Woman: Okay. So for measure 3566, we will be voting on the overall suitability for endorsement. Does the measure of the entry if criteria for endorse it? Please note that this may not yet be a recommendation for endorsement. Final recommendation for endorsements may depend on assessments of any related and competing measures. The options are yes or no. Our voting is open.

(Matt): Ms. James dropped off. We will close this and follow up accordingly with those individuals that were now able to vote. And we can move forward. So also as well, Pamela Roberts, who had drop off she's going to be coming back on at three. So she was really discussing for 2496. So perhaps we can then shift to 3565 since this is also the other new measure the ED measure. Raj, are you on the line?

(Raj): Hi.

(Matt): Thanks Raj. So Raj, are you on the line?

(Raj): Yes. I'm Matt.

(Matt): Hello. Thanks Raj. Okay. And there was somebody else who was coming in?

(Elizabeth): Hey, sorry. It's Elizabeth. Sorry. The developers I thought your saying we're on the line. We are sorry to jump in prematurely.

(Matt): No. Thanks you. Thank you for being patient. We're running a little behind and having to sort of sort through things on our end, just to make sure that we're getting folks to participate and mainly discussion. So I appreciate Liz, you are hanging on line as well with your team. Right now we're switching to 3565 and Christy, I believe that's your measure. So I'll turn it to you.

(Christy): Okay, thank you. This is 3565. The Standardized Emergency Department encounter ratio for dialysis facilities. The developer is UEN kidney epidemiology and cost center, the steward is CMS. This is also a new measure. And you can see the description in front of you. A couple of things I will point out and it's an emergency department encounter. It's an outpatient

encounter that does not end in a hospital admission. It can be its calculated ratios that can be expressed as a rate. And it was reviewed by the renal technical expert panel.

And I would like to turn it over to John. I know that you made some comments in our last measure that also apply to this one. But please take the time to give us any overview of the measures that you would like to.

(John): Thanks very much actually. I go in, we need just give time, I'll wait for any other additional opening statements. I think we've captured most of the key issues that are relevant for both of the measures. But thank you.

(Christy): Sure. Thank you. John. With that, I will ask Raj, if he would like to walk us through the criteria. And we will start with evidence. So Raj, do you have any comments about evidence?

(Raj): So we do have some comments that came through the Kidney Care Partners. Actually, they're quite a bit. And I'm sure Matt everybody got a copy of those. And you should I read them out fairly expansive. So we…

(Matt): Yeah, Raj if you won't just mind just. Sorry. Raj. Yeah, you can read them out. And there has been a copy provided in the SharePoint show.

(Raj): Sure. Absolutely. So the first comment they made for us the all cost construct will unfairly penalize dialysis facilities for random ED visits that are beyond their control and sphere of influence. Second comment they made was strongly recommend that ratio measures be avoided and that risk adjusted rates up a year-over-year normalization be used.

Third comment, they made was recommends two additional exclusion. One is end stage renal disease patients who seek care in an ED for any reason after missing their most recent scheduled dialysis, and second was ESRD patients who decide in a long-term care or nursing home facility.

Also they recommend that urgent care centers revenue codes ED included in the EDI-30 and CDR numerators. The exclusion of Medicare Advantage patients will create an unreasonable scenario in which EDI measures will effectively address a population that diverges considerably from that of other measures.

The next comment then made was variation in Medicare Advantage coverage patterns compromises the validity of the measure putting states, regions and individual facility with low proportion of MA patients at a substantial disadvantage with the ED measure.

Next method concerned that risk models will not adequately discriminate performance and a minimum C-statistic of 0.8 is a more appropriate indicator of a model goodness of fit, predictive ability and readability to represent meaningful difference among facilities. Those were the comments to Kidney Care Partners. Anybody has anything to say or to add? Christy you or John?

(Christy): Well, thank you so much for helping explain what those comments are at the beginning. They do kind of go across a lot of the criteria that we'll be looking at. So, you know, if we can let's try to remember or flag some of these comments as we go through each criterion before we take a vote relative to it, but I don't have any other comments on for it.

I know it's going to be hard to kind of remember like where to plug in some of these comments as we go along. But maybe the NQF staff can help us do that as well. So you want to start with evidence Raj?

(Raj): Absolutely.

(Christy): Right. Thank you.

(Raj): The importance or evidence and performance yes, the developers state that there are numerous out care processes that can influence the likelihood of a patient requiring care in the ED. That would be distinct from the need for hospitalization.

These practices include fluid management or fluid removal processes, vascular access management, which particularly I think is definitely that differentiates facilities with access and access to access actually, and then management of electrolyte abnormalities. We definitely see a lot of the people ED people with the severely elevated potassium levels being the reason for visit and admission.

The developer cites one study that showed a two-fold or higher increase in ED visits due to dialysis treatments. The developer also cites studies suggesting that improved health literacy, improved here with some treatment schedules and the speed of telehealth services can reduce ED utilization in dialysis patients. This includes high risk dialysis patient, especially telehealth. Just put a comment there or it just note.

(Christy): So that’s sounds good.

(John): So sorry.

(Christy): (Unintelligible) unmute. Thank you. Okay. Raj. Do you have anything else under evidence or is it time to us to get?

(Raj): Yes. We…

(Christy): Okay. So… Go on.

(Raj): I think unmuted you. Can you hear I'm Raj?

(Christy): Yeah. I can hear you Raj.

(Raj): Okay. So yeah, so there's more. I think I got muted earlier with the mass muted. Okay. So the developer cites one study that reports ED visits rate were higher in the day following longer hence their dialectic interval over the weekend.

And additionally developer cites that Center for Medicare and Medicaid Services, are comprehensive and same disease care models. It has shown 3% reduction in ED use when the model was launched. And then the developer provides the distribution of Standardized Emergency Department encounter during the or CDR during the three-year period from 2014 to 2017.

The developer notes range zero to 4.3 of standardized ED visit rates, variation across the facilities for clinational groups during the three years, man. So that's what we have on evidence.

(Christy): Thank you so much. And any questions or comments from the committee? And Matt, I don't think I can still see anything. So I'll rely on you to let me know if anyone's raised their hand or something in the chat.

(Matt): No, I do not see any questions or any hand raises at this point.

(Christy): Great, thank you. We are seeing none. And I think we might be ready to go on and vote on evidence.

Woman: Okay. For measure 3565 voting on important measure and report evidence for this outcome measured. So we're voting on the empirical data whether it demonstrates a relationship between the outcome and at least one healthcare structure, process, intervention or service.

And if not available, why variation and performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systemic bias. Voting is now open.

(Matt): So I believe we're at the number of votes. Has anybody not voted? Okay. So we have 11 votes. So we won't be reading off the results. Again, I think we'll have more folks to be joining us here as we get closer to three. Maybe we'll get quorum back. But at this point again, we won't be reading off the votes.

(Christy): Okay.

(Matt): Thanks, Christy.

(Christy): Let's move on to gap and I think Raj that you did talk about the gap that the developers showed in the distribution of or the opportunity for improvement in Standardized Emergency Department and current ratios ranging from zero to 4.30. Is there anything else you wanted to add around gap or opportunity to…

(Raj): No, no, I included both the evidence and the gap in the first statement. So we should be ready to get vote on gap too.

(Christy): Great. Any comments or questions from the committee members before we vote on gap?

(Matt): No, hands raised no questions in the chat box.

(Christy): Okay. Let's move to voting then.

Woman: Okay. So for measure 3565 for evidence performance gap, we're going to be looking at the data demonstrated considerable variation or overall less than optimal performance across providers and or population groups, disparities and care. So the options are A. High, B. Moderate, C. Low and D. Insufficient. Voting is currently open.

(Matt): Anyone not voted. Okay. All right. Thank you.

(Pamela): Okay. We have little vote.

(Matt): All right. Thank you, Pamela. Back to you Christy.

(Christy): Okay. Well, just as a reminder for you all, we're going to move into the reliability and then after reliability, validity and the scientific methods panel did pass both of these at the moderate level, and you have their votes in your packet. So when we do get ready to vote for reliability, which will be our first week.

We'll be voting on whether or not we want to uphold the scientific method panel's recommendation which was passed on, which was passed. So, I just

wanted to let you all know that you could be thinking about it from that perspective. And Raj, do you have any comments about reliability?

(Raj): So, the information we have here is the underlying signal to noise ratio is 0.62 and the PIUR is generally acceptable at 0.89. So on that we just have to see if anybody wants to make comments or discuss that PIUR methodology is appropriate given below. As you already mentioned?

(Christy): Great. Thank you. And I think from an interim staff or others on the committee can correct me if I'm mistaking this, but I think we have often endorsed or recommended endorsement at an IUR that is at or above this level 4.62 for this measure in the past. So just to kind of give you a little bit of context on that. Any questions or comments from the committee around liability? Anything showing up, Matt?

(Matt): No, I don't see any hands raised or any comments in the chat box.

(Christy): Okay. One last call before we go to vote. Okay. Well, let's move to the vote.

Woman: Okay. For measure 3565 we will be voting on the question. Do you accept the scientific method panel rating for the liability? Voting is currently open.

(Matt): And is there anybody not? Sorry. I was going to say is anybody not voting the voting? Okay.

(Christy): Great.

(Matt): So we have 11 love and votes. Okay. We can move forward. Thanks for Christy.

(Christy): All right. Well next is the whether they in and just to remind you, we'll be taking the same vote that we just took for the liability. The scientific methods panel did recommend passed at the moderate level. And I'm going to turn it over to Raj for any comments?

(Raj): So on validity, a few things that I added the measure was evaluated you know test for clinical relevance and the chapter is concerned regarding attribution, risk adjustment and reliability. And then empirical validity testing method that compared equivalent outcome measures certified by expected performance was appropriate.

Also, does the committee agree the developer's decision based on the analysis to not include certain socioeconomic status factors including race, ethnicity, patient level factors and their risk adjustment model. And then finally, those measures identify meaningful difference about quality? Those are the few comments.

(Christy): Thank you Raj. Questions or comments from the committee around validity?

(Matt): So I think this is Matt. Well, while folks maybe think through that, again, bigger questions. This is where I think a lot of those kidney care partners comments come into play. And I don't know if the developer wanted to comment on any of this.

But there was some recommendations around two additional exclusions that ESRD patients who seek care in ED for any reason, for any reason after missing their most recent scheduled dialysis session, as well as an exclusion consideration for ESRD patients who reside in or are discharged from a long-term care facility.

There was also comments regarding concerns regarding the risk model that would not adequately discriminate performance. This is based on three specifics on point eight and then again more appropriate goodness of fit, model or test should be done. Then there was a piece about Medicare Advantage.

And the exclusion of Medicare Advantage, I think, would also be worthwhile maybe sort of the developer to comment on as the kid's kitty care partners mentioned that this will create unintentional scenario, which ED measures will effectively address the population that diverges considerably from that of the other measures.

So I think all of those be relevant to the validity aspect. So maybe the developer could comment on the exclusion recommendations the exclusion of Medicare Advantage, and some additional commentary around the risk adjustment.

(John): Sure, let me start with the exclusion criteria. So the first issue was excluded patients who missed the treatment and then showed up in the emergency department. And we would actually make the argument that that's exactly the patient population that we want to try and target because we know that there's an association between the style of and ED encounters.

And so the goal is obviously to try and have dialysis facility staff to work on either rescheduling treatments or working on patient education to try and make sure that they remove barriers to this treatment.

So we didn't feel like that was kind of appropriate exclusion criteria for what we're trying to capture. In terms of patients who are in a long-term care

facility, we do adjust them in our risk adjustment strategy. We do look at both short- and long-term skilled nursing stays.

So we are able to, to capture that patient population and try and risk adjust based on the amount of time that somebody spends on long term care facility. With regards to the EMA patient population, we do recognize that there's variation and the proportion of EMA patients at the regional and state level.

Because we can't account for these outpatient encounters and because we can't accurately capture comorbidities without having outpatient claims, we don't see a way to try and include Medicare Advantage patients. And in fact, if we did try and include them, I think we're more concerned that the measure would actually potentially have a higher risk of being biased than by excluding them uniformly across the board.

So that we're only looking at Medicare Fee-for-service patients in each of the facilities. So we understand that a proportion will vary, just like it varies based on the proportion of patients who have commercial insurance.

But we think that we can accurately capture the comorbidity adjustment in the in the patient population at the facility level. And in terms of the risk adjustment and he felt like our model performance was quite reasonable in terms of the comorbidity adjustment in our statistics.

So, you know, obviously, we as part of ongoing measure maintenance always look to see if we can't we always like to try and see if we can't improve our model fit and make tweaks to it. But we were and we think that the current model is reasonable enough for implementation.

(Christy): Thank you, John. Questions or comments or from the committee either for the developer or for Raj?

(Raj): All right, so I'm. give one second. So on the on the feasibility side.

(Christy): Just a moment Raj. Just a moment we're going to finish up the validity and then we'll go to feasibility. Okay. We're going to vote first on validity. I was just, I was just calling for any last-minute questions. Did you see any Matt?

(Matt): No Christy.

(Raj): No, Matt. And I can see the suits my specialty personally is long term care. I, I do have mixed feelings about excluding that and, but, you know, I think it from my perspective at this kind of mix. It's safe to keep it like this. And maybe the annual reiteration next year or probably we can we can look into that.

(Christy): Thank you. Raj. I would like to as John, just a clarifying question around that you use the term that they're in the risk adjustment model on. So, is it? Are they excluded completely or is there some type of calculation that takes them into account in the model?

(Matt): We do not exclude long term patients who reside in long term care facilities, but we do risk adjust for them in our model, and we do it at two, we essentially have it stratified as no time in a long term care facility, short term long term in a short amount of time to long term care facility, or then a long term resident in a skilled facility. So we look at it three different ways non, short or long term? And that's in our risk adjustment model.

(Christy): Great, thank you Matt. I thought that's what you had mentioned, but I just wanted to be sure. So they're not excluded.

(Matt): Correct.

(Christy): Any other comments before we go to voting on validity?

(Matt): Okay. They just confirming, just confirming I see no hands raised and no questions in the chat box.

(Christy): Thank you. All right. Who got the question? I'll let interrupting team, read the question I was going to do it. I can't do.

(Matt): For me are you there?

Woman: I'm sorry. I was thinking on you. I apologize. Yeah, now we will vote on measure 3565. Do you accept the scientific method panel rating for validity? The first option is yes and the second option is no. Voting is currently open.

(Matt): And I'm going to recognize that Sheila has joined us. Once again, I think our numbers might change. Sheila, are you on?

(Shelia): Yes.

(Matt): Thanks Shelia. So Sheila, while you were gone, we had some more folks drop off so we lost quorum. So we won't be reading off any responses to the group until quorum comes back. We'll have to follow up with those individuals, including yourself on those criteria that you missed, because you had to hop off for something else.

So as well as there'll be a survey that goes out to those individuals for those specific criteria? Because we could see your responses and we can identify who was not able to answer that question. So we see that your vote has been here. So we now have twelve and so that's good. And I think you're the only one who come back. So, okay. Well, responses. Okay. Christy back to you.

(Christy): Welcome back Shelia. Thank you, Raj. We'll move to feasibility now if you'd like to give us any comments on that?

(Matt): Absolutely apologize for jumping that you on earlier.

(Christy): You are eager.

(Raj): So on feasibility, only thing I have to add is a that the data source for this measure is derived from the administrator firm. So, just wanted to have that in mind before we work.

(Christy): Right. Thank you. Any other questions or comments about feasibility? Did I assume?

(Matt): No, no? Correct? No hands raised and no questions in the chat box.

(Christy): Okay. Well we can move to voting then.

Woman: Okay. So now we will be voting on feasibility for measure 3565. So we will be voting based on data generated during care, electronic forces and data collection that can be implemented whether e-measure usability, assessment of data elements and logic. So the voting is currently open. The options are A. Moderate, A. High, sorry, B. Moderate, C. Low and D. Insufficient. I see all of the responses. So I'm going to go ahead and mark the vote.

(Christy): Great. Thank you all. And so we have our final criteria, which is use and then usability. So any comments around use first? Or you can do both, of them probably same time Raj.

(Raj): Yeah. Yeah. I'll do both. So first of all, you know, as long as this is a new metric, and then developer has a standard that that CMS will consider implementing the measure as part of CMSs dialysis facility public reporting program.

And this program provides information that can help dialysis patient and caregivers compare the quality of care between different dialysis units. And then and then developer does not provide information or rationale to determine an accurate preliminary reading, rating and the standing committee all should discuss for final rating on this specific criteria. That's what I had to add on that.

(Christy): So let's, let's take use first, and then we'll do usability. And under the usability John we will probably come back to you I assume some of the comments she made on the prior measure would be applicable to this (unintelligible). But let's focus on uses. Are there any questions or comments from the committee around the use? New measure not in current use, but may be considered for the public reporting program.

(Matt): And I don't see any hands raised or any questions in the chat box Christy.

(Christy): Great, thank you. So let's move to a vote.

Woman: Okay. So for measure 3565 for use, I will be voting based on accountability slash transparency. So use an accountability within three years, public

reporting within three years support is new, a credible plan and feedback on the measure by those be measured for others. The options are have or do not have. Voting is currently open. All right, with 12 votes, it seems that everybody has voted, I will go ahead and lock the motion.

(Christy): Thank you very much. So now we're moving to the usability, component of use and usability. And I think it was originally rated insufficient, because it was not provided in the application itself. But John, I think you mentioned a couple of things that just for the record might be good to mention for this measure as well.

(John): Sure. And I think I'll just add the points or echo the point that I had made earlier in the opening statement, which is that since dialysis facilities don't have an easy way to track emergency department encounters on their own, do you think this this measure will, will actually be quite usable in terms of the ease of you know, there's no burden on the facilities in terms of the data collection, they'll end up being able to see performance of the facility relative to other, you know, the national average, and then based on any changes in their care practices, and the facility can then track those outcomes over time.

So similar to our other standardized measures, we feel that this ED measure will also be quite usable in terms of improving care performance. Thanks.

(Christy): Thank you. Any comments or questions from the committee? Anything come in Matt?

(Matt): Nope. No, I was just yeah, that was…. no, no hands raised and no questions in the chat box.

(Christy): Well, let's move on to the voting.

Woman: Okay. So for measure 3535 for usability, I will be voting based on improvement, progress demonstrated if new, credible rationale and benefits whether they outweigh evidence of unintended negative consequences that the patients or populations. The options are A. High, B. Moderate, C. Low or D. insufficient. Voting is currently open.

(Matt): Looks like we have 10 votes. Has anybody not voted? Still seeing 10 anyone not vote. Okay. So now its 11 and I believe looks like Leslie, Kelly Hall just step away. She said. Here we go. Okay. Now I see 12 votes. Okay.

(Christy): Okay. Good.

(Matt): Thanks, Leslie.

Man: The anticipation is the hardest part.

(Christy): Well, I think that the next vote that we have is an overall recommendation for endorsement. Does anybody have any final comments they would like to make before we take that vote? I assume none are showing up now. Matt

(Matt): That is correct. I have no hands raised and no questions.

(Christy): Okay. So let's move to that vote.

Woman: All right. Go for measure 3565, you must be voting on the overall suitability for endorsement. Does the measure meet and to have criteria for endorsement? And please note, this may not yet be a recommendation for endorsement. Final recommendation for endorsement may depend on

assessment of unrelated and competing measures. The options are A. Yes or B. No. Voting is currently open.

(Matt): Missing a vote anybody not vote? Okay. We are at 12. Okay. All right. So at this time that concludes again for this measure obviously we want you to follow up with those individuals who are missing and gain their votes. We was removed 2496 Pamela Roberts. Have you joined us? Come back. She was going to come back at three.

So currently she believes discussing for this. However, since we are moving right along, we shall do 2496. And then I can fill in as we've discussed and until potentially, she comes back. But John, I believe this is, this is your measure as well.

(John): Okay. We have it up on the screen. All right. So this is the 2496 is the standardized readmission ratio for dialysis facilities comes from the same group we've been talking with it is a maintenance measure.

And this looks at the ratio number observed index discharges from acute care hospitals that facility that resulted in an unplanned readmission within 40 to 30 days of discharge, the expected number readmission. So this is a standardized readmission ratio, you know this is based on Medicare covered dialysis patients and I believe then the developer can comment because it is admissions.

This includes and readmissions includes Medicare Advantage. And this was reviewed by a technical expert panel. And, Matt, do you want to give any preamble as the already discussing?

(Matt): Not, not that's beyond this so much I mean, I think everything was mentioned, this is a, this is a maintenance measure. So looking at this a little bit differently as far as some of the criteria specifically used being must pass criteria for a maintenance measure validity testing. We would be looking for that empirical validity testing. In this case, this is the measure that also had reliability was consensus not reached.

We'll just get into that a little bit and when we get to that section. And for validity, there was also a not pass from the SNP on validity. And so we'll get into to that when we get to those, those sections. But I'll see if there's anything else. Any other questions from the committee on that before we go into evidence.

(Christy): Okay. Sorry. Is the developer for another measure for 2539 colonoscopy, we're just trying to understand when we might come up, so we have our staff ready?

(Raj): I think so. Thank you. So it's for 2539.This would be the last measure for spring 2020. We were thinking about maybe taking a break after we get through 2496 and then reconvening to finalize to finish up with the last measure for colonoscopy.

I know that we also have the developer for the fall 2019 depending on where we are, we may actually have to defer that the discussion until the July 2nd meeting, which we have scheduled. So we may have to defer the fall 2019 for common discussions to July 2nd, depending on where we are and how much time we will have for these last two measures.

But we very much appreciate your patience and time as we go through these measures today. But 2496 we will do now we'll just the people to kind of get

up use the restroom. Then we'll come back and do the last measure around colonoscopy and see how much time we have left to potentially do for 2019 but we may have to defer that to July 2nd.

(John): All right. Thank you. Thanks, Matt. Thanks, everybody for your patience as we work through this virtually. So I'm going to give the developer a couple of minutes to give an overview of this measure. So Joe.

(Joe): Yep, (Unintelligible). Thank you.

(John): Yeah, excellent.

(Joe): I'm in the probably just at the Michigan I'd work with the rest of the people in the team you've heard today. So thanks for the opportunity to introduce the proposed updates to SRR standard grid's readmission ratio, resulting from a comprehensive review. The measures intended for evaluation of outpatient chronic dialysis facilities and the SRR first received into endorsement in 2016. We believe that dialysis facilities play an important role in the quality of chronic dialysis patient post hospitalization care for the following reasons.

First, Medicare regulations require facility to provide care organize this an interdisciplinary care team almost like the medical homes that we have come to come become acquainted with. That includes treating pathologists, nursing, social work, and renal dietician and put it at a minimum.

That’s the roles of these providers. Both the nephrologist and the facility employed; providers are aligned to better achieve the team's goals. This interdisciplinary care team is extremely well positioned to coordinate care after treatment plan changes resulting from major health events including hospitalization.

Second, many, but not all hospitalizations as we've talked about today, in this population result from complications of ESRD or its treatments. Third, most dialysis patients receive in-facility treatment thrice weekly or 140 to 150 times per year. The dialysis facility is typically the first outpatient health care facility that seizes the chronic dialysis patient post hospitalization. The facility is really in a privileged position to coordinate care with the discharging hospital. So shifting to update to the measure from our comprehensive review.

First, we've updated the comorbidity adjustment categorization scheme, the original SRU, CMS 2008, HCC hierarchal condition code categories to define prevalent comorbidities. From the comprehensive review, we replaced the HCC categories with AHRQ, CCS diagnosis category since they're a bit more cohesive within category regarding clinical groupings of components, ICD 10 diagnosis codes.

Secondly, we address the potentially important bias issue related to Medicare advantages that you've heard about during all the measures. ME patient acute hospitalizations have always been included in the SSR index hospitalization definition.

However, outpatient claims for determination of comorbidity adjusters are not available for MA patients. Our previous version defined claims-based comorbidities using both inpatient and outpatient claims sources. This approach introduced potential bias for MA patient risk adjustment, potentially affecting results for facilities with very many or very few Medicare Advantage patients.

In the measure before a week, we've introduced two revisions to mitigate this Medicare Advantage bias. First, we are limiting the identification of claims-based comorbidity adjusters to inpatient claims sources for both fee-for-service and Medicare Advantage patients analogous SHR heard about from Dr. Delores this morning.

We use all available inpatient claims from the index discharge and other patient claims in the 12 months prior to the index discharge for both fee-for-service and Medicare Advantage patients. While we agree that limiting comorbidity ascertainment to inpatient claims result in a somewhat less comprehensive set of comorbidities and the order of about 70% or 75% of the original.

Our recommended methodology does protect against potential bias in determining comorbidity burden due to differences in fee-for-service and MA claim with comorbidity discussed above. The use of the inpatient claim from the hospitalization all available inpatient claims in the prior 365 days to define comorbidity, it reflects more current conditions that are more likely to be predictive of hospitalization risk.

Finally, to account for potential underlying comorbidity differences that cannot be observed. We added a model covariate that indicates whether or not the patient with Medicare Advantage at the time of index discharge is pretty recently mentioned by Dr. Delores the use of inpatient claims only for the comorbidity risk adjustment and SRR does harmonize with other admission readmission metrics with active NQF endorsement. I'll stop there, because the day is running out. Thank you very much for your time.

(John): Great, thank you. So we're going to move right away into evidence. Appreciate that overview. And, Matt, do you want to give the

(Matt): Sure.

(John): The overview of evidence, please?

(Matt): Sure. Right. So the evidence criteria. So the developer does cite several studies in the ESRD chronic dialysis population that did demonstrate an impact of pre and post discharge interventions to reduce it, missions and unplanned readmission rates. Additionally, the developer also cites several articles references and dialysis facility level processes of care interventions that likely influence the outcome.

So internally, that the staff did feel that this was sufficient to be able to identify processes or structures that could actually improve on this specific outcome for the given population of interest. In this case goes with kidney disease or those with end stage renal disease and we felt that this was a pass for preliminary ratings.

(John): Okay. Any questions at all from committee members? I don't see any hands up. I don't see any comments. So we will go to vote.

Woman: Okay. So for measure 2496, we'll be voting on evidence outcome. So the empirical data has it demonstrates a relationship between the outcome in at least one healthcare structure, process intervention of service is not available wide variation in performance can be used as evidence, assuming the data are from a robust number of providers, and results are not subject to systemic bias. The options are pass or do not pass. Votes are currently open.

(John): I see 12 votes but just to make sure Pamela have you joined us?

(Pamela): I'm coming back right now.

(John): Great. Are you able to did you vote?

(Pamela): I'm trying to get back online.

(John): Okay. Okay.

Man: We'll give you a couple seconds.

(John): Where you, where you? Right?

(Pamela): Okay. I have voted.

Man: Pam, this is we just started 2496. We did, we did the preamble and then we actually were just voting on evidence. So…

Man: So I did see there was a vote, and then it went away. There's there, there's the votes. Up not. It keeps going back and forth. So, Pam, have you?

(Pamela): I'm sorry.

Man: Okay. Okay. Unfortunately, we're still less than 15. So we only have 13. Right now I just wanted to confirm once more. Is there anybody that has not voted? Okay.

(John): So we're still at 13. We will track the votes we won't be able to say one way or the other and now the Pam's back she can do the lead discussing role as we go through this.

(Pamela): I apologies.

(John): No problem. It’s great. I'm glad you could come back. Alright, so, we are at opportunity for improvement. And Pam, we are you know, some of this was I think discussed as part of the evidence put any comments around opportunity for improvement.

(Pamela): I don't have any say if I’m wrong sorry I’m trying to get my draw back there. I didn't write anything major down represent. I had reliability and validity.

(John): Okay. Any questions, comments from committee members? All right. We'll go to the vote.

Woman: For the importance to measure and report for measure 2.964 for performance gap. You will be voting based on the data demonstrated considerable variation or overall less than optimal performance across providers and or population groups, disparities suggest.

Voting is currently open. The options are A. High, B. Moderate, C. Low or D. Insufficient. We are currently having 12 votes, waiting on one more. All right. We are at 13 votes. If there's anybody else on the line, just going leave a couple seconds. All right, so nobody else has voted. So with 13 votes, I'm going to go ahead and lock it.

(John): All right. Great. So next we'll go to reliability and remember that the scientific methods panel they received a consensus not reached on reliability was not a do not pass it was a consensus not reached. And, you know, we'll talk about that as we go through here. Pam, do you want to start out on reliability?

Pamela Roberts: I do. So, as you went and said (Unintelligible) panel had, they couldn't reach consensus and the IUR was .35 and indicated 35% of the variation in the FFR and to be attributed to the between facility differences and the remaining within the facility variation. The PIUR was .61 and this was updated based on I mean it dropped significantly. And basically that was discussed earlier today.

There was discussions in the comments that would be helpful if the measure developer would require some justification on the substantial drop saw the measure developer content such as PIUR .61 would be effective at detecting outlier facilities and statistically meaningful differences in performance scores across outlier facilities would have been informative to see how much incremental number of outlier facilities have identified by the PIUR versus the IUR.

And then there was discussion for multiple different people that whether the PIUR is the appropriate methodology and I think we had some of that earlier today. And the tech panel had discussion about the drop off though. So, those were the main issues that I found from reading through all the comments. I will turn it back to the committee.

John Bulger: Excellent, thank you. Any response from the developers around this other than what you've talked about?

Jerome Asana: Yeah, briefly, this is Jerome Asana. As Jack mentioned this morning in the discussion, he was talking about IUR and the components of between facility variants. You can imagine that if we change our method of risk adjustment and it became more effective, so we were now risk adjusting for things that were unmeasured as before, that should make our IUR go down.

And, in fact, we did some sensitivity analysis to show that using the HCC Categories, which weren't as effective risk registers as the current approach contributes it's not the sole cause but contribute to the reduction in IUR.

In addition, over we've changed several other aspects of the method. And in a weird way, not that it helps reliability discussion but a drop in IUR is actually suggested to us that the measure is more accurate and more accurately risk adjusted than the prior measure. And some of the between facility variants have contributed to a higher IUR in the past is probably now explained the way by better risk adjustment.

John Bulger: Great, thank you. Are there questions from the committee or comments or concerns? Seeing none I don't see anything in I see Helen Chan is back (Unintelligible) she may have been back for a while. I just happened to notice that I don't know if that changes our numbers Matt but.

Matthew Pickering: No, she's been back, she's been back for a while.

Man: Okay. Okay, no questions let's go to voting on reliability and remember this is we've rank voting ranking ourselves this is not based on scientific method panel though.

Pamela Roberts: Okay, so for measure 2.96 we're voting on the liability and this is reliability, including precise specification and testing appropriate method in scope with adequate results. So, the options are A high; B moderate; C low; and D insufficient. Voting is currently open. So, we currently have 13 votes. Give a couple of seconds for others to respond in case there's anybody else who has not yet voted. Okay, so we're still at 13 votes. So, there's no more responses I will go ahead and lock the vote.

John Bulger: Okay, great. So, now we're going to go to validity. And in validity the Scientific Method Panel this did not pass on validity. And the Scientific Method Panels concerns were centered around the adequacy of the correlations presented for measures core validity testing. And the reviewers found that the results did not adequately demonstrate measures core validity and did not pass thus did not pass the measure on validity. Pam, do you have any further comments on validity?

Woman: Yeah, it's also that there was a test panel that looked at clinical relevance that may raise concerns regarding attribution risk adjustment and reliability. And the developer did have a preface model for risk adjustment that looked at first of which is the fifth effects of logistic regression models, second of which is double random effect logistic regression model and third which is a mixed effect with logistic regression model and developer noticed that due to nominal differences in the flagging on adjusting for FPS or FBS coupled with the risk of reducing patients access to high quality care support decisions and not just for (Unintelligible) selected and FPS FBS measures.

And so we might want to ask the developer to comment on that. And then a couple other comments from the committee members where there were questions about the Medicare Advantage of patients and also readmissions for non-dialysis events and measure identifying meaningful differences. And they thought there's all sorts of comments from some of the panel members regarding missing data might be some threats to the validity of the measure. So, with that I don't know if the developer wants to comment.

John Bulger: I guess I take the opportunity there are a number of things there, but again, the day is running late. So, I would like to make a general statement that reflects some of the discussion that went on at the methodology panel as this as the validity of this measure is being discussed. What Keck as an experienced

method developer asks is only that this measure be treated the same way that other measures that interest and this group evaluates are treated.

We do not believe that if you look objectively at the correlations, the strength of the correlations, the magnitude of the correlations, that this measure deserved to failed validity based on is that you all consider this measure for validity using the same criteria that are used generally for your measure for the measure set of proceed before this committee and other standing committees of NQF.

We think that you would respond favorably if you compare actually the correlations that we present for this measure to others that we and other developers have prevented. Secondly, the issue about disparities and whether or not to just for socio demographic factors the issues are the same as everyone discussed this morning and I don't believe there is consensus on what the right thing to do is.

There are two competing outcomes either you adjust or you don't adjust and it really requires information about whether the facility has control over the factors associated with social disparities and the socio demographic factors, and we've taken the approach of first do no harm.

We are recommending not to adjust until we're certain that there's enough science to know whether facilities can or cannot influence the care of patients in those categories. I'll stop there. I think those were the two big points that I was interested in making.

Pamela Roberts: Thank you. I'll turn it over to the committee for other comments.

John Bulger: Any questions, comments from the committee? So I see don't see hands raised. There's no comments. We will go to a vote on validity.

Pamela Roberts: All right. So, for this measure 2496 do you accept the Scientific Methods Panel ratings for validity voting is currently open.

John Bulger: So, we clarified for everybody what our voting here with what a vote which way is for please? So, I think that because the Scientific Methods Panel voted no essential validity a yes by the committee is a no on validity is that correct?

Matthew Pickering: Right. If you vote yes, to uphold the SMPs rating, you are saying that the measure will fail or not pass on validity. And so, if you vote no, you are saying that you do not accept the SMPs decision. And just to further clarify with this we have not been asking those additional questions. So, those additional questions will be going out to the committee in that survey, so there is this high moderate, low insufficient questions will be going out to the committee in that survey.

If we find that after looking at the except the validity or the SMP question is more than 60% we will then go to the subsequent questions of high moderate low that will be sent out to the committee for you all to answer and accept that rating. If we find that it is not, if it is upheld then the measure does not pass.

John Bulger: Correct. So, this is you're essentially everybody. If you think it's the validity is okay, you need to vote no, if you think the validity is not okay you vote yes.

Pamela Roberts: We are currently at 11 vote voting is still in. Okay, so now we are at 13 votes there were a couple seconds in case there's anybody else on the line. I'm seeing none with that 13 votes I'm going to go ahead and lock in votes.

Matthew Pickering: Okay, great. Thank you. And so we'll go to feasibility, any quick comments Pam on feasibility.

Pamela Roberts: No feasibility is the electronic claims (Unintelligible) system so there were no issues from any other comments on feasibility.

John Bulger: Great, thank you. Any questions or concerns from any of the committee members? Seeing none, we'll go to vote on feasibility please.

Pamela Roberts: Okay. So, for feasibility for measure 2496 it's going to be on data generated during care. So, electronic sources, data collection can be implemented in measure feasibility assessment of data elements and logic. The options are A high; B moderate; C low; D insufficient. Voting is currently open. We're currently at 10 votes. Okay so, it looks like we are at 13 votes. I'm going to go ahead and lock these votes in.

John Bulger: Okay, thank you. So, we will go to use Pam.

Pamela Roberts: There were no major comments on use.

John Bulger: Okay, great. Any questions or concerns from the committee about use in this measure? Seeing none, we'll go to a vote on use.

Pamela Roberts: Okay, so for this measure as we're voting on use, we will be looking at the accountability and transparency. So using accountability within three years public reporting within six years for SMU (Unintelligible) a credible plan, and feedback on the measure by both being measured or others the options are pass or do not. We're currently at nine votes. Okay, so we're currently at 13 votes. I'm going to go ahead and lock these votes in.

John Bulger: Okay, thank you. And usability is our last area. Pam any comments on usability?

Pamela Roberts: The measure is currently used by the dialysis facility (Unintelligible) and there were no issues identified by the committee.

John Bulger: Any questions or concerns from the committee? I don't see any. So, let's go to vote on usability.

Pamela Roberts: Okay, so for this measure with usability we're going to be looking at improvement so the progress demonstrated if new, credible rationale and benefit that they are way evidence of unintended negative consequences to patients or populations. The options are A high; B moderate; C low; or D insufficient. Voting is currently open and we are at the six votes. Okay, we're currently at 13 votes, in case anybody has not gotten a chance to vote and has just joined the line just been given a couple seconds.

John Bulger: And I'll just say, here before we're waiting there and before we vote on the recommended measure, and Matt, you can hold me honest with this. But just so everybody's aware if the committee upheld the Scientific Methods Panel on validity, it validity is a must pass and we would stop there. So, technically you would never get to this vote that we're about to take or the subsequent votes which is so everybody understands that.

And then if we didn't uphold it and we have to come back and rank it ourselves there is technically a possibility we could rank it ourselves and it still would fail for a number of different reasons people changing their vote different people voting etcetera. So, just so everybody understands that but there is a potential here where this vote at the end ends up saying we endorse it, but we never get to that because of the previous votes is that correct Matt?

Matthew Pickering: That's correct, John. Yeah, that's correct.

John Bulger: Okay, just so everybody under memorize you have a lot of new people on the committee, and then the challenges of being virtual I have added to that so. Okay, we're ready to go.

Pamela Roberts: Yes.

John Bulger: Any other comments anyone wanted to make or questions? Seeing none, let's go to vote on the overall suitability.

Pamela Roberts: We're looking at the overall feasibility for endorsements, does the measure need an NQF (Unintelligible) for endorsements. And please note this may not yet be a recommendation for endorsements. Final recommendation for endorsements may depend on the assessment of unrelated and competing measures. The options are yes or no, the voting is open and we are currently at eight votes. We're currently at 12 votes. We have a couple more seconds for everybody to put their responses in.

Matthew Pickering: Has anybody not voted?

Pamela Roberts: Okay, so it looks like we are at 13. I can go ahead and lock these in.

John Bulger: Okay, great. So, Matt, do you want to take this through us where we are in housekeeping, or where we're going here.

Matthew Pickering: Right? Yes. So, first of all, thank you very much to the developer for all four of those real measures for being patient as we sort of reorganize, restructure, and apologies, we did lose quorum, so we will have to follow up

with the Standing Committee on the survey to capture those votes and determine the outcome of those measures which we'll be following up here this week and shortly, hopefully, have a determination.

As far as next test we do have one more measure and I also will say that the fall 2019 discussion will have to be deferred to July 2nd, so we won't be doing the fall 2019 discussion, just because we have one more measure to go through.

And we'll have to move that discussion to July 2nd. So, I do apologize to the developer for measure 3495 as we needed to move that measure to July 2nd. We have this last measure which is measure 2539. Before we get into this measure does the Standing Committee want to finish with this measure or do you want to have a break at all?

Pamela Roberts: Finish.

John Bulger: Let's go.

Matthew Pickering: Anything you'd like to say. Okay alright.

Woman: Hi, this is the developer for 2539 we just have to get our group back together again. So, just to begin, hold on a sec.

Matthew Pickering: Yes, sure.

Jerome Asana: So, Matt while they're doing that this is Jerome Asana from Tech, and I just wanted to, we're going to sign off or drop off the call now. I wanted to thank the NQF teams, and all the admission readmission committee members for your patience and listening to our long and some of the winding explanations.

And thank you for your service to the cause of patient quality. Thanks. Have a good afternoon.

John Bulger: Thank you, and thanks for bearing with us here.

Matthew Pickering: Okay.

John Bulger: And Pam thank you for coming back on to lead us through that.

Pamela Roberts: Oh, no problem. Sorry, I had to be for an hour.

Matthew Pickering: Understandable and very much appreciate the Standing Committees time and all-day virtual meeting plus having to leave here and there and then come back we very much appreciate that as well. I checked in with the developer, the 2539 any -- are you ready to go.

(Doris): Hi, this is Doris from Core we're just waiting for our lead discussion to join the call again.

Matthew Pickering: Okay.

(Doris): She just said she was calling in.

Matthew Pickering: Okay. All right. So, John, I believe you are the lead discussion on this as our discussing had to cancel for this measure. So, you're the lead discussing for 2539.

(Claire): Hi, this is Claire we have everybody together now.

Matthew Pickering: Okay.

John Bulger: All right, let me get back to my where's this format again. Where is this from that again or we're on here 25at.

Matthew Pickering: 2539 is that would start on page 11 and that certainly have.

John Bulger: All right, excellent.

Matthew Pickering: Or the end of page 10 going in.

John Bulger: Okay, great. So we have since 2529 excuse me 2539 this is facility (Unintelligible) hospital visit rate after outpatient colonoscopy. This is for MyoCore. This is a maintenance measure. So, and this is at the facility level to risk standardized rate of unplanned hospital visits within seven days after a colonoscopy which is performed (Unintelligible) hospital outpatient department or an ambulatory surgery center and this is Medicare fee for service beneficiary 65 and older it's not Medicare Advantage again because it's outpatient data and an unplanned hospital visit is defined under this is an emergency department visit observations day or an unplanned inpatient admission.

So, this is all three of those rolled into one, three outpatient issues observation and needy and the inpatient issue, obviously an inpatient admission and it's calculated separately for ASCs and hospital outpatient sites. While give Sheila the lead for end developer.

Matthew Pickering: For the developer no, doctor Elizabeth.

Pamela Roberts: No it's Elizabeth Tryon.

John Bulger: Okay, great. Elizabeth, you want to give us an overview?

(Elizabeth): Sure. Thank you for starting that overview very nicely. Hi, it's Elizabeth Tryon. I'll just give you a quick overview and then obviously we're here to answer any questions. So, on as described, these are really the same measure applied into setting hospital outpatient department and ambulatory surgery center for routine colonoscopy.

And it's a measure fills a gap in that, as you know, there's very few outcome measures for any ambulatory procedures. And this is one of the most common ambulatory procedures nationally with 1.6 million colonoscopy and are fee for service Medicare annually. This is a (Unintelligible) three years of data to enhance its reliability.

And these are big groups of procedures over 2 million procedures at both HOPD the 2.2 million plus and then 2.5 million at ambulatory surgery centers. So, I think one of the highest volume averages you'll see, thanks for talking about the outcome.

The reason we focused on returns within seven days to the hospital either ED visits observations, days for admissions is these are four reasons that matter to patients like a minor thing the relatively minor like urinary retention, abdominal pain that is relatively benign, two more severe problems like perforation or bleeding.

And historically, these just were not very visible to providers performing colonoscopy, because they were performing them in the ambulatory settings and patients of course in return they're for care, they were returned to the ED setting typically, and then there are a subset where ultimately admitted.

We're targeting routine procedures so for stable patients, we do exclude from the measures, patients who might be getting colonoscopies as part of the valuation and then end up in short order in the hospital for treatment, specifically patients with inflammatory bowel disease and diverticulitis because for those patients admission is not a quality signal.

But otherwise it's an inclusive measure and the only other exclusions are if we don't have call data, for example for enrollment during the measurement period in Medicare. The measures are risk adjusted and typical logistic regression modeling that we do, there are 16 risk adjustment variables, including age common upper GI endoscopy.

So, if you're having which is common both endoscopy and a colonoscopy, we adjust for that. If you're having a high-risk endoscopy procedure, we take you out of the measure all together. If you have a Polypectomy, we adjust for that. And then there are 12 comorbidity variables and we just mentioned age I think already.

I'm going to talk about social risk factor adjustment in a minute. But before I get to that, I just want to give you a sense of the measure score and variation. So, even though this is a high-volume procedure, the outcome rate is relatively low. If you'll see us describing it in the application for hospital outpatient colonoscopies at 16.4 per thousand or 1.64% and for ambulatory surgery centers, it's the national rate is 12.2 colonoscopies per 1,000.

So this is what I just read somehow, we pay attention to things like reliability and sample size especially these are important numbers of cases and numbers of outcome because the number of procedures is so high that the outcome rates are relatively low.

However, for both hospitals and ambulatory surgery centers we see meaningful variation, and both in the range of rates, and also we do as for other publicly reported measures in our calculate outliers, that are better facilities that are better or worse with a 95% confidence intervals so very high statistical certainty. And we see outliers for both HOPD Hospital Outpatient Departments also we fondly call them HOPD and ambulatory surgery center. Just one last word about the way the score is reported.

These are a few, these are pay for reporting programs. So, neither the hospital outpatient departments or hospitals, or the ambulatory surgery centers are paid on their score just but they need to participate, to get their payment updates under their reporting program.

So, finally just mentioned about socio risk factors. You'll see in the application that we extensively analyze two socio risk factors for their relationship to the outcome returned to the hospital within seven days, dual eligibility for Medicare and Medicaid and also we look at the arc SCS index and we do see a relationship in both Hospital Outpatient Departments and ambulatory surgery centers with those variables and the outcome.

We look at that relationships and from a number of different angles there's, as you probably saw pages and pages of analyses, and we can talk about any of them in more detail.

But just to summarize we do see that the relationship is attenuated, but doesn't go away when we adjust for comorbidities and the other variables in the model. And we do see that these patients are concentrated and really in a sort of a quarter of the hospitals are ambulatory surgery centers, and they're actually a lot of fewer patients with socio risk factors to get their colonoscopies at ambulatory surgery centers so that’s kind of background.

When we look at those hospital visits and the last analyses, analyses seven and AFCs where their most concentrated, there's a correlation between the proportions that are in those facilities and the measure (Unintelligible) it's a pretty weak correlation.

So, looking at all of those factor, CMS decided in this context not to adjust for socio risk factors, I'll say when this measure went through development, we had our expert panel, there was a feeling that this setting in which this is scheduled procedure, and it's a short period, and there should not be a need for follow up in the ED or unusual and shouldn't be a need for an admission that it was, there were more of the set of things that might influence the risk of any revisit for example for patients with socio risk factors like transportation or social support or literacy.

Those kinds of factors should be something that providers could anticipate if a little more we regular revisits, scheduled procedure. So, all of that on that, given the trade-offs and the risk of adjusting away quality differences that we want to see in these population if we did put social risk factors in the model, the decision is to leave them out. And that was a quick summary of a long history of this measure has been in public reporting for several years.

And that we do see a bit of a downward trend in the outcome rate and more of a narrowing of the distribution, which is, we'd like to see that because we hopefully we're it's part of what we're doing through measuring and providing facilities and hospitals with their patient level data so they can see what happened to their patients, that we're hopefully having the impact that we want in terms of improving attention and understanding the outcome. So, let me stop there and see what questions you all have. Thanks so much for the chance to talk about the measures little bit.

John Bulger: All right, great, thanks Elizabeth. So, we're going to go through and step through this. We'll start with evidence and, I'll just do the evidence and performance gap comments here together but there is a study out there from 2008 that shows that people who experienced an ED visit within seven days of outpatient colonoscopy about a little over two thirds 68% or due to something to do with the colonoscopy.

So, there is a fairly a correlation there. Developer also cited that the reported emergency room visit rates after colonoscopy were about three quarters of a percent .76 in an average seven-day hospital visit rate that's the combined outcome of ED visit observation stay and inpatient hospitalization of 1.63%.

There's also evidence that from a gap standpoint, that's part of the materials we got that shows that there's still a fairly high degree of variation in these risk standardized hospital rates between centers so that would suggest that there is still a gap that exists. Are there any questions from the committee members around evidence? Seeing none, let's go to a vote on evidence.

Pamela Roberts: Okay, so on evidence, we are looking at the outcome empirical data demonstrate the relationship between the outcome and at least one healthcare structure process intervention or service if not available wide variation in performance can be used as evidence, assuming the data are from a robust number of providers.

End results are not subject to systemic bias. The options are pass or do not pass votes are currently open and we are currently at eight votes. We are currently at 13 votes. Everybody has their votes locked in.

John Bulger: Okay, excellent. So, let's go to performance gap. And I already noted the what's in the developer report and any questions from the Committee for the developer around performance gap. Seeing none, let's go to a vote on the performance gap.

Pamela Roberts: Okay, so on performance gap, we're looking at data demonstrated considerable variation or overall less than optimal performance across providers in or population groups. The disparities in care, the options are A high; B moderate; C slow; or D insufficient voting is open and we are currently at 10 votes. We're currently at 12 votes it looks like we're missing one. Anybody can go ahead and put in their vote. All right, it looks like we are at 13. I'm going to go ahead and lock in the vote.

John Bulger: Excellent, thank you. So, we'll go to reliability. So, reliability there's it was passed by the Scientific Methods Panel. So, we will be voting on whether or not to uphold the Scientific Methods Panel recommendation of passing on reliability.

There's really two pieces of this one for the hospital outpatient departments if you look at using three years of data the median facility level reliability was 0.744 with the IQR of .489 and to .883. If you look at the hospital outpatient departments that had 30 cases, the median reliability score was .782 with an IQR of .596 to .892.

And same type of numbers actually even better for ambulatory surgery facility for all ambulatory surgery facilities it was .864 excuse me with a .628 to a .938 IQR and for those with more than 30 cases it was a .883 with an IQR of .714 to .942. So, again, the Scientific Method Panel did pass this through on reliability? Any questions from the committee on reliability?

(Elizabeth): Hi it's Elizabeth (Unintelligible) from Elegant. I can also just add for context that the reason we're giving you 30 (Unintelligible) sets some minimum sample size when they publicly report the measures.

So, if facilities have fewer than 30 cases, they'll report publicly as they do for many other risk-adjusted measures, that there are too few cases to classify those providers as no different than the typical provider or better or worse. So, we're, that we're reporting specifically since that's what is currently used.

John Bulger: Great. That's very good context. Thank you. Any questions? I don't see any hands. Let's go to vote. And this will be yes no to poll the committee's vote.

Pamela Roberts: Okay, so for this measure 2539 do you accept the Scientific Methods Panel, bleeding for reliability, and your options are yes or no voting is currently open. We're currently at 12 votes. We're currently at 13 votes. It looks like everybody has voted. So, I'm going to go ahead and lock these in.

John Bulger: Okay. So, we go to validity. It's important to recognize that only face validity was conducted for this measure. And there really are not exist, the developer felt that there were not appropriate existing measures that these could be used as a competitor for validity testing.

There was a technical expert panel which was seated and 71% of the technical expert panel indicated at least moderate agreement that's valid and 86% of the technical expert panel indicated somewhat moderately or strongly agree around validity.

The developer did provide a response to that saying many ASC specialize in a single procedure and then few ASCs performing colonoscopies for the same facilities that would be measured by the ASC general surgery measure as a

way of saying validating the notion that they're not existing measures, appropriate compares. Any other comments around that from the developer first?

Pamela Roberts: No, I think it's just we would love to be able to validate this measure out where it's still a challenge to validate outcome measures that are sort of the first outcome measures into their area with other good measures for ourselves, trying to be creative, but as you noted, we just really couldn't come up with a measure here that was comparable, that was measuring the same anything really, that was the same that applies to a similar group of facilities that was something similar enough.

And we just note them methods been in use and there has not at this juncture there's a lot of familiarity with an acceptance of a measure. So we're by hospitals in ASCs, we haven't really heard recently any honestly, I'm not sure if this is the right moment to be saying that it's not a formal validation of the method but I think at this juncture, it's expected as reflecting an important domain of quality.

(Doris): And I just want to add one other things. This is Doris from Core we also had a discussion with the Scientific Methods Panel about validating the outcome of the measure looking at reasons for the hospital visit. As you mentioned before, there was the study showing that 68% it’s almost 70% of hospital visits were due to the procedure and we did the similar assessment looking at IC 10 and CCS codes that were the diagnoses codes related to the hospital visit for the patient who had the colonoscopy.

And we found the same thing in our results, we didn't actually tally up the percent that we thought was related to the visit. But if you look at the top reasons for returns, they are for things like hemorrhage, pain, urinary

retention, urinary tract infections. So, similar validating of the outcome. And yeah, so I think the Scientific Methods Panel is encouraged by those data.

John Bulger: Great, thank you. Any questions or comments from the committee? I don't see any hands raised. So we'll go to a vote. Again, this vote will be yes or no to uphold the scientific methods panel passing of validity.

Woman: Okay, so for measure 2539 do you accept the scientific methods panel waiting for validity yes or no. Voting is currently open. So, with 13 votes, I'm just going to go ahead and lock in the responses.

John Bulger: Great, thank you. So feasibility is next, and feasibility. These are all electronic claims elements. So, there has not been an issue around feasibility. Any questions from the committee? Seeing none, we'll go to a vote on feasibility.

Pamela Roberts: Okay, so with feasibility we will be looking at data generated during care electronic forces. Data collection can be implemented in measure feasibility assessment of data elements and logic. The options are A high; B moderate; C low; or D insufficient. Voting is currently open it currently stands at nine votes. All right, so with 13 votes, I'm going to go ahead and lock in responses.

John Bulger: Okay, thank you again. So, use and usability and I'll give these two together and we'll vote separately these measures are in the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgery Quality Reporting Program for CMS. Their developer has a list of ways and steps to gain feedback during the development implementation of the measure.

There have been a number of situations identified, it's just that the need to make minor refinements to ensure the algorithm for processing claims that are accurately identifies cases for inclusion in the planned admission algorithm

captures additional plan, hospital visits and from a outcome standpoint, if you look at the hospital outpatient department measure the rate has decreased over time from 16.4 in 2018 reporting to 14.8 2019 reporting, they're having small declines in the ambulatory surgery center from 2018 to 2019 and now seeing some of that decline in 2020. Any comments the developer wants to make quickly around use and usability?

Pamela Roberts: No, that was a great summary thanks.

John Bulger: Okay. And as you noted, these are paid for reporting measures in both of those areas. Any questions from the committee? Seeing none, let's go to use please voting.

Pamela Roberts: Okay, so for measure 2539 we're looking at accountability and transparencies for use and accountability within three years, public reporting within six years or if new credible plan give feedback on the measure by those being measured or others, the options are pass or do not pass.

Voting is currently open and we currently stand at eight votes. We're currently at 12 votes. Looks like we're waiting on one more. Okay, and with 13 votes it looks like everyone has responded and I will go ahead and lock in the responses.

John Bulger: Okay, and we'll go right away any comments on usability? We'll go to a vote on usability.

Pamela Roberts: All right, so with usability, we're looking at improvements progress demonstrated if new, credible rationale and benefits outweigh evidence of unintended negative consequences to patients or populations. The options are A high; B moderate; C low; or D insufficient. Voting is currently open and we

now stand at nine votes. We currently have 12 vote looks like we're waiting on one more. All right, so with 13 votes I'm going to go ahead and lock in the responses.

John Bulger: Okay, so that brings us to our final vote on this particular measure which is around our overall recommendation is suitable for endorsement. Any further comments anyone wanted to bring up around this measure? Seeing none, we'll go to a vote on overall suitability.

Pamela Roberts: We are currently at 10 votes. We're now at 11 votes. We are still at 11 votes; I would like to encourage the committee to go ahead and put in your vote. All right, as I'm seeing that no other votes has come in, I'm just going to go ahead and ask is there anyone else who has not put in their vote before I go ahead and lock in these responses. As I'm hearing none I'm going to go ahead and lock in the 11 responses received.

John Bulger: Okay. So thanks everybody for working through that and thank you to the developers and Elizabeth, for working this through that. Appreciate your time and patience for sticking with us all day. Thank you.

(Elizabeth): No problem.

John Bulger: Okay, Matt, where are we?

Matthew Pickering: Yeah. So yeah, so thanks, John. So we went through that measure quite quickly. So we are now at 407. I just wanted to check I know we have folks still on the line from the planning committee so thank you for your patience. But I just wanted to check if the other developer for measure 3495 is still on? And if so, would they want to consider proceeding with this fall 2019 post comments discussion? Doris, are you still on are you in your team?

(Doris): Well, I'm actually on the other team I'm on 2539 team. So, I can check with them. No, no, no you wouldn't know. They were anticipating that this would get pushed off. So but I can check with them real quick and see let me see. Hold on a sec.

Matthew Pickering: Yeah, sure, sure. We still have public comment and some next steps on this so we can kind of move forward with that for the spring 2020. And I know folks on the Standing Committee, we went through that quite quickly. If we're able to utilize this time and do the post comments discussion for 3495 that would be great.

That way, we don't have to reconvene on July 2nd. So, if you wouldn't mind holding on just a little bit longer and we'll see if we can get the developer for 3495 ready for that discussion. If not, we will proceed with July 2nd. So apologies for that as we kind of went through that last measure quite quickly. Okay, so I will switch it over to Roma she's going to follow up with the public comment next steps for spring 2020.

(Roma): Thank you, Matt. At this time, we're going to open the lines for any public comments or comments from NQF membership. And we'll hold for about 20 seconds. Again, we're using this time for any NQF member comments or public comments.

Okay, having heard none, we can proceed with next step. Okay, so thank you again to standing committee members and developers, all coaches and interior staff for today's evaluation meeting. On July 2nd we will be holding the committee post Measure Evaluation web meeting if in a few minutes, we confirm that we are not able to proceed with measure 3495.

However, if we are able to close out the remaining of the day with the discussion on 3495 then we will not have to be on July 2nd. So, we will know this shortly here any time. Now, following the call today, and after we completely collect all votes on the measures that were just discussed we will be entering the draft report comments period and that will be from July 28 to September 1st.

The draft report will be posted to the public and will be available for comments. Now following that we will be entering the committee post comment web meeting period where we will be holding a call if we receive any comments during the draft report comment period that will require Standing Committee discussion.

So again, this would be the committee post common web meeting for these five measures that were just discussed today and that will take place September 24th. Following the common web meeting, we will enter this to stack review and that is a two day meeting from November 17th to 18th that is when the consensus body will review all measures that are being evaluated the cycle, and then we will enter the appeals period which is a 30 day period in which the public and or any other constituents are able to submit an appeal for any measures that were not recommended for endorsement.

And that will be November 23rd through December 22nd. Okay, moving forward to some critical dates upcoming is the Fall 2020 cycle and the intent to submit deadline for that is August 3rd 2020 and the measure submission deadline is November 9th 2020.

As you all know, there are several ways to keep in contact and stay up to date on the project. If you have any questions or concerns or feedback please email our project box at readmissions@qualityform.org. We can be reached by

telephone as well. And our project page is listed there as well as the SharePoint site which is available to our Standing Committee member.

So I will talk a little bit more about this I'm sure before we close the callback, for those who are not present on the call, but we're perhaps roll call at the beginning of the call we received a link to complete the offline survey. Okay, so, before I close the next step are there any questions or was any information unclear? Okay, if no questions, I will go ahead and hand it over back to Matt. And we can check in on the developer for (Unintelligible) to see if they are available to resume the call today.

(Doris): Yeah, we're working on it. We have a few people who are who have confirmed they can.

(Roma): Oh, great.

(Doris): So they're just getting themselves together.

(Roma): Okay. So it's likely that we will proceed with 3495.

(Doris): Yeah, if you can wait a few more minutes just to get everybody back together.

John Bulger: Sure, sure thank you. Thank you. No, thank you. No, we didn't expect going through that last measure so quickly. So very much appreciate that if we could try to do this and also for the standing committee, thank you very, very much for your time as we tried to go through this last little bit. That way, we do not have to have the July 2nd call.

And so what we'll do in the meantime, as we're waiting for the developer is really just go over a sort of a roll call just to make sure who's on the phone for

this discussion? And so, before we dive into the roll call as well, really the purpose of this meeting is to evaluate any of the comments that came through in the 60-day comment period for fall 2019, which we had one measure 3495.

So we evaluate any of those comments. And we really want to see if there's anything new that has been raised from the comments, public comment period, that's standing committees to deliberate on and decide if there's any changes that need to be made in some of the decisions.

So really thinking about is there anything new that has been raised, that the Standing Committee needs to discuss and move forward with in any sort of differences in their decision making from fall 2019.

So, what will happen is after I go through roll call, and we'll see where the developer is that I will proceed to present the measure and the comments, the major themes of those comments, specifically summarizing those and also provide just a high level of a summary from the developers side of a response. And then sort of a proposed response from the Standing Committee.

The standing committee can then discuss and then decide whether or not they want to move forward. Just accept the proposed response or if there's any other questions they may have for the developer, they may be able to raise them. So, I'll start with just going through the list as well. So John, John Bolger are you present?

John Bolger: I am present.

John Bulger: Thank you. Christy Travis.

Christy Travis: Yes.

John Bulger: Thank you. Frank Bricks. Okay. Nay Santino. Helen Chen.

Helen Chen: Present.

John Bulger: Thank you. Edward Davidson.

(Edward): Here.

John Bulger: Thank you. James (Unintelligible). Lisa Freeman.

Lisa Freeman: I'm here.

John Bulger: Thank you. (Unintelligible)

Woman: I'm here.

John Bulger: Thank you. (Unintelligible)

Woman: I'm here.

John Bulger: Thank you. Michelle Lynn. (Unintelligible) Raj Mahajan.

Raj Mahajan: I'm here thanks.

John Bulger: Thank you (Unintelligible).

Woman: I'm here thanks.

John Bulger: Gaither, Pennington. Carol Pulaski. Pamela Roberts.

Pamela Roberts: I'm here.

John Bulger: Thanks Pam. Okay. Sheila Roman. Terry Schuler. Chloe Slocum.

Chloe Slocum: I'm here. Thanks.

John Bulger: Thank you, Chloe. We're just double-checking Sheila, Sheila Robert are you there? Okay. So again, there's we have a 11 participants on this part of the meeting so we can have the meeting, if there's any determination that there needs to be a revote for any reason, we will have to follow up after the call for a revote of any of those criteria for the themes that were for the comments that reflect those criteria. So, I'll just check again from the Yale group. Are you on the call the developers for 3495?

(Doris): Yeah, we have some of our team on we just wanted to clarify, if you were going to run through the public comments first, or did you need us to start out with an introduction?

John Bulger: So I think that would be nice. If you wanted to start out with an overview of the measure of the intro, then we can go through the comments, and then proceed accordingly with the committee discussion.

(Doris): Okay, Erica, if you can hear if you're on you want to start with an intro. Are you ready to do that?

(Erica): This is Erica. I'm on can everyone hear me all right.

John Bulger: Yes, yes, Erica, thank you.

(Erica): Okay, fantastic. Yep, I'm happy to provide an overview of the measure and I can do that now. So thank you everyone for joining. I know, this isn't this is a difficult time for many of us. So thanks for joining and participating in this discussion.

So, we're talking about -- number 3495 which is hospitalized 30-day all cause unplanned readmission rate for the merit-based incentive payment system. NET top the wide readmission we refer to it as short for short. It is an adaptation of the existing hospital level, hospital wide all cause unplanned readmission measure that's currently in the ICR program, as well as the re specification of the call cause or ACR measure that's currently reported in MIPS.

The measures intended to replace the current ACR measure within MIPS and specifically assessed eligible clinician groups. So the measure is aligned entirely with the original two measures the IQ or measure in the ACR measure within MIPS in terms of outcome cohort and risk adjustment. So briefly, the outcome is unplanned all cause 30-day readmission.

The cohort is almost all 65 or older Medicare fee for service admissions except for those that aren't considered a quality signal. And those admissions are assigned to one or five specialty cohorts based on their discharge diagnosis.

So that is either surgery gynecology, cardio, respiratory, cardiovascular, neurology or medicine. And those five separate risk models account for both case mix and service mix through adjustment for age and comorbidities, as well as the types of conditions and procedures within each of those specialty cohort.

So, the measure only differs in terms of attribution and statistical modeling that allows us to attribute readmissions to multiple eligible clinician groups. For the current ACR measure within MIPS attributes readmissions solely to the primary outpatient physician that provides the plurality of care during the 12 months measurement period.

And then this raises the possibility that a single outpatient clinician who might never have seen the patient prior to their index admission is currently being held accountable for the unplanned readmission outcomes.

That primary outpatient -- may not be the only or best opportunity to impact readmissions. And this measure intensity improves upon that attribution by ensuring shared accountability across up to three of the three clinician groups.

So again, again, the intent of this measure is to improve upon the attribution of the current ACR measure and incentivize collaboration of care across both inpatient and outpatient settings by considering joy attribution for up to three punishing groups or practices that provide care for patients inside and outside of the hospitals, prior to the discharge and therefore are in positions to influence and patient's risk of readmission. And can everyone still hear me all right.

John Bulger: Yes.

(Erica): Okay, sorry, I thought there was something going on with my phone. Apologies for that. And so specifically, this measure would attribute each readmission to the clinician group of the primary inpatient clinicians, the discharge clinician, and third, the primary outpatient clinician.

The primary inpatient clinician is defined as the clinician group that builds the most charges for the patient during their hospital stay, and they are responsible for medical care during the hospital stay referring the patient to impatient specialists as needed and prescribing medications.

They can help reduce readmissions influence whether the patient returns with unresolved medical issues or side effects from medication through the delivery of their care during the hospital stay. The discharge clinician is defined as the clinician group transitioning the patient from inpatient to outpatient care.

They're responsible for preparing the patient for discharge, including the patient as well enough to leave the hospital understand their conditioning treatments and has been referred to outpatient specialist or therapy as needed. And they can reduce readmissions by providing clear instructions and arrangements that help ensure that the patient is your care, medication and lifestyle changes outside of the hospital.

And third, the primary outpatient clinician is defined as the clinician group with the greatest number of claims for primary care during the 12 months prior to the hospital admission date. They're responsible for the care of the patient outside of the hospital and can reduce readmissions by ensuring accessibility to care and availability of appointments within 30 days after discharge, following up on pending tests and monitoring recovery. So that's a really brief overview of the measure.

Again, it's aligned in terms of outcome cohort and risk adjustment with two measures, which I'm sure a lot of people on the phone are familiar with, and just differ in the attribution to up to those three clinician groups and then the statistical modeling to support the shared attributions.

I do want to add a few clarifications based on the public comments that we received. So, I just want to make it really clear that the measure would only attribute readmissions to clinician groups, not individual clinicians. And then furthermore, consistent with the ACR measure currently in MIPS, the rates would only be reported for clinician groups with 16, NPI, at least, NPI and 200 cases.

So using the minimum case count of 200 cases signals the signal to noise reliability testing that we did resulted in a range from 0.82 for the surgical cohort size to 0.92 for the neurology cohort and which all around indicates very high reliability.

And then in addition to the literature and the expert input that we have solicited, the variation in clinician group performance, which ranges from seven to 25.1% demonstrates a clear gap in performance in search as additional evidence for the attribution of readmissions to the clinician group.

So I will close there I do want to mention, you know that this measure does have a history with NQF over the past two cycles, and it was reviewed by both the spring 2019 and the current cycle and today most of the voting from the scientific methods panel, and the committee for both cycles has been in favor of this measure. And I'm happy to answer any questions that anyone might have.

Matthew Pickering: Great, thank you very much, Erica. Really appreciate that. Before we go into any questions, which I will have Christy facilitate any of that dialogue, NQF just want to highlight three of the themes across the comments that were received for this measure.

So we did receive 10 comments across eight organizations and really centering around three themes, the reliability at minimum case volume, the evidence to support attribution. Risk adjustment testing and social risk factors. So, as we go through this, I will summarize the reliability piece for each theme.

We will then open it up for any questions in I also mentioned a proposed response, it will then open it up for any questions that the committee has facilitated with discussion by Christy.

And we will see if the committee would like to move forward with the proposed response or if there's any further decision making on these themes and these elements of reliability the evidence and risk adjustment which would be factoring in validity. Again, this is if anything new has been proposed to the committee for additional consideration, do to take that into account as well.

So, for the reliability peace, the comments that were raised concerning reliability regarding testing of reliability and the results across five specialty cohorts several commenters noted that the reliability results were insufficient at case volumes of 25. And as the results were still lower than optimal at a minimum case, volume of 200.

Additionally, one commenter expressed concerns about the generalizability of the measure of scores or measures across MIPS eligible condition groups at a case volume of 200. For the proposed committee response, we had indicated that we are thanking the commenter for their comments, and that the Standing Committee discussed the issue during its evaluation meeting on February 4 2020 in which the developer noted that the measure has minimum case

volume of 200 in response to questions raised by the committee during their preliminary review.

The committee agreed to accept the scientific methods panel rating of moderate for reliability. As far as the developer they had also indicated as their opening remarks that there is that minimum of 200 eligible cases in the measurement period, the measure would only be attributed to clinician groups of 16 or more eligible clinicians.

When the intended minimum cake count of 200 is applied, the mean sequence would always ratio of each of the specialty cohorts was as follows cardio respiratory was .89 again, these are the reliability results, cardiovascular .88 medicine .85 neurology .92 and surgical .82. So a range of mean Signal to Noise reliability of .82 to .92 across specialty cohorts indicates from the developer's response a high reliability from the developer. Again, that's at a minimum case of 200. Christy, I'll turn it to you for any committee discussion.

Christy Travis: Okay, thank you so much, Matt and the developers for opening up our discussion. Does the committee have any questions or comments relying on reliability focusing in on as Matt said that we're looking for any new information that would result in the need to kind of rethink this measure? And so does anybody have any comments or questions around that? It doesn't appear that there's any new information that's been provided today. And Matt you'll have to let me know if anybody.

Matthew Pickering: Right. I don't see any hands up. No questions in the chat box at this time.

Christy Travis: And does anybody have any thoughts? The recommended response sound inappropriate to me. Any issues around that for any committee members. Okay, Matt do I need to do anything else relative to that.

Matthew Pickering: No, I think that's it. I'm hearing nothing from the committee, we can move on to the next theme.

Christy Travis: Right.

Matthew Pickering: Okay, so the next theme we have was evidence to support attribution. So commenters expressed concerns regarding the supporting evidence related to the measure's attribution to three types of clinician groups and several commenters stated that the evidence really relies on general statements, and that the studies provided are inadequate to support the attribution logic to discharging clinicians. One commenter raised concerns that certain specialties will be inappropriately impacted due to the attribution logic, and recommended that the measure should include a broader range of specialties.

The developer did open up with a series of explanation and overview around the evidence of attribution so I won't go too much into detail with that as that was very inclusive in their responses for this these comments. So the proposed committee response for this evidence retribution was thank you again for the comments.

The Standing Committee discussed this issue during the evaluation meeting on February 4 2020 and agreed that the evidence supports interventions physician groups can take to influence this outcome and the measure passed on evidence and in fact, the measure passed unanimously on evidence for this measure. Christy.

Christy Travis: Okay. Once again, with the focus on any new information being presented in these comments, which it does not appear that any has been on, are there any

comments or questions from the committee? And any comments or input regarding the recommended response?

Matthew Pickering: So I do have a hand raised.

Man: Yeah, I raised my hands. Just because a thought came to mind that and maybe I missed it in the plurality of the responses, but was there a particular specialty group that would be impacted because of the threshold of 16 NPIs in a practice. And that was the reason for the issue with the - some specialties feeling like they may be impacted more. That make sense.

Christy Travis: I'm trying to kind of flush the asset. And in terms of that, you know, Matt was just so.

Matthew Pickering: So there. So there might be family physicians or might be more likely your interns might be likely more likely to have 16 providers in a practice than say, you know neurosurgeons or, you know, some other group. And so that those that had more providers felt like the impact might be greater on their type of practice, because they would be more inclusive.

Man: I will say, does the developer maybe the developer doesn't really have a response to any to Ed's question.

(Lisa): Hi, this is Lisa (Unintelligible). I'm not sure I’m on an open line can you guys hear me?

Christy Travis: Yes.

Matthew Pickering: Yes.

(Lisa): Great. Thank you. So I don't know, we don't have any evidence to support just is the case although we haven't looked specifically at that. I certainly think that internist and primary care doctors are not the only multi-specialty groups, particularly academic centers in general may be more likely to be pulled into this measure.

But recall that the attribution is spread across three different types of clinicians and therefore practices that are only focused in the outpatient setting would only be potentially pulled in at a greater rate for the in the primary outpatient provider category.

And there are two additional categories. So, although there may be some practices that are more heavily captured in the MIPS program that is universal across the MIPS program and this the whole idea behind the multiple activation, which was driven by the clinicians, including surgeries and some specialists on the tap was to spread responsibility across multiple inpatient and outpatient providers which the three attribution three clinician group attribution methodology does.

Matthew Pickering: Okay, that makes sense. I appreciate that explanation.

Christy Travis: Thank you very much. Any other raise hand, Matt. Sorry, I'm missing it. I can't see him.

Matthew Pickering: Yes. Okay, so I do have. I do have Helen Chen her hands raised.

Helen Chen: Hi Christy, hi, Matt. So I appreciate the expansion to at least 200 and also the increase in the attribution model for expansion to different groups. And I support that. Although I think that the evidence may or may not be great for this.

And what I really want to say maybe a little bit off topic, I know it's off topic, actually. But you know, regarding MIPS and other quality measures in the setting of COVID this has really become a big issue, especially for primary care practices, who were blindsided by this in terms of just scrambling to meet any kind of patient need during this time.

And it could be argued that we're all going to have difficulty actually managing Care Coordination effectively, when we're just trying to keep people alive and out of our offices and out of the hospital. So it's a concern, especially since some of these measures regarding MIPS, and even the re-hospitalization measure may require more patients facing context and we can actually reasonably achieve, especially if there's another way that's all.

Christy Travis: Well, thank you, Helen. And just kind of in response to that, you know, we were looking for new information that was provided today in here and I do appreciate the comments that you've made, and I think they are important that this information was available to us and we did adjudicate it.

So, I'm just trying to kind of be sure we stay within kind of the focus of what the post comment period is supposed to be about but thank you so much for adding those comments. And really appreciate that. Any other?

Matthew Pickering: Yeah, Ed I see your hands still raised. Are you still wanting to have a you have a question still?

(Edward): No, I intended to pull it down if for some reason. All right.

Christy Travis: Thank you Ed. Okay.

Matthew Pickering: I see no other hands raised or anyone in the chat box.

Christy Travis: Okay, I think we're ready with testing them. One more.

Matthew Pickering: Okay. So the next was a risk adjustment testing and social risk factors. So really one commenter expressed concern regarding the risk adjustment models specifically, they stated that the risk adjustment testing and overall model was not robust, especially when considering risk factors.

So, the Standing Committee for the proposed comments, really thank you for the comments thinking the comments are for the comments. And during the February 4 2020 measure evaluation meetings the committee did agree that social risk factors, including community and personal factors, can have a strong impact on readmissions.

So again, this is a component of validity. And so the standing committee did pass on validity. And so if the standing committee would like to discuss anything further, this is the time to do so. The developer did provide a response talking about the risk factor testing use two variables that are available and reliably measured for all Medicare beneficiaries in the cohort.

There's a large body of evidence to support or link these various different social risk factors to worse health status and higher mortality over a lifetime so income education occupation, are most commonly examined social risk factors that are studied.

Unfortunately, these variables are not available in the patient level. For this measure things that we've discussed previously on this call. Therefore a proxy measure for income education level and economic status were selected, so the developer use that to dual eligible status and the arc FCS index score.

Ultimately, they chose not to include either of these social risk factors for two reasons, both the social risk factor for social risk factors, both of those but the correlation between the adjustment and adjustment scores was .99 indicating extremely high agreement, which supports that adding the social risk factors would have minimal impact on the measure of scores.

Another reason was that one of the key principles behind development of this measure was to align when possible with the original hospital wide readmissions measure reported within the IQR with the Inpatient Quality Reporting reported with an IQR. As that measure doesn't adjust for social risk factors the developer stated that they would suggest that they that this President argues for admitting here in this measure as well.

But again, the Standing Committee was presented this information previously and fall in for the fall 2019 and February 4th did agree that social risk factors are important, but then ultimately did pass the measure on validity, which risk adjustment is within the validity component.

Christy Travis: If I remember correctly, we did have a robust discussion around social risk factors. Any comments from the committee?

Matthew Pickering: I don't see any hands raised. No hands raised no questions in the Christy.

Christy Travis: All right, thank you very much. And just to close the loop being sure that there's no comments or suggestions regarding that proposed response.

Matthew Pickering: No hands raised and no questions in the chat box.

Christy Travis: Okay. So that takes us through those comments Matt.

Matthew Pickering: Great. Well, thank you, Christy. Thank you for the measure developer. I know that this was something that we anticipated maybe moving to July 2nd. So apologies for all of that. And thank you very much for getting back on line as we went through the fall 2019 post comments discussion. So we will move forward with those proposed comments from the Standing Committee. I will then turn it over to Roma at this Point to finish up with public comment in next steps for fall 2019.

(Roma): Great, thank you, Matt. We will now move to public comments and we will welcome any anchor of members on the line or any members of the public to state your comments. Okay, having heard none, we'll proceed the next step. So as we look at the remainder of fall 2019 here are some upcoming dates to keep in mind.

Following the post comment portion of the review for fall 2019 will be the C stack review and that is in November, it's November 17 through the 18 2020 and so in case there's any confusion here, we just want to clarify that 3495 is a false May 19 cycle measure however, we split measures into track one, track two and track two is sending fall measures to the spring 2020 C Stack review so that is why the data is so far out.

So this measure will move to the spring 2020 C Stack review on November 17, to the 18th and then we will get Brazil which spring 2020 appeals period which will take place November 23rd through December 23rd. So, it will be quite some time between now and then when we revisit the measure but that's the timeline to keep in mind.

So, again, as stated before, there are several ways to reach us and stay abreast of project updates. Do you have any questions or concerns? Please email the project staff at readmissions@qualityform.org you can contact us by phone.

And then you can also access information on our project page and for the standing committee members only the SharePoint site. Before we transition to the conclusion of this call are there any questions from anybody on the line? Okay, well, thank you so much. I'm going to go ahead and hand it over to Matt for closing comments and co-chairs to also weigh in. Thank you.

Matthew Pickering: I'm sorry, I was on mute. I was just saying, we at NWF cannot thank you enough for your time today for being on this call for those that stuck out through the whole thing. But also coming back to the call. If you had to step away, we recognize the competing priorities that are going on for others currently, and also just thank you for taking the time prior to this call to evaluating the measures to put in your thoughtful inputs into the measure evaluation, and leading to a good dialogue today.

I also want to recognize John and Christy, thank you so much for your time and efforts in facilitating the dialogue today. We greatly appreciate it as always. And thank you so much to the developers, for hanging on as we reordering the agenda as we go through it today. We really appreciate you coming back and finishing out the fall 2020 discussion as well. So thank you. Thank you very much, John. Christy, I know if you want to have any closing remarks as well.

Christy Travis: Well, this is Christy, I'll add my thanks to everybody and also, obviously to the NQF team, for helping us be so prepared and organized and structured and flexible, so that we could actually get through the full agenda today. And I also want to add a special thank you to our league discussing and who helped

us really focus our thinking around the criteria for each of the measures, and obviously as well to the developers for being with us today.

John Bulger: Yeah, thank you to everybody that helped. And then thank you for your patience. Obviously, it's a nine to five, virtual meeting on things this technical can tend to be somewhat tedious. So really appreciate everybody sticking in there and coming and going as you could and doing the work we need to do. So thank you very much.

Matthew Pickering: Thank you all and you'll receive an email around that survey for those that we need those responses to for spring 2020 measures. And then we will follow up with the committee with the final determination on those on those results, as well as the developers here in the next week. So thank you all very much. Really appreciate it and have a great remainder of your week. Thank you.

Christy Travis: Thank you. Bye.

END