NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
October 2, 2019
1:55 pm ET

Suzanne Theberge: Hi, this is NQF. Who's just joined?

Jo Ann Brooks: This is Jo Ann Brooks.

Suzanne Theberge: Hi there. Thanks for joining.

Jo Ann Brooks: Hi.

Suzanne Theberge: We'll be started in a few minutes.

Jo Ann Brooks: Okay.

Suzanne Theberge: Hi, this is NQF. Who's just joined?

Leslie Kelly Hall: Oh, this is Leslie Kelly Hall calling.

Suzanne Theberge: Hello. Thanks for joining. We'll be getting started pretty soon. Hi this is NQF who just joined?

Paula Minton Foltz: This is Paula Minton Foltz from Harbor View.

Suzanne Theberge: Thank you. We'll be getting started in about five minutes.

Paula Minton Foltz: Great. Thank you.

Suzanne Theberge: Hi, this is NQF. Who's joined?

Cristie Travis: This is Cristie.

Suzanne Theberge: Hi, Cristie.

Cristie Travis: Hello.

Suzanne Theberge: Heard a couple of more beeps. Hi, this is NQF. Who's just joined?

Anthony Grigonis: Hi, this is Tony Grigonis.

Suzanne Theberge: Hi there. We'll be getting started in just a couple of minutes.

Anthony Grigonis: Sure. Thank you.

Suzanne Theberge: Anyone else joined and not introduced themselves yet, from the committee? Hi, this is NQF. Who's just joined?

(Yokor): Hi, this is (Yokor).

Suzanne Theberge: Great. Thank you. We'll be getting started shortly. Hello, this is NQF. Who's joined?

Laurent Glance: Larry Glance.

Suzanne Theberge: Great. Thank you. We'll be getting started soon.

Laurent Glance: Great. Thank you.

Suzanne Theberge: Hi, this is NQF. Who's just joined?

(Jeff Herron): This is (Jeff Herron) from Core.

Suzanne Theberge: Great. Thank you.

(Jeff Herron): I'm having trouble with the Web meeting. Is it open?

Suzanne Theberge: Yes, it is open. What browser are you using?

(Jeff Herron): Oh, I think I got it. Thank you.

Woman: You have to register first.

(Jeff Herron): Yes, I was missing one of the hurdles there, but I got it.

Suzanne Theberge: We'll be getting started in just a few moments. I see there are still some folks dialing in, so we'll give them a moment to get started.

John Bulger: Hi, it's John Bulger…

Suzanne Theberge: I'm sorry, who just joined?

John Bulger: John Bulger.

Suzanne Theberge: Great. Thank you. Hi, this is NQF. Who's just joined?

Pamela Roberts: Pam Roberts.

Suzanne Theberge: Great. Thank you. Hi. Who's just joined?

Mat Reidhead: Hi, this is Mat Reidhead.

Suzanne Theberge: Great. Thank you. We have a few folks dialing in, so we will just wait another minute or two for those people to connect, and then we'll go ahead and get started. I heard a couple of beeps. Who's just joined?

Carol Raphael: Hello. Oh.

Suzanne Theberge: Hi.

Carol Raphael: Hi. It's Carol Raphael.

Suzanne Theberge: Great. Thank you.

Paul Heidenreich: And Paul Heidenreich has joined.

Suzanne Theberge: Great. Thank you.

All right, I think we can go ahead and get started. I don't see any lines actively dialing in. So, welcome to today's All Cause Admissions and Readmissions Spring 2019 Cycle Post Comment Web Meeting. We appreciate you joining us today. This is Suzanne Theberge, I'm a Senior

Project Manager on the team. I'm joined by my colleagues (Aroma), (Asaba) and Taroon.

And just going to briefly go over a couple of housekeeping items before we go into the agenda and conduct roll call. So, just the usual, which I think you are all familiar (unintelligible). Please don't put the call on hold, so we don't get that feedback on the line. And then we do ask that you mute your line, your microphone on your computer, and then your phone line, when you're not speaking. In addition, please do say your name before you speak, to help us know who's speaking. And you can, in addition to the mute buttons on your phone, you can use Star 6 to mute and Star 7 to unmute. And finally, we also have a chat option for any folks that need technical support or have other concerns.

With that, we're going to (unintelligible) over the agenda. We will do a roll call. We will review and discuss (unintelligible) on the measure under review. Then we will have our standard public comment period (unintelligible) go over the next steps for the project. And then we will adjourn.

I'll now turn it over to (Aroma) to conduct the roll call. (Aroma)? Or (Asaba)? Sorry.

(Asaba): Thank you, Suzanne. I'll just pass on to the co-chairs, Cristie and John to welcome the committee, then I'll do a quick roll call.

Cristie Travis: Oh, well, this is Cristie. I do want to take the opportunity to thank everybody for coming to our post comment meeting. And I look forward to the discussion.

John Bulger: Yes, likewise. You know, we have a few measures we need to go over (unintelligible) comments. Remember that we did split the one measure, so that a lot of comments came in for the measure in general. We ended up splitting what we did. So I think that'll be important (unintelligible). Thank you for being with us.

(Asaba): Thank you, John and Cristie. We just want to go through a quick roll call now.

Katherine Auger?

Jo Ann Brooks?

Jo Ann Brooks: Present.

(Asaba): Helen Chen? Thank you, Jo Ann. Helen Chen?

Susan Craft?

William Wesley Fields?

Steven Fishbane?

Laurent Glance?

Laurent Glance: Here.

(Asaba): Thank you. Anthony Grigonis?

Anthony Grigonis: Here.

(Asaba): Thank you. Bruce Hall?

Bruce Hall: Present.

(Asaba): Thank you. Leslie Kelly Hall?

Leslie Kelly Hall: Present.

(Asaba): Thank you. Paul Heidenreich?

Paul Heidenreich: Present.

(Asaba): Thank you. Karen Joynt?

Keith Lind?

Keith Lind: Yes, I'm here.

(Asaba): Thank you. Paulette Niewczyk?

Carol Raphael?

Carol Raphael: I'm here.

(Asaba): Thank you, Carol. Mathew Reidhead?

Mat Reidhead: I'm on.

(Asaba): Thank you. Pamela Roberts?

Pamela Roberts: I'm here.

(Asaba): Thank you. Derek Robinson?

Thomas Smith?

Paula Minton Foltz, said earlier that she's on the call. So, thank you for joining, Paula.

Paula Minton Foltz: Yes, thank you. I'm here.

(Asaba): That's it for roll call. I'll now pass it to Suzanne to continue.

Suzanne Theberge: Great. Thank you.

Man: Hi. (Unintelligible) real quick. There were people that I think joined while the roll call was going. Anyone who was not called that is on the call?

Katherine Auger: Hi, it's Kathy Auger.

Man: Great. Thank you.

Woman: Thank you, Kathy.

Man: Anybody else?

Okay. Thank you.

Suzanne Theberge: Great. Thanks everybody for joining us today.

So, just a brief review of what we did in the most recent cycle, before we dive into the discussion. So as you'll recall, you did look at two measures. And the first was 3495, hospital-wide 30-day all-cause unplanned readmission rate for the merit-based incentive payment system. As you probably recall, this measure ended up being split. It was recommended at the clinician group practice level of analysis, and it was not recommended at the individual clinician level of analysis. So, moving forward, it is only recommended at the group level and not at the individual clinician.

The committee did also look at Measure 2539, facility seven-day risk standardized hospital visit rate, after outpatient colonoscopy. However, that measure was withdrawn during the evaluation process and is no longer under consideration.

During the public comment period, on the draft report that was posted for 30 days, in August, we did receive one comment from one NQF member, raising some concerns about, you know, the CDP process and then about the potential reliability and validity issues with the measure.

So with that, I will turn it over to Taroon and to our co-chairs, Cristie and John, to facilitate the committee's discussion on the comment. We do ask that you review the comments and the response that was sent out in the memo last week and attached to the calendar invite, and then we just would like you to discuss that comment and formalize your response.

Taroon Amin: Thanks, Suzanne. So this is Taroon. Before I turn it over to John and Cristie, I just wanted to review the nature of the comments that were submitted by the AMA related to 3495, the hospital 30-day all-cause unplanned readmission for the merit-based incentive program.

As John pointed out, this comment was received related to eligible clinicians and eligible clinician groups. The AMA pointed out several process concerns related to the consensus development process, specifically related to the limited number of members that were able to participate in the evaluation of the measure on the June 21st Webinar, specifically the fact that several members were able to ultimately evaluate the measure, who are now present as part of the discussion. Secondly, noted some concerns related to the omissions related to voting that was in the final report.

Before we get on to the related content related issues on the - as it relates to the comments, I did want to point out that the CDP recognizing the new biannual nature of the CDP, recognizing the increased frequency and the burden on committee members, as - if we are not able to achieve quorum during the call, we have an established process for taking votes from committee members by distributing the transcript and recording of the call after the committee discussion, and then soliciting feedback via voting survey.

As it relates to the votes and the published version of the report, this was brought to our attention by the commenter and was an oversight by NQF's staff. We corrected the version that was on the public-facing Web site with the full information as soon as the comment was received before the end of the comment period.

The AMA also pointed out several content-related just topics that were part of their comments, and I'll just review them for the committee. And many of these are familiar. Some of these were discussed, many of these discussed during the committee's evaluation of the measure. And we would also welcome feedback from the developer as it relates to these topics.

But the first was insufficient evidence was provided to support attribution of the measure to physician - individual physicians and physician group practices in the absence of coordinated programs or targeted interventions.

The second was the assignment - concerns about the assignment of responsibility of the reduction of readmission to multiple physicians and practices and this may not be appropriate, and the developer has not provided sufficient information to support the attribution of the measure up to three physicians or practices.

Third, the measure score reliability, there was concern that it's too low, one based on the minimum sample size - case size of 30 - or 25 patients. Twenty five patients. And the measures should need a minimum (acceptable) threshold of 0.7 for reliability.

And then finally, the conceptual basis used to explain the risk factors that were tested from the commenter's perspective were inadequate, and additional testing is needed to evaluate clinical factors in conjunction with the risk factors.

So those were the four main topic-related comments that we received as it relates to measure. So I'll turn it over to our co-chairs to facilitate the conversation among the committee members.

Cristie Travis: Great. Thank you so much, Taroon. John, would you like to lead or you want me to - we didn't discuss this part.

John Bulger: Yes, go ahead. You start.

Cristie Travis: Okay. Thank you. So we do want to open it up for discussion among the committee. We do have the developer on the phone. They are available to answer questions, especially any clarifying questions that you may have.

And so, just to kind of summarize again, we're focusing on the content-related topics that Taroon just outlined -- insufficient evidence around individual physician and group level; assignment of responsibility to multiple physicians; reliability, especially as it relates to the minimum size of 25 patients; and then the conceptual basis for risk factors -- were the primary issues that were raised.

And just one last reminder, I appreciate John mentioning this at the beginning and of course we just went through it, we did split this into two pieces, one for the group and practice level and one to the individual clinician level. We recommended endorsement at the group and practice, but did not recommend endorsement at the individual clinician level.

So, are there any comments that anybody would like to share with us, from the committee?

Leslie Kelly Hall: This is Leslie Kelly Hall. I'd like to hear the developer's response to those four issues.

Cristie Travis: Thank you. Someone from Core?

(Jeff Herron): This is (Jeff Herron) from Core, one of the developers on this measure. And, you know, we have provided some detailed responses, but just I think generally, to try and summarize.

Their first concern was about evidence to support attribution to physicians or practices in the absence of some (unintelligible) program or targeted intervention. It's difficult to know exactly how that could be addressed by the developers. We felt that, you know, provision of the measure provides a tool for developing interventions that might - for which this tool might be useful. But I think that sort of the beyond the scope of our development process to provide, you know, targeted interventions that correspond to the measure.

I think for their second concern, we have a more thoughtful response. They're concerned about the assignment of responsibility, readmissions to multiple physicians and practices. Our assignment attribution to multiple physicians for this measure was something that was driven almost entirely by stakeholder feedback, not only technical experts but also outpatient provider working groups and patient working groups.

There was a strong feedback from all of these stakeholders that readmission was not the responsibility of a single clinician, that it should be - that it typically was shared among different providers and that attribution to multiple providers would incentivize coordinated care among the clinicians that care for a patient. So, and I think we, you know, whether we provided sufficient information to support that, we did provide the, you know, information on feedback we had, so.

The third concern, about the measure score reliability results being too low, this is something that was partly addressed by the NQF committee when they endorsed the use of this measure for the (TIN) level where there were higher volumes and not at the individual level where there were lower volumes.

We agreed that it's already reported for provider, you know, either clinicians or (TINs) that have high enough volume to be reliable. We don't - we haven't

said what that is. We did give a range of volumes and corresponding reliabilities, many of which were above the threshold of 0.7 that they suggest.

And then finally, the point about the use of social risk factors in the testing. They say additional testing is needed. We did follow NQF's guidance on testing. We did look at two social risk factors. We did find that the inclusion of them had very little impact to correlation between the scores when we included the risk factors and did not, was in the order of 0.99. The understanding is that we should consider first clinical conditions and then only add the social risk factors if they contribute meaningfully. And so we felt like it was appropriate to not include those.

That in brief is our response to their four points. I have others in my team on the phone and they have something else to add.

Cristie Travis: Well, thank you for that, (Jeff). This is Cristie. Just one kind of clarifying question. Can you remind us what the volume threshold was for the group or practice level of analysis?

(Jeff Herron): I think that we showed that, for groups with 100 patients during the year, the reliability was well over - averaged - some reliability was over 90%. As I said, we won't - I think we reported a range of reliabilities for different volume thresholds. You know, I think it would be up to - a final decision about volume thresholds should refer to that table. But, you know, I don't think we…

Cristie Travis: Okay.

(Jeff Herron): …specify (a particular) volume.

Cristie Travis: All right. So if I'm…

Woman: This is (unintelligible). We're just pulling that exact result up for you. If you want to ask another question, and we'll try and circle back to respond with the exact table that (Jeff) is referring to, to give you a little more context of the - but as I recall, almost all of the levels of volume cutoff that we examined has reliabilities above 0.7. So…

Cristie Travis: Okay.

((Crosstalk))

Cristie Travis: Okay. Let us know when you have it available. That will be helpful.

So, Leslie, did you have any follow-up questions based on the developer's comments?

Leslie Kelly Hall: No, thank you.

Cristie Travis: Okay. Any other questions or comments from committee while we're awaiting this information?

Paul Heidenreich: This is Paul Heidenreich and I am - I had a question about whether the - whether different types of physicians needed to - should need to be included in the (TIN) if that was part of it? So it would seem, in - if we're going to be improving or incentivizing coordination of care, that we would potentially need a discharging physician, the outpatient physician, included in that (TIN), if we're going to be, you know, really making an, you know, (unintelligible) functionally coordinated care.

But, was that part of the evaluation or assumption?

(Jeff Herron): This is (Jeff Herron). We did not assume that the physicians who were - or the different physicians who were attributed a patient outcome belonged to the same (TIN). It is often the case that they are, but I don't know.

Paul Heidenreich: I just would assume it's…

((Crosstalk))

Paul Heidenreich: Yes. It just seems maybe most places would have practices in place where they could coordinate within their (TIN), it would be a lot harder to coordinate with competing (TINs). So, and I think many of us or a lot of people when they say, oh, yes, the group level and group in quotes are thinking a group that maybe would cover the span of care.

(Jeff Herron): I would say, you know, we had discussions around this issue. The thinking was that if you were the discharging clinician and you knew the patient had a primary care provider, even if they were not in your (TIN), that you would want to in some way coordinate with them, if only to be sure the patient followed up with them. So, you know, it may not be happening, but it seems not unrealistic to expect that kind of coordination to happen and for this kind of measure to (unintelligible).

Paul Heidenreich: Yes, I would agree with you. I'd say, although if that's true, then there's no reason not to have it at the individual level as well. And I think - and my guess is there's concerns with that, just wasn't yet happening enough, but.

(Lisa): Hi, this is (Lisa) (unintelligible). So, thank you for the inpatient. So an admission cut off for individual clinician (unintelligible) ratio is also

reliability at the measure result level, have a mean signal to noise reliability of 0.967. At the eligible clinician group or practice level, the mean signal-to-noise reliability for clinician groups or practices is 0.996. And that's at the 25 volume cutoff. So in both instances, that, you know, supports that high level of reliability for those measure results.

I also heard some questions about, one, diversity of practices for clinicians being captured. We did look at results across, and looking at other data, so, (Jeff), if you already addressed this, stop me. But the - how many of the specialty cohorts within the measure clinicians are being evaluated on, and the vast majority of the clinicians are being evaluated on multiple cohorts or four or five of the cohorts. And so there is a sense that we are capturing a diverse set of clinicians, capturing clinicians that are seeing diverse sets of patients across the measure.

Bruce Hall: Hi, this is Bruce Hall. I want to say this very respectfully and with an openness to be educated, reeducated, or convinced, but those levels of reliability seem implausible. I wonder if maybe those calculations need to be shared. Those just seem implausible.

(Lisa): So those calculations were shared with the scientific methods panel and (unintelligible) scientific methods review, and it was given a moderate or high rating, I don't remember, but it would pass first scientific reliability of the measure results through the scientific (unintelligible).

(Jeff Herron): Yes. If I recall, the concern about the individual level was not that the mean reliability was low, but that the range, the lower ranges were often low. So, you know, the 25 and above average reliability was 0.96, but for those on the smaller volume, you know, the distribution reliability was (unintelligible) so. And that was the concern there.

So, you know, we have checked it. We agree that, you know, they're high, but for (unintelligible) reliability, these are the kind of numbers that are not unusual for measures that we've seen.

Bruce Hall: Yes, I just wanted to respectfully disagree. At the provider level, with 25 cases, reliabilities at 0.96?

(Jeff Herron): Well, no. For all the providers who have at least 25 patients, so the whole set of providers 25 up to a thousand.

Bruce Hall: Understand. Understand, yes.

(Jeff Herron): The mean reliability is 0.96. So as I said, the concern was that, you know, in the lower end of that, distribution, where the volumes were smaller, yes, the reliability, individual reliability was lower.

Bruce Hall: Yes, yes, I get that. But even that mean seems - again, I don't want to skew the conversation, but that, I think there's a question there.

Laurent Glance: Hi. This is Larry Glance. I want to say that I agree with the comment that Bruce Hall is making. That number seems somewhat implausible.

I'd also like to say that what, and I'm on the scientific methods panel, what we were looking for would be reliability for ranges of provider volume, meaning, say, your provider volume is between 25 and 50 cases or 55 and a hundred, and so on and so forth. When you say that the reliability is x for provider volumes greater than 25, that essentially includes all the provider volumes. So that really doesn't give you a lot of - it doesn't give you any information about the reliability for low-volume providers.

John Bulger: Yes. So this is John Bulger. So you had made the comment, developer, that you had that data. Do you have that data?

(Jeff Herron): When you say - I'm sorry - that data…

John Bulger: Well, you said that there was a - you said you had a, you know, essentially a spreadsheet as I - with the way that I understood it, but you may not have used that word, that suggested that there was data at different levels of volume, so that then a user of this, say CMS, could see that and would be able to see that, you know, the reliability between 25 and 50 is, you know, 0.62, and the reliability between, you know, over 100 is 0.999, and that, you know, you would be able to - and the public would be able to see that as well, so that if CMS were to say that, they would be able to, you know, make a comment of approval or disapproval of the measure being used in that method.

So, is there the range that Larry has talked about?

(Jeff Herron): Yes. So in the - in our (unintelligible) report, and I'm, you know, I don't (unintelligible) I'm looking at what we reported, I'm seeing something a little different from what…

(Lisa): So, (Jeff), this is (Lisa). I will go to the - we're in the testing form that was submitted to NQF, Page 8, Section (unintelligible) a little bit, 2A 2.3, the statistical results on reliability testing. Sorry, I'm really trying to read this (unintelligible).

So, at the cohort level, at the clinician level for 25 clinicians, the minimum reliability for signal-to-noise analysis, at the clinician level, for the cardio respiratory, was 0.39. The median was 0.63. The 75th percentile was 0.69.

The 90th is 0.74. The 95th percentile is 0.78. And the maximum was 94. That's the cardio respiratory cohort.

Minimum…

Bruce Hall: Can I just pause here? So those numbers are not consistent with what was said previously.

Man: Yes.

Bruce Hall: Sorry, this is Bruce Hall again.

(Lisa): These are at the cohort - the specialty cohort level, they are the overall measure results. Slow down a little bit. The overall mean was - mean signal-to - you are correct, they are not consistent with what was reported before. Those results were - must have been at a higher volume level. So the main signal-to-noise reliability, this cohort - can you slow down? I apologize. (Jeff), can you help me look for the…

(Jeff Herron): Yeah.

(Lisa): …measure result reliability in the NQF form?

(Jeff Herron): I'm looking - yes. I just apologize, I've got a few versions here, so.

Bruce Hall: And this is Bruce Hall. I apologize, I don't mean to skew the conversation, but I also apologize, I'm in transit so I don't have a computer in front of me. So I apologize for not being more helpful to resolve the issue. But it just sounded like - it sounded like the numbers were off.

Cristie Travis: So the other -- this is Cristie -- the other piece I guess, so (unintelligible) but can we focus on the group and practice level, since that is the one with which we recommended endorsement, and then move, if we need to, to the individual clinician level?

Leslie Kelly Hall: This is Leslie Kelly Hall. And I do recall a discussion on the group level about being able to accommodate hospitalists and such, and that that was one of the reasons why we felt the group level split-out could accommodate multiple types of groups, including hospitalists. That's from my memory.

Although I do empathize with the measure and coordinated program and targeted intervention, and although I don't think that that, for, at least, for my point of view, changes my opinion on the vote. I do think that this consideration, as we get closer to actual uses of electronic medical records (unintelligible) measurement, we're going to see continued disconnects between the data that we are getting access for in claims, coordinated responses, and the ability to track interventions that would accommodate movement on the measure. And I think that's worth some offline discussion about a strategy to support those disconnects in the future. But, thank you.

Cristie Travis: Thank you.

John Bulger: Yes. Cristie, I think the point too was, one of the reasons why we did not endorse the individual measure and we did endorse the group measure is because I believe we saw a range, and as the N's went up, the measure became more reliable. And our concern was there were going to be a lot of individuals that had low N's and would be in the reliable - wouldn't have adequate reliability, so that it was unlikely that there were going to be large numbers of providers that - larger groups of providers, excuse me, that would be - there will be a large number of providers that will be excluded. Versus

when you did at the group level, it was more likely because of the increase again. But if that doesn't exist, I'm pretty sure it did because I think that was part of our discussion of why we endorsed - we voted to endorse the one and didn't vote to endorse the other.

So I mean, I don't know that it's important - I think it's important that we - that that sliding scale, if you will, is available, so that it could be used. I don't know that we need to re-adjudicate all of the reliability numbers at each different level.

Cristie Travis: So, John…

Taroon Amin: This is Taroon, can I just…

Cristie Travis: Yes, Taroon.

Taroon Amin: Sorry, Cristie. So, on that point, John, just to open it back to Bruce and Larry, my general sense from the group was that was the case, that, you know, we should make these reliability numbers transparent, the various case levels, both the distribution and the mean. Is it generally agreeable as the main reason for the, you know, one of the main reasons for the support for the group level was more around conceptually around attribution issues, not necessarily the reliability statistics? Is there general agreement about that? And then we can, you know, then it'll help us determine a path forward on this.

(Lisa): This is - sorry, this is (Lisa) (unintelligible) I know that you - from the measure developer. I'm sorry to interrupt. I just wanted, regarding the volumes, while this particular measure has not been proposed for use in (MIPS), it is a re-specification of an existing measure that is already in use in

(MIPS), called the All-Cause Readmission Measure, that is reported at the group level with a 200 case minimum.

Just again this is a different - this is a re-specification of that measure. That measure is only attributed to the outpatient provider. It's not attributed to inpatient providers or multiple providers. And it is currently restricted to providers that are in a group with a 200 case minimum. So at least in one iteration of use, this measure has had a higher volume in implementation than we have presented data for at the reliability results in the NQF form, although this measure that you're looking for - in front of you has not actually been proposed for use (unintelligible). Sorry to interrupt.

Cristie Travis: So, Taroon, do you want to kind of restate what your question is, so that we can address it?

Taroon Amin: Yes, Cristie. It was, in hopes of moving the committee along in discussion, I think the question, appropriately so, was raised by Bruce and Larry around questions around the distribution of the reliability statistics at various caseload levels, and understanding not only the distribution but the mean performance. It sounds like that was more for the purposes of making it transparent for stakeholders, that was sort of a point to be made around clarification and (unintelligible) that was clear to all, including the members of the public. But it does sound, to John's point, the main issues related to the physician group, splitting the measure related to physician group or physician clinician level was really more around conceptually issues around attributing all-cause hospital readmission to an individual provider rather than a group, which seems more plausible.

So I wanted to just clarify that it seemed, again, from our prior conversation and then again today, it does seem that the issue is more conceptual, not

attributing to a physician - individual physician rather than physician group, and the reliability information would be helpful to make public and transparent for the purposes of being thorough. But I'm trying to understand, is it - do we need to reengage in the conversation around reliability statistics for the physician group level, which is the one that was endorsed, you know, recommended for endorsement by the committee?

Bruce Hall: This is Bruce. I think what you just stated is very fairly stated. I don't pretend to speak for Larry, but I would say for myself, I wasn't meaning to reopen all of the conversation. I think the reliability numbers are relevant numbers. And in general, reliability is not only determined by case volume, but certainly in general, when case volumes are lower, concerns around reliability will be greater. And that means that, in combination with other aspects such as concerns around attribution, the recommendation to avoid individual provider level and stick with a higher level of aggregation of group, or whatever that is, helps mitigate concerns.

So, you know, I think it's all of a piece of one conversation. It's all relevant. But I think the way you stated it in general is that the concerns are not based on reliability numbers alone. The conceptual concerns stand either way. And the thought to move to a higher level of aggregation of providers into a group, or whatever helps mitigate concerns in general.

Cristie Travis: Any comments, Larry?

Laurent Glance: No, I agree.

I agree with what Bruce said. Thanks.

Cristie Travis: Well, thank you, all three of you, and thank you, Taroon, for, you know, kind of finding a way to articulate it that reflects what the issues are.

So, you know, based on that, unless there is any other comment from the committee members around that, then I think the way that Taroon has expressed it is reflective of how we as a committee views it. But certainly if you're on the committee and you have a concern with that, please chime in right now.

Okay. Thank you.

Are there any other questions or comments from the committee on other topics related to the concerns raised in the comment?

Okay. Hearing none, I do want to look to NQF staff to be sure that I follow the process correctly here. It seems that, my read, and certainly people can correct me if I'm not reading it correctly, is that how we - the decisions that we made would be standing as is. Do we need to have a formal vote on that, NQF staff?

Taroon Amin: Cristie, we only need to - so, yes, I think the question in front of the committee is that we have comments from members of the public related to attribution primarily, reliability, statistics, and then assignment of responsibility to multiple positions, and then the question around social risks, which have been discussed today by the developer and by the committee, and then also many of these topics were also discussed during the more extensive time that we had together on the first review of this measure.

Really the question in front of the committee is whether any committee member feels like there needs to be, in light of the information provided by

the commenter, is there a need to reconsider the measure? And any one committee member can raise their hand for that and we can decide whether, you know, we can decide then to move forward with a vote if necessary.

But really the question from the committee, Cristie, would be, you know, if you can call a question of whether anyone would like, based on the information presented, is there new information that has not been adjudicated already either in this call or prior that needs to be considered in the final vote? And again, with the final vote essentially representing support for measure at the clinician group level but not support at the clinician level.

Cristie Travis: Okay.

Taroon Amin: And so I would - yes, go ahead, Cristie.

Cristie Travis: Yes. No. Thank you for that guidance. So I will ask the committee if there is anyone who would like to put it on the table, does this measure need to be reconsidered based on information that is presented by the commenter and the discussion that we have had today, with the developer as well?

Mat Reidhead: Hey, Cristie, this is Mat. Appreciate the conversation. (Jeff), appreciate you all's explanations as well. But I think the points raised by the AMA were all really important points, particularly around attribution. So I would feel like we weren't doing good service to the commenters if we didn't return to their specific concerns and actually get numbers on reliability and more information on the developer's attribution model. So, yes, I'll raise my hand.

Cristie Travis: Okay. Well, thank you. It's my understanding then entering, please correct me if I'm wrong, that what we need to do is take a vote on whether or not to reconsider this measure. Is that correct?

Taroon Amin: I'll actually turn it over to the team to weigh in on that because they have better information about the quorum numbers. But that is, yes, I'll turn it over to Suzanne and the rest of the team.

Suzanne Theberge: Yes. We do need to, if someone has motion for a vote, or called for a vote, we do need to take a vote on whether to reconsider. We have, at the time of attendance, we did have quorum on the phone, which was 14 out of the 21 committee members. So as long as we haven't lost anyone, we can do that vote live. It would be a yes/no question on whether to reconsider. And we would need…

Cristie Travis: And just to make sure, reconsidering our recommendation which right today is to split it between groups and individuals, and no on individual, yes on groups. That's what we would be reconsidering, is that correct?

Suzanne Theberge: Yes. So you would be asked to revote on - so what your recommendation was, was recommended the group, not recommended clinician - I mean, not individual clinicians. So, yes, you'll be asked to vote yes or no. And a no vote would take us back through to discuss and revote on each of the criteria at this split level of analysis. So we do, first, group, and individual, and a - sorry, go ahead.

Cristie Travis: No. I just wanted to be sure, because as I understand it, and please, Suzanne, correct me, it - I think that what we need to do is vote on whether we will reconsider. And then we go through a reconsideration process that would be in the next cycle.

Suzanne Theberge: Yes.

Cristie Travis: So this is kind of a two-step process.

Suzanne Theberge: Yes.

Cristie Travis: We would need, if notes are correct, 60% to vote to reconsider. But the vote to reconsider does not necessarily imply that we would change our vote later…

((Crosstalk))

Cristie Travis: …recommendation.

Suzanne Theberge: Yes. So, apologies, I misspoke a little bit there, I jumped ahead of myself. First, the committee needs to decide, yes or no, to reconsider. And then if you wanted to reconsider, it would go back through. If you did not want to reconsider, your recommendation would stand with - going forward, and the measure would continue on to (CSAC) with recommended at the group and not recommended at the individual. So right now it is simply a yes/no vote on whether or not to reconsider.

Cristie Travis: So, yes to reconsider, and no if you don't want to reconsider and let our current decision stand. Correct?

Suzanne Theberge: Great. Yes, that's correct.

And we should have - you should have just received the voting link via email. So, committee members, please submit your vote.

Mat Reidhead: So, Cristie, this is Mat again. So, just to be clear, a yay means that we withdraw our recommendation for endorsement for the time being.

Cristie Travis: That's correct. If you want to reconsider it, vote yes.

Mat Reidhead: Okay. Thank you.

Cristie Travis: And NQF staff, I don't know how the question's worded, so, be sure I answered that correctly.

Taroon Amin: Yes, that's how it's - that's how it's framed. Do you wish to reconsider your current vote?

Woman: We have sent a link to the (unintelligible) all the committee members. You can also receive those via the chat box if you don't have access to the (unintelligible). And the question is, do you wish to reconsider measure 3495, hospital-wide 30-day all-cause unplanned readmission rate for merit-based incentive payment system clinician group level of analysis (unintelligible) yes or no?

Cristie Travis: And just as to be sure that we know our vote's getting counted, when we vote, it turns blue. Does that mean it's come in to you?

Woman: Yes, it does. And right now we're doing screen share, so you should be able to see the poll going live.

Cristie Travis: And all I see is the question with the two responses. Is that all I'm supposed to see?

Woman: Yes.

Cristie Travis: Okay.

Woman: Right now we have 13 people that have voted, missing one committee member.

Suzanne Theberge: Is there anyone that is not able to access the vote? If so, you can send us an email or a chat.

Bruce Hall: This is Bruce Hall. I'm in a car on a laptop, so, can you tell if mine worked?

Suzanne Theberge: My understanding is that if you can't - if you no longer have the option to vote, it worked. If you still have the option to vote, it did not work.

Bruce Hall: Okay. So I clicked an option, one option turned blue, but nothing else happened. So I guess I just assume it's working.

Suzanne Theberge: That sounds like it's working.

Bruce Hall: And just for full transparency, I'm not driving while I do this.

Cristie Travis: Good. We're glad to hear that.

Taroon Amin: So while the team is figuring this out, I guess we need to reach 60% of the committee on a yes to reconsider this measure, and it appears we still need one vote.

Woman: Hi everyone. This is (unintelligible) NQF. I just wanted to let you know, we're trying to identify who hasn't voted. So if you can just bear with us, because the vote is very close. We just want to make sure we get that extra vote.

Man: So while we're waiting to understand, I mean there's only, just doing mental math here, it seems like, even if there was a yes, it would be seven, seven, which would be difficult to reach 60%. Could we understand a little bit from those that wanted to reconsider the measure a little bit more detail so that we can make sure to provide that back to the developer on what the concerns were? I want to be able to make sure that we characterize that in the response to the committee, the committee response that goes back to (CSAC). Is it related to the - is it related to the discussion we had around reliability statistics? Is that the main cause of the reconsideration vote?

Mat Reidhead: So this is Mat. Since I started this, and apologize everybody, I'll jump in quickly, but there were four main points raised by the commenters, and I don't feel like any of those were addressed adequately.

Also, you know, just from my own standpoint, and I apologize, we were - I was on a bit of a hiatus in June so I wasn't able to participate in the dialogue at that time, but just considering, you know, some of the larger questions on unintended consequences surrounding the readmission reduction program, I think that as a group we should, you know, consider that and expand the measures of readmission at the physician level.

But primarily, you know, just (unintelligible) service to the comment makers, I feel like, you know, a more thoughtful address of each of their concerns is probably merited.

Leslie Kelly Hall: This is Leslie Kelly Hall. And I do feel some irony here in that this is the first measurement to see whether incentive payment changed behavior, which seems to be what has been requested of AMA for considerable amount of time, is that, you know, we want to do the right thing well (unintelligible) give us opportunity to reimburse. And I think that this is a measurement that

addresses readmission but it also determines that, when methods of payment are aligned with desired behavior, we can effect change. I just would encourage us not to minimize this opportunity. And that was discussed in our previous meeting.

John Bulger: Yes. This is John Bulger. I mean, I think, you know, now I'll give my opinion, I think we adjudicated all these comments in the previous discussion. You know, I think we need to be as transparent as we can with the data, which is why I think the - all the comments we had today were important. But to reconsider it, we should be seeing something that we didn't think about or we didn't adjudicate at the time, and then it was given to us in a comment where we say, a-ha, we didn't think about that, let's reconsider it so we think about it. And I don't think this comment rises to that level.

I think the other comment…

Woman: I agree.

John Bulger: …I would make is we only received one comment. I mean if there was - if there were big holes, I think we would have received multiple comments. And that didn't happen either.

Cristie Travis: Taroon, any update on where we are with the voting process?

Woman: We have identified one committee member who has not voted and we're trying to see how we can get a vote from that member.

Woman: If (unintelligible) let me know (unintelligible) getting readmissions emails from you guys.

Taroon Amin: So, Cristie, I guess I would offer this in terms of trying to use the committee's time as efficiently as possible. The vote was six to seven, and ultimately, even if the one committee member that was missing, and they're trying to track it down, you know, the team will track it down, but ultimately that's still seven to seven. That doesn't meet the 60% threshold to reconsider the measure.

Cristie Travis: Right.

Taroon Amin: So, obviously the team can, for the purposes of, you know, obviously we should - we'll track down that last vote, but it doesn't seem to meet the threshold. But I want to be respectful of the committee members that did feel like we need to reconsider. I would also emphasize, John, bar, while I'm not trying to (weigh) anyone's opinion, the bar for reconsideration should be the comments raised a point that was not considered during the committee deliberation.

And obviously, for that purpose, we would want to be able to communicate back to the developer what they should work on prior to our next discussion. And certainly I hear very loud and clear requests from the committee to make transparent distributional statistics about reliability results at various levels of case numbers, both mean and distribution. And we certainly will follow up with the developer to make sure that that's clear. And we will make sure to include that in the committee's response that will go to (CSAC) for evaluation.

Ultimately, you know, there are multiple more steps in this process, whether that information can carry forward. But at the risk of not wanting any of the committee members to feel like we haven't fully adjudicated this, not that, you know, carry this call out too much longer, but I don't want us to, you know, I don't want - I want - whoever had that, you know, those opinions about re-

adjudicating, let's, you know, make sure that those - at lease the issues are laid out on the table even if we don't actually adjudicate, and this measure will continue to move forward.

Cristie Travis: Thank you for that. I guess the issue is that we're not going to be at the 60% to have a formal reconsideration. But if there are comments that have not yet been made from those who would support reconsideration that can, you know, that can kind of be part of our work, please, if you haven't already, feel free to let us know what your concerns were.

Bruce Hall: This is Bruce Hall. I have spoken my piece. Thank you.

Cristie Travis: Thank you, Bruce.

So I guess I'm going to ask NQF staff. We're not going to reach the 60%, but is finding out that 14th vote critical to this being an official action of this committee?

(Elisa): Hi, this is (Elisa). Cristie, unfortunately, that additional vote gets (unintelligible) so essentially, you know, we have a good sense that the committee is split (unintelligible) from the votes we have right now. But, you know, technically we don't have quorum. We lost one. We had it at the beginning of the call and unfortunately it looks like somebody dropped out.

Cristie Travis: So, what do we need to do, (Elisa)?

(Elisa): I think now, Suzanne, do we have a plan laid out for the lack of quorum. We're nervous about not reaching quorum at the beginning, but I think Suzanne had articulated a plan before.

Suzanne Theberge: Yes. So we'll follow the NQF standard process for when quorum is not achieved. We will send out a survey along with a transcript and recording of the call to the folks who were not in attendance, and we will collect votes, until we do reach that quorum number. So we will - we'll be following up with the final decision after we've reached quorum.

But yes, that's correct, that we do need an actual quorum of votes in order to have a final decision.

Cristie Travis: Great. I just wasn't sure if 14 was the magic quorum number. So, thank you for that.

Taroon Amin: And Cristie, just so that everyone feel, you know, we will also reflect all of these comments in the response, the committee response, I suppose, you know, regardless of the disposition of whether there's a formal vote for reconsideration or not. And we will also be following up with the developer for those data points that were discussed earlier during the call, the distributional statistics of the reliability performance at various case levels, and the mean performance obviously.

Cristie Travis: Great. Thank you, Taroon. Okay.

Mat Reidhead: This is Mat, I've got a procedural question. So you're going to solicit votes from non-present committee members and you will stop once you receive one? Is that what I heard or will you accept votes from all of those non-present willing to vote?

Man: It would have to be the whole committee.

Mat Reidhead: Okay, great. Thanks.

Man: The whole committee, meaning even those of us who are present now, everyone?

((Crosstalk))

Mat Reidhead: …and revote. Yes.

Carol Raphael: And when do you expect this to happen? This is Carol.

Suzanne Theberge: We would send out the voting survey…

Woman: Can I interject real quick? Is this Carol Raphael.

Carol Raphael: Yes. I'm traveling so I'm having trouble kind of connecting.

Woman: Hi, Carol. Your vote is what we actually need.

Carol Raphael: Okay, because I just tried to vote twice, so I didn't know if it registered, as I'm in transit.

Woman: So, Carol, if you don't mind telling me…

Man: It sounds like it didn't, right?

Woman: …we can record your vote for you.

Carol Raphael: Okay. I voted against reconsideration.

Woman: Okay. Thank you.

Cristie Travis: Well, thank you, Carol. I'm glad you were able to connect at this point. Thank you for that.

Okay. So, does someone from NQF want to summarize on the next steps regarding this? Taroon, I think you did a good job of being sure that the comments from today will be part of, you know, our report as it comes out. And so, if somebody from NQF wants to take us through kind of what the next steps are, we'd appreciate that.

Suzanne Theberge: Prior to that (unintelligible) in terms of this decision, I, team, correct me if I'm wrong, I believe the vote is six yes to eight no. So that's not enough to reconsider. And prior to the next steps discussion, we would open the lines for NQF member and public comments. And then we have a series of next step slides.

Cristie Travis: Thank you.

Suzanne Theberge: So, yes, we will now open the lines for - oops, we're just polling up the votes here. So, 43% yes, 57% no, which is of course not 60% to reconsider.

So I think at this time, we can open the lines for comments. For folks that are not on the committee, please submit a comment at this time. You can do that either verbally or via the chat box, if you have a comment or a question for the committee. And we'll pause now for that.

Leslie Kelly Hall: This is Leslie Kelly Hall, and I don't mean to be rude, but I want to make sure we're not getting to Groundhog Day in this effort. And so, what could we do to make sure that we gather as many people and have this done as quickly as possible?

Cristie Travis: Oh, we've already done it. We were able to find our 14th…

Leslie Kelly Hall: Thank you.

Woman: Yes. Apologies for not making that more clear. We did get that 14th vote. So we are good with quorum. We're done.

Leslie Kelly Hall: Thank you.

Cristie Travis: Thank you for asking.

Suzanne Theberge: Okay. I don't think that we have any public comments. I didn't hear anybody wishing to speak, and we don't see anything in the chat box. So we will go ahead and go into the next step. I'll turn it over to my colleague for the next steps discussions.

Woman: Thank you, Suzanne. So we would like to acknowledge a few committee members whose terms are going to be ending. These members have committed lots of hours to the all-cause admissions and readmissions project in the last couple of years, and their terms are going to be ending so we might not be working with them on this particular project anymore. So, NQF would like to acknowledge Katherine Auger, Jo Ann Brooks, Sue Craft, Steven Fishbane, Laurent Glance, Anthony Grigonis, Bruce Hall, Paul Heidenreich, Karen Joynt Maddox, Sherrie Kaplan, Keith Lind, Paulette Niewczyk, Carol Raphael, Mathew Reidhead, Derek Robinson, and Thomas Smith.

Cristie Travis: And this is Cristie. I would like to thank all of those as well. We've been together for a very long time. Honestly, I didn't realize the list was going to be so long. So there will be some clear changes to this committee moving

forward. But I just want to say it's been a pleasure in working with all of you. And hoping our paths will cross (unintelligible).

(Elisa): And this is (Elisa) from NQF. I just wanted to echo Cristie's thanks to the entire committee and the co-chairs. And we know, even before we officially launched standing committees, readmissions was one of those (standing) committees. We tackled a lot of tough issues, and we appreciate all of the work and time you've given to this work. And we thank everyone else who will be continuing on to serve on the committee. And we're looking forward also to our new members going into (unintelligible).

Woman: So, to continue, the next (unintelligible) timeline for this project, we have the first comment Web meeting, which is today. There's also going to be (CSAC) review on October 21st and 22nd. And following that, there'll be a 30 days appeals period from October 30th to November 28th. The final report for this project is going to be February 14th of 2020.

Bruce Hall: Hey, hi. It's Bruce Hall again. Sorry I don't mean to beat a dead horse, but just for clarity. So, are there any - will there be any other interactions meetings or anything that you are expecting from those of us wrapping up our time? Will there be any more details for us, or is this it?

Suzanne Theberge: We will be keeping you posted on the progress of the project and letting you know, you know, when the measures are going to (CSAC) and sharing the final report with you, etcetera. But you don't have to - there will be no more calls for you to participate in. And you are welcome to listen to (CSAC) as committee members are always invited, but you're not obligated to attend. So this is kind of your final call for your work on the committee, and thank you again for your time.

Bruce Hall: Okay, great. Thanks for that clarity.

Leslie Kelly Hall: This is Leslie Kelly Hall. If I can just add a comment, as the non-scientist, non-doctor on the call, I just want to thank all these people who have served and made it easy for me to understand very complex things, and especially Larry and Bruce and Sherrie. Thank you.

Man: Thank you.

Man: Thank you so much.

Woman: So, for the fall 2019 cycle, the nominations for new committee members is going to be open now, so, October 1st to October 30th. We're going to have an orientation (meeting) on January 13, 2020, and also a strategic Web meeting on March 19, 2020.

For this comment cycle, the all-cause admissions and readmissions project did not have any measures submitted, so that's why we're going to be doing the strategic Web meeting.

Any questions?

All right. That's it, Suzanne, I'll pass it on to you.

Suzanne Theberge: Okay. That concludes this call. If folks have any questions, please do reach out. We'll be in touch with the updates as the rest of the project proceeds. But this really does conclude the committee's work. And we thank everybody for their time throughout this cycle of work, and especially for your time today. Thank you.

Woman: Thank you.

Cristie Travis: Thank all of you at NQF too. Bye.

Suzanne Theberge: All right. Goodbye everyone.

END