



## Measure Applications Partnership Coordinating Committee Meeting January 24-25, 2017

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NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC 20005

### *Streaming Playback Audio Online*

- For Day 1, direct your web browser to:  
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### Meeting Objectives:

- Finalize recommendations to the Department of Health and Human Services (HHS) on measures for use in federal programs for the clinician, hospital, and post-acute care/long-term care settings;
- Consider strategic issues that span all of the MAP Workgroups; and
- Update the Medicaid Task Forces' processes for assessing measures that address the needs of the Medicaid adult and child populations

### Day 1: January 24, 2016

**8:30 am**      **Breakfast**

**9:00 am**      **Welcome Remarks**

*Kate Goodrich, MD, Director and CMS Chief Medical Officer, Center for Clinical Standards and Quality, CMS*

**9:15 am**      **Review of Meeting Objectives**

*Harold Pincus, MAP Coordinating Committee Co-Chair  
Chip Kahn, MAP Coordinating Committee Co-Chair*

**9:30am**      **MAP Pre-Rulemaking Approach**

*Erin O'Rourke, Senior Director, NQF  
Harold Pincus*

- Review the 2016-2017 MAP Pre-Rulemaking Approach

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- 9:45 am**      **NQF Strategic Plan**  
*Helen Burstin, Chief Scientific Officer, NQF*  
*Chip Kahn*
- 10:00 am**      **Opportunity for Public Comment on Hospital Programs**
- 10:15 am**      **Pre-Rulemaking Recommendations for Hospital Programs**  
*Cristie Travis, MAP Hospital Workgroup Co-Chair*  
*Ron Walters, MAP Hospital Workgroup Co-Chair*  
*Melissa Mariñelarena, Senior Director, NQF*  
*Harold Pincus*
- Discuss key themes from the Hospital Workgroup meeting
  - Review and finalize broader guidance about programmatic issues
  - Review and discuss input from the Dual Eligible Beneficiaries Workgroup
  - Review and finalize workgroup measure recommendations
- 12:00 pm**      **Lunch**
- 12:30 pm**      **Opportunity for Public Comment on PAC/LTC Programs**
- 12:45 pm**      **Pre-Rulemaking Recommendations for PAC/LTC Programs**  
*Deb Saliba, MAP PAC/LTC Workgroup Co-Chair*  
*Jean-Luc Tilly, Project Manager, NQF*  
*Chip Kahn*
- Discuss key themes from the PAC/LTC Workgroup meeting
  - Review and finalize broader guidance about programmatic issues
  - Review and discuss input from the Dual Eligible Beneficiaries Workgroup
  - Review and finalize workgroup measure recommendations
- 2:30 pm**      **Break**
- 2:45 pm**      **Opportunity for Public Comment on Clinician Programs**
- 3:00 pm**      **Pre-Rulemaking Recommendations for Clinician Programs**  
*Bruce Bagley, MAP Clinician Workgroup Co-Chair*  
*Eric Whitacre, MAP Clinician Workgroup Co-Chair*  
*John Bernot, Senior Director, NQF*  
*Harold Pincus*
- Discuss key themes from the Clinician Workgroup meeting
  - Review and finalize broader guidance about programmatic issues
  - Review and discuss input from the Dual Eligible Beneficiaries Workgroup

- Review and finalize workgroup measure recommendations

**5:00 pm**      **Adjourn for the Day**

**Day 2: January 25, 2016**

**8:30 am**      **Breakfast**

**9:00 am**      **Day 1 Recap**  
*Chip Kahn*  
*Harold Pincus*

**9:15 am**      **Pre-Rulemaking Cross-Cutting Issues: Attribution**  
*Harold Pincus*  
*Taroon Amin*  
*Erin O'Rourke*  
*Helen Burstin*

- Findings from the Attribution Expert Panel
- Off-label measure use
- Shared accountability in context of setting-specific programs

**10:45 am**      **Break**

**11:00 am**      **Pre-Rulemaking Cross-Cutting Issues: Risk Adjustment for Sociodemographic Factors**  
*Kate Goodrich*  
*Helen Burstin*  
*Chip Kahn*

- Update on 21st Century Cures Act
- Implications of the Assistant Secretary for Planning and Evaluation (ASPE) Report: *Social Risk Factors and Performance Under Medicare's Value-Based Payment Programs*
- Request from the Consensus Standards Approval Committee (CSAC)

**12:30 pm**      **Opportunity for Public Comment**

**12:45 pm**      **Lunch**

**1:30 pm**      **Refinements to the Medicaid Task Force Processes**  
*Debjani Mukherjee, Senior Director, NQF*

- Update the Medicaid Task Forces' processes for assessing measures that address the needs of the Medicaid adult and child populations

**2:45 pm**      **Potential Improvements to the Pre-Rulemaking Process**  
*Kim Ibarra, Senior Project Manager, NQF*

- Round-Robin Plus/Delta
- Input on improving the review of current measure sets
- Feedback loops

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**3:30 pm            Opportunity for Public Comment**

**3:45 pm            Closing Remarks**

*Chip Kahn*

*Harold Pincus*

**4:00 pm            Adjourn**



NATIONAL  
QUALITY FORUM

# Measure Applications Partnership

Coordinating Committee In-Person Meeting

*January 24-25, 2016*

# Welcome

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# Disclosures of Interest

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## MAP Coordinating Committee Members

- **Charles Kahn III, MPH (Co-Chair)**
- **Harold Pincus, MD (Co-Chair)**
- **Academy of Managed Care Pharmacy**
  - *Marissa Schlaifer, RPh, MS*
- **AdvaMed**
  - *Steven Brotman, MD, JD*
- **AFL-CIO**
  - *Shaun O'Brien, JD*
- **America's Health Insurance Plans**
  - *Aparna Higgins, MA*
- **American Board of Medical Specialties**
  - *R. Barrett Noone, MD, FACS*
- **American Academy of Family Physicians**
  - *Amy Mullins, MD, FAFAP*
- **American College of Physicians**
  - *Amir Qaseem, MD, PhD, MHA*
- **American College of Surgeons**
  - *Bruce Hall, MD, PhD, MBA, FACS*
- **American HealthCare Association**
  - *David Gifford, MD, MPH*
- **American Hospital Association**
  - *Rhonda Anderson, RN, DNSc, FAAN*
- **American Medical Association**
  - *Carl Sirio, MD*
- **American Nurses Association**
  - *Mary Beth Bresch White*
- **AMGA**
  - *Samuel Lin, MD, PhD, MBA, MPA, MS*
- **Blue Cross and Blue Shield Association**
  - *Carole Flamm, MD, MPH*
- **Consumers Union**
  - *John Bott, MSSW, MBA*
- **Healthcare Financial Management Association**
  - *Richard Gundling, FHFMA, CMA*
- **Maine Health Management Coalition**
  - *Brandon Hotham, MPH*
- **The Joint Commission**
  - *David Baker, MD, MPH, FACP*
- **The Leapfrog Group**
  - *Leah Binder, MA, MGA*
- **National Alliance for Caregiving**
  - *Gail Hunt*
- **National Association of Medicaid Directors**
  - *Foster Gesten, MD, FACP*
- **National Business Group on Health**
  - *Steven Wojcik, MA*
- **National Committee for Quality Assurance**
  - *Mary Barton, MD*

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## MAP Coordinating Committee Members

### Organizational Members Cont.

- The Joint Commission
  - *David Baker, MD, MPH, FACP*
- The Leapfrog Group
  - *Leah Binder, MA, MGA*
- National Alliance for Caregiving
  - *Gail Hunt*
- National Association of Medicaid Directors
  - *Foster Gesten, MD, FACP*
- National Business Group on Health
  - *Steven Wojcik, MA*
- National Committee for Quality Assurance
  - *Mary Barton, MD*
- National Partnership for Women & Families
  - *Carol Sakala, PhD, MSPH*
- Network for Regional Healthcare Improvement
  - *Chris Queram, MS*
- Pacific Business Group on Health
  - *William Kramer, MBA*
- Pharmaceutical Research and Manufacturers of America (PhRMA)
  - *Jennifer Bryant, MBA*
- Providence Health and Services
  - *Ari Robicsek, MD*

### Subject Matter Experts (Voting)

- Richard Antonelli, MD, MS
- Doris Lotz, MD, MPH

### Federal Government Liaisons (Non-Voting)

- Agency for Healthcare Research and Quality (AHRQ)
  - *Nancy Wilson, MD, MPH*
- Centers for Disease Control and Prevention (CDC)
  - *Chesley Richards, MD, MH, FACP*
- Centers for Medicare & Medicaid Services (CMS)
  - *Patrick Conway, MD, MSc*
- Office of the National Coordinator for Health Information Technology (ONC)
  - *David Hunt, MD, FACS*

## Meeting Objectives and Agenda

## Meeting Objectives

- Finalize recommendations to HHS on measures for use in federal programs for the clinician, hospital, and post-acute care/long-term care settings;
- Consider strategic issues that span across all of the MAP Workgroups; and
- Update the process used by the Medicaid Taskforces

## Day 1 Agenda

- Review pre-rulemaking process
- Finalize pre-rulemaking recommendations
  - *Hospital programs*
  - *PAC/LTC programs*
  - *Clinician programs*



## Day 2 Agenda

- Discuss pre-rulemaking cross-cutting issues:
  - *Attribution*
  - *Risk adjustment for sociodemographic factors*
- Review refinements to the Medicaid Taskforce processes
- Discuss potential improvements to the pre-rulemaking process

## Review MAP Pre-Rulemaking Approach

## Approach

**The approach to analyzing and selecting measures has four steps:**

1. Provide program overview
2. Review current measures
3. Evaluate MUCs for what they would add to the program measure set
4. Provide feedback on current program measure sets

## Holistic Review of Measure Sets

- MAP has expressed a need to better understand the program measure sets in their totality:
  - *How MUCs would interact with current measures;*
  - *Endorsement status of current measures;*
  - *Experience with current measures*
- For the 2016-2017 pre-rulemaking cycle, MAP will offer guidance on measures finalized for use:
  - *MAP will offer input on ways to strengthen the current measure set including recommendations for future removal of measures.*
  - *This guidance will be built into the final MAP report but will not be reflected in the "Spreadsheet of MAP Final Recommendations."*

## MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set adequately addresses each of the National Quality Strategy's three aims
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

## Evaluate Measures Under Consideration

- MAP Workgroups must reach a decision about every measure under consideration
  - *Decision categories are standardized for consistency*
  - *Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached*
- The decision categories were updated for the 2016-2017 pre-rulemaking process
  - *MAP will no longer evaluate measures under development using different decision categories*

## MAP Preliminary Analysis Algorithm

1. The measure addresses a critical quality objective not currently, adequately addressed by the measures in the program set.
2. The measure is an outcome measure or is evidence-based.
3. The measure addresses a quality challenge.
4. The measure contributes to efficient use of resources and/or supports alignment of measurement across programs.
5. The measure can be feasibly reported.
6. The measure is NQF-endorsed or has been submitted for NQF-endorsement for the program's setting and level of analysis.
7. If a measure is in current use, no implementation issues have been identified.

## MAP Decision Categories

Decision Category	Evaluation Criteria
<b>Support for Rulemaking</b>	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6. If the measure is in current use, it also meets assessment 7.
<b>Conditional Support for Rulemaking</b>	The measure is fully developed and tested and meets assessments 1-6. However, the measure should meet a condition (e.g., NQF endorsement) specified by MAP before it can be supported for implementation. MAP will provide a rationale that outlines the condition that must be met. Measures that are conditionally supported are not expected to be resubmitted to MAP.
<b>Refine and Resubmit Prior to Rulemaking</b>	The measure addresses a critical program objective but needs modifications before implementation. The measure meets assessments 1-3; however, it is not fully developed and tested OR there are opportunities for improvement under evaluation. MAP will provide a rationale to explain the suggested modifications.
<b>Do Not Support for Rulemaking</b>	The measure under consideration does not meet one or more of the assessments.

## Finalize Pre-Rulemaking Recommendations – *Process at a Glance*

Workgroup (WG) Chairs / NQF Staff present measures and the programs evaluated

WG Chairs / NQF Staff outline strategic issues and relevant input from MAP Duals

Coordinating Committee (CC) Chairs ask CC members if measures need to be pulled for discussion

CC member will identify which part of the WG recommendation they disagree with

All other measures will be considered ratified by the MAP CC

## Voting Step 1. Staff and Workgroup Co-Chairs will review the Workgroup Consent Calendar

- Staff and Workgroup Co-Chairs will present each group of measures as a consent calendar reflecting the consensus by the MAP workgroup

## Voting Step 2. MUCs can be pulled from the Consent Calendar

- The Co-Chairs will ask Coordinating Committee members to identify any MUCs they would like to pull off the consent calendar for individual discussion.
  - *The MAP member requesting discussion must provide a rationale*
- After measures are removed for discussion, Co-Chairs will ask if there is any objection to accepting the MAP Workgroup recommendations of the MUCs remaining on the consent calendar.
- If no objections are made for the remaining measures, the consent calendar and the associated recommendations will be accepted (no formal vote will be taken).

## Voting Step 3. Voting on Individual Measures

- Coordinating Committee member(s) who identified measures for discussion will provide their rationale for pulling the measure for discussion. They will describe how their perspective differs from the Workgroup's recommendation.
- Other Coordinating Committee members should participate in the discussion, but refrain from repeating others' points.
- After discussion, the Coordinating Committee will vote on the measure with four options:
  - *Support for rulemaking*
  - *Conditional support for rulemaking*
    - » Conditions must be stated before the vote
  - *Refine and resubmit prior to rulemaking*
    - » Refinements must be stated before the vote
  - *Do not support for rulemaking*

## Voting Step 4: Tallying the Votes

DO NOT SUPPORT	REFINE AND RESUBMIT	CONDITIONAL SUPPORT	SUPPORT
> 60% consensus of do not support	≥ 60% consensus of refine and resubmit	≥ 60% consensus of conditional support	≥60% consensus of support
< 60% consensus for the combined total of refine and resubmit, conditional support and support	≥ 60% consensus of refine and resubmit, conditional support and support	≥ 60% consensus of both conditional support and support	N/A

## Provide Feedback on Current Measure Sets

- Consider how the current measure set reflects the goals of the program
- Evaluate current measure sets against the Measure Selection Criteria
- Identify specific measures that could be removed in the future

## Potential Criteria for Removal

- The measure is not evidence-based and not linked strongly to outcomes
- The measure does not address a quality challenge (i.e. measure is topped out)
- The measure does not utilize measurement resources efficiently or contributes to misalignment
- The measure cannot be feasibly reported
- The measure is not NQF-endorsed or is being used in a manner inconsistent with endorsement
- The measure has lost NQF-endorsement
- Unreasonable implementation issues that outweigh the benefits of the measure have been identified
- The measure may cause negative unintended consequences
- The measure does not demonstrate progress toward achieving the goal of high-quality, efficient healthcare

## Commenting Guidelines

- Public comments have been incorporated into the discussion guide
- There will be an opportunity for public comment before the discussion to finalize the pre-rulemaking recommendations for each setting.
  - *Commenters are asked to limit their comments to that setting and limit comments to **two minutes**.*
  - *Commenters are asked to make any comments on MUCs or opportunities to improve the current measure set at this time.*



# Q&A

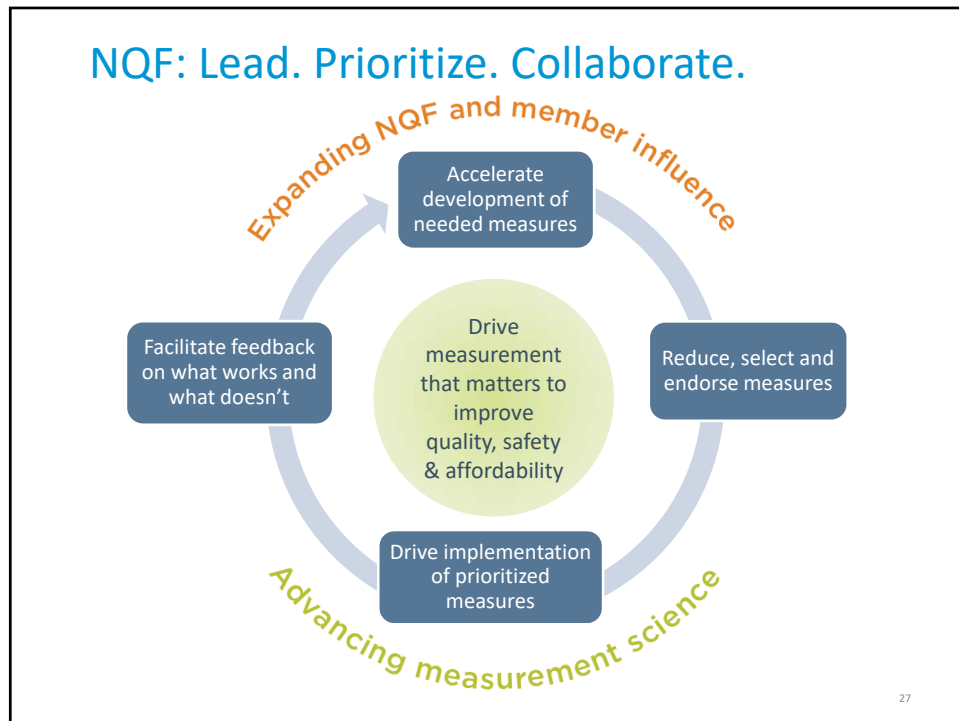
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# NQF Strategic Plan

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## Finalize Pre-Rulemaking Recommendations

## Opportunity for Public Comment on Hospital Programs

### Commenters are asked to:

- Limit their comments to the Hospital programs recommendations
- Limit comments to **two minutes**
- Make any comments on MUCs or opportunities to improve the current hospital measure set at this time

## Finalize Pre-Rulemaking Recommendations for Hospital Programs

### Presented by:

Cristie Travis, Workgroup Co-Chair  
Ron Walters, Workgroup Co-Chair  
Kate McQueston, Project Manager, NQF

## Finalize Pre-Rulemaking Recommendations – *Process at a Glance*

Workgroup (WG) Chairs / NQF Staff present measures and the programs evaluated

WG Chairs / NQF Staff outline strategic issues and relevant input from MAP Duals

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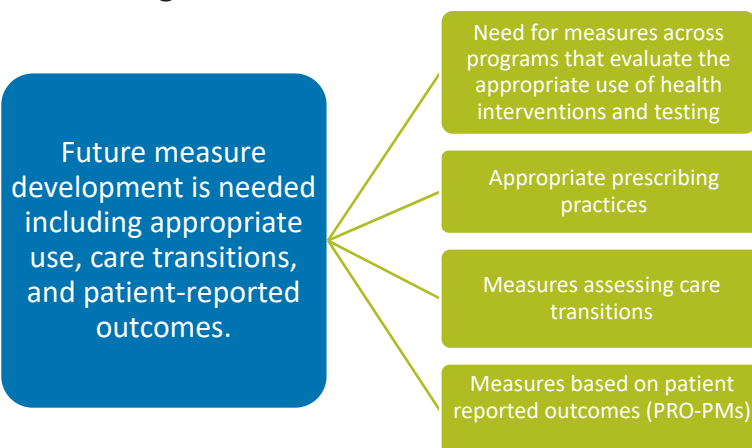
## MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Hospital Programs

The MAP Hospital Workgroup reviewed 33 measures under consideration for seven setting-specific federal programs:

Program	# of Measures
End Stage Renal Disease Quality Incentive Payment	3
PPS-Exempt Cancer Hospital Quality Reporting	5
Ambulatory Surgical Center Quality Reporting	3
Inpatient Psychiatric Facility Quality Reporting	3
Hospital Outpatient Quality Reporting	3
Hospital Inpatient Quality Reporting (IQR)/ Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	15
Hospital Value-Based Purchasing	1
Hospital Readmissions Reduction Program	0
Hospital Acquired Condition Reduction Program	0

## Hospital Workgroup Meeting Themes

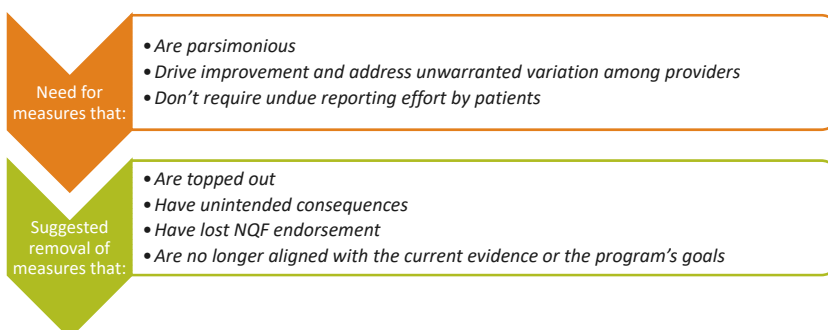
### Move to High-Value Measures



## Hospital Workgroup Meeting Themes

### Balance Measurement Burden with Opportunity for Improvement

Measure sets should balance the effort required for data collection and reporting and potential to improve quality of care and patient outcomes



## Considerations for Specific Programs

### ■ End-Stage Renal Disease Quality Incentive Program

- *Stressed the importance of managing anemia and avoiding unnecessary blood transfusions in patients with ESRD and encouraged better care coordination between dialysis facilities and hospitals.*
  - » Supported two measures intended to replace the current vascular access measures.
  - » Recommended that MUC16-305 be revised and resubmitted due that patients may receive the transfusion in other care settings, limiting the ability of Dialysis Facilities to control their performance on this measure.
- *Need for a comprehensive measure set that looks at both treatment and outcomes that would drive quality and safety for those with ESRD and gap areas including pediatrics and gaps relating to management of comorbid conditions, such as congestive heart failure, diabetes and hypertension.*
- *Commenters agreed with the MAP recommendations overall, though commenters did have suggestions for improvements for specific measures, such as improving the precision of the specifications.*

## Considerations for Specific Programs

### ■ PPS-Exempt Cancer Hospital Quality Reporting

- *Increased alignment between the IQR and PCHQR programs*
- *Need for measures of global harm in inpatient settings and informed consent.*
  - » Supported four measures related to end-of-life care.
  - » Did not support one measure, PRO Utilization in Non-Metastatic Prostate Cancer Patients (MUC16-393) because it is a structural measure related to the measurement of PRO utilization rather than a patient reported outcome measure.
- *Public comments differed regarding MUC16-393, as many commenters noted the increasing importance of patient-reported outcomes to CMS and to value-based care. Commenters generally agreed with MAP recommendations regarding the end-of-life measures.*

### ■ Ambulatory Surgical Center Quality Reporting Program

- *Need for measures should address surgical quality: infections and complications, patient and family engagement, efficiency, and appropriate pre-operative testing.*
- *New and existing measures should undergo testing and undergo NQF endorsement.*
- *Public comments supported many of the recommendations, but commenters did note that NQF endorsement is not required by the Social Security Act for measures adopted for the ASCQR Program*

## Considerations for Specific Programs

- **Inpatient Psychiatric Facility Quality Reporting**
  - *Increase alignment with IQR; measures needed to address medical comorbidities, emergency department patients not admitted to the hospital, discharge planning, and readmissions.*
  - *High number of alcohol and tobacco measures*
    - » While such measures are important, they should not be the highest priority indicators for quality treatment in psychiatric hospitals.
  - *Recommended MUCs be revised and resubmitted due to incomplete testing and need for NQF review and endorsement.*
  - *The majority of commenters supported MAP's conclusions. Commenters noted concern that measures (such as MUC16-428) may lead to over testing. There were general comments regarding the MAP identified gap area of access—where commenters were concerned that hospitals have limited control over this domain.*

## Considerations for Specific Programs

- **Hospital Outpatient Quality Reporting**
  - *Need measures with greater emphasis on communication and care coordination*
  - *Notable Measure Discussions:*
    - » Median Time from ED Arrival to ED Departure for Discharged ED Patients (MUC16-055)
      - *The Workgroup conditionally supported this measure contingent that 1) the testing data demonstrate this eMeasure more accurately determines patient arrival and discharge times compared to the chart abstracted version of the measure (NQF #0496) currently in the HOQR and HIQR programs and 2) this eMeasure is submitted to NQF for review and endorsement*
    - » Safe Use of Opioids – Concurrent Prescribing (MUC16-167)
      - *Not supported since there are times when concurrent prescriptions of opioids and benzodiazepines are appropriate. The Workgroup was also concerned that patients may unintentionally suffer withdrawal symptoms if previously prescribed opioids and/or benzodiazepines are reduced and/or stopped prior to discharge.*
  - *Public comments varied regarding the discussion of MUC16-167, both supporting the MAP hospital recommendation and suggesting that the measure be refined and resubmitted prior to rulemaking. Regarding MUC16-055, public commenters noted that making it an e-measure would not fix the inherent problems with the measure.*

## Considerations for Specific Programs

- Inpatient Quality Reporting Program/Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use)
  - Reviewed 15 measures for rulemaking
  - Need for alignment among hospital programs (for example: alignment of readmissions measures used both IQR and HRRP).
  - Remove measures that are no longer driving improvements in patient care and add PROs
  - **New information regarding malnutrition measures available.**
    - » The Workgroup engaged in a lengthy discussion about the concerns identified by the Health and Well-Being Standing Committee which just recently concluded in reviewing the measures.
  - NQF received over 50 comments regarding IQR measures. The majority of commenters agreed with MAP recommendations. Commenters that disagreed with MAP decisions primarily commented on the malnutrition measures as well as MUC16-262 (Measure of Quality of Informed Consent Documents for Hospital-Performed, Elective Procedures)

## Considerations for Specific Programs

- Hospital Value-Based Purchasing
  - Did not support Communication about Pain During the Hospital Stay (MUC16-263) (HP1, HP2 and HP3) for rulemaking because it did not meet the program requirements for the HVBP program.
  - Need to develop the next generation of patient safety measures and develop ways to mitigate the effect of the VBP program on safety net hospitals.
  - Commenters agreed with the MAP recommendation and agreed that there was need for further debate and revision of this measure.
- Hospital Readmissions Reduction Program (HRRP)
  - No new measures under consideration
  - CMS consider ASPE's recommendations to mitigate the impact of the HRRP on safety net hospitals.
- Hospital Acquired Condition Reduction Program (HACRP)
  - No new measures under consideration
  - Recommends that CMS develop measures that could replace PSI-90 in the HACRP.



## Dual Eligible Beneficiaries Workgroup Input to the Coordinating Committee

- Perspective on Hospital Recommendations
  - *For PRO-PMs, encourage*
    - » Testing in appropriate sub-populations (e.g., individuals with cognitive impairments, physical or intellectual disabilities)
    - » Assessing the patient/person's perspective on whether the measure is meaningful, understandable, and achievable
  - *Clarity is needed around how PRO-PMs are or should be incorporated into patient care & accountability programs*
  - *Encourage the inclusion of measures providing quality information related to population health and the functioning of the system as a whole*

## Ambulatory Surgical Center Quality Reporting Program Workgroup Recommendations

- [Ambulatory Breast Procedure Surgical Site Infection \(SSI\) Outcome Measure](#) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received: [3](#); MUC ID: MUC16-155)
- [Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received: [3](#); MUC ID: MUC16-152)
- [Hospital Visits after Urology Ambulatory Surgical Center Procedures](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received: [2](#); MUC ID: MUC16-153)

## End-Stage Renal Disease Quality Incentive Program Workgroup Recommendations

- [Hemodialysis Vascular Access: Long-term Catheter Rate](#)  
(Workgroup Recommendation: Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-309)
- [Hemodialysis Vascular Access: Standardized Fistula Rate](#)  
(Workgroup Recommendation: Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-308)
- [Standardized Transfusion Ratio for Dialysis Facilities](#)  
(Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[3](#); MUC ID: MUC16-305)

## End-Stage Renal Disease Quality Incentive Program Workgroup Recommendations

- [Hemodialysis Vascular Access: Long-term Catheter Rate](#)  
(Workgroup Recommendation: Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-309)
- [Hemodialysis Vascular Access: Standardized Fistula Rate](#)  
(Workgroup Recommendation: Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-308)
- [Standardized Transfusion Ratio for Dialysis Facilities](#)  
(Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[3](#); MUC ID: MUC16-305)

## Hospital Inpatient Quality Reporting and EHR Incentive Program Workgroup Recommendations

- [Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol & Other Drug Use Disorder Treatment at Discharge](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[2](#); MUC ID: MUC16-180)
- [Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[2](#); MUC ID: MUC16-178)
- [Alcohol Use Screening](#) (Workgroup Recommendation: Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-179)

- [Appropriate Documentation of a Malnutrition Diagnosis](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-344)
- [Communication about Pain During the Hospital Stay](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[7](#); MUC ID: MUC16-263)
- [Completion of a Malnutrition Screening within 24 Hours of Admission](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[3](#); MUC ID: MUC16-294)
- [Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 Hours of a Malnutrition Screening](#) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:[10](#); MUC ID: MUC16-296)

- [Follow-Up After Hospitalization for Mental Illness](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[3](#); MUC ID: MUC16-165)
- [Measure of Quality of Informed Consent Documents for Hospital-Performed, Elective Procedures](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[6](#); MUC ID: MUC16-262)
- [Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking ; Public comments received:[8](#); MUC ID: MUC16-372)
- [Patient Panel Smoking Prevalence IQR](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[1](#); MUC ID: MUC16-068)

- [Safe Use of Opioids – Concurrent Prescribing](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[7](#); MUC ID: MUC16-167)
- [Influenza Immunization \(IMM-2\)](#) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:[3](#); MUC ID: MUC16-053)
- [Tobacco Use Screening \(TOB-1\)](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[1](#); MUC ID: MUC16-050)
- [Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[2](#); MUC ID: MUC16-041)

## Hospital Outpatient Quality Reporting Program Workgroup Recommendations

- [Median Time from ED Arrival to ED Departure for Discharged ED Patients](#) (Workgroup Recommendation: Conditional Support for Rulemaking; Public comments received:[3](#); MUC ID: MUC16-055)
- [Median Time to Pain Management for Long Bone Fracture](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[4](#); MUC ID: MUC16-056)
- [Safe Use of Opioids – Concurrent Prescribing](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[6](#); MUC ID: MUC16-167)

## Hospital Value-Based Purchasing Program Workgroup Recommendations

- [Communication about Pain During the Hospital Stay](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[6](#); MUC ID: MUC16-263)

## Inpatient Psychiatric Facility Quality Reporting Program Workgroup Recommendations

- [Identification of Opioid Use Disorder](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[3](#); MUC ID: MUC16-428)
- [Medication Continuation following Inpatient Psychiatric Discharge](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[4](#); MUC ID: MUC16-048)
- [Medication Reconciliation at Admission](#) (Workgroup Recommendation: Refine and Resubmit Prior to Rulemaking; Public comments received:[4](#); MUC ID: MUC16-049)

## Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program Workgroup Recommendations

- [PRO utilization in in non-metastatic prostate cancer patients](#) (Workgroup Recommendation: Do Not Support for Rulemaking; Public comments received:[6](#); MUC ID: MUC16-393)
- [Proportion of patients who died from cancer admitted to hospice for less than 3 days](#) (Workgroup Recommendation: Support for Rulemaking; Public comments received:[7](#); MUC ID: MUC16-274)
- [Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life](#) (Workgroup Recommendation: Support for Rulemaking; Public comments received:[8](#); MUC ID: MUC16-273)

## Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program Workgroup Recommendations

- [Proportion of patients who died from cancer not admitted to hospice](#) (Workgroup Recommendation: Support for Rulemaking; Public comments received: [6](#); MUC ID: MUC16-275)
- [Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life](#) (Workgroup Recommendation: Support for Rulemaking; Public comments received: [5](#); MUC ID: MUC16-271)

## Measure Ratification by MAP Coordinating Committee

- MAP CC Chairs will ask CC members if any individual measures need to be pulled for discussion
- CC member will identify which part of the WG recommendation they disagree with
- All other measures will be considered ratified by the MAP CC

## Committee Discussion

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## Lunch

Measure Applications Partnership CONVENED BY THE NATIONAL QUALITY FORUM

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## Opportunity for Public Comment on PAC/LTC Programs

### Commenters are asked to:

- Limit their comments to the PAC/LTC programs recommendations
- Limit comments to **two minutes**
- Make any comments on MUCs or opportunities to improve the current PAC/LTC measure set at this time

## Finalize Pre-Rulemaking Recommendations for PAC/LTC Programs

### Presented by:

Deb Saliba, Workgroup Co-Chair

Jean-Luc Tilly, Project Manager, NQF

## Finalize Pre-Rulemaking Recommendations – *Process at a Glance*

Workgroup (WG) Chairs / NQF Staff present measures and the programs evaluated

WG Chairs / NQF Staff outline strategic issues and relevant input from MAP Duals

Coordinating Committee (CC) Chairs ask CC members if measures need to be pulled for discussion

CC member will identify which part of the WG recommendation they disagree with

All other measures will be considered ratified by the MAP CC

## MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for PAC/LTC Programs

- The MAP PAC/LTC Workgroup reviewed 22 measures under consideration for six setting specific federal programs addressing post-acute care and long-term care:
  - *Inpatient Rehabilitation Facility Quality Reporting Program (3 measures)*
  - *Long Term Care Quality Reporting Program (3 measures)*
  - *Skilled Nursing Facility Quality Reporting Program (3 measures)*
  - *Skilled Nursing Facility Value Based Purchasing Program (0 measures)*
  - *Home Health Quality Reporting Program (5 measures)*
  - *Hospice Quality Reporting Program (8 measures)*

## IMPACT Act

- MAP encouraged alignment of measurement across settings using standardized patient assessment data and acknowledged the importance of preventing duplicate efforts, maintaining data integrity, and reducing burden.
- MAP and public commenters recognized the challenging timelines required to meet IMPACT Act legislation, but also expressed some discomfort supporting measures with specifications that have not been fully defined, delineated, or tested.
- Overall, the MUCs introduced represent significant progress toward promoting quality in PAC settings.

## Continued Opportunities to Address Quality

- Patient-reported outcome measures:
  - *Key to understanding quality*
  - *Increase patient and family engagement*
  - *New tools, such as PROMIS, have potential to spur groundbreaking measurement*
- Other measures important to patients:
  - *Nutrition*
  - *Care preferences beyond end-of-life*
  - *Medication management*

## Shared Accountability Across the Continuum

- Partnerships between hospitals and PAC/LTC providers are critical to successful transitions and improved discharge planning.
- Health information technology and interoperability-focused efforts offer an opportunity for improvement
- Settings share accountability to treat the 'whole' person, including care preferences

## Considerations for Specific Programs

### Inpatient Rehabilitation Facility Quality Reporting Program

#### *New opportunities for measurement:*

- CAHPS or other experience of care assessment specific to the IRF setting

#### *Measures under consideration:*

- New or Worsened Pressure Ulcers - Conditional Support for Rulemaking:
  - » Evaluate the impact of revised specifications on observed rates for IRF patients
  - » Public comments were mixed; some supported MAP's recommendation, and others recommended the measure be re-evaluated for endorsement and further tested.
  - » CMS submitted a memorandum detailing the rationale for changes to the measure, findings from their testing, and a specific examination of the IRF setting

## Considerations for Specific Programs

### Inpatient Rehabilitation Facility Quality Reporting Program (continued)

#### *Measures under consideration:*

- Transfer of Information at Admission – Refine and Resubmit:
  - » Include transfers between attending clinicians as well as between settings
  - » Complete testing and submit to NQF for endorsement
  - » Public comments were generally supportive of MAP's recommendation, and noted existing regulations may make this measure duplicative, that the standard to meet the measure should be higher, and that obtaining information 'upstream' may not be within a provider's control

## Considerations for Specific Programs

### Skilled Nursing Facility Quality Reporting Program

#### *New opportunities for measurement:*

- CAHPS or other experience of care assessment specific to the SNF setting
- Measures to address the presence of advance directives
- Measures of nutrition

#### *Measures under consideration:*

- New or Worsened Pressure Ulcers - Support for Rulemaking
- Transfer of Information at Admission – Refine and Resubmit:
  - » Include transfers between attending clinicians as well as between settings
  - » Complete testing and submit to NQF for endorsement
  - » Public comments were generally supportive of MAP's recommendation, and noted existing regulations may make this measure duplicative, that the standard to meet the measure should be higher, and that obtaining information 'upstream' may not be within a provider's control

## Considerations for Specific Programs

### Long-Term Care Hospital Quality Reporting Program

*New opportunities for measurement:*

- CAHPS or other experience of care assessment specific to the LTCH setting
- Measures of nutrition

*Refine existing measures:*

- Replace infection-specific measures with general facility-acquired infections measure
- Reconsider Ventilator-Associated Event measure

## Considerations for Specific Programs

### Long-Term Care Hospital Quality Reporting Program (continued)

*Measures under consideration:*

- New or Worsened Pressure Ulcers - Support for Rulemaking
- Transfer of Information at Admission – Refine and Resubmit:
  - » Include transfers between attending clinicians as well as between settings
  - » Complete testing and submit to NQF for endorsement
  - » Public comments were generally supportive of MAP's recommendation, and noted existing regulations may make this measure duplicative, that the standard to meet the measure should be higher, and that obtaining information 'upstream' may not be within a provider's control

## Considerations for Specific Programs

### Home Health Quality Reporting Program

#### *New opportunities for measurement:*

- CAHPS or other experience of care assessment specific to the SNF setting
- Measures to address the presence of advance directives
- Measures of nutrition

#### *Measures under consideration:*

- New or Worsened Pressure Ulcers – Support for Rulemaking
- Transfer of Information at Admission – Refine and Resubmit:
  - » Include transfers between attending clinicians as well as between settings
  - » Complete testing and submit to NQF for endorsement
  - » Public comments were generally supportive of MAP's recommendation, and noted existing regulations may make this measure duplicative, that the standard to meet the measure should be higher, and that obtaining information 'upstream' may not be within a provider's control

## Considerations for Specific Programs

### Home Health Quality Reporting Program (continued)

#### *Measures under consideration:*

- Functional Assessment at Admission and Discharge, Care Plan – Conditional Support:
  - » Resubmit to NQF for endorsement in new setting
  - » Public comments concurred with the MAP recommendation, and recommended ensuring patients and families were involved in developing the care plan
- Falls with Major Injury– Conditional Support:
  - » Resubmit to NQF for endorsement in new setting
  - » Public comments concurred with the MAP recommendation – some suggested expanding the measure to include all falls, others cautioned the home health setting presents unique challenges to mitigating falls

## Considerations for Specific Programs

### Hospice Quality Reporting Program

*New opportunities for measurement:*

- Medication management at end of life
- Providing bereavement services
- Patient care preferences beyond end-of-life care (e.g. turning)
- Symptom management for dementia, other end-of-life conditions

*Refine Existing Measures:*

- Re-evaluate process measures to assess relationship to outcome measures/patient satisfaction

## Considerations for Specific Programs

### Hospice Quality Reporting Program (continued)

*Measures Under Consideration:*

- Eight measures derived from the CAHPS Hospice Survey:
  - » Getting Emotional and Spiritual Support
  - » Getting Help for Symptoms
  - » Getting Hospice Care Training
  - » Getting Timely Care
  - » Hospice Team Communications
  - » Rating of Hospice
  - » Treating Family Members with Respect
  - » Willingness to Recommend
- All received Support for Rulemaking
- Public comments were generally supportive, noting the measures recently received NQF endorsement.



## Dual Eligible Beneficiaries Workgroup Input to the Coordinating Committee

- Perspective on PAC/LTC Recommendations:
  - *Support measures capturing the degree to which providers and the care they provide is integrated across settings*
  - *Encourage continued examination of the role that social risk factors play in care delivery and performance measurement*
  - *For PRO-PMs, consider*
    - » Cultural and language barriers
    - » Patient/Person's perspective on whether the measure is meaningful, understandable, and achievable
  - *Additional measure gaps to consider:*
    - » Population health
    - » Transitions from institutional settings to the community

## Home Health Quality Reporting Program Workgroup Recommendations

- [The Percent of Home Health Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function](#) (Workgroup Recommendation: Conditional Support; Public comments received:[6](#); MUC ID: MUC16-061)
- [The Percent of Home Health Residents Experiencing One or More Falls with Major Injury](#) (Workgroup Recommendation: Conditional Support; Public comments received:[4](#); MUC ID: MUC16-063)
- [The Percent of Residents or Home Health Patients with Pressure Ulcers That Are New or Worsened \(Short-Stay\)](#) (Workgroup Recommendation: Support; Public comments received:[1](#); MUC ID: MUC16-145)

## Home Health Quality Reporting Program Workgroup Recommendations

- [Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[2](#); MUC ID: MUC16-347)
- [Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[2](#); MUC ID: MUC16-357)

## Hospice Quality Reporting Program Workgroup Recommendations

- [CAHPS Hospice Survey: Getting Emotional and Spiritual Support](#) (Workgroup Recommendation: Support; Public comments received:[4](#); MUC ID: MUC16-037)
- [CAHPS Hospice Survey: Getting Help for Symptoms](#) (Workgroup Recommendation: Support; Public comments received:[5](#); MUC ID: MUC16-039)
- [CAHPS Hospice Survey: Getting Hospice Care Training](#) (Workgroup Recommendation: Support; Public comments received:[4](#); MUC ID: MUC16-035)
- [CAHPS Hospice Survey: Getting Timely Care](#) (Workgroup Recommendation: Support; Public comments received:[4](#); MUC ID: MUC16-036)

## Hospice Quality Reporting Program Workgroup Recommendations

- [CAHPS Hospice Survey: Hospice Team Communications](#) (Workgroup Recommendation: Support; Public comments received:[4](#); MUC ID: MUC16-032)
- [CAHPS Hospice Survey: Rating of Hospice](#) (Workgroup Recommendation: Support; Public comments received:[4](#); MUC ID: MUC16-031)
- [CAHPS Hospice Survey: Treating Family Member with Respect](#) (Workgroup Recommendation: Support; Public comments received:[4](#); MUC ID: MUC16-040)
- [CAHPS Hospice Survey: Willingness to Recommend](#) (Workgroup Recommendation: Support; Public comments received:[5](#); MUC ID: MUC16-033)

## Inpatient Rehabilitation Facility Quality Reporting Program Workgroup Recommendations

- [Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened \(Short-Stay\)](#) (Workgroup Recommendation: Conditional Support; Public comments received:[5](#); MUC ID: MUC16-143)
- [Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[5](#); MUC ID: MUC16-319)
- [Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[4](#); MUC ID: MUC16-325)

## Long-Term Care Hospital Quality Reporting Program Workgroup Recommendations

- [Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened \(Short-Stay\)](#) (Workgroup Recommendation: Support; Public comments received:[2](#); MUC ID: MUC16-144)
- [Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[2](#); MUC ID: MUC16-321)
- [Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[3](#); MUC ID: MUC16-327)

## Skilled Nursing Facility Quality Reporting Program Workgroup Recommendations

- [Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened \(Short-Stay\)](#) (Workgroup Recommendation: Support; Public comments received:[2](#); MUC ID: MUC16-142)
- [Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[2](#); MUC ID: MUC16-314)
- [Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received:[4](#); MUC ID: MUC16-323)

## Measure Ratification by MAP Coordinating Committee

- MAP CC Chairs will ask CC members if any individual measures need to be pulled for discussion
- CC member will identify which part of the WG recommendation they disagree with
- All other measures will be considered ratified by the MAP CC

## Committee Discussion

# Break

## Opportunity for Public Comment on Clinician Programs

### Commenters are asked to:

- Limit their comments to the Clinician programs recommendations
- Limit comments to **two minutes**
- Make any comments on MUCs or opportunities to improve the current Clinician measure set at this time

## Finalize Pre-Rulemaking Recommendations for Clinician Programs

Presented by:

Bruce Bagley, Workgroup Co-Chair

Eric Whitacre, Workgroup Co-Chair

John Bernot, Senior Director, NQF

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## Finalize Pre-Rulemaking Recommendations – *Process at a Glance*

Workgroup (WG) Chairs / NQF Staff present  
measures and the programs evaluated

WG Chairs / NQF Staff outline strategic issues  
and relevant input from MAP Duals

Coordinating Committee (CC) Chairs ask CC  
members if measures need to be pulled for  
discussion

CC member will identify which part of the  
WG recommendation they disagree with

All other measures will be considered ratified  
by the MAP CC

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## Program Overview: Merit-Based Incentive Payment System (MIPS)

- MIPS was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Medicare sustainable growth rate (SGR) and aimed to improve Medicare payment for physician services.
  - *Consolidates Medicare's existing incentive and quality reporting programs for clinicians.*
- MIPS is one of two tracks in the Quality Payment Program (QPP) policy designed to reform Medicare Part B payments.
  - *Individual clinicians self-select quality measures to submit to CMS.*
  - *A clinician who participates in an Advanced Alternate Payment Model (Advanced APM) is excluded from MIPS.*

## Program Overview: Merit-Based Incentive Payment System (MIPS)

- MIPS makes positive and negative payment adjustments for Eligible Clinicians (ECs) based on performance in four categories:
  - *Quality: replaces the current Physician Quality Reporting System (PQRS) program*
  - *Cost: replaces the current Value-Based Payment Modifier (VBPM) program*
  - *Advancing Care Information: replaces the Meaningful Use program*
  - *Improvement Activities: new component*
- 18 measures were reviewed for the MIPS program



## Program Overview: Medicare Shared Savings Program (MSSP)

- MSSP is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs.
- Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned.
- One measure was reviewed for the MSSP program.

## Clinician Workgroup Meeting Themes

### Move to High-Value Measures

- Importance of development and inclusion of high-priority measures in the each of the programs
- Measures endorsed for the programs should clearly
  - *Address the NQS aims and priorities*
  - *Align with other initiatives*
  - *Focus on patient outcomes*
  - *Be sensitive to the burden of reporting the measures.*
- Move towards outcome or composite measures
- Development of more performance measures based on patient-reported outcomes
  - *PROMIS® Discussion- Workgroup members expressed support for the concept and were pleased with the tool's ability to crosswalk to existing survey tools*

## Clinician Workgroup Meeting Themes

### Attribution Considerations

- Clinician-level attribution can limit the use of many outcome measures that a clinician may perceive as measuring the results of efforts by a full medical team
- An individual clinician should feel capable of regulating the outcome of the quality metric in order to conclude that the result of the measure is reliable and valid.
- Timeliness of the attribution can be problematic to measurement
- Need to encourage shared accountability and improve cooperation and communication across the healthcare system
  - *However, a measure must attribute results to an entity that can influence the outcomes*

## Considerations for Specific Programs

### Merit-Based Incentive Payment System (MIPS)

- Desire for more high-value measures
- Need for more outcome measures
  - *Consider the measure development challenges at the clinician level, such as having an adequate sample size to ensure reliability, the attribution of the outcome, or the timeliness of the patient outcome*
  - *Continue partnerships between CMS, NQF, and specialty societies to drive further adoption of outcome measures*
- Pursue ways to improve process measures when they are necessary
  - *Consider use of composites measures*
  - *Select process measures more closely tied to outcomes that are most important to patients*

## Considerations for Specific Programs

### Merit-Based Incentive Payment System (MIPS)

- Address gap in measures of appropriate use
- Need for more cross-cutting measures
- Need to further measurement science around “topped out measures”
  - *Assess when to remove topped out measures*
  - *Balance the need to include measures that allow all ECs to participate in the program*
  - *Consider that measures are optional and current rates of performance could be disproportionately selected by already high performers*
  - *Take into account that performance could regress if measures are removed and that there is inadequate data in this area*

## Considerations for Specific Programs

### Medicare Shared Savings Plan (MSSP)

- Desire to see more outcome measures
- Need for measures that can help ensure care coordination within the ACO with a focus on communication and timeliness of care
  - *suggested adding measures of avoidable emergency department use in addition to avoidable hospitalizations to provide a more complete picture of a patient's need for acute care.*
- Desire to see more measures of person and family engagement
- Importance of cross-cutting measures given the high number of clinical areas not addressed by the current set
- Need to better link quality and appropriate use measures in the set

## Notable Measure Discussions

- **MUC16-069 Adult Local Current Smoking Prevalence (MSSP & MIPS)**
  - *Need to engage clinicians in important public health initiatives such as smoking cessation*
  - *MAP encouraged continued refinement of this measure, citing concerns around attribution and the accuracy of the underlying data.*
- **MUC16-398 Appropriate Use Criteria – Electrophysiology (MIPS)**
  - *Workgroup members noted support for the concept of this measure, and asked the measure developer to further specify the attributable population.*
  - *Additionally, the Workgroup commented on the need to ensure that new appropriate use measures align with practice guidelines*

## Notable Measure Discussions (cont.)

- **MUC16-074 Fixed-dose Combination of Hydralazine and Isosorbide Dinitrate Therapy for Self-identified Black or African American Patients with Heart Failure and Left Ventricular Ejection Fraction (LVEF) <40% on ACEI or ARB and Beta-blocker Therapy (MIPS)**
  - *eMeasure that has been approved for trial use*
  - *Workgroup noted that this measure could address both effective clinical care and potential disparities in heart failure as it would track use of a therapy that can reduce morbidity and mortality in patients who self-identify as African American*
  - *Workgroup raised concerns that this measure is based on the use of a fixed-dose regimen, and American College of Cardiology/American Heart Association guidelines suggest that individual components of the combination therapy could be substituted.*

## Dual Eligible Beneficiaries Workgroup Input to the Coordinating Committee

- Perspective on Clinician Recommendations
  - *Models of care and the incorporation of performance measurement into those models must consider the unique needs and preferences of various sub-populations*
  - *Consumers want to provide feedback or data on a regular basis*
    - » Effort/burden could be minimized through data collection processes that are familiar and understandable to the population of interest
  - *For PRO-PMs, consider*
    - » Cultural and language barriers
    - » Patient/Person's perspective on whether the measure is meaningful, understandable, and achievable

## Merit-Based Incentive Payment System Workgroup Recommendations

- [Adult Local Current Smoking Prevalence](#) (Workgroup Recommendation: Refine and resubmit; Public comments received:[2](#); MUC ID: MUC16-069)
- [Appropriate Use Criteria - Cardiac Electrophysiology](#) (Workgroup Recommendation: Refine and resubmit; Public comments received:[2](#); MUC ID: MUC16-398)
- [Average change in back pain following lumbar discectomy and/or laminotomy](#) (Workgroup Recommendation: Conditional support ; Public comments received:[3](#); MUC ID: MUC16-087)
- [Average change in back pain following lumbar fusion.](#) (Workgroup Recommendation: Conditional support ; Public comments received:[2](#); MUC ID: MUC16-088)

## MIPS Workgroup Recommendations

- [Average change in leg pain following lumbar discectomy and/or laminotomy](#) (Workgroup Recommendation: Conditional support; Public comments received:[2](#); MUC ID: MUC16-089)
- [Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy](#) (Workgroup Recommendation: Refine and resubmit; Public comments received: 0; MUC ID: MUC16-287)
- [Febrile Neutropenia Risk Assessment Prior to Chemotherapy](#) (Workgroup Recommendation: Conditional Support; Public comments received:[2](#); MUC ID: MUC16-151)

## MIPS Workgroup Recommendations

- [Fixed-dose Combination of Hydralazine and Isosorbide Dinitrate Therapy for Self-identified Black or African American Patients with Heart Failure and Left Ventricular Ejection Fraction \(LVEF\) <40% on ACEI or ARB and Beta-blocker Therapy](#) (Workgroup Recommendation: Refine and resubmit; Public comments received:[8](#); MUC ID: MUC16-074)
- [HIV Medical Visit Frequency](#) (Workgroup Recommendation: Refine and resubmit; Public comments received:[1](#); MUC ID: MUC16-073)
- [HIV Viral Suppression](#) (Workgroup Recommendation: Conditional support; Public comments received:[1](#); MUC ID: MUC16-075)

## MIPS Workgroup Recommendations

- [Intravesical Bacillus Calmette-Guerin for NonMuscle Invasive Bladder Cancer](#) (Workgroup Recommendation: Refine and resubmit; Public comments received: 0; MUC ID: MUC16-310)
- [Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use](#) (Workgroup Recommendation: Support; Public comments received: 2; MUC ID: MUC16-269)
- [Otitis Media with Effusion: Systemic Corticosteroids - Avoidance of Inappropriate Use](#) (Workgroup Recommendation: Do Not Support; Public comments received: 0; MUC ID: MUC16-268)

## MIPS Workgroup Recommendations

- [Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems \(CAHPS\)® Surgical Care Survey \(S-CAHPS\)](#) (Workgroup Recommendation: Support; Public comments received: 1; MUC ID: MUC16-291)
- [Prescription of HIV Antiretroviral Therapy](#) (Workgroup Recommendation: Refine and resubmit; Public comments received: 0; MUC ID: MUC16-072)
- [Prevention of Post-Operative Vomiting \(POV\) - Combination Therapy \(Pediatrics\)](#) (Workgroup Recommendation: Conditional Support; Public comments received: 2; MUC ID: MUC16-312)

## MIPS Workgroup Recommendations

- [Safety Concern Screening and Follow-Up for Patients with Dementia](#) (Workgroup Recommendation: Conditional Support; Public comments received: [2](#); MUC ID: MUC16-317)
- [Uterine artery embolization technique: Documentation of angiographic endpoints and interrogation of ovarian arteries](#) (Workgroup Recommendation: Refine and Resubmit; Public comments received: 0; MUC ID: MUC16-343)

## Medicare Shared Savings Program Workgroup Recommendations

- [Adult Local Current Smoking Prevalence](#) (Workgroup Recommendation: Refine and resubmit; Public comments received: [2](#); MUC ID: MUC16-069)



## Measure Ratification by MAP Coordinating Committee

- MAP CC Chairs will ask CC members if any individual measures need to be pulled for discussion
- CC member will identify which part of the WG recommendation they disagree with
- All other measures will be considered ratified by the MAP CC

## Committee Discussion

# Adjourn



## Measure Applications Partnership

Coordinating Committee In-Person Meeting

*January 24-25, 2016*

### Day 2 Agenda

- Day 1 recap
- Discuss pre-rulemaking cross-cutting issues:
  - *Attribution*
  - *Risk adjustment for sociodemographic factors*
- Review refinements to the Medicaid Taskforce processes
- Discuss potential improvements to the pre-rulemaking process

## Day 1 Recap

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## Pre-Rulemaking Cross-Cutting Issues: Attribution

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## Slide 4

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**KI6** I recycled the slides from HB's other presentations with an update to the Selection Guide slide - not sure how much detail to go into here. We could use the member call slides if you want fewer slides. I got those down to about 9 slides instead of 17.

Kim Ibarra, 1/12/2017

## Current Landscape

- Recent legislation such as IMPACT and MACRA demonstrate the continued focus on value-based purchasing to drive improvements in quality and cost by re-aligning incentives.
- Implementing pay for performance models requires knowing who can be held responsible for the results of the quality and efficiency measures used to judge performance.
  - *Increasingly challenging as quality is assessed on outcome measures rather than process or structural measures.*
- Attribution can be defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians.
  - *Attribution models help to identify a patient relationship that can be used to establish accountability for quality and cost.*
- Moving the system away from fee-for-service payment to alternative payment models has highlighted the need to better understand how patient outcomes and costs can be accurately attributed in a system increasingly built on shared accountability.

## Attribution Project Purpose

- Taking in account trends toward providing care in shared accountability structures, provide multistakeholder guidance on the field on approaches to issues of attribution:
  - Identify key challenges in attribution
  - Develop a set of guiding principles
  - Identify elements of an attribution model
    - » Explore strengths and weaknesses
  - Identify recommendations for developing, selecting, and implementing an attribution model

## Attribution Committee Members

- **Ateev Mehrotra, MD, MPH (co-chair)**
- **Carol Raphael (co-chair)**
- Michael Barr, MD, MBA, MACP
- Jenny Beam, MS
- Jill Berger, MAS
- Anne Deutsch, PhD, RN, CRRN
- Elizabeth Drye, MD, SM
- Troy Fiesinger, MD
- Charles Hawley, MA
- Ari Houser
- Keith Kocher, MD, MPH, MPhil
- Robert Kropp, MD, MBA, MACP
- Danielle Lloyd, MPH
- Edison Machado, MD, MBA
- Ira Moscovice, PhD
- Jennifer Nowak, RN, MSN
- Jennifer Perloff, PhD
- Brandon Pope, PhD
- Laurel Radwin, PhD, RN
- Jack Resneck, MD
- Michael Samuhel, PhD
- Robert Schmitt, FACHE, FHFMA, MBA, CPA
- Nathan Spell, MD
- Srinivas Sridhara, PhD, MS
- Bharat Sutariya, MD, FACEP
- L. Daniel Muldoon **(Federal Liaison)**

## Environmental Scan Highlights

- **Models categorized by:**
  - Program stage
  - Type of provider attributed
  - Timing
  - Clinical circumstances
  - Payer/programmatic circumstances
  - Exclusivity of attribution
  - Measure used to make attribution
  - Minimum requirement to make attribution
  - Period of time for which provider is responsible
- **163 models in use or proposed for use**
  - 17% currently in use
  - 89% use retrospective attribution
  - 77% attribute to a single provider, mainly a physician

## Commissioned Paper Findings

- Best practices have not yet been determined
  - *Existing models are largely built off of previously used approaches*
  - *Trade-offs in the development of attribution models should be explored and transparent*
- No standard definition for an attribution model
- Lack of standardization across models limits ability to evaluate

## Challenges

- Greater standardization among attribution models is needed to allow:
  - *Comparisons between models;*
  - *Best practices to emerge.*
- Little consistency across models but there is evidence that changing the attribution rules can alter results.
- Lack of transparency on how results are attributed and no way to appeal the results of an attribution model that may wrongly assign responsibility.



## Addressing the Challenges

- To address these challenges the Committee:
  - *Developed guiding principles*
  - *Made recommendations*
  - *Created the Attribution Model Selection Guide*
- These products allow for greater standardizations, transparency, and stakeholder buy-in:
  - *Allow for evaluation of models in the future*
  - *Lay the groundwork to develop a more robust evidence base*

## Guiding Principles Preamble

- Acknowledge the complex, multidimensional challenges to implementing attribution models as the models can change depending on their purpose and the data available.
- Grounded in the National Quality Strategy (NQS) as attribution can play a critical role in advancing these goals.
- Recognize attribution can refer to both the attribution of patients for accountability purposes as well as the attribution of results of a performance measure.
- Highlighted the absence of a gold standard for designing or selecting an attribution model; must understand the goals of each use case.
- Key criteria for selecting an attribution model are: actionability, accuracy, fairness, and transparency.

## Guiding Principles

1. Attribution models should fairly and accurately assign accountability.
2. Attribution models are an essential part of measure development, implementation, and policy and program design.
3. Considered choices among available data are fundamental in the design of an attribution model.
4. Attribution models should be regularly reviewed and updated.
5. Attribution models should be transparent and consistently applied.
6. Attribution models should align with the stated goals and purpose of the program.

## Attribution Model Selection Guide

- **Current state:**
  - *Tension between the desire for clarity about an attribution model's fit for purpose and the state of the science related to attribution*
  - *Desire for rules to clarify which attribution model should be used in a given circumstance, but not enough evidence to support the development of such rules at this time.*
- **Goals of the Attribution Model Selection Guide:**
  - Aid measure developers, measure evaluation committees, and program implementers on the necessary elements of an attribution that should be specified.
  - Represent the minimum elements that should be shared with the accountable entities

## The Attribution Model Selection Guide

<b>What is the context and goal of the accountability program?</b>	<ul style="list-style-type: none"> <li>• What are the desired outcomes and results of the program?</li> <li>• Is the attribution model evidence-based?</li> <li>• Is the attribution model aspirational?</li> <li>• What is the accountability mechanism of the program?</li> <li>• Which entities will participate and act under the accountability program?</li> </ul>
<b>How do the measures relate to the context in which they are being used?</b>	<ul style="list-style-type: none"> <li>• What are the patient inclusion/exclusion criteria?</li> <li>• Does the model attribute enough individuals to draw fair conclusions?</li> </ul>
<b>Which units will be affected by the attribution model?</b>	<ul style="list-style-type: none"> <li>• Which units are eligible for the attribution model?</li> <li>• To what degree can the accountable unit influence the outcomes?</li> <li>• Do the units have sufficient sample size to meaningfully aggregate measure results?</li> <li>• Are there multiples units to which this attribution model will be applied?</li> </ul>
<b>How is the attribution performed?</b>	<ul style="list-style-type: none"> <li>• What data are used? Do all parties have access to the data?</li> <li>• What are the qualifying events for attribution, and do those qualifying events accurately assign care to the right accountable unit?</li> <li>• What are the details of the algorithm used to assign responsibility?</li> <li>• Have multiple methodologies been considered for reliability?</li> <li>• What is the timing of the attribution computation?</li> </ul>

## Recommendations for Attribution Models

- Build on the principles and Attribution Model Selection Guide.
- Intended to apply broadly to developing, selecting, and implementing attribution models in the context of public and private sector accountability programs.
- Recognized the current state of the science, considered what is achievable now, and what is the ideal future state for attribution models.
- Stressed the importance of aspirational and actionable recommendations in order to drive the field forward.

## Use the Attribution Model Selection Guide to evaluate the factors to consider in the choice of an attribution model

- No gold standard; different approaches may be more appropriate than others in a given situation.
- Model choice should be dictated by the context in which it will be used and supported by evidence.
- Measure developers and program implementers should be transparent about the potential trade-offs between the accountability mechanism, the gap for improvement, the sphere of influence of the accountable entity over the outcome, and the scientific properties of the measure considered for use.

## Attribution models should be tested

- Attribution models of quality initiative programs must be subject to some degree of testing for goodness of fit, scientific rigor, and unintended consequences.
  - *Degree of testing may vary based on the stakes of the accountability program, attribution models would be improved by rigorous scientific testing and making the results of such testing public.*
- When used in mandatory accountability programs, attribution models should be subject to testing that demonstrates adequate sample sizes, appropriate outlier exclusion and/or risk adjustment to fairly compare the performance of attributed entities, and sufficiently accurate data sources to support the model in fairly attributing patients/cases to entities.

## Attribution models should be subject to multistakeholder review

- Given the current lack of evidence on the gold standard for attribution models, perspectives on which approach is best could vary based on the interests of the stakeholders involved.
- Attribution model selection and implementation in public and private sectors, such as organizations implementing payment programs or health plans implementing incentive programs should use multistakeholder review to determine the best attribution model to use for their purposes.

## Attribution models should attribute care to entities who can influence care and outcomes

- Attribution models can unfairly assign results to entities who have little control or influence over patient outcomes.
- For an attribution model to be fair and meaningful, an accountable entity must be able to influence the outcomes for which it is being held accountable either directly or through collaboration with others.
- As care is increasingly delivered by teams and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control.

## Attribution models used in mandatory public reporting or payment programs should meet minimum criteria

- In order to be applied to mandatory reporting or payment program attribution models should:
  - *Use transparent, clearly articulated, reproducible methods of attribution;*
  - *Identify accountable entities that are able to meaningfully influence measured outcomes;*
  - *Utilize adequate sample sizes, outlier exclusion, and/or risk adjustment to fairly compare the performance of attributed entities;*
  - *Undergo sufficient testing with scientific rigor at the level of accountability being measured;*
  - *Demonstrate accurate enough data sources to support the model in fairly attributing patients/cases to entities;*
  - *Be implemented with adjudication processes, open to the public, that allow for timely and meaningful appeals by measured entities.*

## Coordinating Committee Discussion

- What are the implications of the Attribution Committee's findings for the work of MAP?
- How should MAP Workgroups consider attribution issues in their recommendations?
- How should MAP consider measures being used at different levels of analysis than endorsed?
- How can MAP balance attribution concerns with fostering shared accountability?

# Refinements to the Medicaid Task Force Processes

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## Medicaid Project Background

- Core Set Creation and Updates
- Core Set Purpose
- MAP Medicaid Task Force Charge

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## The Affordable Care Act (ACA) and Adult Core Set

- ACA called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid.
- HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.
- HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ) National Advisory Council. It has been updated annually since that time, with recent iterations reflecting input from MAP.

CMS. Adult health care quality measures website. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html>. Last accessed May 2016.

CMCS Informational Bulletin "2017 Updates to the Child and Adult Core Health Care Quality Measurement Sets." Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf>. Last accessed December 2016.

## The Affordable Care Act (ACA) and Adult Core Set

- The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP.
- CMS and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.
- The measures contained within the core set are relevant to children ages 0-18 as well as pregnant women.

Centers for Medicare & Medicaid Services (CMS). CHIPRA Initial Core Set of Children's Health Care Quality Measures. Available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>. Last accessed January 2017.

CMCS Informational Bulletin "2017 Updates to the Child and Adult Core Health Care Quality Measurement Sets." Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf>. Last accessed December 2016.



## Medicaid Core Set Updates

- Core Sets must be updated annually
- MAP recommends updates to HHS/CMS
- Center for Medicaid and CHIP Services (CMCS) reviews MAP feedback with various internal/external stakeholders:
  - *Internal discussions with CMCS components*
  - *Broader discussions with CMCS Quality TAG, other stakeholders, CMS's Quality Improvement Council*
- CMS releases annual updates to both Core Sets in December of the following year

## Medicaid Core Set Charge

- Consider states' experiences implementing the Core Sets
- Develop concrete recommendations for strengthening the Core Sets through identification of:
  - *Most important measure gaps and potential measures to address them*
  - *Measures found to be ineffective, for potential removal*
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals



## MAP Task Forces

- The Medicaid Core Set work is facilitated by the Medicaid Adult and Child Task Forces.
- Task forces are time-limited and membership is drawn from current MAP Workgroups and Coordinating Committee based on relevant experience.
- Prior task forces include the Health Insurance Exchange Task Force, the Measure Selection Criteria and Impact Task Force, and the Strategy Task Force.

## How CMS Uses Core Set Data

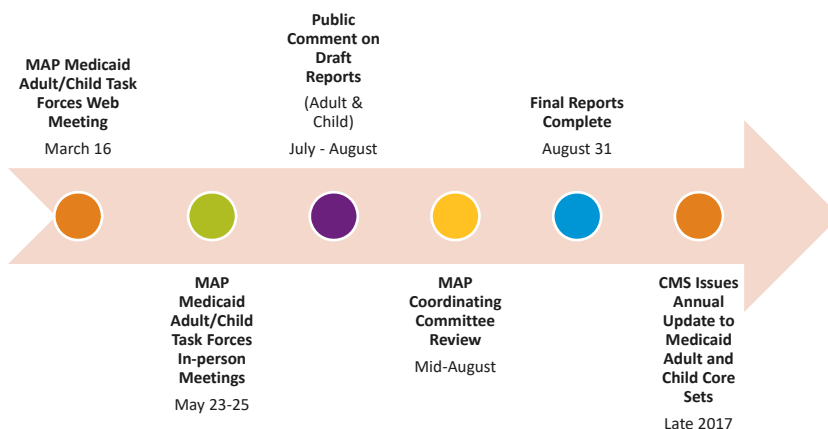
### **CMS uses core set data to obtain a snapshot of quality across Medicaid and CHIP**

- Annual Child Health Quality Report
- Annual Adult Health Quality Report
- Chart pack and other analyses
- Inform policy and program decisions

## MAP Medicaid Child and Adult Task Forces Charge

- The charge of the MAP Medicaid Child and Adult Task Forces is to:
  - *Review states' experiences reporting measures to date*
  - *Refine previously identified measure gap areas and recommend potential measures for addition to the set*
  - *Recommend measures for removal from the set that are found to be ineffective*

## Medicaid Project Timeline



## Medicaid Project Evolution

### Goals

- Align with MAP's Measure Review Processes
- Standardize workflow
- Facilitate standardized assessment and recommendations across project years
- Systematically review measures recommended for addition

## Medicaid Process Improvement

### Process Improvement Documents for Review and Discussion

- Core Set measure recommendations are based on Medicaid population specific gap areas and guided by the Measure Selection Criteria
- Introduce a standardized way of discussing potential measure recommendations based on a Medicaid specific Algorithm and Preliminary Analysis
- Note: the MAP Pre-rulemaking Algorithm and Preliminary Analysis has been adapted for the Medicaid Core Sets

## Medicaid Decision Categories

### **SUPPORT**

- Addresses a previously identified measure gap
- Measures that are ready for immediate use
- Promotes alignment across programs and settings

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## Medicaid Decision Categories contd.

### **CONDITIONAL SUPPORT**

- Pending endorsement from NQF
- Pending change by the measure steward
- Pending CMS confirmation of feasibility
- Et cetera.

## Medicaid Decision Categories contd.

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## Medicaid Decision Categories contd.

### DO NOT SUPPORT

- Measure and/or measure focus inappropriate or a bad fit for use in the Core Sets
- Duplication of efforts
- Resource constraints
- Medicaid agencies at the state level will need to tweak and or vary the level of analysis to increase measure adoption and implementation.

## Medicaid Decision Categories contd.

### DO NOT SUPPORT

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## Changes to the MAP Preliminary Analysis Algorithm

### Additions

- Added Medicaid specific clarification such as “high-impact gap area,” and Medicaid population

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## Changes to the MAP Preliminary Analysis Algorithm contd.

### Adaptations and Deletions

- Edited Assessment #5 to “operational feasibility” from “reporting feasibility”
  - *Measure can be reported **changed to** measure can be implemented*
- Deleted #7 regarding feedback from current measure users, i.e. if the measure is currently in use
  - *Does not provide Medicaid specific information*
  - *For MAP CC discussion: Should this assessment still be done?*

## Changes to the MAP Preliminary Analysis Algorithm contd.

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  - *Does not provide Medicaid specific information*
  - *For MAP CC discussion: Should this assessment still be done?*

## Discussion

- Should any other factors and or considerations be added to the Medicaid Preliminary Analysis for assessment?
- Any additional edits?

## Opportunity for Public Comment

# Lunch

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# Potential Improvements to the Pre-Rulemaking Process

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## Round-Robin Plus/Delta

- What worked?
- What could be improved?

## MAP Decision Categories

Decision Category	Evaluation Criteria
<b>Support for Rulemaking</b>	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6. If the measure is in current use, it also meets assessment 7.
<b>Conditional Support for Rulemaking</b>	The measure is fully developed and tested and meets assessments 1-6. However, the measure should meet a condition (e.g., NQF endorsement) specified by MAP before it can be supported for implementation. MAP will provide a rationale that outlines the condition that must be met. Measures that are conditionally supported are not expected to be resubmitted to MAP.
<b>Refine and Resubmit Prior to Rulemaking</b>	The measure addresses a critical program objective but needs modifications before implementation. The measure meets assessments 1-3; however, it is not fully developed and tested OR there are opportunities for improvement under evaluation. MAP will provide a rationale to explain the suggested modifications.
<b>Do Not Support for Rulemaking</b>	The measure under consideration does not meet one or more of the assessments.

## Holistic Review of Measure Sets

- MAP has expressed a need to better understand the program measure sets in their totality:
  - *How MUCs would interact with current measures;*
  - *Endorsement status of current measures;*
  - *Experience with current measures*
- For the 2016-2017 pre-rulemaking cycle, MAP will offer guidance on measures finalized for use:
  - *MAP will offer input on ways to strengthen the current measure set including recommendations for future removal of measures.*
  - *This guidance will be built into the final MAP report but will not be reflected in the "Spreadsheet of MAP Final Recommendations."*

## Provide Feedback on Current Measure Sets

- Consider how the current measure set reflects the goals of the program
- Evaluate current measure sets against the Measure Selection Criteria
- Identify specific measures that could be removed in the future

## Potential Criteria for Removal

- The measure is not evidence-based and not linked strongly to outcomes
- The measure does not address a quality challenge (i.e. measure is topped out)
- The measure does not utilize measurement resources efficiently or contributes to misalignment
- The measure cannot be feasibly reported
- The measure is not NQF-endorsed or is being used in a manner inconsistent with endorsement
- The measure has lost NQF-endorsement
- Unreasonable implementation issues that outweigh the benefits of the measure have been identified
- The measure may cause negative unintended consequences
- The measure does not demonstrate progress toward achieving the goal of high-quality, efficient healthcare

## Input on improving the review of current measure sets

- How can MAP improve review of current measures sets?

## Feedback Loop Pilot

- The goal of the feedback loop is to provide updates based on stakeholder concerns on whether:
  - *a measure has been submitted for NQF endorsement and results of the Endorsement and Maintenance Standing Committee's review;*
  - *a measure is performing as expected; and*
  - *updates have been made to a measure to address MAP conditions of support.*
- This review is not intended to allow for a change in MAP's recommendation about a measure.
- For 2016-2017 Pre-Rulemaking, NQF and CMS pilot tested a "feedback loop" process with the PAC/LTC Workgroup.
- During the October web meeting, NQF and CMS provided updates on the development and endorsement of selected measures.

## Feedback Loop Coordinating Committee Discussion

- How can MAP strengthen the feedback loop?

**Break**

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## **Pre-Rulemaking Cross-Cutting Issues: Risk Adjustment for Sociodemographic Factors**

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## **Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs: An Overview of ASPE's Report to Congress**

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## **Update on 21<sup>st</sup> Century Cures Act**

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## Update on the NQF Trial Period for SDS Adjustment

### NQF Policy Change: Trial Period

- The NQF Board approved a **two-year trial period** prior to a permanent change in NQF policy.
- Under the new policy, adjustment of measures for SDS factors is no longer prohibited.
- During the trial period, if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute:
  - *SDS-adjusted measure*
  - *Non-SDS version of the measure (clinically adjusted only) to allow for stratification of the measure*

## SDS Trial Period Update

- Cost and Resource Use:
  - *The NQF Board heard appeals of its decision to endorse three cost and resource use measures without SDS adjustment.*
  - *The Board voted to uphold endorsement of the measures.*
- Readmissions:
  - *The Executive Committee ratified the endorsement of 17 new and maintenance measures and 15 conditionally endorsed measures.*
  - *Additionally, the EC recommended:*
    - » SDS adjustor availability be considered as part of the annual update process;
    - » NQF should focus efforts on the next generation of risk adjustment, including social risk as well as consideration of unmeasured clinical complexity;
    - » Given potential unintended effects of the readmission penalty program on patients, especially in safety net hospitals, CSAC encourages MAP and the NQF Board to consider other approaches; and
    - » Directs the Disparities Standing Committee to address unresolved issues and concerns regarding risk adjustment approaches, including potential for adjustment at the hospital and community-level.

## Summary of Data Availability for Social Risk Factor Indicators

SOCIAL RISK FACTOR	DATA AVAILABILITY			
	1	2	3	4
<b>SEP</b>				
Income		■		
Education		■		
Dual Eligibility	■			
Wealth			■	
<b>Race, Ethnicity, and Cultural Context</b>				
Race and Ethnicity		■		
Language		■		
Nativity	■			
Acculturation				■
<b>Gender</b>				
Gender identity				■
Sexual orientation				■
<b>Social Relationships</b>				
Marital/partnership status		■		
Living alone			■	
Social Support			■	
<b>Residential and Community context</b>				
Neighborhood deprivation		■		
Urbanicity/Rurality	■			
Housing		■		
Other environmental measures				■

1. Available for use now  
 2. Available for use now for some outcomes, but research needed for improved, future use  
 3. Not sufficiently available now; research needed for improved, future use  
 4. Research needed to better understand relationship with health care outcomes and on how to best collect data

## Committee Discussion

- What are the implications of these findings for MAP's work?
- Does the Coordinating Committee have any guidance on how we can better account for social risk factors?

## Discussion

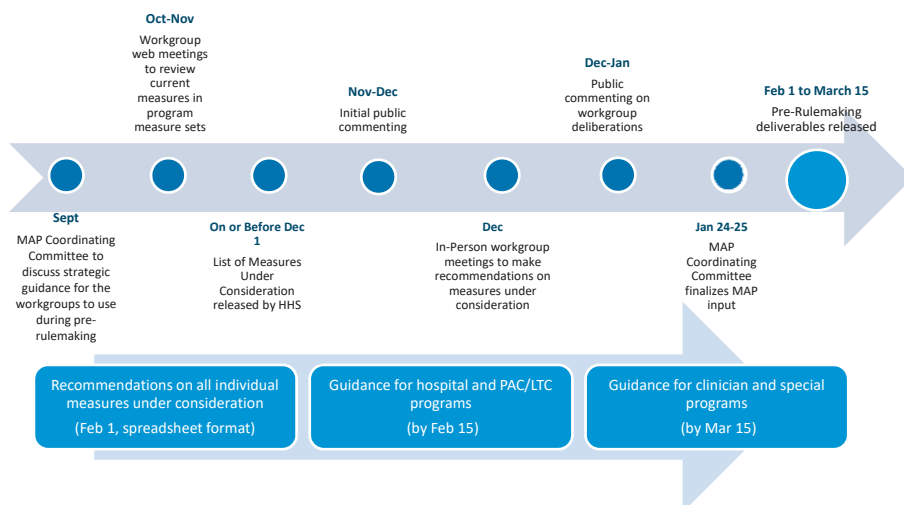
- Should any other factors and or considerations be added to the Medicaid Preliminary Analysis for assessment?
- Any additional edits?

# Opportunity for Public Comment

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## MAP Pre-Rulemaking Timeline



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# Closing Remarks

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# Adjourn

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MEASURE APPLICATIONS PARTNERSHIP  
COORDINATING COMMITTEE MEETING

+ + + + +

TUESDAY,  
JANUARY 24, 2017

+ + + + +

The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, NW, Washington, DC, at 9:00 a.m., Charles Kahn and Harold Pincus, Co-Chairs, presiding.

PRESENT:

CHARLES KAHN III, MPH, Co-Chair  
HAROLD PINCUS, MD, Co-Chair  
RHONDA ANDERSON, RN, DNSc, FAAN, FACHE, American  
Hospital Association  
DAVID BAKER, MD, MPH, FACP, The Joint Commission  
MARY BARTON, MD, National Committee for Quality  
Assurance  
LEAH BINDER, MA, MGA, The Leapfrog Group  
JOHN BOTT, MSSW, MBA, Consumers Union  
MARY BETH BRESCH WHITE, American Nurses  
Association  
STEVE BROTMAN, MD, JD, AdvaMed\*  
JENNIFER BRYANT, MBA, Pharmaceutical Research  
and Manufacturers of America (PhRMA)  
CAROLE FLAMM, MD, MPH, Blue Cross Blue Shield  
Association  
FOSTER GESTEN, MD, FACP, National Association of  
Medicaid Directors\*

DAVID GIFFORD, MD, MPH, American HealthCare  
Association

RICHARD GUNDLING, FHFMA, CMA, Healthcare  
Financial Management Association

BRUCE HALL, MD, PhD, MBA, FACS, American College  
of Surgeons

APARNA HIGGINS, MA, America's Health Insurance  
Plans

BRANDON HOTHAM, MPH, Maine Health Management  
Coalition\*

GAIL HUNT, National Alliance for Caregiving

WILLIAM KRAMER, MBA, Pacific Business Group on  
Health

SAMUEL LIN, MD, PhD, MBA, MPA, MS, AMGA

AMY MULLINS, MD, FAAFP, American Academy of  
Family Physicians

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

SHAUN O'BRIEN, JD, AFL-CIO

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

CHRIS QUERAM, MS, Network for Regional Healthcare  
Management

ARI ROBICSEK, MD, Providence Health and Services

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

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

CARL SIRIO, MD, American Medical Association

STEVEN WOJCIK, MA, National Business Group on  
Health

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, MS

DORIS LOTZ, MD, MPH\*



FEDERAL GOVERNMENT LIAISONS PRESENT:

PATRICK CONWAY, MD, MSc, Centers for Medicare  
and Medicaid Services (CMS)  
DAVID HUNT, MD, FACS, Office of the National  
Coordinator for Health Information  
Technology (ONC)  
CHESLEY RICHARDS, MD, MPH, FACP, Centers for  
Disease Control and Prevention (CDC)  
NANCY WILSON, MD, MPH, Agency for Healthcare  
Research and Quality (AHRQ)

WORKGROUP CO-CHAIRS PRESENT:

BRUCE BAGLEY, Clinician Workgroup\*  
DEB SALIBA, PAC/LTC Workgroup\*  
CRISTIE TRAVIS, Hospital Workgroup\*  
RON WALTERS, Hospital Workgroup  
ERIC WHITACRE, Clinician Workgroup\*

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer  
ELISA MUNTHALI, Vice President, Quality  
Measurement  
MARCIA WILSON, Senior Vice President, Quality  
Management  
TAROON AMIN, NQF Consultant  
JOHN BERNOT, Senior Director  
KIM IBARRA, Project Manager  
KATE MCQUESTON, Project Manager  
YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst  
ERIN O'ROURKE, Senior Director  
MELISSA MARINELARENA, Senior Director  
DEBJANI MUKHERJEE, Senior Director  
JEAN-LUC TILLY, Project Analyst

ALSO PRESENT:

JOEL ANDRESS, PhD, CMS\*  
MARY ELLEN DEBARDELEBEN, MBA, MPH, HealthSouth\*  
KATE GOODRICH, MD, CMS  
PEGGI GUENTER, PhD, ASPEN\*  
TROY HILLMAN, UDSMR\*  
LANE KOENIG, PhD, NALTH\*  
WILLIAM LEHRMAN, PhD, CMS\*  
ALAN LEVITT, MD, CMS\*  
TED LONG, MD, MHS, CMS  
STACE MANDL, RN, CMS\*  
SOEREN MATTKE, DSc, MPH, RAND Corporation\*  
MEREDITH PONDER, JD, DefeatMalnutrition.Today  
CAROLINE SPARKS, PhD, MA, Milken Institute  
School\*  
TRACY SPINKS, BBA, ADCC\*  
LISA SUTER, Yale School of Medicine\*  
PIERRE YONG, MD, CMS

\* present via telephone

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

9:06 a.m.

CO-CHAIR KAHN: Okay, let me call the meeting to order and we are going to -- actually, let's start six minutes early.

We have two very, very long days and I appreciate, and Harold appreciates, all of you being here this morning for the marathon we are about to begin. Most marathons go three or four hours or whatever it is. This one goes for 16 or whatever it is.

CO-CHAIR PINCUS: But we get to sleep in the middle of it.

CO-CHAIR KAHN: Right. Hopefully we will all survive. Most of you have been at these meetings before and survived. So we will survive this one, too. But it is an important process, and I really appreciate everyone taking part in it.

I am going to say a few words and Harold is going to say a few words, and then we will introduce Kate.

1 CO-CHAIR PINCUS: And we will go  
2 around and introduce everybody.

3 CO-CHAIR KAHN: Oh, maybe we should do  
4 that first.

5 CO-CHAIR PINCUS: Okay.

6 CO-CHAIR KAHN: I'm Chip Kahn, and I'm  
7 from the Federation of American Hospitals and Co-  
8 Chair.

9 CO-CHAIR PINCUS: And I'm Harold  
10 Pincus. I am from New York-Presbyterian Hospital  
11 and Columbia University Department of Psychiatry.

12 MS. O'ROURKE: I'll just jump in. I'm  
13 Erin O'Rourke, one of the senior directors here  
14 at NQF.

15 MR. AMIN: Hi, Taroon Amin, a  
16 consultant to NQF.

17 DR. BURSTIN: Helen Burstin. Welcome  
18 back, everybody, Chief Scientific Officer here at  
19 NQF.

20 MEMBER BAKER: David Baker, the Joint  
21 Commission.

22 DR. GOODRICH: Kate Goodrich, CMS.

1 MEMBER ROBICSEK: Ari Robicsek from  
2 Providence/St. Joseph Health.

3 MEMBER FLAMM: Carole Flamm, Blue  
4 Cross Blue Shield Association.

5 DR. ANTONELLI: Richard Antonelli,  
6 Boston Children's Hospital.

7 MEMBER ANDERSON: Rhonda Anderson,  
8 American Hospital Association.

9 MEMBER HIGGINS: Aparna Higgins, AHIB.

10 MEMBER MULLINS: Amy Mullins, American  
11 Academy of Family Physicians.

12 MEMBER KRAMER: Bill Kramer, Pacific  
13 Business Group on Health.

14 MEMBER HALL: Bruce Hall, American  
15 College of Surgeons.

16 MEMBER BOTT: John Bott with Consumer  
17 Reports.

18 MEMBER WOJCIK: Steve Wojcik with the  
19 National Business Group on Health.

20 MEMBER O'BRIEN: Shaun O'Brien,  
21 AFLCIO.

22 MEMBER BRESCH WHITE: Mary Beth Bresch

1 White, The American Nurses Association.

2 MEMBER GIFFORD: I'm David Gifford,  
3 American HealthCare Association.

4 DR. HUNT: David Hunt, ONC.

5 DR. WILSON: Nancy Wilson, AHRQ.

6 MEMBER SAKALA: Carol Sakala, National  
7 Partnership for Women and Families.

8 MEMBER SCHLAIFER: Marissa Schlaifer,  
9 Academy of Managed Care Pharmacy.

10 MEMBER SIRIO: Good morning. Carl  
11 Sirio, American Medical Association.

12 MEMBER QUERAM: Chris Queram with the  
13 Network for Regional Healthcare Management.

14 MEMBER QASEEM: Amir Qaseem, American  
15 College of Physicians.

16 MS. OGUNGBEMI: Yetunde Ogungbemi,  
17 National Quality Forum.

18 MS. MUNTHALI: Elisa Munthali,  
19 National Quality Forum.

20 MS. IBARRA: Kim Ibarra, National  
21 Quality Forum.

22 MS. O'ROURKE: And I just wanted to --

1 are there any Coordinating Committee members on  
2 the phone? If you could, introduce yourselves.

3 MEMBER BROTMAN: Hi, it is Steve  
4 Brotman, AdvaMed.

5 MEMBER NOONE: Barrett Noone, American  
6 Board of Medical Specialties.

7 CO-CHAIR KAHN: Anyone else?

8 Okay, great. So what we are about  
9 today is to finalize the recommendations for HHS  
10 on the measures for use in federal programs, for  
11 the clinician, hospital, post-acute care, long-  
12 term care settings. We are going to consider  
13 strategic issues that span all the MAP Workgroups  
14 and update the Medicaid Task Force's processes  
15 for assessing measures that address the needs of  
16 the Medicaid adult and child populations.

17 I can't -- one, I can't overstate my  
18 appreciation for all the work that the Task  
19 Forces have done and the other groups leading  
20 into this -- or the workgroups leading into this  
21 effort, and express my feelings that this is one  
22 of the most important parts of the year in terms



1 of being impactful regarding what is going to  
2 happen next year and in the future regarding  
3 performance assessment, quality assessment, and  
4 pay-for-performance. So this is really an  
5 important process that we go through.

6 I think the Department and CMS does a  
7 good job every year with putting their ducks in a  
8 row, but this process to assess that and give  
9 input from the outside is really critical and it  
10 is unique because it is done prior to the  
11 regulatory process when things are a little more  
12 regimented and I think less open to a real  
13 dialogue that we have here.

14 And so I appreciate CMS being willing  
15 to go through this process, and it is nice that  
16 this process was included, basically, in the law  
17 back many years ago and if other parts of the law  
18 go away, I am confident that this will remain.

19 I spend a lot of time worrying about  
20 the other parts of the law but so be it. Anyway,  
21 I will pass off to Harold.

22 CO-CHAIR PINCUS: So as Chip said,

1       this is going to be a lot of hard work. It is  
2       kind of a marathon, but we are very fortunate  
3       that the NQF staff have really done a terrific  
4       job in analyzing, examining the different  
5       measures, working with the workgroups and having  
6       the workgroups who have done a lot of work to go  
7       through the measures, made some preliminary  
8       determinations. And so the process that we are  
9       using is actually going to be, hopefully, very  
10      efficient, that there has been sort of a pre-  
11      digestion, initially by the staff and then  
12      secondarily by the workgroups to create consent  
13      calendars that essentially would, if those  
14      consent calendars go through, those are,  
15      essentially, passed. We don't need to discuss  
16      the issues on the consent calendar.

17                   However, every member has the  
18      opportunity to pull any measure they want for  
19      further discussion and a number of them have  
20      already been pulled, and we are going to have an  
21      opportunity to have an additional round of people  
22      who would desire to pull measures for further

1 discussion.

2 And everybody is aware that there is  
3 a tool that we can use to access the information,  
4 both in terms of information about the measure,  
5 as well as information about what the decision-  
6 making was from the workgroup -- from the staff  
7 and from the workgroup. And so all of you should  
8 have that available if you need further  
9 information that you can look up as we continue  
10 the discussion.

11 As we go through this, we are going to  
12 hear first from Kate Goodrich from CMS but we are  
13 also going to be hearing a bit more from each of  
14 the workgroups and also I think we are going to  
15 be hearing some input initially from the MAP Dual  
16 Eligible Beneficiaries Workgroup, as well as --  
17 and then we are going to be hearing from Kate who  
18 is going to sort of give us the background and  
19 sort of the process that they went through in  
20 terms of how they came up with the MUC List. I  
21 really can't stand that name MUC List, but you  
22 could describe whether it is an appropriate

1 metaphor or not.

2 But as I said, we are going to try to  
3 have an open discussion about any of the measures  
4 that are pulled, discussion back and forth, but  
5 then we are going to promptly start to do a vote  
6 on each of those measures that are pulled.

7 And the rules are that it is, in terms  
8 of the recommendation that is made, it is a  
9 plurality of the individuals that are choosing --  
10 it is worth going over the rules.

11 MS. O'ROURKE: Oh, sure. So, I can  
12 cover those in more detail, but 60 percent is  
13 consensus.

14 CO-CHAIR PINCUS: So, Kate.

15 DR. GOODRICH: So good morning,  
16 everyone. Good to be here with all of you again.  
17 This is our, I believe, sixth MAP season. I do  
18 think of it as a season. We have our rulemaking  
19 season and then we have the MUC MAP season. And  
20 this is actually the first year that I have not  
21 been involved with the separate workgroups and I  
22 have to say I actually kind of miss it. I always

1       come to the Coordinating Committee and that is  
2       always a lot of fun but I have missed the  
3       discussions in December.

4               I do want to introduce two people from  
5       my team who are here, and we have several of our  
6       staff members on the phone as well to help answer  
7       questions.

8               The first is Dr. Pierre Yong, who is  
9       going to be sitting here. He had to step out for  
10      a call. Pierre is the Director of our Quality  
11      Measurement and Value-based Incentives Group.  
12      That is the group I used to lead. And he will be  
13      sitting in for me a couple times during the day  
14      today and tomorrow when I have to step out, but  
15      we will both be there to answer questions.

16              I also want to introduce Dr. Ted Long  
17      over here, our senior medical officer in the  
18      quality measurement group who has gotten very,  
19      very involved in our quality measurement work and  
20      I believe will also be here during the  
21      proceedings.

22              So, a little bit about our process.

1 We have always approached, in partnership with  
2 NQF, the MAP process as one of continuous  
3 improvement. Many of you know and participated  
4 in a kaizen event we did a few years ago that led  
5 to some of the improvements that those of you who  
6 have been on the MAP or been paying attention for  
7 the last few years have undoubtedly seen, over  
8 the last few years, there is still room for  
9 improvement I think for both bodies, CMS and NQF  
10 and we, every year, do a debrief to think about  
11 ways that we can improve for the following year.

12 But I do want to say that this process  
13 is very, very important to us. I just want to  
14 echo what Chip said. I think we see this as one  
15 of the most important activities that we take on  
16 throughout the year. We take it very seriously.  
17 We put a lot of resources into it in terms of  
18 people time and effort, just as the NQF staff  
19 does. And actually the process continues  
20 throughout the year. It doesn't just start in  
21 December and end in February. It goes throughout  
22 the year.

1                   So our process really begins about in  
2     April each year, which is actually at the same  
3     time that we are writing our regulations for all  
4     of the different quality and value-based  
5     purchasing programs, where we start to really put  
6     together the list. And it used to be in the  
7     first couple of years that we just had folks  
8     within HHS contribute measures to that list based  
9     upon things we have been developing at CMS  
10    through our call for measures through the  
11    clinician programs at the time, PQRS. We would  
12    put those measures on the list. But one of the  
13    things that we heard from a lot of different  
14    stakeholders is that they wanted visibility into  
15    that list as it was being developed and wanted to  
16    be able to contribute measures to that list that  
17    we could put on the final MUC List.

18                  And so we opened it up, and we have  
19    definitely had a lot of different entities  
20    contribute measure suggestions to the MUC List,  
21    some of which make it to the list, some of which  
22    don't. Typically the ones that don't are ones

1       that just aren't ready. But we have tried to  
2       open it up. I think that is a process that still  
3       could be improved because it is definitely not  
4       easy to get all the information there.

5               The other thing we have really tried  
6       to do is work with NQF staff and the MAP to  
7       understand what information it is that you need  
8       to help you make -- to render recommendations to  
9       CMS. And so the type of information that we  
10      require that goes on a list has been modified  
11      from year to year really very much based upon the  
12      feedback that we have received from you.

13             So I think it is a better process. It  
14      is not a perfect process and we do, of course,  
15      strive to continuously improve it.

16             We do have a whole clearance process  
17      for those of you who have worked in the federal  
18      government. I don't know if you know what  
19      clearance is, but it is a process where we, for  
20      something that is going out for public comment or  
21      certainly related to a regulation, we needed to  
22      have it reviewed by our partners within HHS and



1 the Office of Management and Budget and so forth.  
2 And that is a process that does take a little  
3 while. So typically our list is closed sometime  
4 in July and then it starts through the clearance  
5 process.

6 It is statutorily due to be publicly  
7 posted by December 1st of each year. I think we  
8 got it to you guys earlier than ever this year, a  
9 full two weeks early. We were popping some  
10 champagne over that one. It has usually been a  
11 scramble to get it out by December 1st. I think  
12 because of some efficiencies, we were able to do  
13 that.

14 And the other thing I wanted to point  
15 out is that, as David and Nancy know, and others  
16 within HHS, one of the big improvements we made  
17 about three or four years ago was to get our  
18 federal partners involved in the process early  
19 on. And that just really I think helped us to  
20 have a set of measures that there was agreement  
21 across HHS, were the right measures to put on the  
22 list. And that has been absolutely critical to

1 the success of this entire process.

2 I do also want to note that we are now  
3 in the process of implementation at the very  
4 early beginnings of our measure development  
5 strategy for the quality payment program. We  
6 posted a measure development plan related to QPP  
7 last year, I think it was about May 1, 2016. We  
8 have to do an annual update each year. So we are  
9 working on that but we are putting forward our  
10 strategy for development of measures and  
11 procuring contracts and whatnot in the very near  
12 future.

13 And we have very deliberately and  
14 intentionally gone back to all of the MAP reports  
15 over the previous six years or five years to look  
16 at specifics around what the MAP has recommended,  
17 both the individual workgroups and the  
18 coordinating committee around measurement gaps to  
19 inform not only that plan that came out last year  
20 but also our procurement strategy for measure  
21 development.

22 I do want to say for this year, the

1 feedback I got from my team, I was briefed on the  
2 meetings along the way and got briefed again last  
3 week, and the feedback was overwhelmingly  
4 positive. They really felt like things went  
5 very, very well this year. There is always some  
6 measures that are more controversial and that is  
7 normal and that is good and that is fine but they  
8 felt like the process went really well but the  
9 feedback was particularly meaningful.

10 So I just want to thank you and thank  
11 those who were on the workgroups who were not  
12 here for that.

13 So I am very much looking forward to  
14 hearing your input. My role and Pierre's role  
15 for today is primarily to give you the "what was  
16 CMS thinking" perspective, which is usually the  
17 role that we play at the MAP and to answer any  
18 questions that you have.

19 And I, in particular, do want to thank  
20 the NQF staff for just the tremendous work that  
21 they do on this in partnership with us every year  
22 and it just -- again, it is because of you all

1       that it went so well this year and that it goes  
2       so well every year.

3               I do want to touch on a couple of non-  
4       MAP things, if you will, if you will allow me to  
5       do that.

6               First, we obviously have a transition  
7       underway. I will get to that in a moment. I  
8       will first talk about though the transition that  
9       is about to be underway for NQF, in that NQF is  
10      getting a new CEO. And this is a guy I know  
11      pretty well. So, as was announced I believe  
12      earlier last week, Shantanu Agrawal, Dr. Shantanu  
13      Agrawal from CMS is starting as the NQF CEO on  
14      Monday. Correct? Yes.

15              And I just wanted to say a few words  
16      about Shantanu because I know him well, and I  
17      think he is just a marvelous selection for NQF.  
18      So Shantanu, for those of who don't know, has  
19      been the Director of the Center for Program  
20      Integrity at CMS for the past several years. He  
21      is an emergency medicine physician. And I have  
22      had the opportunity to work pretty closely with

1 Shantanu, particularly over the last year. We  
2 didn't really work together until Andy Slavitt  
3 asked us to co-lead a couple of initiatives at  
4 CMS, one around our opioid strategy and another  
5 around our ESRD work. So he and I have been  
6 doing that work together. I will say he has  
7 probably done more of the work than I have over  
8 the last year.

9 And he is just a tremendous  
10 collaborator. I think as the leader of a multi-  
11 stakeholder organization, he is particularly  
12 well-suited for that kind of a role. He is  
13 somebody who actively and meaningfully listens to  
14 all viewpoints, and I think you will find him to  
15 be not only obviously very, very bright. We will  
16 get up to speed on quality and the work of NQF  
17 very quickly. He definitely does understand  
18 quality. Although it hasn't been his subject  
19 matter expertise, he does know quality and will,  
20 I think, get right up to speed very quickly. And  
21 I think that you all will find him very, very  
22 engaging, very easy to work with, very, very

1       bright with I think lots of tremendous ideas.

2               And so I think for the MAP, you will  
3       not have an opportunity to meet him today and  
4       tomorrow, but hopefully in the very near future,  
5       and I just think NQF is very, very lucky to have  
6       him. So I just wanted to say that.

7               And finally about the big transition  
8       that is happening, I do want to note a few new  
9       acting positions within CMS which have been in  
10      the news so many of you probably know it but just  
11      because it is relevant here. So, of course,  
12      Patrick Conway is the Acting Administrator, as of  
13      last Friday. Liz Richter is who has been the  
14      Director -- I'm sorry -- the Deputy Director of  
15      the Center for Medicare is the Acting Principal  
16      Deputy Administrator. Karen Jackson is the  
17      Acting Chief Operating Officer. So, the three of  
18      them are really the major decision-makers for  
19      now, until we have the new political  
20      administration in place.

21              Some of you know that the Chief  
22      Medical Officer role, which Patrick had held was

1 transitioned over to me last December. That had  
2 actually always been planned as the CMO role has  
3 always lived with the Director of the Center for  
4 Clinical Standards and Quality. So, that had  
5 always been planned.

6 Amy Bassano is Acting Director of the  
7 Innovations Center. Tim Hill is Acting Director  
8 of the Center for Medicaid and CHIP Services. I  
9 think those are the parts of the Agency that are  
10 most relevant for the NQF work.

11 Oh, and sorry, Jeff Wu is Acting  
12 Director of CCIIO. So I know there is some  
13 marketplace work that the MAP has done. So I  
14 just wanted to be sure you are aware of that.  
15 Jonathan Morse, Acting Director of the Center for  
16 Program Integrity.

17 We don't have any new administration  
18 folks in yet. We understand that the beachhead  
19 team, which I love that term, as one of my said,  
20 what is this, the Normandy Invasion? He has been  
21 there a long time. I think he has said that --

22 CO-CHAIR KAHN: It may feel like that.

1 DR. GOODRICH: But they have not  
2 landed yet, at least at CMS. We anticipate we  
3 will meet some new folks coming up this week.

4 And then just to proactively address  
5 a couple of things that have been in the news.  
6 Obviously, there is a hiring freeze. We expected  
7 that. We are working through that with our  
8 folks.

9 I think the other big thing, of  
10 course, is the Executive Order around ACA. I  
11 don't have any information about what that means  
12 here, about that means for us. We are still  
13 waiting for guidance on that. So any questions  
14 that you all may have about that, my answer will  
15 be I don't know. So just in case you do have any  
16 questions because, obviously, there are parts of  
17 the ACA that are relevant for the work that we  
18 are doing today.

19 I do want to say though that at CMS,  
20 we are continuing to do the work apace. We are  
21 working on our regulations. We are doing this  
22 work. We are continuing to do the work of survey



1 and certification for protection of the health  
2 and safety of the Medicare and Medicaid  
3 beneficiaries and actually all patients.

4 And all of the work that we do every  
5 day is continuing apace. I continue to be amazed  
6 by the people who work with us at CMS and how  
7 mission-driven they are. And the vast majority  
8 of folks are sticking around. They really  
9 believe in our mission are very dedicated to  
10 public service.

11 And so I also want to say that I want  
12 to thank you all, the MAP, because you are  
13 actually doing a public service as well. You all  
14 and the NQF staff are doing a public service. It  
15 is a public good and I just want to thank you for  
16 that.

17 So thank you.

18 CO-CHAIR PINCUS: Well, Kate, thank  
19 you very much. We really appreciate your doing  
20 what we need to do, which is sort of plow ahead,  
21 despite all the uncertainty and all the political  
22 mishegas, that there are certain tasks that need

1 to get done and we are glad to participate in it.  
2 And thank you so much for your service in this.

3 So Erin is going to go over the  
4 process. I think there are a couple of important  
5 points about the process. There are some sort of  
6 modest changes in terms of, number one, I think  
7 the staff, as we discussed actually at our last  
8 meeting, that the process has really been  
9 enriched by sort of a greater clarity of the  
10 different criteria for the different options for  
11 voting.

12 Number two is that really we have a  
13 more robust set of materials in terms of the tool  
14 that has been developed and enable us to do that.  
15 And the staff has done tremendous work in terms  
16 of also helping us to understand some more about  
17 the context because we have more information  
18 about the measures sets that are used in the  
19 programs.

20 So all of that should make our  
21 decisionmaking a little bit more well-informed  
22 and, hopefully, clearer and better as we go

1 through this and hopefully, also, quicker, so we  
2 can actually get through and make good decisions  
3 and recommendations.

4 So, Erin.

5 MS. O'ROURKE: Thank you, Harold. So  
6 just some housekeeping items before I get  
7 started.

8 Does everyone have access to the  
9 discussion guide that Harold is referencing? If  
10 you are having issues downloading it or getting  
11 online, just email the staff and we will come  
12 around and help you.

13 And secondly, I want to make sure  
14 everyone has a blue remote control-looking thing  
15 that you will use to cast your votes.

16 So if you are missing that, unless you  
17 are from the federal government, please let us  
18 know so that we can make sure that you can vote.  
19 And then finally, I think there is a few new  
20 committee members who joined us on the phone, if  
21 you wouldn't mind introducing yourselves.

22 DR. LOTZ: Yes, this is Doris Lotz.

1 I am the Chief Medical Officer for the Department  
2 of Health and Human Services in New Hampshire.

3 And Erin, really quickly, for those of  
4 who are calling in, how shall we vote, via the  
5 chat box perhaps, or do you have another idea?

6 MS. O'ROURKE: Kim will follow-up with  
7 you on that. I believe that you will be sending  
8 her chats through the web platform, and she will  
9 cast your vote for you.

10 DR. LOTZ: Thanks.

11 MEMBER GESTEN: Good morning,  
12 everyone. This is Foster Gesten, Chief Medical  
13 Officer in the Office of Quality and Patient  
14 Safety in the New York State Department of  
15 Health, representing NAMD on this call. Sorry I  
16 can't be there with you.

17 MS. O'ROURKE: Great. Thank you so  
18 much. So I just wanted to really accomplish two  
19 things before we get started. One was to refresh  
20 you on the pre-rule making approach. As Kate and  
21 Harold said, this is something we have been  
22 striving to improve every year. As you know, we

1 met back in September to implement some changes  
2 to the process and get guidance from the  
3 coordinating committee on how the workgroups  
4 should go about making their recommendations to  
5 you all. So I just want to make sure everyone is  
6 up to speed on how the workgroups did their job  
7 and what process was used.

8 And then secondly, I want to briefly  
9 cover the process that we will be using at this  
10 meeting so you are comfortable with how the  
11 conversation and voting will go.

12 So, next slide. So MAP uses a four-  
13 step approach to analyzing and selecting  
14 measures. We first provide the workgroups with  
15 an overview of each Value-based Purchasing or  
16 Quality Reporting Program. We then review the  
17 measures that are currently in that set to give  
18 the workgroups an idea of what is currently  
19 addressed, allow them to think about potential  
20 gap areas and to evaluate how every measure under  
21 consideration could potentially add to the  
22 program measure set.

1                   Finally, and new for this year, the  
2                   workgroups provided feedback on the current  
3                   measure sets, in addition to the gap analysis  
4                   that they have usually done. They also suggested  
5                   ways that these sets could be strengthened or  
6                   measures that CMS may wish to consider removing  
7                   in future years. Next slide.

8                   So a few more details on what we are  
9                   calling a holistic review of the measure sets.  
10                  This is something that has really come out of  
11                  what we heard from you and from the MAP Workgroup  
12                  members about a need to better understand the  
13                  measure set in its totality and how the measures  
14                  under consideration would interact with what is  
15                  currently addressed by the set. We have heard  
16                  that members want to know more about the  
17                  endorsement status of current members and what  
18                  has happened over time through the NQF  
19                  endorsement and maintenance process, as well as  
20                  what the experience is on the ground with using  
21                  these measures and implementation challenges.  
22                  Are these driving to improvement? Are we getting

1 to what matters most through these quality  
2 programs?

3 So for the 2016-2017 pre-rulemaking  
4 report, we will offer on guidance on measures  
5 that have been previously finalized for use,  
6 including input on ways to strengthen the current  
7 measure set, including some potential  
8 recommendations. We will build this into the  
9 final MAP report but you will not see this in the  
10 spreadsheet of final recommendations. I just  
11 want to clarify that if anyone is looking for  
12 where MAP's guidance can be found. It is in  
13 these series of reports that will be issued after  
14 the February 1 spreadsheet of deliverables. Next  
15 slide.

16 Again, mostly a refresher slide for  
17 you all. But I did want to just bring up the MAP  
18 Measure selection criteria since these are really  
19 the main tool that MAP uses to makes it  
20 recommendations on measures under consideration.

21 Just a few things to highlight that  
22 they are not absolute rules, and we know that no

1 one measure would address all of these criteria,  
2 rather, they are meant to evaluate the measure  
3 set as a whole.

4 Again, I don't want to belabor this or  
5 read them to you but I just want to show them to  
6 the Coordinating Committee again so that we can  
7 ground ourselves in this as MAP's primary  
8 decisionmaking tool. Next slide.

9 So for this year, we really stress  
10 that the workgroups must reach a decision about  
11 every measure under consideration. That was the  
12 main thing we have heard from the Coordinating  
13 Committee over time that it is challenging when  
14 we brought split decisions or decisions where  
15 there was no Workgroup input and you don't have  
16 the input of receiving a preliminary  
17 recommendation from the Workgroup. So that is  
18 something through the process improvements that  
19 we have really tried to eliminate and ensure that  
20 you do have a starting point recommendation on  
21 each measure under consideration.

22 We did update the decision categories



1 for the 2016-2017 process, again, out of your  
2 deliberations in September. We will no longer  
3 evaluate measures under development using  
4 different decision categories. We heard that  
5 really while well-intentioned, introduced some  
6 confusion to the process. We have streamlined  
7 down to a set of four standard decision  
8 categories that we will use for all measures  
9 under consideration. Next slide.

10 As Harold was saying, one of the tools  
11 we have introduced to our process improvement is  
12 the preliminary analysis that staff performs on  
13 each measure under consideration.

14 We take every MUC, if you will,  
15 through this series of assessments in an attempt  
16 to provide the Workgroup and the Coordinating  
17 Committee members with a snapshot of that measure  
18 and what it could potentially add to the program  
19 measure set. We know we give you an overwhelming  
20 volume of information and when there is --  
21 actually down to only 40 measures this year but  
22 in the past when it was hundreds of measures, it

1 was a lot for the committee members to take in in  
2 such a short time. So this was our attempt to do  
3 a little bit of your homework for you and at  
4 least give you a starting point to research the  
5 measures.

6 So again, don't want to belabor, since  
7 this is something we covered extensively in  
8 September, but I did want to just briefly refresh  
9 you on the assessments that each measure under  
10 consideration went through.

11 And as I was saying, we have now four  
12 standard decision categories for every measure  
13 under consideration. They are support for  
14 rulemaking; conditional support for rulemaking;  
15 refine and resubmit prior to rulemaking; and do  
16 not support for rulemaking.

17 And again, this is really out of what  
18 you discussed in September and the homework that  
19 we did after the meeting. I do want to just  
20 briefly draw your attention to the refine and  
21 resubmit category, since this is new.

22 This is really our attempt to preserve

1        what we heard worked about the measure under  
2        development pathway and that Workgroup members  
3        wanted this chance to echo their support for the  
4        concept of a measure but to stress that it is  
5        really not ready to go into a quality reporting  
6        or VBP program, and there is work that needs to  
7        be done before MAP would really want to see it go  
8        into use. So, just highlight that this is new  
9        for this year.

10                Slightly different from conditional  
11        support, conditional support is like a category  
12        up, if you will, and has more around the idea of  
13        a concrete condition that could be met, generally  
14        something like NQF endorsement before MAP would  
15        fully support it.

16                And the key caveat is that measures  
17        that are conditionally supported MAP would not  
18        expect to be resubmitted. So I do want to just  
19        highlight a few distinctions among the decision  
20        categories since this is our first time working  
21        with them.

22                CO-CHAIR PINCUS: And it is worth just

1 emphasizing that one of the things that we have  
2 gotten feedback from from CMS is that while we  
3 want to emphasize the different criteria for the  
4 different categories, what they feel is it is not  
5 just about the vote. It is really about the kind  
6 of input we give them in the discussion about our  
7 rationale and thinking behind the voting that is  
8 really very important.

9 Giff.

10 MEMBER GIFFORD: On that point,  
11 Harold, and this goes back to the consent  
12 calendar, if we are fine with the decision voting  
13 category but want to have additional comments and  
14 feedback added to that vote, do we need to pull  
15 it off the consent calendar, or can we add that  
16 as part of the consent calendar? Because as you  
17 point out, not only is CMS interested in it, they  
18 have a statutory obligation to address our  
19 comments in rulemaking, should they go forward,  
20 regardless of what the vote is. The vote has no  
21 binding on them. The comments have binding on  
22 them.

1 MS. O'ROURKE: Sure, so I can take  
2 that one. When you pull a measure, we would ask  
3 if you could just let us know if it is for  
4 discussion or if you disagree with the decision  
5 category and are requesting a revote. If you  
6 just want to make comments or, like you were  
7 saying there is clarifying points, we could  
8 discuss that and provide that feedback to CMS.  
9 But if you do disagree with the preliminary  
10 recommendation, if you could let us know it is  
11 for a revote versus discussion.

12 MEMBER GIFFORD: Well I guess because  
13 we send over to the CMS the MUC List with our  
14 vote but also with our comments but then all the  
15 other group comments and public comments.

16 MS. O'ROURKE: Yes. So --

17 MEMBER GIFFORD: But we categorize  
18 them, I believe, and Kate you can correct me if I  
19 am wrong, you guys really are only obliged to  
20 address this committee's comments back to CMS in  
21 rulemaking, should you go forward with a measure  
22 regardless of what the vote is. Is that correct?

1 DR. GOODRICH: As opposed to the other  
2 committees?

3 MEMBER GIFFORD: Yes.

4 MS. O'ROURKE: So, I can actually  
5 share a little bit about how we -- I can't,  
6 obviously, speak to CMS's obligations but just  
7 how we send the material along to CMS.

8 So we package it in an Excel  
9 spreadsheet, since we have been told that is the  
10 most useful format, and you will see columns, one  
11 that has the decision category and what the vote  
12 was, and then we have another category for MAP  
13 rationale, and that really includes feedback here  
14 from the Coordinating Committee, from the  
15 Workgroup. We don't tease it out. Generally, it  
16 is the rationale we hear from both committees.  
17 We might put some -- we try to capture as much of  
18 the nuances we can. We do include if there was  
19 dissenting opinions; if the Workgroup had one  
20 opinion but the Coordinating Committee expressed  
21 a different. We try to put all of those details  
22 in the spreadsheet to CMS so it all travels

1 along, and they can use that for their  
2 rulemaking.

3 MEMBER GIFFORD: I guess my question  
4 really is directed to Kate because I understand  
5 our process and what we send. Because you do  
6 have to address in rulemaking comments that come  
7 to you. Are you only addressing comments that  
8 come from this committee or all of the comments  
9 that come in the process rooting through this?  
10 Because that would change when I pull things off  
11 the MUC List of conditions or not.

12 If it is all there, then most of the  
13 comments are there. If it is only the comments  
14 that come from us, we have distilled them down to  
15 I think the most priority ones. If there is a  
16 disagreement, then some of us around the table  
17 may think some of those comments should be  
18 addressed and rulemaking and that is why I go how  
19 the voting is for that because that is where I  
20 think there is a real important nature to our  
21 role as the MAP group.

22 So, I'm trying to get a sense where

1       that is.

2                   DR. GOODRICH:  So there is not a  
3       statutory requirement to like only address the  
4       comments of the Coordinating Committee.  The  
5       statute says the multi-stakeholder group or  
6       whatever it says.

7                   I think in the past I think NQF has  
8       done a really good job of trying to get all the  
9       comments in one place in the spreadsheet that you  
10      were talking about.  I forgot that that is how we  
11      did it.

12                   I would say if there are things that  
13      you are concerned, that you want to be sure are  
14      on the record and that we address, that is fine  
15      to make sure that they are -- for my purposes,  
16      fine to make sure they are brought up here.  It  
17      doesn't mean that wouldn't go back to the PAC/LTC  
18      Committee and see what they were because as we  
19      talk about it internally, as we are going through  
20      rulemaking, we talk about sort of the breadth of  
21      comments.  So we don't just look at one or the  
22      other.  I'm not close enough to the details of



1 the process to tell you that we look more at one  
2 than the other, but we really try to look at the  
3 breadth of the comments.

4 I don't know how else to answer it.

5 CO-CHAIR PINCUS: So basically it  
6 sounds like what you guys address or what gets  
7 examined is sort of the union of all the comments  
8 that come through the MAP process.

9 But I think for the purposes of the  
10 process here, if there is something that is  
11 really important that you want to emphasize, I  
12 think it is okay but if it simply going through  
13 the same things without necessarily a particular  
14 emphasis, it is probably not necessary to bring  
15 it up for discussion because it would be  
16 addressed.

17 MEMBER GIFFORD: We just may, in the  
18 future, want to talk a little bit more about this  
19 because you could have the opposite. You could  
20 have a cranky old man from nursing homes throwing  
21 everything in there, which would really drive CMS  
22 insane and would be very inappropriate from a

1 policy standpoint. So you may not want to take  
2 everything that comes through all the process as  
3 well.

4 CO-CHAIR PINCUS: And also there are  
5 CMS people at the different workgroups and so  
6 forth that are hearing and sort of taking in the  
7 discussion. So that is, obviously, in some ways,  
8 among the most influential kinds of materials  
9 that they hear because they get more of the full  
10 spectrum of discussion.

11 MS. O'ROURKE: So with that, next  
12 slide.

13 So to quickly take you through how  
14 this is going to flow for finalizing the pre-  
15 rulemaking recommendations, we will first have  
16 the chairs and the staff who supported each of  
17 the setting-specific workgroups to present to you  
18 an overview of the workgroup's findings and  
19 recommendations. They will highlight the  
20 crosscutting themes that came out of the  
21 deliberations, as well as some notable measure  
22 discussions where there may have been particular

1 controversy or an end of discussion that we feel  
2 the Coordinating Committee should be aware of.

3 The staff and chairs will also outline  
4 some of the strategic issues and the relevant  
5 input from the Dual Eligible Beneficiaries  
6 Workgroup. As Harold mentioned, we convened that  
7 group via web meeting in January to look at all  
8 of the measures under consideration and the  
9 preliminary input from the workgroups to ensure  
10 that we are really keeping a special focus on  
11 people who are eligible for both Medicare and  
12 Medicaid.

13 After the presentation, the  
14 Coordinating Committee chairs will ask the  
15 Coordinating Committee members if there are any  
16 measures that you would like to pull either for  
17 discussion or for a formal revote. And we will  
18 ask you to identify specifically what part of the  
19 workgroup recommendation you disagree with or  
20 what issue you would like to discuss further.

21 If a measure is not pulled from the  
22 consent calendar for Coordinating Committee

1 discussion or vote, it would be considered  
2 ratified. Next slide.

3 So just to cover briefly how the  
4 voting process will work, the staff and workgroup  
5 co-chairs will review the workgroup consent  
6 calendars. We will present each group of  
7 measures as a consent calendar, reflecting the  
8 consensus recommendation by the MAP Workgroup.  
9 Next step.

10 So then, again, we will ask you to  
11 pull any measures under consideration from the  
12 consent calendar that you would either like to  
13 discuss further or request that it be voted, if  
14 you disagree with the initial recommendation from  
15 the workgroup. If there are no objections for  
16 the remaining measures, we will consider what  
17 remains on the consent calendar to be ratified.  
18 We don't take a formal vote on that to try to  
19 save you one click, because we have heard that  
20 the voting things can be a little arduous. So we  
21 try to cut as many formal clicks out of your  
22 lives as we can.

1                   So on to step 3, please. We will then  
2 go through measure by measure. We will ask the  
3 Coordinating Committee member who identified that  
4 measure for discussion to provide their  
5 rationale, in particular, please highlight if you  
6 disagree with the workgroup's initial  
7 recommendation so we can know if we need to queue  
8 it up for a formal vote or if there are just  
9 clarifying questions you wanted to ask of CMS or  
10 the developers or the workgroup chairs to  
11 elucidate what the conversation around that  
12 measure was.

13                   At that point, we will ask the chairs  
14 to open it up for discussion among the  
15 Coordinating Committee. We invite everyone to  
16 participate but would ask you to refrain from  
17 repeating points just because we do have an awful  
18 lot to cover in the next 16 hours here.

19                   So after the discussion, the  
20 Coordinating Committee will vote on the measure  
21 if it has been put for a revote and you disagree  
22 with the workgroup's initial recommendation and

1       it is not just additional commentary that you  
2       would like staff to ensure that we put into the  
3       deliverables. So if you do want a formal revote,  
4       again, your options are there for support,  
5       conditional support, refine and resubmit, or do  
6       not support. Next slide.

7               Oh, and before I go through the  
8       tallying, we would ask if you have a condition  
9       that you would like highlighted or there is a  
10      specific refinement you would like to the  
11      measure, if you could please state that before we  
12      cast votes so that the committee can be clear  
13      about what exactly they are voting on and what  
14      either conditions you would like to see attached  
15      to MAP supports, or what additional work you  
16      think needs to be done to the measure.

17              So this slide shows how we will tally  
18      the vote. The top column is, obviously, the  
19      cleanest way to get to a decision. This is one  
20      of the categories, hits greater than 60 percent  
21      on its own. To clarify Harold's point, we do  
22      define consensus as greater than 60 percent of

1 the committee members.

2 The second category shows when we  
3 don't hit 60 percent cleanly in one category how  
4 we will get there. Essentially, the default  
5 position would be a do not support. So to get  
6 out of a do not support, you would need to get to  
7 greater than 60 percent in the three positive  
8 categories, if you will.

9 So we would start by seeing if there  
10 is 60 percent in the support category. If we  
11 don't get to 60 percent in support, we would add  
12 together the conditional support and support  
13 votes to see if that gets us to greater than 60  
14 percent. If that does not get us to greater than  
15 60 percent, we add in the refine and resubmit.

16 And if that does not still get us to  
17 60 percent, it would be a do not support. And  
18 when we do add the categories, it goes down a  
19 level. So we would support and conditional  
20 supports to get to a conditional support and then  
21 the three together to get to refine and resubmit,  
22 again, based on the assumption that if you were

1 more positive about the measure, you would like  
2 to see it kept in the highest possible support  
3 category, rather than defaulting down to the do  
4 not support.

5 CO-CHAIR PINCUS: So just to clarify  
6 the arithmetic, so if we don't get to a 60  
7 percent or greater point for any of the  
8 categories, then we keep the same denominator.  
9 We don't revote.

10 MS. O'ROURKE: Correct.

11 CO-CHAIR PINCUS: We keep the same  
12 denominator, and we then sort of proceed to move  
13 whatever was in the support category to  
14 conditional support. So assume it is one down to  
15 conditional support. And if that is not  
16 achieving greater than 60 percent, we move what  
17 was in that category, that numerator into the  
18 refine and resubmit.

19 MS. O'ROURKE: That's it.

20 DR. BURSTIN: You got it quicker than  
21 the support group.

22 MS. O'ROURKE: And then finally,



1 again, this is new for this year and an  
2 improvement that we are excited about for the  
3 process. We would ask if the Coordinating  
4 Committee members also consider the workgroup's  
5 feedback on the current measure sets and if there  
6 is anything you would wish we add there. Again,  
7 asking you to consider how the current measure  
8 set reflects the goals of the program, evaluate  
9 the measure sets against the measure selection  
10 criteria to identify any areas for improvement  
11 and see how well the sets addressing MAP's key  
12 decisionmaking tool, and, too, perhaps identify  
13 any specific measures you think might need to be  
14 removed in the future. This is, again, a new  
15 conversation for this year but we do want to make  
16 sure we are seeking input from the coordinating  
17 committee on these current measure sets, since  
18 the workgroups didn't include that in their  
19 recommendations to you.

20 CO-CHAIR PINCUS: So is this also  
21 essentially where we also identify priorities?

22 MS. O'ROURKE: Yes, this would also be

1 if you have a priority for measure development to  
2 please raise it. Next slide.

3 So again, this is some of the criteria  
4 for removals that the workgroup worked off of.  
5 This was based off of the Coordinating  
6 Committee's input in September, essentially a  
7 flip of the preliminary analysis algorithm that  
8 staff uses. So asking the workgroup to highlight  
9 potential issues with the measure that might  
10 necessitate its removal from one of the programs.

11 PARTICIPANT: Is the first bullet  
12 "and" or "or?"

13 MS. O'ROURKE: It says "and" but I  
14 think "or" would be more --

15 DR. BURSTIN: Again, I think this one  
16 comes from the endorsement side of the house, so  
17 it is an "and" there. So I think it just flowed  
18 here. I think that is certainly up for  
19 discussion at this table, since it doesn't have  
20 to always follow the endorsement.

21 MS. O'ROURKE: And to kind of  
22 piggyback on Helen's point, this is actually a

1 key area that we will be looking for input from  
2 you all tomorrow when we get to the process  
3 improvement section of the discussion. This is  
4 new for this year, something we really want to  
5 build up and improve for next year's pre-  
6 rulemaking. So again, this is something I would  
7 highlight for you to think about and provide that  
8 feedback when we get to that section of the  
9 agenda because we see this as an important part  
10 of the strategic plan that Helen is going to  
11 highlight and an exciting opportunity to really  
12 allow MAP to think about the measure sets in  
13 their totality, rather than just an individual  
14 measure under consideration so that we could  
15 hopefully get to the highest impact measures and  
16 the least burden. Next slide.

17 And then the final part of the  
18 approach I just wanted to highlight was the  
19 public comment. We have actually had two formal  
20 public comment periods, in addition to the  
21 comments we solicited during the workgroup  
22 meetings. As soon as we receive the Measure

1 under Consideration List, we put it out for  
2 public comments so that stakeholders could share  
3 any information they had on the measures with the  
4 workgroups. Those were part of the discussion  
5 guide that went to the workgroup so that they had  
6 the benefit of the public's input before making  
7 their initial recommendations to you.

8 We also put the workgroup's  
9 recommendations out for public comment. Those  
10 comments are included in your discussion guide,  
11 if you want to see the feedback people had on the  
12 workgroup's recommendation.

13 We will also be asking for public  
14 comments before the committee discusses  
15 finalizing the pre-rulemaking recommendations for  
16 each setting. We do ask public commenters to  
17 limit comments to only measures for that setting  
18 and to limit your comments for two minutes. So  
19 if you want to discuss a hospital measure, please  
20 do so before we finalize the hospital votes. We  
21 would ask you to refrain from discussing post-  
22 acute care or clinician until we get to that

1 point in the meeting, just so that we can make  
2 sure that the committee can hear your comments  
3 when they are most relevant.

4 So, next slide. I think that is it.  
5 So I am happy to take any questions on the  
6 approach or how our meeting will flow.

7 CO-CHAIR PINCUS: Any questions about  
8 the process? Okay. Thank you, Erin.

9 Now we are going to hear from Helen.

10 DR. BURSTIN: Good morning, everybody.  
11 Just a few opening remarks before I get to  
12 Strategic Plan. As Kate pointed out, we are  
13 delighted that Shantanu begins with us on Monday  
14 as our new CEO. I also want to just add our  
15 thanks to how lucky we have been to have Helen  
16 Darling for this interim period. She has truly  
17 been a delight for us to work with and we are  
18 thrilled to get her back on our Board. She is  
19 not leaving us completely and she will part of  
20 this transition, but it has really been a gift to  
21 all of us. I just want to publicly thank her on  
22 behalf of the NQF staff, although thrilled to

1 have Shantanu join us on Monday.

2 So I want to show, I want to turn to  
3 before I get to the Strategic Plan, is an issue  
4 that arose at the Clinician Workgroup. And I  
5 don't want to get into the details of it but just  
6 to say they raised a policy issue for the  
7 Coordinating Committee.

8 And the issue came up at the Clinician  
9 Workgroup specifically around a question about  
10 whether measure developers should provide  
11 disclosures of interest regarding funding for the  
12 measure development. It has not been something  
13 that has been part of NQF's current disclosures  
14 of interest policy. We have disclosures for all  
15 of you, all of our committee members. It has not  
16 been something we have done to date for measure  
17 developers. They specifically asked us to bring  
18 this to this group, just to let you know this was  
19 an issue they raised. They specifically wanted  
20 disclosures for anybody presenting to the  
21 workgroup.

22 All disclosures of interest policy is

1 a really a board level discussion. So I just  
2 want to let you know we have already prepared a  
3 memo going to the Executive Committee of the  
4 Board next week to actually have this initial  
5 discussion with pros and cons and really thinking  
6 through what would be the logical next steps if  
7 we did move this forward.

8 So I just want to let you know and  
9 particularly for those on the phone and I know  
10 Bruce Bagley, the co-chair, is joining us on the  
11 phone today, that this will be taken up, an issue  
12 raised up through the MAP. I just want to put  
13 that out there, and we will certainly keep you in  
14 the loop.

15 Go ahead, Marissa.

16 MEMBER SCHLAIFER: Was the suggestion  
17 that if funding is being provided for the  
18 development of a measure or funding being  
19 provided to the measure developer in just general  
20 sponsorship, et cetera?

21 DR. BURSTIN: Again, this is why this  
22 is a complex issue we are not going to get into

1 today. We have raised all those issues in the  
2 memo to the Board. You could have helped us  
3 write it, Marissa, thank you. So those are  
4 exactly the kinds of issues.

5 I do think the big question really is  
6 understanding the funding as it relates on the  
7 measure development side.

8 I will say just one of the things that  
9 is very obvious at our tables is when something  
10 is funded through CMS because that is very  
11 public. So I think some of this is also ensuring  
12 there is that same degree of disclosure across  
13 all measure developers. So more on that to  
14 follow, mainly just queuing it up because I want  
15 to make sure we are having -- oh, I'm sorry,  
16 Mary. Go ahead.

17 MEMBER BARTON: I just want to support  
18 that as loudly as I can. Of course, NCQA went  
19 through this ten years ago and has established a  
20 firewall around measure development and funding  
21 for it. And so I think it would be a terrific  
22 addition to the public conversation. So, thank



1       you.

2                   DR. BURSTIN: I appreciate that, Mary.  
3       And also since NQF now supports the Measure  
4       Incubator, where we are taking private funds, at  
5       times, to develop measures, we will be very  
6       transparent about the sources of that. And  
7       again, from the endorsement side and also from  
8       the MAP side, it is not as if there is a  
9       criterion that says the funding of a measure is  
10      something you will consider as part of your  
11      evaluation. We are just saying really it is just  
12      part of disclosure. It is part of disclosure for  
13      guidelines. It is part of disclosure for journal  
14      articles, and I think we just want to be able to  
15      follow that.

16                  CO-CHAIR KAHN: And this is a question  
17      from ignorance, maybe not with CMS but with other  
18      uses of the measures, do any of these developers  
19      have income streams post -- with the use of the  
20      measure, rather than I mean obviously they may  
21      fund the development of it. And then do they get  
22      anything later on from the measure?

1 DR. BURSTIN: There is a small set of  
2 measures that come to NQF that have associated  
3 fees, a very small number of them. So ongoing  
4 use, they could get additional support. That is  
5 fully disclosed as part of the process. If it is  
6 a measure with associated fees, that is already  
7 part of our process.

8 It is a good point, actually. We  
9 should weave those together logically.

10 CO-CHAIR KAHN: Okay and then second,  
11 in terms of the discussion around this, even  
12 though it came up in the clinician group, I guess  
13 is the Board discussion going to be -- I mean is  
14 it just the clinicians, or will this be a broad  
15 recommendation regarding all of the different  
16 workgroups?

17 DR. BURSTIN: It will go actually all  
18 the way up through MAP and endorsement. It will  
19 be trans-NQF. So our feeling is that is why we  
20 didn't want this to be something just the MAP  
21 discussed and we think it is equally relevant on  
22 the endorsement side, equally relevant in any

1 other work we do regarding measures.

2 So it will be broader than the  
3 Clinician Workgroup, all of MAP, all of  
4 Endorsement, if that is the path they go down.  
5 And we will keep you informed on this as the  
6 Board has its deliberations.

7 So anyway, quickly just a couple words  
8 and feedback for you on where we are so far with  
9 the Strategic Plan. Next slide, if I could.

10 So I just have this one visual again  
11 for you of our visual of where we see ourselves  
12 going in the Strategic Plan. We are now about, I  
13 guess, six, seven months in and have actually  
14 made some good progress, very much the idea of us  
15 thinking about how we can accelerate the  
16 development of needed measures, partly through an  
17 effort to prioritize measures and gaps that I  
18 will talk more about in a moment, some of our  
19 work on incubation, some of our work on  
20 continuing to push on new measurement areas where  
21 there has not been a lot of emphasis or growing  
22 emphasis like PROs, for example, our new work we

1 are doing on the quality and safety of diagnosis,  
2 for example, another example of new measurement  
3 areas we are continuing to push on, areas where  
4 we think important measurement needs to occur; we  
5 don't yet have very many measures.

6 Part of that then logically leads us  
7 to wanting to continue our work certainly around  
8 the selection process of MAP and endorsement but,  
9 very importantly, have added that verb "to  
10 reduce." We really do see it as an important  
11 part of our role to try to reduce the number of  
12 measures, particularly those that are duplicative  
13 or not adding value, which comes logically to our  
14 work around feedback. And that is part of what I  
15 want to talk to you about today is where we are  
16 on both the prioritization piece, as well as  
17 facilitating feedback. We find it difficult to  
18 be able to fully do our jobs well without having  
19 feedback from the field of those who use the  
20 measures, those who are being measured in terms  
21 of how well measures are performing. Are they  
22 serving their intended purpose? Are they driving

1 improvement? And especially, is there any  
2 evidence that they may be driving unintended  
3 consequence?

4 So with that, just a couple of  
5 updates. We are now finalizing, as a first step,  
6 our prioritization criteria that we will use to  
7 identify the top priority measures and gaps.

8 And in fact, in your packet next to  
9 your table there is a one-page survey we would  
10 like each of you to complete, and we will collect  
11 it at the end of the day. It is very simple.  
12 You just have to list out your top five criteria.

13 So you are the final stop in this  
14 train I will tell you. We have now done this  
15 evaluation and gotten feedback from Executive  
16 Committee, from the CSAC, from all the MAP  
17 Workgroups have completed this survey. And I  
18 have also done a bit of a road show with some of  
19 the existing quality collaboratives as well. And  
20 we just had a webinar and tremendous feedback  
21 from our membership as well.

22 Our thinking is we would like to try

1 to get to a parsimonious list of criteria that we  
2 can use to drive all of our prioritization  
3 efforts going forward, both in terms of measures,  
4 what are the highest priority measures, but also  
5 in terms of using a similar set of criteria to  
6 identify the top gaps.

7 Part of that will be the next steps  
8 will be once we have these criteria established,  
9 we will develop a draft set of sort of thinking  
10 about this as our pyramid. The top set of  
11 measures would be really a set of the top  
12 outcomes for the nation that we think are really  
13 important to drive towards and the second layer  
14 of that pyramid would be well then what are the  
15 driver measures within the healthcare system that  
16 we can collectively use to drive towards those  
17 top measures.

18 So for example, if total harm wound up  
19 being among the top outcomes that would be at the  
20 top of that pyramid, we would then think through  
21 then logically using those criteria which  
22 measures would logically move up to say these

1 would be the driver measures to drive towards  
2 improvement of that top outcome.

3 And then finally, the bottom of the  
4 pyramid is we would use those same criteria in  
5 our processes, MAP endorsement, et cetera, to  
6 have all of our committees, for example, identify  
7 the top priority measures and gaps within their  
8 work as well. So for example, the Cardiovascular  
9 Committee will be asked to use the same criteria  
10 to rate the top measures. Some of this is,  
11 again, our assistance of trying to be more  
12 parsimonious, help with reduction while driving  
13 to a set of national priorities.

14 So we would very much welcome your  
15 thoughts on this. I know some of these are  
16 duplicative. They are somewhat intentionally  
17 duplicative to get a read from you of the wording  
18 that matters. We have pulled this, just some of  
19 you who may not recall, in September we did a  
20 fairly exhaustive review of all of the sets of  
21 prioritization criteria used across the U.S. and  
22 the world, in fact pulled in about ten different

1 countries' prioritization criteria as well. And  
2 our hope is if we have a set of consistent  
3 prioritization criteria, then every time we are  
4 asked to prioritize, it would help us with  
5 consistency to have that same set of criteria  
6 drive our work.

7 So I would very much welcome your  
8 feedback on this. We will collect it from you  
9 and we will enter it into our final database and  
10 get our final set of criteria to move it forward.

11 Some, interestingly, very much rise to  
12 the top across all of the groups. There is  
13 certainly something about meaningfulness to  
14 families and patients rises to the top.  
15 Something about whether it is actionable and  
16 improvable on the part of the healthcare system,  
17 logically, tends to rise the top. Not to  
18 influence your decisionmaking, we would welcome  
19 your thoughts on this as well.

20 But just, interestingly, across  
21 different audiences, those are a couple that  
22 always seem to rise to the top. And we are



1 hoping we don't have to reinvent the wheel every  
2 time we get more work on prioritizing behavioral  
3 health, prioritizing this, prioritizing that,  
4 that we just start from a ground plan of saying  
5 here are criteria and move forward.

6 The second one I just want to give you  
7 a brief update on is our work around feedback --  
8 I'm sorry. Any questions? I can stop at the  
9 end, if you would like.

10 So just briefly on feedback, the other  
11 really critical piece, we can't do our work truly  
12 well without knowing how measures are performing  
13 in the wild out there as people respond to them  
14 and find them useful or not.

15 So the first thing you will see, as  
16 Erin mentioned, is, thanks to our collaboration  
17 with CMS, we have added this new piece this year  
18 to the MAP process for each of our workgroups,  
19 review the existing measure sets, not just the  
20 new measures under consideration, as part of a  
21 global assessment of what is already in the  
22 program to make recommendations for the future

1 about what could potentially be removed, as well  
2 as overall recommendations for the measure set.

3 This is only the first time we have  
4 done this, so we would very much welcome your  
5 thoughts about the kind of information that would  
6 be useful to make this a better process going  
7 forward. And we recognize a big piece of this is  
8 more information on the measures.

9 So with that, we are also working in  
10 a couple of different ways. First really,  
11 working with a group of member organizations.  
12 Some of them are at this table who will help us  
13 think through this issue of how to kick off  
14 measure feedback. What is the pull strategy?  
15 What makes somebody want to submit feedback to us  
16 that we can then share with the developer, CMS,  
17 and others? As well as we are also going to  
18 launch at our annual meeting April 3rd and 4th,  
19 we would very much welcome your -- let me make  
20 sure I got those dates right -- very much welcome  
21 your thoughts on -- welcome your attendance  
22 there.

1                   We will be launching a new measure  
2                   feedback tool at that annual meeting. So we have  
3                   had, for a long time, somewhat buried, I think it  
4                   is about seven layers down, as a part of our  
5                   quality positioning system, the QPS, our measure  
6                   database, the ability to provide feedback.

7                   So we will now have a design team at  
8                   work, Marcia, Elisa, and John Bernot in the back,  
9                   working on this, where you will be able to use  
10                  this tool to much more easily provide measure-  
11                  specific feedback, as well as it will be comments  
12                  that can be provided at any time, not just when a  
13                  measure is up for review and endorsement but any  
14                  time provide that feedback, and you will be able  
15                  to easily see the other submitted comments on the  
16                  measure. So we are trying to make it really more  
17                  of a marketplace. So provide your feedback.  
18                  Give us feedback.

19                  So we are planning to announce that at  
20                  our annual meeting, as well as this initial set,  
21                  as I mentioned, of the criteria and the top two  
22                  parts of that pyramid of the overall national

1 outcomes and the driver measures.

2 So we are excited. This is a really  
3 live active strategic plan and delighted to have  
4 Shantanu help us take it to the next level. But  
5 I just wanted to let you know where we were.

6 We are actively working on it and  
7 happy to take some questions, if we have time.

8 CO-CHAIR KAHN: Yes, I have a dual  
9 question, both for you and Kate. And let's take  
10 an example and, again, if I am ignorant of stuff  
11 that is going on, then I'll -- let's take  
12 readmissions measures, for example.

13 So everyone, and I have done it  
14 myself, takes the raw results, oh wow, we have  
15 reduced readmissions, and has the charts when we  
16 give talks and say wow, this is great.

17 But in terms of the feedback loop, is  
18 it great? No, all we know is I mean from the  
19 data that I see, is that we have made progress on  
20 readmissions. But in terms of this feedback  
21 loop, does that make a real difference for  
22 patients, beyond just the notion that we want to

1       reduce readmissions, how much do we really know  
2       and what is the evaluation? And that is a big  
3       one because that is a program. I mean it is not  
4       buried in 50 different measures.

5               So I throw that out sort of to find  
6       out how CMS, and I guess I could see how NQF is  
7       going to begin to try to cope with that. But  
8       where is the feedback loop here?

9               And the trouble with readmissions is  
10      it is a statutory program. So you have got to  
11      have a measure. But the question is, does it  
12      mean anything, the measure?

13              DR. GOODRICH: So a couple of things  
14      on that. I mean I think there certainly has been  
15      a body of evidence that a lot of readmissions are  
16      avoidable. So driving down readmissions I think  
17      was, I think fairly universally felt to be a  
18      laudable goal. Never mind how it was implemented  
19      in statute and everything but just that it was  
20      something that needed to happen. So starting  
21      there.

22              I do think you highlight, though, a

1 particular challenge with designing how to go  
2 about developing the feedback loop and what the  
3 data sources should be. And we have talked about  
4 that a little bit before here at the MAP about  
5 how it probably needs to be sort of a combination  
6 of quantitative and qualitative data. We  
7 definitely do, for a lot of our measures,  
8 including readmission measures, we look at our  
9 claims data at things like observation stays and  
10 other potential unintended consequence that we  
11 can glean from claims data. That is a source.  
12 It is not the ultimate and only source by any  
13 means. In fact, I would argue that qualitative  
14 data is something that would definitely be needed  
15 here.

16 We don't have a mechanism in place  
17 that is systematic across our programs to get  
18 this feedback yet. We do get feedback on measure  
19 implementation in some places more systematically  
20 than others. And if Pierre were here, he could  
21 probably speak to this a little more as well. We  
22 certainly do solicit feedback from our

1 stakeholders, from the hospital community, the  
2 physician community, and so forth. And we also  
3 get a lot of it without asking for it, which is  
4 great, actually. A lot of it just comes to us  
5 naturally. But I would say we probably need to  
6 do this, again, in a partnership with NQF. This  
7 shouldn't just be isolated to one or the other,  
8 to have a more systematic, data-driven, but  
9 again, qualitative and quantitative data-driven  
10 way to do that. A lot of -- it definitely  
11 happens now but it is probably a little bit more  
12 ad hoc and less systematic, but I would say it  
13 has been getting more systematic over time, but I  
14 think a ways to go, just to be perfectly honest.

15 DR. BURSTIN: Yes and I agree. I mean  
16 we have already had these discussions with CMS.  
17 We very much see this as something that we would  
18 do collaboratively, and I think one of the key  
19 questions is also how will we handle that  
20 qualitative data as it comes to us, and then how  
21 does that actively feed into the review processes  
22 that undertake. So lots more work to do, and we

1 are hoping to work with some of our member  
2 organizations who are helping us as part of this  
3 thinking process to identify some of those  
4 issues, and certainly CMS at that table as well.

5 CO-CHAIR KAHN: Okay, Harold.

6 CO-CHAIR PINCUS: So I guess, and  
7 Helen I have had this conversation before but  
8 where in that feedback loop do we put the whole  
9 issue of both funding and stewardship of the  
10 basic science of measurement? Where does that  
11 come from currently? Where in the federal  
12 government? Where from other sources does that  
13 come?

14 And this is a perfect example. I mean  
15 with readmissions, like what is the right rate?  
16 It is certainly not zero. And where do we set  
17 that? And how do we do the science of  
18 understanding how we determine what the right  
19 rate is?

20 Those are the kinds of I think key  
21 questions that come up not just in this area but  
22 in multiple other areas. And there doesn't seem



1 to be -- for that feedback loop to work well,  
2 there has to be some effort around this kind of  
3 basic science of measurement.

4 DR. BURSTIN: And we intentionally put  
5 this around the idea of advancing measurement  
6 science as being I think one of the core  
7 principles of our work going forward.

8 Fortunately, CMS has funded us quite  
9 a bit over the last several years to do more and  
10 more of the measurement science stuff, and I  
11 think it is an important role for us. I do  
12 think there are a lot of outstanding issues where  
13 reliability, validity issues continue to come up,  
14 issues around measure testing, risk adjustment,  
15 et cetera.

16 So I think, hopefully, there will be  
17 more resources in that respect, but I think it is  
18 a really important question. I don't know if  
19 Kate has anything to add.

20 DR. GOODRICH: I actually just want to  
21 make one other point to Chip's question. So one  
22 of the other things that was in ACA was the

1       assessment of impact of impact of measures that  
2       we have to do every three years. We are gearing  
3       up for the 2018 report that is due in March of  
4       2018. The first two reports were a little bit  
5       more limited than what this one will be because  
6       of the availability of data. And I think we  
7       learned a lot from those first two reports about  
8       what we need to look at both on the quantitative  
9       and qualitative side. So that is a more  
10      systematic way in which we are evaluating the  
11      impact of measures, again, using both types of  
12      data. However, that is every three years.

13               So while that is a good thing that we  
14      have to do that and that we are doing that, there  
15      is a need for that more sort of ongoing  
16      continuous feedback loop, which is sort of what I  
17      was getting to before.

18               MEMBER BAKER: I just wanted to first  
19      really applaud this focus on getting this  
20      feedback loop and continue with the example of  
21      the readmission rate because you talked about the  
22      studies showing preventability. But the rate has

1       come down by about two to three absolute  
2       percentage points, and now the last three of four  
3       years it has been flat. So any study from more  
4       than five years ago, it was no relevant. We  
5       don't know what the preventability rate is now.  
6       So we need to be continually monitoring this.

7               We know when to retire -- at least we  
8       have a pretty good feel when to retire process  
9       measures. But for this measure, are we nearing  
10      the point where there is no more juice left to  
11      squeeze? So we really do need to be continuing  
12      to have that feedback loop, but some of the --  
13      what you were talking about, Harold, drilling  
14      down on the science of measurements, some of this  
15      is also funding these studies to be able to know  
16      whether some of these measures should be  
17      continued.

18             CO-CHAIR KAHN: This is really a  
19      critical question, and I would have to go back to  
20      look at the law whether the law even really, in  
21      terms of readmissions, allows that. The question  
22      is does it allow a notion that you have just a

1 threshold level; you don't have to keep pushing  
2 it down? Because there will always be some  
3 people pushing it down. And the question is do  
4 they then become the winners? I mean it is  
5 really a problem.

6 MEMBER GIFFORD: So on updating, sort  
7 of as David was saying, one of the things we have  
8 noticed in some of our measures that because of  
9 the rapid improvement over time, we have to go  
10 back and revise the risk adjustment weights in  
11 the variables, and some even the variables in the  
12 risk adjustment model are changing. And so that  
13 is another thing we may throw back into the  
14 feedback of not just updating the measure, but  
15 because of both changes in population but of  
16 practices, the risk adjustment models don't work  
17 anymore or are performed very differently.

18 Second, on the theme of getting to  
19 zero and stuff, it is almost there is a whole  
20 sort of science about goal-setting. And I think  
21 we need to think about, and NQF may want to think  
22 about how you recommend to users or measures on

1 goal-setting.

2 And that leads to, I would say, the  
3 last comment that unintended consequence I have  
4 seen in a number of our settings is people  
5 practicing to the measure specs, and that is just  
6 never good. And then we have also seen  
7 enforcement to the measure specs in ways, and  
8 that just sort of drives some bad behavior and  
9 bad practices out there.

10 DR. BURSTIN: I would just say that is  
11 a really good point, David. I think the other  
12 thing we have heard, for example, our Surgery  
13 Committee raised issues around some of the  
14 outcome measures for surgery, and how would we  
15 even begin understanding whether cherry-picking  
16 was happening? So are we seeing behavior change?  
17 Measures is all about incentivizing good behavior  
18 change, but are we seeing negative behavior  
19 change as a result of being fearful of how the  
20 measure will quantify you? And then you are  
21 making some decisions around cherry-picking.

22 So even thinking through how you would

1 even measure and understand those unintended  
2 consequences, I think also --

3 MEMBER GIFFORD: Even when all these  
4 things were going on, getting the measures out  
5 there definitely helped improve outcomes. It is  
6 just like with everything, there is pros and  
7 cons, and there is going to be some bad things  
8 and good things, but the net is clearly getting  
9 better.

10 But to David's point, too, as we get  
11 a lot better, then that ratio starts to change,  
12 and we need to be careful of when that ratio is  
13 changing.

14 CO-CHAIR PINCUS: Now we are going to  
15 move ahead and actually start our process for  
16 reviewing individual programs and individual  
17 measures.

18 And so the first measure set that we  
19 are going to be looking at are the Hospital  
20 Programs. And as Erin discussed earlier, the way  
21 we are going to start this off is by hearing any  
22 public comments with regard to the workgroup

1 report and sort of overall looking at the  
2 Hospital Program's issues.

3 So are there people in the room that  
4 would like to make public comments? So maybe  
5 people could sort of line up.

6 And so what we are asking them to do  
7 is to limit their comments just to the Hospital  
8 Programs, and number two, to limit their comments  
9 to just two minutes.

10 Okay, do you want to identify  
11 yourself?

12 MS. PONDER: Yes. Hi, good morning.  
13 My name is Meredith Ponder and I am commenting on  
14 Defeat Malnutrition Today, which is a coalition  
15 of over 50 organizations and stakeholders, and we  
16 share the goal of achieving the recognition of  
17 malnutrition as a vital sign of older adult  
18 health. And so we are working to achieve greater  
19 focus on malnutrition screening and intervention  
20 across community, acute care, and post-acute care  
21 settings to improve patient outcomes and decrease  
22 cost to the system.

1                   This includes convening the  
2                   Malnutrition Quality Collaborative, which is a  
3                   voluntary multi-disciplinary stakeholder group,  
4                   to develop a blueprint for improving malnutrition  
5                   care quality and outcomes for older adults across  
6                   the care continuum.

7                   Older adults are at high risk of  
8                   becoming malnourished and undernourished due to  
9                   chronic illness, disease, injury, or social  
10                  determinants, which makes it harder for them to  
11                  recover from surgery or illness, more difficult  
12                  for their wounds to heal, increases their risk  
13                  for infections and falls, and decreases their  
14                  strength that they need to take care of  
15                  themselves. Their healthcare costs can be up 300  
16                  percent greater than those who are not  
17                  malnourished on entry to the healthcare system.  
18                  It is critical to ensure that an individual's  
19                  nutritional status is identified early and that a  
20                  nutrition care plan and malnutrition diagnosis  
21                  are documented in the medical record to ensure  
22                  prompt nutrition intervention and continuity of



1 care for older adults upon discharge to home or  
2 post-acute care settings.

3 We request that the MAP Coordinating  
4 Committee support the Hospital Workgroup  
5 recommendation for conditional support for the  
6 MUC16-296 completion of a nutrition assessment  
7 for patients identified as at-risk for  
8 malnutrition within 24 hours of a malnutrition  
9 screening.

10 While we support provider adoption of  
11 the entire malnutrition measure set, we agree  
12 with the Hospital Workgroup that adoption of  
13 MUC16-296 in the Hospital IQR is a good start to  
14 fill the gap, improve outcomes, and maintain  
15 older adult independence. Thank you.

16 CO-CHAIR PINCUS: Thank you. Are  
17 there other public comments from people in the  
18 room?

19 Are there public comments from people  
20 on the phone?

21 OPERATOR: At this time, if you would  
22 like to make a public comment, please press star

1 then the number 1.

2 DR. GUENTER: Okay, you have a public  
3 comment from Peggi Guenter.

4 DR. GUENTER: Yes, please. My name is  
5 Dr. Peggi Guenter. I am the Senior Director of  
6 Clinical Practice Quality and Advocacy for the  
7 American Society of Parenteral and Enteral  
8 Nutrition. I also served as co-author for two  
9 recent AHRQ HCUP statistical briefs on  
10 malnutrition.

11 I recognize the MAP Coordinating  
12 Committee is considering malnutrition measures  
13 and specifically the assessment measure MUC16-296  
14 to support for inclusion in the IQR program.

15 I would like to present some recent  
16 evidence that has just been published since the  
17 NQF Health and Well-Being Committee met to vote  
18 on these measures, and this highlights the impact  
19 of malnutrition on patient outcomes. That data  
20 is, namely, the AHRQ Statistical Brief 218  
21 entitled All-Cause Readmissions Following  
22 Hospital Stays for Patients with Malnutrition,

1 which was released in December of 2016.

2 The brief reported that in 2013, all-  
3 cause, 30-day readmission rate for patients with  
4 malnutrition was 23.0 per 100 readmissions  
5 compared to 14.9 for those patients without  
6 malnutrition. This equates to about 371,000  
7 patients or over 151,000 patients that are 65  
8 years and older.

9 The average cost per readmission was  
10 26 to 34 percent higher, depending on the type of  
11 malnutrition than the readmission cost for  
12 patients without malnutrition during their index  
13 stay. The difference in these readmission costs  
14 between those malnourished and well-nourished was  
15 over \$1 billion.

16 65 years and older age group, the  
17 readmission rate was higher, again in those  
18 malnourished than not, and in parallel, in those  
19 malnourished with Medicare coverage had a higher  
20 readmission rate than those who were not  
21 malnourished. Those with Medicaid coverage was  
22 even higher.

1                   These malnourished patients with  
2                   higher readmission rates had primary readmission  
3                   diagnoses of sepsis, surgical complications, and  
4                   pneumonia, and these are conditions that are  
5                   often associated with malnutrition.

6                   In summary, these new large data  
7                   support the findings of the September 2016  
8                   statistical brief on inpatients. These data  
9                   highlight the impact of malnutrition on patient  
10                  outcomes and cost of care and, for this reason,  
11                  we are hopeful the MAP will continue to support  
12                  the recommendation to move forward with the  
13                  assessment measure.

14                  Thank you.

15                  CO-CHAIR PINCUS: Other public  
16                  comments on the phone?

17                  OPERATOR: There are no public  
18                  comments at this time.

19                  CO-CHAIR PINCUS: Okay, thank you.

20                  So why don't we move ahead and  
21                  actually hear from the co-chairs of the Hospital  
22                  Program?

1                   WORKGROUP CO-CHAIR WALTERS: Hi. My  
2 name is Ron Walters. Christie, are you on the  
3 phone?

4                   WORKGROUP CO-CHAIR TRAVIS: Yes, I am,  
5 Ron.

6                   WORKGROUP CO-CHAIR WALTERS: Okay.  
7 Cristie Travis is co-chair and I would really  
8 like to thank the staff, Kate and Melissa for  
9 their help in getting this done.

10                  As you can see, the first slide -- go  
11 on to the next slide -- summarizes the work that  
12 was done. Again, the process and so on that you  
13 have already been through.

14                  The second one is the programs that  
15 were reviewed. So as usual, the IQR, the  
16 Inpatient Quality Reporting Program, dominated  
17 with almost half of the measures. The rest were  
18 spread out through a majority of the other  
19 programs, and we will go through those  
20 individually.

21                  Helen has already covered a lot of  
22 this, but these are themes that came up during

1 the discussion. I am going to add a couple more  
2 to this. But the need for health interventions  
3 and testing appropriately, prescribing practices,  
4 care transitions, and we spent a long time  
5 talking about patient-reported outcomes.

6 I will say that as you discussed  
7 already both in your comments and earlier, the  
8 first hour of our meeting was spent talking about  
9 conditional support versus refine and resubmit  
10 also and prompted a lot of discussion.

11 The second theme that occurred, you  
12 have already alluded to, was the pulling and  
13 discussion and the importance of that. But  
14 obviously, the more measures that are pulled, the  
15 meeting does slow down a little bit.

16 Retired measures was another strong  
17 theme, as Helen alluded to earlier. We paid  
18 particular attention to those measures that had  
19 topped out or could be retired for many other  
20 reason.

21 And then as we will get into some of  
22 the discussions that we had, this drive towards

1 harmonization and reducing the number of measures  
2 to the fact that measures are frequently written  
3 by a given steward for a given program, and how  
4 do you accomplish that in a way. And that is  
5 specifically relevant to the renal discussion,  
6 smoking and alcohol abuse identification and  
7 cessation, and the malnutrition discussion that  
8 you just heard about.

9 So those are going to be themes you  
10 are going to continue wrestle with as we go  
11 through the day and we wrestled in the Hospital  
12 Workgroup. Next slide.

13 So again, this is a balancing act that  
14 needs to occur between trying to get measures  
15 that are being parsimonious, as well as  
16 addressing the relevant programs, and removing  
17 the ones that are already topped out continues to  
18 be an issue.

19 So with that said, I am going to turn  
20 it over to Kate to take us through individual  
21 programs for your review.

22 MS. McQUESTON: Thank you, Ron. My

1 name is Kate McQueston, and I am the project  
2 manager working with the MAP Hospital Workgroup.

3 Before we dive into the consent  
4 calendars, we will do a brief overview of each of  
5 the programs that the Hospital Workgroup looked  
6 at, including some of the key issues that were  
7 discussed by the workgroup.

8 The first was the End-Stage Renal  
9 Disease Quality Incentive Program. When  
10 discussing this program, the workgroup stressed  
11 the importance of managing anemia and avoiding  
12 unnecessary blood transfusions for patients with  
13 ESRD and noted the need for measures that would  
14 encourage better care coordination between  
15 dialysis facilities and hospitals.

16 There were three measures discussed  
17 for this program. The workgroup supported two  
18 measures that were intended to replace the  
19 current vascular access measures currently  
20 included in the program. And then the workgroup  
21 recommended that MUC16-305, Standardized  
22 Transfusion Ratio for Dialysis Facilities, be



1 revised and resubmitted, as patients may receive  
2 a transfusion in other care settings, limiting  
3 the ability of dialysis facilities to control  
4 their performance on the measure.

5 The workgroup noted the need for  
6 comprehensive measure sets that look at both  
7 treatment and outcomes and that would drive  
8 quality and safety for those with ESRD and noted  
9 gap areas such as pediatrics and management of  
10 comorbid conditions, including congestive heart  
11 failure, diabetes, and hypertension.

12 Public comment received overall agreed  
13 with the MAP recommendations, though commenters  
14 did have suggestions for specific changes and  
15 improvements on measures, especially around the  
16 specifications. Next slide, please.

17 We will take questions at the end.

18 Thanks.

19 The next program that we looked at was  
20 the PPS-Exempt Cancer Hospital Quality Reporting  
21 Program. When discussing this program, the  
22 workgroup noted the need for increased alignment

1       between the IQR and PCHQR programs. They also  
2       noted the need for measures of global harm in  
3       inpatient settings and measures related to  
4       informed consent.

5               The workgroup looked at five measures  
6       for this program and supported four measures that  
7       related to end of life care. The workgroup did  
8       not support one measure, PRO Utilization of Non-  
9       Metastatic Prostate Cancer Patients, because it  
10      was a structural measure related to the  
11      measurement of PRO utilization, rather than a  
12      patient-reported outcome measure itself.

13             Public comments ranged regarding this  
14      measure, as many commenters noted that there was  
15      an increasing importance of patient-reported  
16      outcomes to CMS and value-based care. And  
17      overall, commenters generally agreed with the MAP  
18      recommendations regarding the end of life  
19      measures suggested for this program.

20             The next program that we looked at was  
21      Ambulatory Surgical Center Quality Reporting  
22      Program. The workgroup noted a need for measures

1 that addressed surgical quality, infections and  
2 complications, patient and family engagement,  
3 efficiency, and appropriate preoperative testing.  
4 Overall, the workgroup noted that new and  
5 existing measures should undergo testing and  
6 undergo NQF endorsement to be included in the  
7 program. Public comment supported these  
8 recommendations, but commenters did note that NQF  
9 endorsement is not required by the Social  
10 Security Act for measures to be adopted into the  
11 program.

12 The next program was Inpatient  
13 Psychiatric Facility Quality Reporting. For this  
14 program, the workgroup noted the need for  
15 increased alignment with IQR and also noted a  
16 need for measures to address medical  
17 comorbidities, emergency department patients who  
18 are not admitted to psychiatric hospitals,  
19 discharge planning, and readmissions. They also  
20 noted that there is currently a high number of  
21 alcohol and tobacco measures included in the  
22 measure set. And they noted that while these

1 measures are important, they should not be  
2 considered the highest priority indicators for  
3 quality treatment in psychiatric hospitals.

4 For the three measures proposed for  
5 this program, the workgroup members recommended  
6 that the MUCs be revised and resubmitted due to  
7 incomplete testing and the need for NQF review  
8 and endorsement.

9 Most commenters supported the MAP  
10 recommendations. Commenters noted concern that  
11 measures such as MUC16-428 may lead to  
12 overtesting. 428 is identification of opioid use  
13 disorder.

14 In general, there were also comments  
15 relating to an area that the workgroup identified  
16 as a gap area. That is access. And commenters  
17 were concerned that hospitals have little control  
18 over this domain.

19 Next comes hospital Outpatient Quality  
20 Reporting. The workgroup noted there was a need  
21 for measures with greater emphasis on  
22 communication and care coordination for this

1 measure set. There were three measures  
2 considered; two of them had pretty lively  
3 discussions.

4 The first was Median Time from ED  
5 Arrival to ED Departure for Discharged ED  
6 Patients, MUC16-055. The workgroup conditionally  
7 supported this measure under two conditions. The  
8 first was that testing data demonstrates that the  
9 eMeasure more accurately determines patient  
10 arrival and discharge times compared to the  
11 current measure included in the measure set, the  
12 chart abstracted version, and also that the  
13 eMeasure is submitted to NQF for review and  
14 endorsement.

15 The second measure that had a notable  
16 discussion was Safe Use of Opioids - Concurrent  
17 Prescribing. The workgroup noted that it was not  
18 supported since there are times when concurrent  
19 prescriptions are appropriate. The workgroup  
20 also was concerned that patients may  
21 unintentionally suffer withdrawal symptoms if  
22 previously prescribed opioids and/or

1 benzodiazepines are reduced or stopped prior to  
2 discharge.

3           There is a spectrum of public comment  
4 regarding the discussion of MUC16-167, both  
5 supporting the MAP Hospital Recommendation as it  
6 stands and also suggesting that the measure be  
7 changed to a decision category of refine and  
8 resubmit prior to rulemaking.

9           Regarding MUC16-055, public commenters  
10 noted that conversion of this measure to an  
11 eMeasure would possibly not fix the inherent  
12 problems discussed with the measure.

13           The next measure set discussed was the  
14 Inpatient Quality Reporting Program/Medicare and  
15 Medicaid EHR Incentive Program for Hospitals and  
16 Critical Access Hospitals.

17           The workgroup looked at 15 measures  
18 for rulemaking for these programs and noted an  
19 overall need for alignment among hospital  
20 programs. An example of this was readmission  
21 measures could be more aligned between IQR and  
22 HRRP.

1           The workgroup recommended the removal  
2 of measures that are no longer driving  
3 improvements in patient care and quality and to  
4 consider the addition of patient-reported  
5 outcomes.

6           Several of the measures that I  
7 discussed related to malnutrition, for which  
8 there was a lengthy discussion about the concerns  
9 identified in the Health and Well-Being Standing  
10 Committee, which just recently concluded in  
11 reviewing the measures, and, as a result, new  
12 information is available regarding these  
13 measures.

14           NQF received a great number of  
15 comments, over 50, regarding these measures. The  
16 majority of commenters agreed with the MAP  
17 recommendations. Commenters that disagreed with  
18 MAP decisions primarily commented on the  
19 malnutrition measures, as well as MUC16-262,  
20 which was a measure relating to the quality of  
21 informed consent documents.

22           The last program that we looked at

1 measures under consideration for was the Hospital  
2 Value-Based Purchasing Program. There was one  
3 measure under consideration for this program  
4 related to communication about pain during  
5 hospital stays, which the workgroup did not  
6 support for rulemaking because it did not meet  
7 the program requirements for the program.

8 The workgroup noted that there was a  
9 need to develop the next generation of patient  
10 safety measures and develop ways to mitigate the  
11 effect to the program on safety net hospitals.

12 Overall, commenters agreed with the  
13 recommendation on this measure and agreed that  
14 there was a need for further debate and revision  
15 of the measure.

16 There were two programs where we did  
17 not consider new measures under consideration:  
18 the Readmissions Reduction Program and the  
19 Hospital Acquired Condition Reduction Program.  
20 But the workgroup did review the current measure  
21 sets and provide feedback on those measure sets.

22 For HRRP, the workgroup noted that CMS



1 might consider ASPE's recommendations on how to  
2 mitigate the impact of the program on safety net  
3 hospitals.

4 And for the Hospital-Acquired  
5 Condition Program, the workgroup recommended that  
6 CMS work to develop measures that could replace  
7 PSI-90 in the program.

8 Thank you.

9 So I believe at this point we will  
10 pass it to the Dual Eligibles Team to discuss  
11 their input on the work of MAP Hospital. No?  
12 Okay.

13 MS. O'ROURKE: So I will just cover  
14 this briefly, since we are a little full around  
15 the table.

16 So we did, as I mentioned, convene the  
17 Dual Eligible Workgroup to provide input to the  
18 Coordinating Committee on the hospital  
19 recommendations. For PRO-PMs, the Dual Eligible  
20 Workgroup encouraged testing in appropriate sub-  
21 populations, such as individuals with cognitive  
22 impairment or physical or intellectual

1 disabilities. And assessing the person's  
2 perspective on whether the measure is meaningful,  
3 understandable, and achievable.

4 The Dual Group stressed the need for  
5 clarity around how PRO-PMs are or should be  
6 incorporated into patient care, as well as the  
7 accountability programs, and encouraged the  
8 inclusion of measures providing meaningful  
9 quality information related to population health  
10 and the functioning of the system as a whole.

11 So they did not make specific comments  
12 on particular measures?

13 MS. O'ROURKE: No, just some cross-  
14 cutting guidance for the committee's  
15 consideration.

16 CO-CHAIR PINCUS: So we are going to  
17 do three things now. One is we are going to see  
18 if there's any comments or questions about the  
19 overall program review. I think Rich had a  
20 question about that. And then we are going to  
21 ask if any of the members of the MAP wish to pull  
22 any other measures. We have 17 measures that

1 have been pre-pulled. Let's see if there are any  
2 other measures. And then we are going to proceed  
3 to go over measure by measure and vote.

4 So any comments about the overall  
5 program review, Rich?

6 DR. ANTONELLI: This is just a  
7 clarification. So when you talked about the  
8 dialysis center, there was a focus around  
9 communication and care coordination. And as you  
10 were going through the presentation, I was trying  
11 to dig into where those pieces were. And one  
12 particular point that caught my attention was the  
13 connection between the dialysis center and the  
14 hospital.

15 And I was thinking about that from the  
16 patient perspective or the family's perspective  
17 and wondering exactly what did that look like.  
18 So did you get into any measure review,  
19 specifically looking at transactions of care?  
20 And what defines the hospital in any of the  
21 measures that you looked at? Is it the  
22 ambulatory component? Is it the inpatient side?

1 Is it the ED? Is it all the above?

2 WORKGROUP CO-CHAIR WALTERS: Yes, I  
3 would say that discussion did occur both in that  
4 and in regards to another measure. And yes,  
5 there is basically two kinds of places,  
6 independent dialysis centers, and that is what  
7 really the majority of the discussion was about,  
8 was that communication, interaction and yet  
9 attribution for blood transfusions given at  
10 another facility. And the second kind, which is  
11 where the dialysis center might be embedded as  
12 part of either a single hospital or a system, and  
13 then, of course, it makes much more sense.

14 DR. ANTONELLI: Were the recipients  
15 and transmitters of that information identified  
16 explicitly in the measure, either the measures or  
17 the measure specs?

18 WORKGROUP CO-CHAIR WALTERS: They are  
19 not, and I think that is some of the concern what  
20 was expressed about that particular measure.

21 DR. ANTONELLI: Because I am just  
22 reacting. The lead off of that top slide was to

1 focus on care coordination. And my admission is  
2 here is I didn't review every single measure in  
3 this set, but I am concerned because it looks  
4 like there isn't anything to react to that is  
5 showing that we are really focusing on improving  
6 the measurement of care coordination between  
7 those entities.

8 CO-CHAIR PINCUS: So we were just  
9 discussing sort of what is the best way to  
10 proceed forward.

11 So we are going to now go through each  
12 of the programs, and the slides that will be  
13 showing up will be looking at all of the measures  
14 that were on the MUC List and what was the  
15 recommendation from the workgroup. And then we  
16 will identify which measures have been pulled for  
17 further discussion. And Erin is going to do  
18 that.

19 If people want to pull an additional  
20 measure, let us know at the time that we are  
21 going through the program. Okay?

22 So the first program is the Ambulatory

1 Surgical Center Quality Reporting Program, and  
2 these were the workgroup recommendations that  
3 were on the consent calendar.

4 MS. O'ROURKE: Sure. So right now,  
5 two of the three measures of have been pulled for  
6 further discussion. So we will circle back to  
7 them.

8 Right now pulled we have MUC16-155.  
9 That is, the Surgical Site Infection outcome  
10 measure. As well as MUC16-152, Hospital Visits  
11 After Orthopedic Ambulatory Surgical Center  
12 Procedures.

13 And we did have, 16-153 is pulled. So  
14 all three have been pulled. So we will come back  
15 to all of these measures. Next slide.

16 For the ESRD QIP, right now we have a  
17 number of measures pulled: 16-309 has been pulled  
18 for discussion; MUC16-305 has been pulled for  
19 discussion. No one has pulled 308 yet.

20 CO-CHAIR PINCUS: Does anybody wish to  
21 pull any other measures from the ESRD program?

22 MEMBER BARTON: I've just been trying

1 to find 648 because you said that it was about  
2 opioids, but the workgroup feedback was that it  
3 would lead to overtesting. And I found that  
4 really confusing. And so I am just wondering if  
5 you could tell me what the name of the measure is  
6 that you were referring to.

7 MS. McQUESTON: That measure was for  
8 the Inpatient Psychiatric Facility Reporting  
9 Program -- or Quality Reporting Program. And  
10 that is number 16-428.

11 CO-CHAIR PINCUS: We're not there yet.  
12 Okay, let's move on to the next program.

13 MS. O'ROURKE: Sure. So for the IQR  
14 Program, right now we have MUC16-080 has been  
15 pulled for discussion; MUC16-178 has been pulled  
16 for discussion; MUC16-263 has been pulled for  
17 discussion; MUC16-294 has been pulled for  
18 discussion; MUC16-296 has been pulled for  
19 discussion; MUC16-262 has been pulled for  
20 discussion. And those are the IQR ones that we  
21 have got pulled so far. So if there is  
22 additional --

1 CO-CHAIR PINCUS: Anybody want to pull  
2 any other measures?

3 Okay, let's move on to the next  
4 program.

5 MS. O'ROURKE: Okay, moving on to the  
6 Inpatient Psychiatric Facility Quality Reporting  
7 Program -- oh, we are going to OQR. Apologies.

8 I don't think we have any -- oh,  
9 MUC16-167 has been pulled for discussion, the  
10 Safe Use of Opioids.

11 MEMBER GIFFORD: Erin, is it possible  
12 just to tell us what number? I'm following along  
13 on the guide, and I can't quite keep up as we  
14 jump forward. On the guide they are just listed  
15 by measure number: 12, 13, 14.

16 MS. O'ROURKE: Oh, sure.

17 MEMBER GIFFORD: But the MUC number is  
18 on the right, but they are not numerical. I'm  
19 just trying to orient. I have got to scroll and  
20 look for the names. I am asking for a little  
21 help. I'm sorry I'm challenged.

22 MS. O'ROURKE: Let me pull up the



1 guide so that I may follow along with you.

2 MEMBER GIFFORD: They are -- no, they  
3 seem to be in this order in the guide. They are  
4 alphabetical? So they are not in this order?  
5 Sorry.

6 MS. O'ROURKE: Yes, would it be easier  
7 maybe if we just start going program by program,  
8 rather than going all the way through? So we  
9 went back and started with the ASCQR, and then we  
10 can go through, since this is probably slightly  
11 easier for you all.

12 MS. O'ROURKE: So maybe you could go  
13 back to the ASCQR slide, and all three measures  
14 under consideration have been pulled for  
15 discussion. So I can turn it to Harold.

16 CO-CHAIR PINCUS: So what we are going  
17 to do is -- Bruce?

18 MEMBER HALL: Just a quick question.  
19 There is a couple places where you are offering a  
20 link to a conceptual summary of the measures, but  
21 that doesn't seem to work for me. I am just  
22 wondering if is that link active, and am I just

1 not doing it right?

2 CO-CHAIR PINCUS: Yes, there are a  
3 couple of links that don't work. I thought that  
4 was sent out. Kim, was that sent out to  
5 everybody?

6 MS. IBARRA: Yes, we are re-uploading  
7 a version with the links that have been fixed,  
8 but I will send an email to the coordinating  
9 committee now with that while we are trying to  
10 get it online.

11 CO-CHAIR PINCUS: Yes, earlier we  
12 identified that there were some links that  
13 weren't connected. And so there is a new version  
14 that is being sent to everybody now that will  
15 have that. Okay?

16 So the process is that we are going to  
17 go program by program. We are going to look at  
18 what is on the consent calendar and then ask the  
19 people that pulled the measure to discuss their  
20 concerns. Okay?

21 So the first measure, that's MUC16-  
22 155, the Ambulatory Breast Procedure Surgical

1 Site Infection Outcome Measure as part of the  
2 Ambulatory Surgical Center Quality Reporting  
3 Program is the first measure that we are going to  
4 discuss that has been pulled.

5 And John Bott and David Baker both  
6 pulled the measure. So David, do you want to  
7 comment?

8 DR. ANTONELLI: Fairly straightforward  
9 question is whether there is a risk adjustment  
10 methodology for this, particularly for patients  
11 with diabetes, as well as obesity. Those may be  
12 risk factors for surgical site infections. And I  
13 didn't see that in the specifications.

14 CO-CHAIR PINCUS: John, did you have  
15 a comment also?

16 MEMBER BOTT: Well, I had pulled the  
17 measure to suggest to revote. So do you want me  
18 to state my rationale that I sent in?

19 CO-CHAIR PINCUS: Yes.

20 MEMBER BOTT: Okay. So regarding the  
21 workgroup's stated condition that the measure  
22 receive NQF endorsement, I suggest that the

1       measure meet its requirements of the decision  
2       category of support for rulemaking. I would just  
3       note that the evaluation criteria in the decision  
4       category does not require receipt of NQF  
5       endorsement. Specifically, criteria 6 talks  
6       about NQF endorsement, or the measure has been  
7       developed, specified, and tested. So it seems to  
8       me adequately that criteria would then not need  
9       to have NQF endorsement. So I don't see the  
10      rationale for NQF endorsement.

11               The second condition stated was the  
12      measure -- the work group stated the condition  
13      the measure undergo additional testing. Just to  
14      point out, the measure has already been tested.  
15      Note that A) the CDC performed testing and they  
16      stated results in their NQF endorsement form; B)  
17      the NQF Patient Safety Standing Committee stated  
18      the reliability and the validity of the testing  
19      results meet NQF criteria. So I would suggest  
20      the conditions are not necessary and the measure  
21      should be support for rulemaking instead.

22               And to respond to that person's

1 comment, I did download the NQF endorsement form.  
2 The measure is risk adjusted but I don't have the  
3 covariates in front of me.

4 CO-CHAIR PINCUS: Kate, you had a  
5 comment?

6 DR. GOODRICH: The only thing I want  
7 to add, I am looking at the conditions:  
8 additional testing and monitoring is conducted  
9 before the measure is used in the Value-Based  
10 Purchasing Program. I would just note that the  
11 Ambulatory Surgical Care Program is not a Value-  
12 Based Purchasing Program. It is a Quality Pay-  
13 for-Reporting Program, just for clarity.

14 CO-CHAIR PINCUS: Giff.

15 MEMBER GIFFORD: Just responding to  
16 John's point, I think there has always been a lot  
17 of concern that the MAP process might bypass the  
18 NQF endorsement process. There has been a lot of  
19 discussion about that. We are not endorsing  
20 measures.

21 I would completely agree with John's  
22 point, though, that there can be very reliable

1 and well-developed measures, and they might be  
2 okay for necessarily for what they are proposing  
3 in rulemaking, but I do believe we don't want to  
4 set a process by which we really start  
5 encouraging bypassing the whole NQF endorsement  
6 process. I think it has caused great angst  
7 amongst many of the NQF members on how that has  
8 happened, and particularly with some of the time  
9 frames that CMS and NQF have been put under by  
10 Congress, that we have seen a large number in the  
11 last couple of years of measures no longer having  
12 NQF endorsement. And Kate last year talked about  
13 trying to make sure she brings measures back  
14 here. I would argue to keep it as a conditional  
15 support.

16 But you know CMS can use any of these  
17 measures they want, even if we vote they aren't  
18 ready. We are just advisory. They just have to  
19 address why they are using it. If Congress put a  
20 statutory thing, and they can say it meets all  
21 the requirements in there, I think the workgroup  
22 did a nice job summarizing a very reliable, well,

1       measure, but they'd apply a reasonable thing that  
2       I think is consistent with we don't want bypass  
3       that, so I would argue to it where we are.

4               CO-CHAIR PINCUS:  So this is something  
5       that we have had multiple discussions about over  
6       time, in terms of whether or not something, even  
7       though it is not endorsed but has a significant  
8       amount of data and evaluations behind it, can be  
9       recommended without conditions.

10              One of the issues, just to clarify,  
11       and I don't know Helen or somebody from NQF can  
12       say, is this on the docket to be endorsed?

13              DR. BURSTIN:  Yes.

14              CO-CHAIR PINCUS:  Other comments,  
15       questions?

16              MEMBER GIFFORD:  I would say, if we  
17       also vote for support, I have seen some of the  
18       NQF endorsement stuff.  Then the committee felt  
19       bound like oh, MAP already endorsed it; CMS is  
20       already using it.  We have got to endorse the  
21       measure, when there might be, while it may be  
22       risk adjusted, it may not include all the

1 covariates, and then people start getting into  
2 arguments. So I would really be cautious about  
3 us suddenly just saying to support it without at  
4 least conditional support.

5 DR. BURSTIN: I believe it has already  
6 gone through the Safety Standing Committee and  
7 positively reviewed. That was their point. Yes,  
8 it is just in its final sweep through the  
9 process.

10 CO-CHAIR PINCUS: Chip, did you have  
11 a comment?

12 David, is your concern addressed?

13 MEMBER GIFFORD: Yes. I can --

14 CO-CHAIR PINCUS: So any other  
15 comments back and forth? Yes.

16 MEMBER BINDER: Leah Binder from  
17 Leapfrog.

18 I actually want to support what John  
19 had to say about this measure.

20 CO-CHAIR PINCUS: Louder.

21 MEMBER BINDER: One balancing factor  
22 -- I, obviously, support NQF endorsement. I



1 think that is very important but a balancing  
2 factor in consideration of the NQF endorsement is  
3 the time frame to achieve that, when balanced  
4 against, in this case, a measure of something  
5 that is a rapidly developing phenomenon. I mean  
6 the movement of care to ambulatory surgical  
7 centers is extremely dramatic and rapid. And I  
8 think it is really critical that we start to have  
9 measure immediately that are able to assess the  
10 quality and safety, especially some of the data  
11 that was presented by the developers on the  
12 incidence of these infections, is alarming to  
13 those of us who work with purchasers who are  
14 actively sending their employees to these centers  
15 and do not understand -- I am certain they don't  
16 understand the level of these infections.

17 So I do think there is a balancing  
18 factor which is that need for rapid response when  
19 we see a phenomenon like the movement to the  
20 outpatient and ambulatory setting.

21 CO-CHAIR PINCUS: So just some  
22 clarification. Since the issue is speed, if this

1 is on the docket, when would it be considered?

2 MS. MARINELARENA: Hi, this is Melissa  
3 Marinelarena. I am the Senior Director for the  
4 Hospital Workgroup. This measure has been  
5 through the endorsement process. I believe it is  
6 at the very end for Board ratification, but it  
7 has gone through, and the committee did approve  
8 it, and it has been recommended for endorsement.

9 CO-CHAIR PINCUS: So when would it be  
10 seen by the Board for --

11 MS. MARINELARENA: It might already  
12 have been. It just hasn't been updated. I'm not  
13 sure what the schedule of the Board is.

14 CO-CHAIR PINCUS: So it would be  
15 officially, potentially --

16 MS. MARINELARENA: A week.

17 CO-CHAIR PINCUS: -- in a week. Okay.

18 WORKGROUP CO-CHAIR WALTERS: As we  
19 speak, it is going through the ratification  
20 process.

21 CO-CHAIR PINCUS: That's fast.

22 Okay any further comments about this

1 measure?

2 MEMBER GIFFORD: We are acting -- I  
3 mean I don't want take away our own authority.  
4 We are acting like the vote actually has some  
5 binding nature on CMS. I mean, if you look at  
6 previous rulemaking, we have recommended refine  
7 or don't even submit, and they put it in the  
8 rules.

9 There is nothing binding about this.  
10 It is really about the guidance. So I don't -- I  
11 just don't want us -- you know, I would agree  
12 with everything everyone is saying, but we are  
13 just starting to set a precedent up to really I  
14 think undermine the NQF endorsement process. And  
15 I think this makes it clear that we are standing  
16 on that point, but everything you have said, they  
17 are going to go ahead and put it in the  
18 rulemaking. Our vote, whether conditional  
19 support, or support, or refine and resubmit isn't  
20 going to affect what they decide to do with  
21 rulemaking on this. They may have a little  
22 trouble if we do not support, political, but they

1 put a number of do not support through because  
2 they are bound by Congress and other things to do  
3 it.

4 CO-CHAIR PINCUS: So it sounds like  
5 the issue is not one -- the issue is primarily of  
6 the MAP Coordinating Committee, the MAP, sort of  
7 setting a precedent of making recommendations for  
8 support for measures that have not been formally  
9 endorsed.

10 Any comments from MAP members on the  
11 phone?

12 Okay, so I guess we are ready to vote.  
13 So do you want to do the procedures for how we  
14 operate these?

15 MS. O'ROURKE: Sure. So you will see  
16 your four options on the slide in front of you.  
17 Vote 1 for support; 2 for conditional support; 3  
18 for refine and resubmit; and 4 for do not  
19 support. And they correspond with the first four  
20 buttons you will see on your clicker. You will  
21 see like 1a, 2b. So, hit 1, 2, 3, or 4.

22 Yetunde, do I need to mention anything

1 else for voting? You are our voting expert over  
2 there.

3 MS. OGUNGBEMI: Pardon me, I'm sorry.  
4 Please point your clickers towards this corner of  
5 the room because I have the device that captures  
6 the votes. If you press more than one option,  
7 the second option is the only one that will be  
8 captured. So if you are changing your vote,  
9 please do so in a timely manner.

10 And I will let you know when to vote  
11 and when voting is closed.

12 CO-CHAIR PINCUS: So when do we vote?

13 MS. OGUNGBEMI: Please vote now. We  
14 are voting on MUC16-155. So your options are 1,  
15 support; 2, conditional support; 3, refine and  
16 resubmit; and 4, do not support.

17 And Kim is over here proxy voting for  
18 all of the people on the phone. So we are going  
19 to wait until all of the votes come in for her.  
20 So be patient, please. Thank you.

21 MS. IBARRA: Barrett Noone, if you are  
22 on the phone, I haven't received your vote, but

1 Doris, Steve, Brandon, and Foster, I have  
2 received your votes and recorded them.

3 MS. OGUNGBEMI: So for -- our results  
4 are, from 16-155, is to conditionally support the  
5 measure for rulemaking. We have 54 percent  
6 support and 46 percent conditional support. And  
7 as Erin so generously explained before, we will  
8 roll down until we get 60 percent, until we reach  
9 60 percent or greater in conditional support.

10 MS. O'ROURKE: And to clarify, we have  
11 captured all of those comments, and we will add  
12 that into the rationale that goes along with this  
13 measure. So we will stress the urgency of the  
14 situation as well as the committee's  
15 reinforcement of the importance of NQF  
16 endorsement. So all of your discussion will go  
17 along with CMS, not just the vote.

18 CO-CHAIR PINCUS: So we are going to  
19 move on to the next pulled measure. Okay, so we  
20 had measure 16-152 that was pulled, but now the  
21 person who pulled it has been sort of satisfied  
22 with that. And also 16-153. Is that correct?

1                   What about 16-309?

2                   MS. O'ROURKE: So that goes on to to  
3 the next program. So this would be, if you have  
4 any additional concerns with the measures for the  
5 ACSQR program, right now the pull has been  
6 rescinded. So the workgroup recommendation would  
7 hold, unless someone else wants to discuss it.

8                   CO-CHAIR PINCUS: Okay, so let's move  
9 on to the next program. Okay, so we will move on  
10 to the End Stage Renal Disease Quality Incentive  
11 Program. Right now we had a couple measures  
12 pulled for that. So why don't we start with  
13 MUC16-309, Hemodialysis Vascular Access: Long-  
14 Term Catheter Rate.

15                  CO-CHAIR PINCUS: So David.

16                  MEMBER BAKER: This was not as much  
17 concern as clarification. The numerator and  
18 denominator were confusing and really didn't seem  
19 to match the description. So I don't know if  
20 people can comment on that. So the description  
21 says the percentage of adult hemodialysis patient  
22 months using a catheter continuously for three

1 months or longer. So it is just confusing the  
2 way it is worded.

3 DR. GOODRICH: For folks on the phone,  
4 this is Kate. I don't know if we had either  
5 somebody from our ESRD team like Joel Andress or  
6 somebody from the measure developer on the phone  
7 who could answer that question.

8 MEMBER BAKER: It is just I think if  
9 you are thinking about a patient-centered measure  
10 to me it is more the proportion of all people who  
11 don't get a catheter within three months --  
12 excuse me, who don't get a catheter within three  
13 months. And it is related to the other measures  
14 but it just is not a patient-friendly measure if  
15 you are talking about catheter months.

16 MS. O'ROURKE: Operator, could you  
17 open Joel Andress' line if he is on the phone.

18 OPERATOR: He has not joined at the  
19 moment.

20 MS. O'ROURKE: If you are from the  
21 developer, could you let the operator know if she  
22 should open your line.



1 OPERATOR: And if you need your line  
2 open, just press star 1.

3 MEMBER BAKER: That's okay. And I am  
4 supporting it but I just don't think it is the  
5 optimal measure.

6 CO-CHAIR PINCUS: And I assume we will  
7 have maybe some time during the course of the  
8 meeting, we will be able to get some feedback  
9 about this and to resolve this. Okay?

10 Okay, so the next measure that has  
11 been pulled is 16-305. David.

12 MEMBER BAKER: So this, again, I don't  
13 understand why the move away from this  
14 intermediate outcome of the proportion of time in  
15 the target hemoglobin range. I mean this was set  
16 up as a refine and resubmit. And one of the  
17 things I said in my comments when I sent in this  
18 is I don't know how much time we want to spend on  
19 the refine and resubmit. But the concerns that  
20 were identified in the rationale statement and  
21 the description, I think they are very unlikely  
22 to change. And I just didn't see why the

1 developers should continue to work on something  
2 when the concerns that were raised I don't think  
3 are going to go away.

4 So I would like to save people time.

5 Yes, the workgroup discussed the  
6 variability and blood transfusion coding  
7 practices. I think it was mentioned earlier that  
8 people tend to get blood transfusions in  
9 different places and that is just not going to  
10 change. I mean it is just conceptually flawed.

11 I guess this is sort of an interesting  
12 issue in terms of how we address the kind of  
13 refine and resubmit concept in terms of is the  
14 problem with the measure or with the measure  
15 concept so that could this -- is it possible that  
16 this measure concept could be addressed in a  
17 different way?

18 MEMBER BAKER: The problem is, it is  
19 also the operationalization of the measure. I  
20 mean if we all had access to all data and you  
21 could say all transfusions in all locations, then  
22 yes. But if this is something that is really for

1       accountability purposes, depending upon the  
2       system of care and how they are delivering their  
3       care, you are going to get different outcomes in  
4       terms of the transfusion rates because you don't  
5       have access to all the information on where all  
6       these transfusions were received.

7               CO-CHAIR PINCUS:   So what you are  
8       arguing is that it is a waste of time, that you  
9       are not going to be able to solve that problem.

10              MEMBER BAKER:   Right you are not going  
11       to be able to solve that problem and there is  
12       another alternative that has been used in the  
13       past, which is the proportion of time that people  
14       are within their target hemoglobin range.   I mean  
15       we all talk about the importance of outcomes as  
16       an intermediate outcome but it is better than  
17       just this process of the transfusion rate.

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

20              MR. AMIN:   I was just clarifying what  
21       is the recommendation, David, is this do not  
22       support?

1                   MEMBER BAKER: Yes, that would be  
2 mine.

3                   CO-CHAIR PINCUS: Is there others that  
4 would like to comment on this?

5                   MS. O'ROURKE: I just want to make  
6 sure do we have anyone from the developer on the  
7 line or if Joel --

8                   I think to some of David's points,  
9 this was one that the Hospital Workgroup  
10 struggled with for a while, really over -- it is  
11 an endorsed measure and claims are that the data  
12 source so some felt it could be feasible and  
13 possible to calculate, but others were concerned,  
14 as you were saying, that a lot of these  
15 transfusions are performed outside of the  
16 dialysis facility and the control that the  
17 facility would have about when their patients  
18 were receiving transfusion.

19                   Others really stress that receiving  
20 the blood transfusion is a pretty negative  
21 consequence for the patient and it is an  
22 important outcome to address. So that is where

1 the workgroup really struggled. Ron, I don't  
2 know if you also wanted to chime in with the  
3 other. There was a quite a discussion on this  
4 measure.

5 WORKGROUP CO-CHAIR WALTERS: We were  
6 very practical. We didn't go into the bigger  
7 question you just raised as to whether it ever is  
8 achievable in that rationale. So I mean it was  
9 very practical about the measurement.

10 MEMBER BAKER: And that is fine. As  
11 long as there are people who think that it is  
12 potentially feasible. I don't but I don't think  
13 that we need to necessarily revote on this but it  
14 is a concern. And I think that is something for  
15 us to just be thinking about. It is always hard  
16 to just pull that string and say we don't support  
17 this measure. It is just not worth continuing to  
18 work on. But I think that is an important task  
19 for us to do. It so much effort to develop these  
20 measures and sometimes we just need to say it is  
21 just we are not going to get there in three  
22 years, we are not going to get there in five

1 years; this shouldn't go forward and we should  
2 look at other alternatives.

3 CO-CHAIR PINCUS: In a perfect world  
4 there might be an ability to do this but it  
5 doesn't look like we are there yet.

6 MEMBER BAKER: Right unless you are in  
7 a system and you are capturing all the care that  
8 somebody received in one database.

9 CO-CHAIR PINCUS: Okay so any further  
10 comments on this measure? It looks like we don't  
11 need to vote on it.

12 Oh, Rhonda. And then Kate.

13 MEMBER ANDERSON: I do want to support  
14 the concept that David is bringing forward  
15 because I think we have had these conversations  
16 before. And so if we could emphasize that in our  
17 comments I think that is important.

18 And also the second piece that Erin  
19 stated but I am no sure we really identified and  
20 that is that many of these transfusions are not  
21 in the dialysis centers and, therefore, it is  
22 very difficult for them to have this attributable

1 to them.

2 MS. O'ROURKE: We do now have Joel  
3 Address from CMS on the phone with some  
4 clarifying comments.

5 DR. GOODRICH: So actually, maybe if  
6 David, you could reiterate your question about  
7 the catheter measure and then again about the  
8 transfusion because Joel is our expert who could  
9 answer your question.

10 MEMBER BAKER: I would be happy to  
11 talk with him afterwards because I just want to  
12 be cognizant of time. I know we have got a lot  
13 of ground to cover and I don't think it is going  
14 to make a difference in the outcome.

15 MR. ANDRESS: Okay. Well, please let  
16 me know what questions you have and I will be  
17 happy to answer them.

18 MEMBER BAKER: Okay, great.

19 CO-CHAIR PINCUS: Kate, was there  
20 anything else you had about this measure?

21 DR. GOODRICH: The only thing I wanted  
22 to say just for context is there is a legislative

1 requirement to have an anemia management measure  
2 in the ESRD QIP program and this has proven to be  
3 a challenge.

4 We have now had three different  
5 measures in the program because the evidence  
6 around what is the right hemoglobin, what is the  
7 right outcome, has not been robust overall in  
8 this space, as I think we would like. So, I just  
9 wanted to offer that as context, not just for  
10 this measure specifically but the challenges  
11 around measurement in this arena overall.

12 DR. LOTZ: This is Doris Lotz.

13 CO-CHAIR PINCUS: Yes?

14 DR. LOTZ: Someone made a comment  
15 about a target in hemoglobin range. I am not  
16 that familiar with the measure set. I am not  
17 seeing it in front of me.

18 When the workgroup looked at all the  
19 measures in total, was there any comment about  
20 that made? It does seem like they are both  
21 tapping into the same concept.

22 WORKGROUP CO-CHAIR WALTERS: Actually



1 it was mentioned that different groups could  
2 apply different criteria for blood transfusions  
3 but that is as far as it went.

4 CO-CHAIR PINCUS: Other comments.

5 Okay so we are not going to be voting  
6 on this. We can move ahead to the next measure  
7 that was pulled. That is MUC16-305 standardized  
8 transfusion ratio.

9 Excuse me. So that is not -- so we  
10 are moving on to the next program, actually.  
11 Okay. So the next program is the Hospital  
12 Inpatient Quality Reporting, the IQR.

13 MS. O'ROURKE: Yes, so I can reiterate  
14 the ones that have been pulled so far. They are  
15 MUC16-180, Alcohol and Other Drug Use Disorder  
16 Treatment Provided or Offered at Discharge and  
17 Alcohol and Other Drug Use Disorder Treatment  
18 Disorder Treatment at Discharge. The workgroup  
19 recommendation was do not support.

20 We pulled MUC16-178, Alcohol Use Brief  
21 Intervention Provided or Offered and Alcohol Use  
22 Brief Intervention. The workgroup's

1 recommendation was do not support.

2 MUC16-263 has been pulled,  
3 Communication about Pain During Hospital Stay.  
4 The workgroup's recommendation was refine and  
5 resubmit prior to rulemaking.

6 MUC16-294, Completion of a  
7 Malnutrition Screening within 24 Hours of  
8 Admission has been pulled. The workgroup's  
9 recommendation was refine and resubmit prior to  
10 rulemaking.

11 MUC16-296 has been pulled, Completion  
12 of a Nutrition Assessment for Patients Identified  
13 as At-Risk for Malnutrition within 24 Hours of a  
14 Malnutrition Screening. The workgroup's  
15 recommendation was conditional support for  
16 rulemaking.

17 And the final IQR measure pulled is  
18 MUC16-262, Measure of Quality of Informed Consent  
19 Documents for Hospital-Performed Elective  
20 Procedures. The workgroup's recommendation was  
21 refine and resubmit prior to rulemaking.

22 CO-CHAIR PINCUS: Okay so let's go

1 back to 16-180, Alcohol and Other Drug Use  
2 Disorder Treatment Provided or Offered at  
3 Discharge and Alcohol and Other Drug Use Disorder  
4 Treatment Disorder Treatment at Discharge.

5 David?

6 MEMBER BAKER: I would just like to  
7 make a plea for a revise and resubmit for this.  
8 You know we are in the midst of an opioid  
9 epidemic. And the idea that we are not going to  
10 hold providers responsible at all for  
11 coordination of care at discharge I think is  
12 really problematic.

13 The rationale that they said in this  
14 is there is no evidence that handing somebody a  
15 prescription increases their -- that they  
16 actually go to their follow-up and that is, of  
17 course, true. But that is not the state of the  
18 art. I mean they should be coordinating care.  
19 They should be able to have these referral  
20 networks set up.

21 SAHMSA now has a website that you can  
22 easily search and identify opioid treatment

1 centers in your community. So, it is just  
2 something -- maybe what I am doing, really, is  
3 saying this is an important gap that we really  
4 need to be able to address.

5 CO-CHAIR PINCUS: So it sounds like  
6 what you are saying is that the concept is needed  
7 and it needs to be better operationalized.

8 MEMBER BAKER: Right. I mean they are  
9 citing literature that I don't think is the state  
10 of the art. And I understand, there may not be  
11 good evidence on this right now but we know that  
12 there are best practices out there for this. We  
13 know that there are hospitals that have set up  
14 relationships with treatment programs and they  
15 get informed consent for contacting them and  
16 actually arranging follow-up, sometimes actually  
17 putting the follow-up on the organization. We  
18 have talked about this at the Joint Commission as  
19 a possible standard. We haven't gone there  
20 because we know there is such a dearth of these  
21 treatment programs around the country that we  
22 can't hold organizations for setting up those

1 appointments but it is just such an important gap  
2 area.

3 DR. ANTONELLI: So I have for  
4 discussion here Rich, Rhonda, Leah, and Giff.

5 MEMBER BINDER: So I agree with David  
6 but I have got a question operationally. David,  
7 to the degree that you are suggesting a refine  
8 and resubmit, it seems like a pretty substantial  
9 pivot from the way this measure is. So I wonder  
10 what the difference between do not support but  
11 with those very precise comments because I think  
12 the intervention actually has more to do with  
13 integration across specialties, across the  
14 community, et cetera. I think that piece is spot  
15 on.

16 But I am not sure that the measure  
17 developer will say oh, I will just tweak this  
18 measure spec and that makes it a resubmit. I  
19 would actually attend the land of the do not  
20 support but proffer that very constructive  
21 evidence-based language.

22 MEMBER ANDERSON: I should be sitting

1 next to Richard because it is the same comment.  
2 But I think all of us agree that there is real  
3 issues here. That is not the issue. The issue  
4 is really about what is appropriate for outcome  
5 measurement. And I think if we could follow-up  
6 on what Richard has said and not support but  
7 really send back the idea that this is an issue  
8 and it needs to be looked at as to how care  
9 coordination can occur and what measures are  
10 appropriate for that.

11 CO-CHAIR PINCUS: Leah.

12 MEMBER BINDER: I actually agree that  
13 we should -- that the importance of this issue is  
14 so critical that we should put this as a high  
15 priority and look at this measure. I would  
16 prefer that this be resubmitted as a result,  
17 simply because the issue is so critically  
18 important.

19 This is probably somewhat out of order  
20 but I had added one measure in the IQR program  
21 for reconsideration that was also for the exact  
22 same reason was the opioid measure. It is on my

1 list.

2 MS. O'ROURKE: Was it the Safe Use of  
3 Opioids -- Concurrent Prescribing?

4 MEMBER BINDER: Yes, 167. I had asked  
5 for that one to be pulled as well.

6 CO-CHAIR PINCUS: Yes, we are going to  
7 get to that.

8 Giff and then Amir, and then I have a  
9 comment.

10 MEMBER GIFFORD: I am struck, though,  
11 this is an NQF -- I am going to be a little  
12 purest here. I am taking the opposite side from  
13 before. This is an NQF-endorsed measure. So it  
14 has gone through all the process. And it looks  
15 like we are trying to go through an endorsement  
16 process here where it has already been endorsed.  
17 I guess the real question in my mind for whether  
18 this is -- is it ready for rulemaking in the IQR  
19 or EHR Incentive Program.

20 So I mean to not support it on what  
21 seems to be the basis of it is not a valid  
22 measure, then we are usurping and saying that the

1 NQF endorsement process is wrong. Now, clearly,  
2 it was a close vote. It was 11 to 9 for  
3 endorsement but it has gone through endorsement.  
4 And so I don't think we should be turning this  
5 down saying it is not a valid measure because  
6 then we are on the flip side of the argument I  
7 said before. We are again exceeding our  
8 authority for the MAP.

9 I would be curious as to what people  
10 would say about how it is used because I don't  
11 know the IQR for the EHR incentive program well  
12 enough to know what I would vote. But I would  
13 certainly agree that this should be voted higher  
14 than do not support but for different rationale  
15 than what has been made around the table.

16 Then I would throw the only other  
17 caveat is that any of these measures like this I  
18 am -- CMS, I would really look at detection bias  
19 issues with these measures. We have seen it a  
20 lot in other measures in our setting like this.

21 CO-CHAIR PINCUS: Just a point. I  
22 mean just because something is endorsed doesn't



1 mean that we should support it. We have  
2 different criteria than the endorsement criteria.

3 MEMBER GIFFORD: I completely agree  
4 with that. I'm just looking at the Hospital  
5 Committee. The reason they didn't support this  
6 was because they didn't think it was a valid  
7 measure. They didn't give an excuse saying we  
8 don't think we should support this because it  
9 doesn't fit IQR EHR incentive programs for the  
10 following reasons. They basically said, we don't  
11 think it is a good measure.

12 CO-CHAIR PINCUS: Well it may be that  
13 even when there is a period of time when a  
14 measure is endorsed and then more information  
15 comes out and it might not get re-endorsed. So I  
16 think that that is --

17 MEMBER GIFFORD: I agree that that is  
18 not what we had before us.

19 CO-CHAIR PINCUS: But also I think the  
20 other point is that really what we are saying is  
21 we are making sort of communication with CMS  
22 about some of the issues. And that may be more

1 important than what we give a specific rating.

2 MEMBER GIFFORD: Well I think this  
3 maybe then a lesson in our continuing improvement  
4 for further guidance to the subcommittees that if  
5 they are going to make these recommendations, if  
6 they don't think the measure is good and it is  
7 already NQF endorsed, they need to tell us why  
8 they think something new has come along to change  
9 that endorsement process. And number two, it  
10 would be more helpful if their comments for why  
11 it isn't ready for rulemaking -- I mean we went  
12 through and our votes are now about ready for  
13 rulemaking, not whether or not it is a good or  
14 bad measure and I want us to stay on that sort of  
15 process.

16 CO-CHAIR PINCUS: Yes, Kate.

17 DR. GOODRICH: Just for clarification  
18 for the committee, the IQR program is a Pay-for-  
19 Reporting Program. It is not a Value-Based  
20 Purchasing Program, although the measures that  
21 are reported through IQR are publicly reported on  
22 Hospital Compare, just people have the context

1 for that

2 CO-CHAIR PINCUS: Melissa.

3 MS. MARINELARENA: Hi, this is  
4 Melissa. I just wanted to also point out that  
5 this measure is in the inpatient psychiatric  
6 program. However, we did not have any results  
7 reported to us on it. So we don't know how it is  
8 actually performing.

9 CO-CHAIR PINCUS: Amir.

10 MEMBER QASEEM: So going back to what  
11 David was saying. I think I absolutely  
12 understand, David, where you are coming from.  
13 One of the questions I have is the treatment  
14 recommendations are really dependent on your  
15 insurance and patients' means and everything. It  
16 is not under entirely providers' control.

17 So I am not really sure if it is going  
18 to still lead to improvement and quality because  
19 it is not. Again, there is so much happening  
20 even if you have certain treatment  
21 recommendations.

22 So I would probably still fall under

1 the category of do not support. I was looking at  
2 the numerator/denominator exceptions in there.  
3 I'm not sure if it is ready for prime time,  
4 still, keeping that into account, unless you have  
5 a response for that.

6 MEMBER BAKER: As I said, I am not  
7 saying that it was ready for prime time as much  
8 as just this is such an important area, whether  
9 it is refine or resubmit or just identified as a  
10 gap. I just think it is important for this  
11 committee to pass that along, that this is such  
12 an important area that somehow we need to be  
13 encouraging organizations to work on it.

14 CO-CHAIR PINCUS: So let me just step  
15 out of the chair for a minute. I mean I strongly  
16 agree with David that this is a critically  
17 important area that we -- especially given the  
18 opioid epidemic but also just the overall sort of  
19 prevalence of substance abuse disorders and the  
20 limitations in both access and sort of having an  
21 infrastructure to provide better care.

22 But I am not sure that it is changing

1 to a revise and resubmit is the answer.

2 MEMBER BAKER: AS long as we are  
3 sending a message somehow. But this is not  
4 something that we should just drop.

5 CO-CHAIR PINCUS: Yes, just to send a  
6 message. This is something that is really  
7 important. And we need to find better and more  
8 clever ways of assessing this.

9 And so I -- Doris.

10 DR. LOTZ: Yes.

11 CO-CHAIR PINCUS: So, let me just  
12 finish. So my recommendation would be that I'm  
13 not sure that we need to vote on this but just to  
14 give a strong message.

15 MEMBER BAKER: I'm fine with that.

16 CO-CHAIR PINCUS: Okay, Doris.

17 DR. LOTZ: Yes, in New Hampshire, we  
18 try to play with applying this measure because it  
19 is out there, NQF-endorsed already, and found it  
20 is extremely difficult. So without wanting to  
21 repeat the other points, they are all very valid  
22 but from an operational, implementation level, I

1 don't think this is really capturing what it  
2 intends to capture.

3 CO-CHAIR PINCUS: Okay. So I am  
4 taking it that we don't need to revote on this  
5 but we are sending a strong message to CMS about  
6 this is an area that is very much in need of  
7 further development.

8 MEMBER GIFFORD: Hold on. It was  
9 pulled.

10 CO-CHAIR PINCUS: Right, David is  
11 withdrawing it.

12 MEMBER GIFFORD: Oh, David withdrew  
13 it. So I missed that.

14 MEMBER BAKER: As long as we are  
15 sending a message that this is a really important  
16 gap area, I mean everybody knows how important  
17 the issue is nationally.

18 MEMBER QASEEM: Just one comment,  
19 Harold, I want to make. Although it is a little  
20 bit tricky, it is a procedural issue. If you are  
21 saying revise and resubmit on the measures that  
22 we just discussed earlier, I think this one

1       qualifies more for revise and resubmit than the  
2       other one that we should not have supported, as  
3       David pointed out and this one should be switched  
4       to revise and resubmit because this can, I think,  
5       get fixed versus the measure that we earlier  
6       discussed.

7                   CO-CHAIR PINCUS:   So are you asking  
8       for a revote?

9                   MEMBER QASEEM:   We don't have to.  I  
10       don't want to waste time but you can see there is  
11       a discrepancy to a certain degree what message  
12       you were sending.

13                   CO-CHAIR PINCUS:   Yes, I think there  
14       is clearly -- and one of the things that we get  
15       to the end when we talk about process improvement  
16       of our process, I think we are going to probably  
17       want to look at how we better define the revise  
18       and resubmit versus the do not support.  It seems  
19       to me that that is something that we want to work  
20       on in the interim.

21                   Okay?

22                   So let's move on to the next pulled

1 measure.

2 DR. ANTONELLI: So Harold, this is too  
3 important and I apologize. If the message back  
4 is not just an affirmation of what the workgroup  
5 said, I think there was some valued commentary  
6 about that, so will that be included in addition  
7 just to the affirmation of what the workgroup  
8 says?

9 CO-CHAIR PINCUS: Yes.

10 DR. ANTONELLI: Okay, thank you.

11 MS. O'ROURKE: So the next one pulled  
12 was MUC16-178, Alcohol Use Brief Intervention  
13 Provided or Offered and Alcohol Use Brief  
14 Intervention. The workgroup recommendation was a  
15 do not support. David, I believe this was also  
16 your pull.

17 MEMBER BAKER: This was just question  
18 that, fortunately, Mary Barton is here for. They  
19 said that there was no evidence to support this  
20 but USPSTF has this as a B rating. So it just  
21 seemed contradictory. If that was the rationale  
22 -- well that was my question because I don't



1 think the USPSTF was specific to --

2 MEMBER BARTON: It may have to do with  
3 the setting but I would have to examine what  
4 their conversation was about. But the task force  
5 recommendation applies to primary care settings  
6 and the impact of that kind of counseling in a  
7 primary care environment. And I am unaware of  
8 whether there is equivalent evidence about the  
9 hospital setting, honestly.

10 MEMBER BAKER: Okay. So that was just  
11 purely for clarification because it did seem like  
12 it was contradictory.

13 CO-CHAIR PINCUS: Ron, was that the  
14 nature of the discussion?

15 WORKGROUP CO-CHAIR WALTERS: Yes and  
16 I think what we are getting into, we are going to  
17 continue a theme here of what the hospital --  
18 what impact hospitals have on a lot of subsequent  
19 care. There is going to be a theme running  
20 through a lot of these things and both of these  
21 came up in that discussion.

22 CO-CHAIR PINCUS: Right. That is

1 getting more complicated, especially as hospital,  
2 you know the length of stay for hospitals get  
3 shorter and shorter. What you can actually do  
4 during that time that is meaningful for what  
5 happens afterward beyond dealing with the sort of  
6 acute condition they were coming in with is going  
7 to be an issue.

8 CO-CHAIR KAHN: Well, the problem is  
9 there is going to be more demand for more things  
10 to be done to the patient -- I mean discussed  
11 with the patient over a shorter period of time.  
12 And somehow, that is going to have to -- and  
13 then and particularly with the readmissions, you  
14 don't want them to come back and have to talk to  
15 them more. So it is a real problem.

16 CO-CHAIR PINCUS: Okay so this one is  
17 not being pulled but just refer to the  
18 discussion. Okay.

19 Let's move to the next one.

20 MEMBER QASEEM: Although I was  
21 surprised that this was not a conditional  
22 support, without getting into the details of what

1 the discussions were in, that the time issue that  
2 you are bringing up, I mean that is an issue that  
3 comes up in individual practice all the time, as  
4 well we have 10 to 12 minutes to do it. So, even  
5 however brief is the time period in hospital  
6 stay, there is evidence that shows that brief  
7 interventions do lead to improvement in quality  
8 of this one. So I was really surprised that this  
9 one was not approved.

10 MEMBER BAKER: And it may be helpful  
11 to just expand out a little bit in the rationale  
12 statement to emphasize and maybe that was there  
13 and I missed it but just to emphasize that there  
14 is a lack of data for the hospital setting.  
15 Because like Amir says, there is a heck of a lot  
16 more time to counsel patients in the hospital  
17 than in our primary care facilities.

18 CO-CHAIR PINCUS: And actually there  
19 is some data but there is not as much.

20 Next.

21 MS. O'ROURKE: Sure, so the next  
22 measure pulled is MUC16-263, Communication about

1 Pain During the Hospital Stay. And this is one I  
2 did want to provide an update. We had a real-  
3 time update from the published specs on the MUC  
4 list. CMS is only moving forward with the first  
5 three questions. So they are: During this  
6 hospital stay did you have any pain? During this  
7 hospital stay how often did hospital staff talk  
8 with you about how much pain you had? And during  
9 this hospital stay how often did hospital staff  
10 talk with you about how to treat your pain?

11 And I believe Bill Lehrman is on from  
12 CMS to give an update about where CMS is going  
13 with this since the publication of the MUC list  
14 for the Coordinating Committee's information.

15 DR. LEHRMAN: Hi, thank you. This is  
16 Bill Lehrman with CMS. I am the Government Task  
17 Leader for the HCAHPS survey.

18 CO-CHAIR PINCUS: It's hard to hear  
19 you. Could you speak closer to the phone,  
20 louder?

21 DR. LEHRMAN: Is that better?

22 CO-CHAIR PINCUS: Yes.

1 DR. LEHRMAN: Okay. This is Bill  
2 Lehrman. I am the Government Task Leader for the  
3 HCAHPS Survey at CMS. As has been explained, we  
4 have the three items for communication about pain  
5 during the hospital stay that we are proposing to  
6 replace the current items in the HCAHPS survey.

7 We presented this to the MAP Committee  
8 back in December. The question was raised about  
9 the testing. At the time that the MUC List data  
10 was required, we had not completed the testing.  
11 So that was not in our package. We have since  
12 completed that testing and we have confidence in  
13 the reliability and validity of the new measures  
14 and how well they test in comparison to the rest  
15 of the survey and in comparison to the current  
16 measures which will be removed from the Value-  
17 Based Purchasing Program beginning in FY2018.

18 I'm not sure if there are specific  
19 comments you would like me to address.

20 CO-CHAIR PINCUS: Did you have  
21 specific comments?

22 MEMBER BAKER: My concern was HP4.

1 And since that is not going forward, I am fine.  
2 It was the idea that during this hospital stay  
3 did you get medicine for pain and the top box  
4 scoring would be always. So think about the  
5 question did you always get medicine for your  
6 pain. So that was the concern that I had.

7 CO-CHAIR PINCUS: Okay. Any other  
8 comments about this measure?

9 Okay, thanks for the clarification.

10 MEMBER GIFFORD: Just a broader point  
11 for maybe future things. This is a repeat of  
12 previous years where between the time something  
13 went on the MUC List and was reviewed by one of  
14 the workgroups and us, CMS has done additional  
15 testing. And yet to say to try to change --  
16 because they are ongoing testing and they are  
17 trying to do things quickly, what is the process?  
18 Because we don't have a chance to look at -- I  
19 mean I have no idea what the data is that CMS has  
20 just presented. We didn't get to see it. Is  
21 that really our role to go back through and look  
22 at the date between the time frame from when they

1       come or not? I just sort of ask that because my  
2       tendency is not to change the vote because I  
3       haven't seen the data and not that I don't trust  
4       what CMS is saying.

5               MS. O'ROURKE: It is an excellent  
6       point and we recognize this is a little bit of a  
7       moving target.

8               MEMBER GIFFORD: Yes.

9               MS. O'ROURKE: And we give you the  
10      information. The specs that you see in your  
11      discussion guide are what was published on the  
12      MUC List, since that was the final cleared  
13      document. But unfortunately, things have  
14      happened in the interim that affects the measure.  
15      So we do try to present those as much as we can  
16      but we know that does complicate your  
17      deliberations. I think that is something we  
18      would be interested in hearing about how we can  
19      present that to you in the most efficient manner  
20      and what you really need to support your decision  
21      making.

22              MEMBER GIFFORD: And my tendency is to

1 go with what is submitted, what was reviewed and  
2 CMS can use that in justification and rulemaking  
3 while they are ignoring us.

4 MS. MARINELARENA: Hi, this is Melissa  
5 again. I also want to clarify that from the  
6 Hospital Workgroup, when we did these  
7 recommendations, refine and resubmit was mostly  
8 recommend to measures that had not been through  
9 NQF endorsement. They were undergoing testing.  
10 Even if the testing was complete, the workgroup  
11 did discuss that they would rather have an NQF  
12 standing committee review that testing and  
13 determine that it was reliable and that it was  
14 valid, rather than there are some testing results  
15 for some of these measure but, again, they wanted  
16 to refer back to an NQF Standing Committee, to  
17 determine the reliability and the validity of the  
18 measures.

19 CO-CHAIR PINCUS: And the  
20 recommendation was revise and resubmit.

21 MS. MARINELARENA: Correct.

22 CO-CHAIR PINCUS: Yes. So, they are,



1 essentially, revising it.

2 So moving on to the next one.

3 MEMBER QASEEM: Before we move on to  
4 the next one, can I just make a brief comment  
5 about the alcohol use because there is another  
6 measure that is in there that was 178 that wasn't  
7 extracted but it is about the alcohol use  
8 screening. And I am not really getting and some  
9 of it might have been discussed. So essentially  
10 we are saying we should be screening but don't  
11 provide an intervention over there. And  
12 screening rationale is a checkbox measure again,  
13 typical checkbox measure, did you screen for  
14 alcohol use.

15 So as a clinician I want to find out  
16 okay this person needs help. And then I am going  
17 to say well, good luck. Which program is that?  
18 It is a measure MUC16-179. That is the very next  
19 measure, alcohol use screening.

20 So what I am trying to understand is  
21 that how can we say screen but don't provide  
22 intervention.

1                   WORKGROUP CO-CHAIR WALTERS: Can I  
2 answer that a second? Because that very  
3 statement was made in the workgroup, actually.  
4 And of course, from a medical practice  
5 perspective, you are going to do what is  
6 appropriate to be done.

7                   The point was from a major  
8 perspective, was there enough evidence to include  
9 it in the program. And so they did not disagree  
10 with what you just said. They looked at it from  
11 a little different slant.

12                  WORKGROUP CO-CHAIR TRAVIS: And this  
13 is Cristie. I will also add that we discuss the  
14 fact that while the patient is in the hospital,  
15 screening for alcohol use would be important to  
16 be sure to prevent alcohol withdrawal syndrome.  
17 So there was a quote, unquote, treatment  
18 perspective for during the hospital stay, not  
19 only thinking about post-discharge.

20                  CO-CHAIR PINCUS: So are you saying  
21 that you want to pull the measure?

22                  MEMBER QASEEM: I actually do. I do

1 think that we need to pull the 179 and then vote  
2 on it. Because just ask and screening for  
3 someone during a hospital stay and again if  
4 someone can have a convincing evidence for it,  
5 then I would be happy to support it. And just  
6 screening is not going to improve outcome in the  
7 hospital. I just don't see that happening. And  
8 I am not aware of evidence, unless I am missing  
9 something. Please let me know if there is some  
10 evidence to support that because just screening  
11 has never improved the clinical outcomes.

12 MEMBER BARTON: This is the alcohol  
13 withdrawal syndrome. So the workgroup said that  
14 the idea is for the very short-term that you  
15 screen for alcohol use in order to prevent  
16 alcohol withdrawal during the hospitalization.  
17 At least that is how I would interpret it.

18 MEMBER QASEEM: But that is not what  
19 the measure is. If you look at the measure  
20 description, the numerator and denominator, they  
21 are not just talking about specifically for that.

22 CO-CHAIR PINCUS: What you are saying

1 is that it doesn't say within the early period of  
2 the hospitalization.

3 MEMBER QASEEM: It's not.

4 MEMBER GIFFORD: What measure are we  
5 talking about?

6 CO-CHAIR PINCUS: Okay, just to  
7 clarify, we are talking about --

8 MEMBER GIFFORD: Did we move on to a  
9 new measure?

10 CO-CHAIR PINCUS: Yes.

11 MEMBER GIFFORD: We went back to an  
12 old measure?

13 CO-CHAIR PINCUS: No, I think what  
14 Amir has done, he has just explained it, is that  
15 he has pulled a new measure.

16 MEMBER GIFFORD: Okay but we haven't  
17 finished the other measure.

18 CO-CHAIR PINCUS: Yes, we did. We  
19 were just in the process of moving on to what  
20 would have been the next pulled measure.

21 MEMBER GIFFORD: Maybe can I just ask,  
22 because we have a lot of measure to go through

1 today, if we are pulling measures, having a  
2 discussion and making the same comments that are  
3 already embedded in the comments and we are not  
4 asking to change the vote, why are we pulling  
5 these measures?

6 We should be pulling the measures, I  
7 think, if we want to change the recommendation or  
8 we are okay with the recommendation but there is  
9 a new feedback we want to give CMS --

10 CO-CHAIR PINCUS: Right.

11 MEMBER GIFFORD: -- that is not  
12 included in the feedback that is going to them.  
13 Otherwise, we are just rehashing the same stuff  
14 over and over again.

15 CO-CHAIR PINCUS: Yes but I think Amir  
16 was adding new comments.

17 MEMBER GIFFORD: Okay, I am just  
18 commenting because we have now had like three or  
19 four pulled and we have not voted on them.

20 CO-CHAIR PINCUS: But that is  
21 permissible, if you want to add to the comments  
22 and I think that is what Amir was doing.

1 MS. MARINELARENA: So this is Melissa  
2 again. The Hospital Workgroup wanted to clarify  
3 that when they supported the screening measure it  
4 was to be able to capture patients and to prevent  
5 patients going into DTs. They were not  
6 supporting it as the first step before you did  
7 the brief intervention because they are presented  
8 as a group. So they were not supporting it for  
9 that reason.

10 MEMBER GIFFORD: Can I just ask are we  
11 pulling this for comment or pulling to comment  
12 and revote? It would just be helpful to follow  
13 the discussion.

14 CO-CHAIR PINCUS: Amir?

15 MEMBER QASEEM: I am pulling it for  
16 comment and revote.

17 MEMBER GIFFORD: And revote for what  
18 category? You want to change to what  
19 recommendation?

20 MEMBER QASEEM: Yes, to change the  
21 category. I think the measure will need to be  
22 changed after what I just heard Melissa just

1 mention.

2 MEMBER GIFFORD: It is currently  
3 recommended as --

4 CO-CHAIR PINCUS: If you would let  
5 Amir --

6 MEMBER GIFFORD: Yes, I just wanted to  
7 know what --

8 CO-CHAIR PINCUS: Let him fully  
9 explain himself, okay?

10 MEMBER QASEEM: So what I am asking is  
11 that we can revote based on what Mary and Melissa  
12 just described, that the point of this measure is  
13 to any toxic impact that might be happening  
14 immediately after admission because of alcohol  
15 withdrawal. And that needs to be clarified  
16 because that is not how the measure is written.

17 So it needs to be either changed into  
18 conditional support or revise and resubmit. I  
19 can live with whatever you guys, the chair  
20 recommend but it cannot be just support.

21 MEMBER GIFFORD: So what you are  
22 saying is that the measure specifications do not

1 specify that the measure be done early in the  
2 hospitalization, which would justify that  
3 rationale. That is what you are saying.

4 MEMBER QASEEM: Correct.

5 WORKGROUP CO-CHAIR WALTERS: They do.  
6 Cristie, isn't it 72 hours, 48 hours?

7 WORKGROUP CO-CHAIR TRAVIS: Yes, I  
8 think it is three days.

9 MEMBER QASEEM: And just if I can add,  
10 Harold, unless we can change the intervention  
11 measure, as well, that the first one -- and I  
12 know I am making it really complicated. Unless  
13 we can have an alcohol use brief intervention  
14 change, 178, which is right now do not support,  
15 then I can live with it.

16 My problem is there is an issue of you  
17 are just screening and not providing  
18 intervention.

19 CO-CHAIR PINCUS: So I am now  
20 confused.

21 MEMBER QASEEM: So what I am saying is  
22 that if you are going to leave 178 as do not



1 support, then this measure needs to change into  
2 revise and resubmit. If 178 can get changed to  
3 we support, or conditional support, or whatever  
4 we want to say, I can live with supporting this  
5 as well. Then at least it makes a little more  
6 sense.

7 CO-CHAIR PINCUS: So for purely  
8 procedure, so are you -- we have already pulled  
9 the previous measure, had a discussion about that  
10 and although we didn't vote, we did make a  
11 determination that we wanted to give a strong  
12 recommendation for trying to address that issue.

13 So you are asking now for pulling this  
14 measure in order to actually change the vote --

15 MEMBER QASEEM: Correct. This one  
16 needs to be revised and resubmitted or whatever  
17 the term is.

18 CO-CHAIR PINCUS: -- to revise and  
19 resubmit from the support.

20 MEMBER QASEEM: Correct.

21 CO-CHAIR PINCUS: Okay. And Doris has  
22 a comment on that. Are there other people that

1 want to comment specifically on the vote that we  
2 are going to make with regard to changing it from  
3 support to revise and resubmit.

4 So Doris is first and then other  
5 people can raise their cards.

6 DR. LOTZ: I think it is fine to  
7 support it for rulemaking. I don't think that in  
8 the application or in the practice that screening  
9 would be the end of the road. I think it is  
10 important to incrementally measure change and I  
11 think it is well articulated as is. And with  
12 respect to 178, as I mentioned before  
13 implementation issues, not conceptual issues. So  
14 I think this one is fine to go forward,  
15 understanding that something will follow. It  
16 won't be measured. And at this stage of the game  
17 that is okay, provided we encourage the first  
18 step, which is to do the screening.

19 Other comments.

20 MEMBER HIGGINS: I just want to  
21 clarify. So if we are saying this is revise and  
22 resubmit, what is the -- what are we -- I get

1 your point, I completely agree that if you have a  
2 screening measure it is important to have an  
3 intervention that follows that. But I am just  
4 trying to understand if we are going to vote --  
5 if we say revise and resubmit what do we want  
6 them to revise. So are we asking for a paired  
7 measure that has a screening component and the  
8 intervention component.

9 CO-CHAIR PINCUS: So I think, if I  
10 could speak to you, I think the revise and  
11 resubmit is to rethink this measure with regard  
12 to, number one, whether it should be paired with  
13 some sort of brief intervention and follow-up?

14 And number two, if it is justified on  
15 the basis of sort of toxic screen, that the time  
16 frame be changed.

17 MEMBER QASEEM: Correct.

18 MEMBER HIGGINS: All right. That's  
19 helpful. Thank you.

20 DR. BURSTIN: Just one quick  
21 reflection from the Hospital Workgroup and maybe  
22 Ron wants to weigh in on this as well but the

1 issue people raised about screening for the sake  
2 of looking for alcohol withdrawal was, I think,  
3 in response to concerns on other hospital members  
4 of the table of not wanting this measure moving  
5 forward.

6 So I think it is being a little bit  
7 conflated as it is the only reason to move this  
8 forward. I think there was a body of the people  
9 at the table who thought this measure had  
10 important medical applicability as well to assess  
11 the issue of withdrawal but it was really a back  
12 about the broader issue of the measure.

13 And again, I think this whole issue of  
14 screening versus screening and doing something  
15 about it is something that continuously comes up  
16 in all of our processes. And I think we have  
17 heard a lot from at least the endorsement side of  
18 a desire for measures that reflect screen and do  
19 something as opposed to screen alone.

20 CO-CHAIR PINCUS: So can I ask a  
21 question of Kate?

22 So given the discussion we have had

1 about both these measures and when you take this  
2 discussion back, how do you think you can respond  
3 to that? I mean would it make a difference if  
4 voted revise and resubmit on this one?

5 DR. GOODRICH: So this is the suite of  
6 measures because it was obviously put on the MUC  
7 List, is one of the ones that we are considering.  
8 I think that the conversation that we have been  
9 having -- and I was not at the Hospital Workgroup  
10 so I didn't hear that whole discussion, is very  
11 helpful to us to understand it.

12 I mean the committee should do  
13 whatever they feel is right in terms of the right  
14 thing for the committee to do in terms of  
15 revoting, whether you revote or not.

16 I think for us, generally, the  
17 discussion is what is really the most important  
18 thing in thinking about whether or not we hold  
19 off on proposing this or we propose it to seek  
20 further comment on it, acknowledging the  
21 limitations that have discussed in this group as  
22 another path forward. I'm not sure what we will

1 do.

2 But to me and, Pierre, weigh in if you  
3 feel otherwise or want to add, the discussion we  
4 have been having is what is most helpful for us  
5 actually.

6 CO-CHAIR PINCUS: So Amir, do you want  
7 to revote on this?

8 MEMBER QASEEM: Sure.

9 CO-CHAIR PINCUS: Okay. So is there  
10 any further discussion before we revote?

11 Okay. Was there a comment from the  
12 phone?

13 So this is a different thing.

14 MS. O'ROURKE: If you could give us  
15 one moment while he is queuing up the slide.

16 WORKGROUP CO-CHAIR WALTERS: If you  
17 think you have fun with those, wait until we get  
18 to malnutrition.

19 CO-CHAIR PINCUS: Yes, we are going to  
20 address that as a group, have a discussion about  
21 that as a group.

22 MS. OGUNGBEMI: So we are now voting

1 on MUC16-179, alcohol use screening. Your  
2 options are support, conditional support, refine  
3 and resubmit, and do not support. The  
4 corresponding numbers are 1, 2, 3, and 4. Voting  
5 is open.

6 MEMBER NOONE: Hello?

7 MS. IBARRA: Doris and Foster, we have  
8 received your votes.

9 MEMBER NOONE: Hello?

10 CO-CHAIR PINCUS: Yes?

11 MEMBER NOONE: How do we vote on the  
12 phone?

13 MS. IBARRA: Please use the chat  
14 feature to send your vote confidentially to NQF  
15 staff and we will record your vote.

16 MEMBER NOONE: NCS dot?

17 MS. IBARRA: You can provide your vote  
18 verbally, if you prefer or you can send an email  
19 to MAPcoordinatingcommittee@qualityforum.org and  
20 I will get your vote and record it that way as  
21 well.

22 MEMBER NOONE: May I do it verbally?

1 MS. IBARRA: Yes.

2 MEMBER NOONE: Support.

3 MS. IBARRA: Thank you.

4 Steve, we also received your vote.

5 And Brandon, we received your vote.

6 MS. OGUNGBEMI: The results are for  
7 MUC16-179 48 percent support, 10 percent  
8 condition support, 31 percent refine and  
9 resubmit, and 10 percent do not support.

10 We reached 60 percent consensus in the  
11 refine and resubmit category.

12 CO-CHAIR PINCUS: Rhonda, I was just  
13 trying to figure out the arithmetic.

14 Rhonda.

15 MEMBER ANDERSON: Just a comment to  
16 take back and that is that we have just spent  
17 quite a bit of time on all three of these. And  
18 it seems as though -- and it is hospital-based.  
19 So it seems as though, when the information goes  
20 back it would be helpful if we emphasized the  
21 fact what can be done in the hospital to deal  
22 with the alcohol and substance abuse issues and



1       what might be a composite that would be  
2       appropriate to use and/or is there another place  
3       for the attribution. So I just would ask that  
4       they think that through that way.

5                   CO-CHAIR PINCUS: I mean I am not  
6       going to comment on it now but I have a number of  
7       thoughts about how one might do that.

8                   Okay, let's go to malnutrition.

9                   WORKGROUP CO-CHAIR WALTERS: Could I  
10      make a request? Cristie has to go to another  
11      meeting at 12:00. Can she summarize the Hospital  
12      Workgroup for Malnutrition?

13                  CO-CHAIR PINCUS: We are going to deal  
14      with the malnutrition measure as a group and go  
15      into the revoting. Okay.

16                  WORKGROUP CO-CHAIR TRAVIS: Great.  
17      Thanks, Ron. In fact I think I need to leave  
18      early.

19                  CO-CHAIR PINCUS: Okay, speak a little  
20      bit louder into the phone.

21                  WORKGROUP CO-CHAIR TRAVIS: Okay.  
22      Actually I didn't know I was going to be called

1       upon to do that. So I don't have my notes in  
2       front of me.

3                   Can staff start in some way so that I  
4       can pull myself together here?

5                   WORKGROUP CO-CHAIR WALTERS: Well I  
6       can tell you we ended up with different things  
7       for every one of them.

8                   So putting them in order and we did  
9       talk about the process. You screen, you assess,  
10      you document, and then you plan, even though they  
11      are not necessarily listed in that order. And  
12      everybody agreed that it was very important to  
13      do. This is a population that can benefit from  
14      it.

15                  Screening got a refine and resubmit,  
16      basically due to evidence as reviewed by the  
17      standing committee. Assessment got a conditional  
18      support and with the conditional support based on  
19      NQF endorsement, documentation which was really  
20      another good discussion was a do not support  
21      again that evidenced doing the assessment counted  
22      but documenting it did not, based on the

1 evidence. And then the plan, nutrition care plan  
2 got a refine and resubmit, again, based on  
3 sending it for review of the evidence.

4 So I can only say that this was a very  
5 complicated discussion that probably lasted over  
6 to 60 to 90 minutes. You heard about the public  
7 comments earlier today and how to reconcile that,  
8 I think this is what our committee came up with.

9 Is there anything else the staff would  
10 like to add to that? And then I will turn it  
11 back to the chair.

12 Cristie?

13 WORKGROUP CO-CHAIR TRAVIS: Yes, this  
14 is Cristie and thank you, Ron. I have so many  
15 documents open, it was difficult to get the one I  
16 needed for this but thank you for that.

17 I would say that the other issue was  
18 that there was some discussion around encouraging  
19 the development of a composite with several of  
20 these nutrition measures put together in a  
21 composite. And there was also discussion about  
22 the fact that this is important. There is no

1 question about that for the information that we  
2 heard earlier in public comment but also that it  
3 needs to be balanced with the rest of the IQR  
4 set. And that was one of the reasons that a  
5 composite measure may also be something for  
6 consideration in the future.

7 CO-CHAIR PINCUS: Elisa, did you say  
8 that there is some update on the endorsement  
9 status?

10 MS. MUNTHALI: Yes, there is an update  
11 on the endorsement status for all three measures.  
12 The two that were pulled were not endorsed, as of  
13 last week. And I think one of them was  
14 conditionally supported and the other was refine  
15 and resubmit. And the other one that has  
16 remained on the calendar was also not endorsed.

17 CO-CHAIR PINCUS: So none of them were  
18 recommended for endorsement by the consensus  
19 development process.

20 MS. MUNTHALI: Actually, the CSAC  
21 endorsed or rendered their endorsement decisions  
22 last week. And so those measures go into

1 appeals. So the process is almost over.

2 CO-CHAIR PINCUS: So in terms of sort  
3 of our process, are we entertaining a motion to  
4 vote on all three or to -- David you were one of  
5 the people that pulled this but I was unclear  
6 whether this was for discussion or for revoting.

7 So is there any movement to make -- is  
8 there any motion to revote or add additional  
9 discussion on any of these three measures?

10 MS. MARINELARENA: Sorry, I can't  
11 revote. But just to clarify or just to bring us  
12 up to speed on the measures, the one that was  
13 refine and resubmit, that recommendation by the  
14 Hospital Workgroup, that one, again, failed  
15 endorsement. The one that was conditionally  
16 supported, which was MUC16-296, completion of a  
17 nutrition assessment, that was conditionally  
18 supported by the MAP Hospital Workgroup with the  
19 condition that the measure was NQF endorsed.

20 So as of last week, the measure did  
21 not receive endorsement so you could revote on  
22 that and change the condition because it did not

1 meet the Hospital Workgroup's conditions.

2 Other discussion on this measure  
3 because we probably should do a revote on the  
4 measure that was conditionally supported since  
5 the condition now is not available right now.

6 Rhonda.

7 MEMBER ANDERSON: This reminds me of  
8 the previous discussion in that a composite would  
9 probably work well and what is appropriate. This  
10 is, again, a very important area but how we can  
11 make certain that it links?

12 And I like the way you described how  
13 you thought as a group. But I think it is  
14 difficult to refine and submit. This one to me  
15 is something to not support and have the package  
16 go forward to look at the process that was  
17 identified, how it fits in a hospital setting and  
18 how an outcome can actually be achieved with  
19 whatever the new proposed measure would be.

20 CO-CHAIR PINCUS: So the only question  
21 here -- I mean unless there is any other comments  
22 is, I guess, there was revise and resubmit for

1 two of these measures and one of them was support  
2 with conditions but that condition is not going  
3 to be met in the near future. The question is,  
4 do we need to revote on this or is the message  
5 pretty clear, based on this?

6 Amir.

7 MEMBER QASEEM: I do think that we  
8 need to revote on this because I do think that it  
9 is sort of low-value measure. Because if you  
10 look at the measure they are talking about,  
11 everyone over the age 18, they are not talking  
12 about just ICU patients. They are not talking  
13 about the patients will benefit like urinary  
14 tract infection, pressure ulcers, the elderly  
15 population and all.

16 And I have really looked into these  
17 malnutrition measures. I am not going to bore  
18 into details but some of the references that were  
19 used, even from the references -- I have actually  
20 the codes that I -- because this was discussed in  
21 the Health Well-Being Committee as well. The  
22 nutrition support interventions recommended this

1 recommendation from one of the organizations. It  
2 says nutrition support intervention is  
3 recommended for patients identified by screening  
4 and assessment at the risk of malnutrition,  
5 malnourished through great -- that is C because  
6 they don't know if it really is going to improve  
7 any clinical outcomes.

8 CO-CHAIR PINCUS: And which measure  
9 are you referring to?

10 MEMBER QASEEM: The one that is up  
11 there.

12 Thank you.

13 CO-CHAIR PINCUS: Okay.

14 MEMBER QASEEM: So essentially, the  
15 bottom line is I do think that revise and  
16 resubmit is not the -- I agree with Ron. I think  
17 we need to send it back and say do not support  
18 for this one.

19 CO-CHAIR PINCUS: So any further  
20 discussion about this measure?

21 Okay, so everybody vote.

22 MS. OGUNGBEMI: We are now voting on



1 MUC16-296, completion of a nutrition assessment  
2 for patients identified as at-risk for  
3 malnutrition within 24 hours of the malnutrition  
4 screening.

5 Your options are 1, support; 2,  
6 conditional support; 3, refine and resubmit; 4,  
7 do not support. Voting is open.

8 MEMBER NOONE: On the phone, vote 3.

9 MS. IBARRA: Thank you.

10 Doris, we received your vote. And  
11 Brandon, we received your vote as well.

12 Foster, we received your vote. And  
13 Steve, we received your vote as well.

14 MS. OGUNGBEMI: So the results are 13  
15 percent support, 13 percent conditional support,  
16 40 percent refine and resubmit, and 33 percent do  
17 not support. We reached consensus. MAP reaches  
18 consensus at 60 percent or greater in the refine  
19 and resubmit category.

20 CO-CHAIR PINCUS: Bill.

21 MEMBER KRAMER: Just a quick comment  
22 on how reporting the results -- sorry to raise

1       this issue again. I understand that we use 60  
2       percent as an indicator of whether we have  
3       reached consensus or not but it does not  
4       represent consensus.

5               So I think it might be more accurate  
6       to simply say we have reached the 60 percent  
7       threshold, rather than implying that that  
8       represents consensus. We are voting. We are not  
9       achieving consensus.

10              CO-CHAIR PINCUS: Right. There is  
11       lots of different ways to define consensus.

12              MEMBER KRAMER: Right but it is not  
13       voting.

14              So can I just ask when report it out  
15       in the official notes that we are not saying that  
16       we reaching consensus, saying that we have  
17       reached a 60 percent threshold which I know we  
18       are using as a proxy for whether we should --  
19       anyway you understand. Thank you.

20              MS. IBARRA: That's appropriate.  
21       Thank you.

22              CO-CHAIR PINCUS: So we have been

1 going at this for quite a while without a break  
2 for biology, or for food, or for anything else  
3 but we are running behind.

4 I propose we take a 15-minute break to  
5 get lunch and then to come back and sort of have  
6 a semi-working lunch to begin the process of  
7 going through the last of these for the Hospital  
8 Workgroup. Okay?

9 (Whereupon, the above-entitled matter  
10 went off the record at 12:01 p.m. and resumed a

11 CO-CHAIR PINCUS: We are running a bit  
12 behind. Okay, Steve Brotman wanted to say  
13 something on the phone.

14 MEMBER BROTMAN: Can you hear me? I'm  
15 sorry.

16 CO-CHAIR PINCUS: A little bit louder.

17 MEMBER BROTMAN: Okay. Is this  
18 better?

19 CO-CHAIR PINCUS: No.

20 MEMBER BROTMAN: Can you hear me? Can  
21 you hear me?

22 CO-CHAIR PINCUS: Yes.

1 MEMBER BROTMAN: Okay, great.

2 Hi. This is Steve Brotman from  
3 AdvaMed. Thanks for recognizing me. I'm sorry  
4 I'm calling in today.

5 As it was mentioned previously, that  
6 the inputs to CMS may be as or more important  
7 than the actual vote, I just want to provide some  
8 different perspective on the discussion on how  
9 important the malnutrition measures are and their  
10 far-reaching implications for positively changing  
11 landscape in all care settings. So, just bear  
12 with me for a minute.

13 Although I have been a physician for  
14 over 30 years, and I have thought that I have  
15 dealt with issues in malnutrition and nutrition  
16 successfully on my own for all my patients, by  
17 recognizing the need for nutrients and  
18 supplements, and especially for elderly patients  
19 in the hospital. And it was only in the last  
20 several years that I was hit with some reality  
21 that there has to be a true culture change, a  
22 major shift, in the hospital and other care

1 settings to place some sort of true emphasis on  
2 not only identifying those that are malnourished  
3 or at risk of being malnourished, but also what  
4 exactly to do to address malnutrition in each  
5 care setting. Because, as you know, the  
6 fragility of the elderly, one small thing goes  
7 out of kilter, and all of a sudden, there is a  
8 cascade of unintended events.

9 So without that culture change in the  
10 hospitals and every setting, we are forced to see  
11 over and over again the repeating cycle of  
12 physicians and nurses that I see all the time in  
13 charge of patients' care. And they're all very  
14 complacent not to fully address malnutrition and  
15 nutrition needs heads-on. And this comes from my  
16 personal experience. So this is really what I  
17 wanted to say.

18 In the last several years, I have had  
19 the privilege of caring for my father in his late  
20 nineties. He has suffered broken hips in falls,  
21 went from hospital to hospital, facility to  
22 facility. Nutrition was rarely brought up in the

1 hospitals and other settings, and when it was, it  
2 was brought up mostly by me, myself, the  
3 physician son.

4 And when I did, the staff's eyes would  
5 always roll, and they would repeat the same  
6 phrase to me, almost, over and over again: all  
7 people in their nineties are malnourished. What  
8 should I expect? And after arguing, they  
9 eventually took the road of least resistance.  
10 They brought cans of Ensure supplements, great,  
11 great supplies into the room, but that was it.

12 You know, my dad had failing eyesight,  
13 limited mobility, typical of the elderly. So,  
14 these cans got delivered every day on a tray, got  
15 removed unopened, and put on the window sill.  
16 And I used to call it the wall of supplements.  
17 And when I went to see other patients in the  
18 rooms next door, lo and behold, they also had a  
19 wall of supplements on their window sill.

20 So, my dad eventually passed, and I  
21 thought I would never see the cause of death on a  
22 death certificate as I saw for him, but his cause

1 of death was failure to thrive due to  
2 malnutrition. And this is appalling because it  
3 is curable.

4 And so I have been on the Coordinating  
5 Committee since its inception over six years ago.  
6 All those years, we talked about the immediate  
7 need for overarching and cross-cutting measures  
8 that could shine a light on this issue and change  
9 the thinking and culture in the care setting.

10 And I believe that, regardless of our  
11 discussions, nothing could effect change more  
12 than these measures addressing malnutrition. We  
13 sit in groups. We split hairs over evidence and  
14 validity, and I am not demeaning the process at  
15 all. I think that's all great, has great merit.

16 But malnutrition measures are sorely  
17 needed for patients and their families. It is  
18 common sense. Importantly, they will save lives,  
19 as indicated by the evidence, some of which is  
20 new, and there is updated evidence which,  
21 unfortunately, did not get presented at the  
22 meeting today, which came after the workgroup,

1 but evidence is there. I think the measure  
2 developer is there as well. But that did not get  
3 presented.

4 And so the one thing that is clear is  
5 that addressing malnutrition has been  
6 demonstrated to improve outcomes for patients and  
7 help providers decrease costs. So I just wanted  
8 to put it in somewhat of a perspective from  
9 somebody else who has had maybe a different  
10 experience than others on the Coordinating  
11 Committee.

12 CO-CHAIR PINCUS: Okay. Well, thank  
13 you. So now we are going to move ahead to the  
14 next measure that was raised for further  
15 discussion. It was pulled for further  
16 discussion. And that is 16-262.

17 MS. O'ROURKE: So just to reorient  
18 everyone, we are still in the Inpatient Quality  
19 Reporting Program, and the next measure, as  
20 Harold said, is MUC16-262, Measure of Quality of  
21 Informed Consent Documents for Hospital-Performed  
22 Elective Procedures.



1 CO-CHAIR PINCUS: And, Leah, do you  
2 want to comment on that?

3 WORKGROUP CO-CHAIR WALTERS: Let me  
4 just give the thinking. Real briefly, the  
5 thinking on this one, there is a real burden to  
6 collecting this data. It is not all electronic  
7 format.

8 Secondly, I think everybody realizes  
9 this is very important. It is certainly a move  
10 in the right direction. But the workgroup felt  
11 that it hadn't been through any sort of testing.  
12 Lord knows what the reliability and validity of  
13 this particular measurement would be. So, it  
14 needs to go through the process, and that is why  
15 they suggested refine and resubmit.

16 CO-CHAIR PINCUS: Okay. Leah, David,  
17 do you want to add to that?

18 MEMBER BINDER: The comment that I  
19 wanted to make, and the reason I wanted it  
20 pulled, is that some of the justification for the  
21 Workgroup's disposition of this measure was that  
22 there was variation among states and regulations,

1 and that that variation made the measure very  
2 difficult and burdensome.

3 What concerned me about that comment  
4 is that I would see that as a reason for the  
5 measure. From the point of view of a patient, to  
6 be frank, as a non-clinician, I have always  
7 assumed that there is standardization of informed  
8 consent processes or forms already. And to find  
9 that, in fact, there is the opposite of that, and  
10 that it is actually of huge variation, is  
11 disturbing.

12 And given the emphasis on patient-  
13 reported outcomes and our emphasis on patient-  
14 centered care and the need to also ensure  
15 appropriateness of care as a major priority for  
16 this, for the MAP process, I thought that, while  
17 this is not an appropriateness outcome measure,  
18 it is certainly a proxy measure that can help us  
19 to make sure that, when procedures are undergone,  
20 that the patient has fully been informed.

21 In terms of the testing, I will say  
22 that I think the measure is elegant, is very

1 well-written, and it has components that I think  
2 are well-established in the literature. Whether  
3 they have been fully tested and vetted, I don't  
4 know, but I do think there is a major -- having  
5 not been aware of the fact that there was such  
6 variation to begin with, it raised a concern for  
7 me that this is another measure that should be  
8 pursued with some level of speed. So, I would  
9 urge, and I would like us to vote, hopefully, to  
10 move this up a notch, perhaps conditional, but to  
11 really move this along. I think it is critically  
12 important.

13 CO-CHAIR PINCUS: Okay. Kate?

14 DR. GOODRICH: I know we have our  
15 measure, I believe we have our measure developers  
16 on the phone.

17 This is a bit of a different measure.  
18 It is sort of a novel measure. We did elect to  
19 begin developing it because, I would say, over  
20 the years, through the MAP and other venues, we  
21 have heard from particularly the patient  
22 community, and informed consent is one of the

1       number one areas that they feel that there is  
2       significant measurement gaps.

3               I noted somewhere in the documentation  
4       there was concern this was a checkbox measure.  
5       It is not a checkbox measure. And so, I don't  
6       know if it would be helpful for the Committee to  
7       hear from our developer sort of how this measure  
8       works.

9               The other thing I would highlight is  
10       that this measure was developed very much in  
11       partnership with patients, actual patients. And  
12       so, that is just important for folks. And they  
13       are the ones who really helped to identify what  
14       are the most important components for patients  
15       for the informed consent.

16              So, given that this is such a, I  
17       think, different kind of measure, and not  
18       everybody here has had the benefit of hearing  
19       about it through the Hospital Workgroup  
20       Committee, I didn't know if it would be helpful  
21       to have our developers maybe quickly describe how  
22       the measure works. Would that work?

1 CO-CHAIR PINCUS: Sure.

2 DR. GOODRICH: Okay. Fair enough. We  
3 have folks from Yale on the phone.

4 DR. SUTER: Yes, this is Lisa Suter.  
5 Can you hear me?

6 DR. GOODRICH: Yes, Lisa. Thank you.

7 DR. SUTER: Thank you, Kate, and thank  
8 you all for the opportunity to revisit this  
9 measure.

10 I wanted to just mention one quick  
11 thing prior to describing the measure in greater  
12 length, about the testing and validity. So, this  
13 measure has been tested. The only thing that the  
14 NQF staff flagged for the MAP review in terms of  
15 its suitability and seeming readiness for NQF  
16 endorsement was that we did not have measure  
17 score reliability. That information was  
18 presented during the MAP through a public comment  
19 process, and that has shown high reliability. So  
20 from a testing standpoint, we fully expect that  
21 this, after review by the NQF staff, will meet  
22 criteria for endorsement.

1           There is not an endorsement project in  
2           the calendar year 2017 applicable to this  
3           measure. So, we do not anticipate that it will  
4           be in front of NQF prior to the 2017 MAP meeting.

5           So, the measure itself is an  
6           assessment of the quality of the informed consent  
7           documents. I have heard a lot about burden, and  
8           we have thought a lot with hospitals and measure  
9           methodologists about the burden of this measure.

10          Currently, the way it was developed  
11          was to have hospitals send us the documents. We  
12          envision this measure would be locally abstracted  
13          by hospitals. We have worked with 25 additional  
14          hospitals to do additional testing on this  
15          measure, supplementing the development sample.

16          That work has demonstrated not only  
17          good reliability and testing metrics, but also  
18          that we know that hospitals can abstract this  
19          data in about three to four minutes per document.  
20          So we are currently evaluating the number of  
21          documents that need to be assessed at a hospital  
22          to give a stable hospital score, but we

1 anticipate it will be well under 100 documents,  
2 which means that the overall burden for hospitals  
3 is fairly limited.

4           The measure itself is scored as a  
5 composite of aggregated all scores for the sample  
6 of informed consent documents that are rated  
7 using an abstraction tool. That abstraction tool  
8 is what takes three to four minutes to fill out,  
9 and it covers a description of the procedure, so  
10 not just the name, cholecystectomy, or whatever,  
11 but a description of it in lay terms; how the  
12 procedure will be performed, large incision,  
13 laparoscopic, small incision; why the procedure  
14 is being performed; any patient-oriented  
15 benefits. This is probably the single most  
16 absent piece of information on any informed  
17 consent documents. Procedure-specific risks,  
18 both a quantitative and a qualitative assessment  
19 of risk, and any alternatives to the procedure.

20           The last piece is the timing of the  
21 procedure. We heard extensively from patients  
22 and our Patient Working Group that one of the

1 largest problems with the informed consent  
2 process for measures that are performed  
3 electively is that patients do not have an  
4 opportunity to review information in a meaningful  
5 way. Oftentimes, people are signing these  
6 documents at the time of the procedure,  
7 oftentimes after anesthesia has started to be  
8 administered.

9           So this is probably the most  
10 disruptive aspect of this measure, but it was  
11 signaled from the patients as one of the most  
12 valuable things. And we are happy to work with  
13 hospitals to think about a way to incentivize  
14 patients getting information ahead of time, but  
15 not necessarily signing the document, and as  
16 well, thinking about things like other documents  
17 to support, you know, decision aids to support.

18           But right now, as it is scored, it is  
19 a very limited number of questions. It takes a  
20 very short period of time for a hospital to  
21 evaluate their own documents. And the  
22 preliminary information we have received from all



1 of the hospitals who participated is that this  
2 information has been incredibly valuable to them  
3 as care providers. And we know that it has been  
4 validated with a large group of patients who are  
5 very much strongly in favor of this measure.

6 Thank you.

7 CO-CHAIR PINCUS: Chip, you had a  
8 comment?

9 CO-CHAIR KAHN: Well, it is more a  
10 couple of questions. I mean, if I understand the  
11 measure, it basically is looking at the documents  
12 and what the documents say.

13 First, as part of a condition of  
14 participation, you have to have these processes,  
15 and you have to have these documents. So I guess  
16 I don't know whether this is the right place for  
17 this to be adjudicated. It seems to me that this  
18 part maybe is better adjudicated in conditions of  
19 participation because this is overlapping with  
20 that.

21 And second, it is the process that  
22 matters, not the documents, although the

1 documents -- so, the question is, will the  
2 documents drive the process? I mean, the  
3 question is, is the doctor, or whoever is doing  
4 the procedure, talking to the patient clearly,  
5 early enough, and providing information the  
6 patient needs either to make decisions or at  
7 least understand what is supposed to happen. And  
8 we are not measuring that. We are only measuring  
9 the hospital's documents that the physician will  
10 use, if I understand it, when they have this  
11 discussion with the patient.

12 So, maybe if the documents are not up  
13 to snuff, then, to me, then the conditions of  
14 participation aren't being met. I mean, I just  
15 wonder, first, whether we have a venue issue here  
16 and then, second, if we really want to get at the  
17 process, then we really need to get at what  
18 happens between the patient and the person who is  
19 responsible for informing the patient.

20 Because, from my own experience, I  
21 never looked at one of those documents. You  
22 know, I just listen to them, I mean when I have

1 had procedures, you know, and maybe I should --  
2 but I just listen to the physician who is  
3 describing it to me. And if it doesn't make  
4 sense, then I ask questions. Now some people  
5 probably don't.

6 But I don't think the document is  
7 going to answer the issue here. I guess your  
8 point would be, well, the document will change  
9 the culture. I don't think documents necessarily  
10 change culture, but that's my two cents.

11 DR. SUTER: So, as a measure  
12 developer, I completely acknowledge that we also  
13 would like to measure the process of informed  
14 consent. We acknowledge this measure does not  
15 measure the process. However, we heard  
16 repeatedly from patients that this is a bare-  
17 minimum requirement for the process not to be  
18 broken, to be able to -- I mean, we all listen  
19 and can take in the complex information that our  
20 physicians are giving us because we are able to  
21 do that.

22 But many people aren't. They need an

1 opportunity to have it on paper and to be able to  
2 look at it and review it with their family  
3 members and then be able to ask questions. Right  
4 now, that is not occurring in a way that  
5 satisfies a patient. It satisfies the legal  
6 requirements of saying that there are certain  
7 risks of doing procedures, but it doesn't  
8 actually give the information that they need for  
9 decision-making.

10 So, we see this as a first step. It  
11 in no way addresses the longer-term goal of  
12 improving that process, although, as the measure  
13 developer, we are not quite scientifically in an  
14 area where we can capture shared decision-making  
15 from a meaningful and valid scientific method.

16 CO-CHAIR KAHN: So I will just  
17 conclude by -- because I don't want to go on and  
18 on, and other people have got their signs up.

19 But it seems to me that, from a CMS  
20 standpoint, the question is, are the conditions  
21 of participation sufficient? Because I just  
22 wonder whether this is the right place for this

1 to happen. It seems to me in the conditioned  
2 participation, either you have consent forms that  
3 are sufficient, or they are not. And what I am  
4 hearing is that the consent forms from your  
5 research are frequently not sufficient. If that  
6 is the case, then where is the deficit? And I  
7 just wonder whether this is the right venue.  
8 That is all I am saying.

9 DR. GOODRICH: This is Kate.

10 I think that is a valid question. I  
11 don't know the details of what is in the CoPs  
12 around informed consent. I would suspect, I  
13 would expect, you know, that if you look at a  
14 representative sample of hospitals and surveyors  
15 go in -- and David, you may have to help me with  
16 this -- and look at their informed consent forms,  
17 they have the requisite information, albeit in a  
18 fairly legalese kind of way that is rather  
19 difficult to understand. So, they meet the  
20 condition of participation, but they remain  
21 relatively difficult for folks to understand. It  
22 is usually, you know, a page of like size 4 font,

1 right, of fairly difficult-to-understand  
2 information?

3 And that may still meet the CoP. So  
4 maybe we need to go back and revisit the CoPs.  
5 That may be true as well. But again, I think for  
6 all the reasons that Lisa articulated, we also  
7 think that measurement is a lever here to improve  
8 this area.

9 CO-CHAIR PINCUS: Okay. Other  
10 comments? So, I have David, Giff, and Leah, and  
11 Bruce.

12 DR. HUNT: This is David Hunt.

13 One question, can this process be  
14 automated? That is to say, can a hospital  
15 basically give, in a digital format, the sum  
16 total of all of their documents and have it in  
17 some machine-readable and have the abstraction  
18 tool do basically a machine-read of this? Or  
19 will that help lower the burden?

20 DR. SUTER: This is Lisa Suter.

21 We are looking into the opportunities  
22 to use electronic format documents and use either

1 natural language processing or electronic reading  
2 to do that. We are not in a situation right now  
3 to be able to accomplish that, and most  
4 hospitals, from our conversations with them, do  
5 not have electronic format informed consents  
6 integrated into their EMR yet.

7 CO-CHAIR PINCUS: Giff?

8 MEMBER GIFFORD: I always find it  
9 really difficult as a sort of clinician in  
10 pushing quality to talk about topics that are  
11 clearly really important for consumers and really  
12 necessary, and where we do a bad job in  
13 healthcare.

14 But that doesn't mean measures are the  
15 right thing for that, and the measure should do  
16 that. And I think there's a lot of problems with  
17 it. I would echo what Chip said. You know, is  
18 measurement of this the vehicle to improve this  
19 process? You have conditions of participation.  
20 You have JOIN out there. I mean, this reads very  
21 much like a standard of care.

22 And the other thing is, for informed

1 consent, and I'm a big believer of informed  
2 consent and really not a big believer of signed  
3 informed consent, and nowhere does it require  
4 signed informed consent, because we know signed  
5 informed consent doesn't make sense. And we have  
6 all heard the stories.

7 As a geriatrician, many of my patients  
8 are demented to beat the band, and they can  
9 barely sign an X, but everyone accepts that as  
10 informed consent when they go in. God forbid  
11 should they refuse to do something. Then, they  
12 suddenly question their cognitive status and say  
13 they are not following it. And then, they enlist  
14 the family to have them get something they say  
15 they don't want, just because they are demented.

16 And that highlights the point of  
17 informed consent is really, the definition of it  
18 is having the person who is undergoing the  
19 procedure understand the risks and benefits and  
20 be able to explain them. Nowhere in here do I  
21 see that coming out other than a checkbox list.

22 The other thing is that this is



1       supposed to help consumers understand and drive  
2       this. This, as best I can tell in the measure,  
3       each hospital will get a score between zero and  
4       20, or some average score across the different  
5       types of procedures they do. I don't even know  
6       how to interpret it.

7               I mean, I think that this is clearly  
8       a topic that we do a terrible job, needs to be  
9       improved. This measure, I don't see us improving  
10      it, and it reminds me very much back with HIPAA  
11      and the early days before HIPAA where we had to  
12      do advanced care planning, and we handed everyone  
13      the little brochure when they walked in the  
14      hospital, whether they had the right to do a DNR,  
15      and we checked the box. And everyone was happy,  
16      and we solved that problem.

17              And I think that this is a real  
18      problem with this the way this measure is. I  
19      think, to Chip's point, if CMS feels that this  
20      should be done differently, I don't think trying  
21      to get people to practice the measure specs is  
22      the way to change this. It could be done through

1 the conditions of participation. It could be  
2 done through other ways. And I think it would be  
3 much more meaningful to get information from  
4 family or consumers, did they really understand  
5 what's going on?

6 And if we really think that for  
7 certain procedures that we are doing a bad job,  
8 we have -- you know, why reinvent the wheel? --  
9 we have VIS statements that CDC has developed  
10 that are used in informed consent for vaccine,  
11 and translated into multiple languages, and  
12 everything else.

13 And so, if there are certain  
14 procedures that we really feel we need to have  
15 some informed consent, I don't see why there  
16 isn't an ability to develop them. So, I would  
17 argue very much to, frankly, not only refine and  
18 resubmit, I would say this is not ready for  
19 rulemaking and would vote such, but would  
20 strongly encourage CMS to continue and try to get  
21 something further, but use this scoring and  
22 checklist thing in a different vehicle to get

1       that done.

2                   CO-CHAIR PINCUS:   So we have now Leah  
3       and Bruce and Rhonda and Rich and Carol.

4                   I remind everybody the recommendation  
5       is revise and resubmit.   And so, please, if you  
6       have something additional to add specifically to  
7       the discussion, you know, let's try to get to it  
8       concisely, because we have a bunch more to go  
9       over.

10                  Leah?

11                  MEMBER BINDER:   Thank you.

12                  I want to make one more point about  
13       this.   I'll have to say this, with Chip sitting  
14       right here saying the opposite, but I think from  
15       my own experience working in a hospital, in a  
16       rural hospital network, we did struggle with a  
17       lot of documents like consent forms.

18                  To me, this would seem to be a real  
19       opportunity and an advantage for hospitals.   It  
20       gives them a set of standards.   It says this is  
21       what patients have said is useful.   It has been,  
22       it sounds like, well-tested by some excellent

1       measure developers. I think it would be useful,  
2       and I don't think -- starting with conditions of  
3       participation in Medicare, that is kind of a  
4       heavy-handed way of starting with this, with  
5       hospitals that have a hundred different consent  
6       documents, apparently, in one system. It seems  
7       to me that this is a way of helping hospitals  
8       reach a higher level of patient-centeredness over  
9       time and not hitting them with anvil when they  
10      are not there already.

11               And so, I do think this has some  
12      advantages for hospitals, but mostly, I think for  
13      patients this is just such a high priority. The  
14      issue that I hear most common from patients and  
15      from purchasers, that they hear, is that: I was  
16      on the gurney being wheeled into the surgery, and  
17      they asked me to sign the consent. So I really  
18      thought that that was actually a good element of  
19      this as well, that it looks at when the signature  
20      took place.

21               CO-CHAIR PINCUS: Bruce?

22               MEMBER HALL: Thank you.

1                   As the American College of Surgeons,  
2                   we are certainly one of the largest groups  
3                   playing in the realm of elective informed  
4                   consent. And we agree with all the comments that  
5                   this is a critical area to address. We are  
6                   thrilled that CMS and our colleagues at Yale have  
7                   begun to address it, and we certainly respect the  
8                   quality of work that has come out of that shop.  
9                   So we are thrilled that the work has begun.

10                  We, however, would feel that this  
11                  should come down a notch to do not support. And  
12                  I think it is a matter of whether we are talking  
13                  about rulemaking or whether we are talking about  
14                  ongoing development. We are fully in favor of  
15                  ongoing development.

16                  We think, as it stands, the measure  
17                  falls short on a number of areas. As a  
18                  professional organization, we have principles we  
19                  would love our members to embrace to be more  
20                  meaningful and more patient-centered in this  
21                  process of informed consent. And we feel that  
22                  the measure falls short on some of those.

1                   In particular, we feel there is an  
2                   important, an increasing role for explicit risk  
3                   calculation and decision-making aids, but also  
4                   that being really patient-centered in this area  
5                   requires us to focus on the relationship between  
6                   the consenting team performing the procedure and  
7                   the patient and family and their stakeholders.

8                   And we think the measure as it is  
9                   focuses a little more on the hospital functions  
10                  and less on the relationship, which is really the  
11                  meaningful and patient-centered part to us, or we  
12                  would like it to be increasingly so.

13                  We have submitted some other comments  
14                  which I think others have raised. And so I won't  
15                  be redundant. I would just say that, from our  
16                  perspective, for rulemaking, we would take this  
17                  down a notch to do not support, but in every  
18                  other aspect of development, we would kick it up  
19                  a notch and fully support its ongoing  
20                  development.

21                  Thank you.

22                  CO-CHAIR PINCUS: Rhonda?

1                   MEMBER ANDERSON: I won't reiterate  
2                   everybody's. I would just say I appreciate the  
3                   comments that Chip has made and others, and add  
4                   one thing.

5                   Should this be -- I would agree that  
6                   it should be do not support, but should it go to  
7                   PROs? Should it be a part of the PRO measure?  
8                   Helen identified the fact that measures are  
9                   important, and they are incentives, but where  
10                  does it really belong? If we are trying to get  
11                  the patient to understand, the process is good,  
12                  but what about really knowing whether they did  
13                  understand or not? So, I would just ask us to  
14                  consider that if we do vote it to do not support.

15                 CO-CHAIR PINCUS: Rich? And then,  
16                 Carol. And then, we are going to vote on do not  
17                 support.

18                 DR. ANTONELLI: That is probably  
19                 exactly what I was going to say. It seems like  
20                 this is ideally suited to be a patient-reported  
21                 measure, not this one.

22                 MEMBER SAKALA: So thanks to the

1 developer for further clarifying.

2 We have very well-documented issues  
3 with decision-making processes and definitely  
4 need a lot of great measures. As one that could  
5 potentially could have a broad applicability  
6 rather than a lot of specific measures, this one  
7 seems to offer a lot of potential from my point  
8 of view.

9 It takes a piece that is standard  
10 across our healthcare system, which is widely  
11 recognized to be really for the service  
12 providers, and it gives us an opportunity to make  
13 those pieces much more patient-oriented. And I  
14 think that that's a real opportunity right now in  
15 this area where we all understand we need to do  
16 better, and we are facing challenges around  
17 development of other approaches.

18 CO-CHAIR PINCUS: Okay. Shall we set  
19 this up to vote?

20 MS. OGUNGBEMI: We are now voting on  
21 MUC16-262, Measure of Quality of Informed Consent  
22 Documents for Hospital-Performed Elective



1 Procedures.

2 Your options are: 1, support; 2,  
3 conditional support; 3, refine and resubmit, and  
4 4, do not support.

5 Voting is open.

6 (Voting.)

7 MS. IBARRA: Steve, Foster, Brandon,  
8 and Doris, we received your votes. Barrett, we  
9 received your vote as well.

10 The results are 7 percent support, 4  
11 percent conditional support, 37 percent refine  
12 and resubmit, and 52 percent do not support. So  
13 we do not reach a threshold anywhere. But  
14 because of the voting procedures or because of  
15 the rules of voting, we will land at do not  
16 support at 52 percent.

17 CO-CHAIR PINCUS: Okay. So let's move  
18 on. So there were several different cancer --

19 MS. O'ROURKE: We have one more.

20 CO-CHAIR PINCUS: One more before  
21 that? Okay.

22 MS. O'ROURKE: The final measure that

1 has been pulled for IQR is MUC16-167, Safe Use of  
2 Opioids - Concurrent Prescribing.

3 CO-CHAIR PINCUS: Leah, did you have  
4 a comment?

5 MEMBER BINDER: Okay. This is an  
6 extremely high priority to purchasers who are in  
7 my constituency as well as the public. It is a  
8 front-page issue.

9 CO-CHAIR PINCUS: Get a little bit  
10 closer to the mic.

11 MEMBER BINDER: Sorry. It's a front-  
12 page issue. I don't need to repeat any of that.

13 This measure appears to have some  
14 potential. So, it is an opportunity to identify  
15 people who have more than one prescription for  
16 opioids at discharge.

17 There is some concern that there could  
18 be an unintended consequence because of benzos  
19 that potentially could be advantageous and also  
20 prescribed along with opioids. But it seems to  
21 me that we should at least consider resubmitting  
22 this measure, not simply voting it down, because

1       there are so few ways for us to measure this.

2               Policymakers across the country in  
3       statehouses as well as here in Washington are  
4       making a lot of policies around opioid use, and  
5       there is so little data that it seems to me that  
6       this should be very high priority to move this,  
7       to move something along that we can measure.

8               These folks that are being discharged  
9       from hospitals would appear to be perhaps most  
10      vulnerable, potentially already addicts or  
11      potentially at-risk for addiction. These are  
12      folks that can be at least identified. Those are  
13      people who are often very difficult to identify  
14      for purposes of data.

15              So I think there is some real  
16      potential in this measure, and I recognize that  
17      there are some clinical issues with the measure,  
18      but it seems to me that those could be addressed  
19      and that there ought to be some way to move this  
20      forward. And I was pleased to see that the MUC  
21      would put this on because I do think that there  
22      has to be more ways for us to identify people at

1 risk or already affected by the opioid epidemic,  
2 which, again, is such a high priority to the  
3 public.

4 So, I would like us to consider moving  
5 this from -- this was do not recommend. I would  
6 like to potentially move it into resubmit.

7 CO-CHAIR PINCUS: Is there a  
8 particular comment you have about how it would be  
9 revised?

10 MEMBER BINDER: I actually don't know,  
11 but it seems to me that it could be addressed.  
12 I'm not a clinician, but it seems to me that  
13 there ought to be ways to address the problem of  
14 the certain circumstances under which it is  
15 appropriate to have the dual prescription.

16 CO-CHAIR PINCUS: Further discussion?  
17 Bruce?

18 MEMBER HALL: I would add that the  
19 American College of Surgeons feels the same way,  
20 that based on the importance of this topic, that  
21 it shouldn't be removed entirely, but should be  
22 reworked. And we did submit in writing two

1 suggestions for revision based on exclusion and  
2 exception. So, I won't re-read them, but we have  
3 submitted some suggestions along those lines to  
4 revise.

5 CO-CHAIR PINCUS: Other comments  
6 before we re-vote?

7 (No response.)

8 Okay. Could we set up the voting  
9 procedures?

10 MS. OGUNGBEMI: We are now voting on  
11 MUC16-167, Safe Use of Opioids - Concurrent  
12 Prescribing.

13 Options are: 1, support; 2,  
14 conditional support; 3, refine and resubmit; 4,  
15 do not support.

16 Voting is open.

17 (Voting.)

18 MS. IBARRA: Brandon, Doris, Steve,  
19 and Foster, we have received your votes.  
20 Barrett, we still are looking for your vote. You  
21 can also provide it verbally.

22 MS. McQUESTON: And just to clarify,

1 it says on the slide it is for outpatient quality  
2 reporting, but this is for inclusion in the  
3 Inpatient Quality Reporting Program. This  
4 measure was also proposed for the Outpatient  
5 Quality Reporting Program.

6 MS. OGUNGBEMI: Results are 0 percent  
7 support, 4 percent conditional support, 62  
8 percent refine and resubmit, 35 percent do not  
9 support. We reach our 60 percent threshold at  
10 refine and resubmit at 62 percent.

11 CO-CHAIR PINCUS: Okay. So, actually,  
12 Erin just raised the issue, to avoid having to  
13 re-vote on this, shall we also apply this vote to  
14 the OQR, the Outpatient Quality Reporting, as  
15 well? Is there anybody dissenting from that?

16 (No response.)

17 Okay, good.

18 So now, what we have remaining are  
19 several different cancer-related measures that  
20 have been pulled, and more for discussion than  
21 anything else.

22 I don't know, David, do you want to

1 comment on those?

2 MEMBER BAKER: I would like to first  
3 talk about the hospice measures. So, first, if  
4 you look at 16-275, Proportion of Patients Who  
5 Died From Cancer Not Admitted to Hospice. And  
6 this is recommended for support.

7 The question for me is why there were  
8 no exclusions for patient refusal. That is  
9 important because there are still many patients  
10 and their families who are not willing to accept  
11 hospice. And equally importantly, that varies  
12 according to race, ethnicity, literacy level. So  
13 it could really create a bias in this measure.  
14 So I was curious to know why there weren't any  
15 exclusions for this. And if there is no good  
16 reason to not have exclusions, then we should be  
17 thinking, and perhaps voting, on conditional  
18 support after adding an exclusion for that.

19 CO-CHAIR PINCUS: Other comments on  
20 this? Do you have some thoughts about the  
21 rationale why there is no exclusions on this?

22 MR. AMIN: Let me check. Is any of

1 the staff on who might be able to comment on  
2 that?

3 CO-CHAIR PINCUS: And did this come  
4 up, by the way, Ron, in the Workgroup?

5 WORKGROUP CO-CHAIR WALTERS: Good  
6 point. The gap is so large actually that that  
7 population is not a major contributor to the gap  
8 that needs to be overcome.

9 And these hospitals, this is, again,  
10 a unique program just applicable to 11 hospitals.  
11 This has been through the End of Life Steering  
12 Committee, and they supported it, and the  
13 hospitals supported it. So I think we're very  
14 anxious, well, I should say, they're very anxious  
15 to get the measure up and running and reporting  
16 and then use it for performance improvement also,  
17 along the lines you just said.

18 But your points are valid. There are  
19 people who just choose not to, especially in  
20 exempt cancer hospitals. So this group of  
21 hospitals is willing to accept that as a  
22 limitation of the measure and move ahead anyway.



1 MS. SPINKS: And I'm sorry, this is  
2 Tracy Spinks. I'm on the phone on behalf of the  
3 ADCC. So, I don't know if now is an appropriate  
4 time for me to add a few additional comments to  
5 what Dr. Walters said.

6 But I would note that this is a  
7 claims-based measure. All of these measures are  
8 claims-based, in which case, we have to accept  
9 that there may be some level of precision that we  
10 won't be able to have in the measure. And so,  
11 again, as Dr. Walters said, you know, this paints  
12 such an important picture of what happens to  
13 patients at end of life and making sure that we  
14 are doing everything we can to give them the  
15 highest-quality death.

16 And it really gets to broader issues  
17 about are we delivering end of life care that  
18 aligns with patient preferences? But this is a  
19 really good starting point for us to look at and  
20 create that picture of what happens to our  
21 patients at end of life, which, then, as Dr.  
22 Walters said, we can, then, use for internal

1 performance improvement to see, well, what are we  
2 doing, and what do we need to be doing to ensure  
3 that our patients are appropriately referred to  
4 hospice and palliative care services in  
5 accordance with their preferences and needs?

6 MEMBER BAKER: Thanks. I didn't  
7 realize this was a claims-based measure. So the  
8 answer to my question is it is not possible.

9 So the second part was essentially  
10 dinging physicians if they don't admit a patient  
11 to hospice within three days of their death. And  
12 as was just said, it is incredibly important for  
13 us to be trying to get more patients into  
14 hospice. And to turn around and say, well, you  
15 tried, but you didn't do a good enough job. You  
16 didn't get them in. And I know the literature on  
17 the proportion of patients who die within three  
18 days of hospice, and it is clear we are too late.  
19 But it just seems like we are penalizing people  
20 at a point, as was just said, when there is still  
21 such a gap in the proportion who are even going  
22 into hospice.

1                   And I will tell you, as a clinician,  
2           I have had patients come in, one patient with  
3           stomach cancer who, you know, would have been  
4           dead in three months, but with current treatment,  
5           had a year of really good quality of life with  
6           chemotherapy and radiation therapy, and came in  
7           and had a CT scan with multiple brain  
8           metastasizes. I admitted him to hospice the next  
9           day, and he was dead two days later. And, you  
10          know, we see that.

11                   So it just seems like that is too  
12          punitive. So I would like us to have a  
13          discussion about whether people support this and  
14          whether it should be do not support.

15                   WORKGROUP CO-CHAIR WALTERS: So this  
16          is neither a pay-for-reporting nor a pay-for-  
17          performance measure.

18                   CO-CHAIR KAHN: But once it is on the  
19          path, I mean, the question is, if it is not the  
20          right thing to do, you are still putting it on a  
21          pathway. I understand what you are saying about  
22          where it would fall.

1                   And also, supposedly, those measures  
2                   are supposed to be meaningful in terms of people  
3                   making decisions because they are looking at  
4                   information. The question is, is this a  
5                   meaningful measure?

6                   WORKGROUP CO-CHAIR WALTERS: And I  
7                   think once we get the rates of referral to  
8                   hospice up, this would be a good measure, right?  
9                   I mean, if we had 80 percent of patients with  
10                  metastatic cancer admitted to hospice, but then,  
11                  the vast majority were admitted in the final days  
12                  of life, then you would say, okay, that is the  
13                  next step for us to be working on, is earlier.  
14                  But as was said before, there is still such a  
15                  huge gap just in the proportion of people who are  
16                  getting to hospice at all.

17                  CO-CHAIR PINCUS: David?

18                  DR. HUNT: Maybe this is a little bit  
19                  too picayune, but given that this is claims-  
20                  based, can we say patients who died from cancer  
21                  rather than patients who died with cancer?  
22                  Because we really don't have a cause of death

1 based on claims. And admittedly, if someone is  
2 stage 4 cancer --

3 CO-CHAIR PINCUS: Well, it depends how  
4 it's operationalized in the measure.

5 DR. HUNT: Yes, but patients with  
6 prostate cancer, say stage 1, how --

7 DR. BURSTIN: I think some of it is  
8 because they are PPS-exempt cancer hospitals, is  
9 what this is proposed for. So they are already  
10 there for that logical reason. It isn't proposed  
11 for a wider program. So presumably, they are  
12 there for cancer.

13 CO-CHAIR PINCUS: Giff?

14 MEMBER GIFFORD: By the way, Dave, you  
15 are not making anecdotal, using anecdotes to do  
16 policy? I wouldn't want to --

17 (Laughter.)

18 But how does your scenario of your  
19 patient not fit in the measure? I guess we are  
20 talking about 267, right?

21 MEMBER BAKER: I'm saying that we see  
22 a lot of people, especially now with the more

1 advanced treatments that we have, who are doing  
2 well, and then they have a rapid, rapid descent.  
3 And the idea that somebody did the wrong thing if  
4 they didn't refer somebody -- because that is  
5 what the measure says, if you didn't admit,  
6 right?

7 MEMBER GIFFORD: Within the last three  
8 days, yes.

9 MEMBER BAKER: Right. So you admit  
10 somebody to hospice, and it frequently takes a  
11 day to arrange that, sometimes a couple of days.  
12 And then, they die two days later. That you did  
13 the wrong thing, I think the message we should be  
14 sending across the country is you should be  
15 getting patients with advanced cancer into  
16 hospice therapy as early as possible, but not  
17 necessarily penalizing those, at this point in  
18 time, who are admitting patients late in the  
19 game, if you will.

20 MEMBER GIFFORD: So you are concerned  
21 because the measure itself shouldn't be 100  
22 percent or 0 percent? And this is the challenges

1 we are having in a lot of measures where there is  
2 no measure that is going to be perfect.

3 Because, I mean, I have the flip side  
4 of that, a number of my patients, or patients I  
5 consulted on, that just can't -- you know,  
6 they're thrown into the hospice at the last  
7 second, and they have been tortured for a while  
8 and should have been in hospice a lot sooner.  
9 And no one is really talking to them about it.

10 Or the fact that you can do treatment  
11 and hospice concomitantly now --

12 MEMBER BAKER: Right.

13 MEMBER GIFFORD: -- allows you to get  
14 them in there. I think there's still the belief  
15 that you're throwing in the towel. And I think  
16 we are really harming a lot of people.

17 So I would counter your anecdote with  
18 my anecdote. So I disagree with you on that.

19 (Laughter.)

20 CO-CHAIR PINCUS: Dueling anecdotes.

21 MEMBER GIFFORD: I've seen your  
22 anecdotes, too.

1 (Laughter.)

2 CO-CHAIR PINCUS: Further comments?

3 So on the phone?

4 Okay, Steve?

5 MEMBER WOJCIK: It seems, looking at  
6 all of these measures, and based on the comments  
7 that were made with the discussion, it seems like  
8 the more relevant measure might not be when they  
9 were admitted to the hospital, whether it was  
10 never or within three days of death, but the  
11 measure that we are going to be talking about  
12 next, but maybe that could be modified. The  
13 proportion of patients who died from cancer  
14 receiving chemotherapy or other forms of  
15 aggressive cancer within X days of death seems to  
16 probably be a better measure than if or when they  
17 were admitted to hospice, especially as I didn't  
18 know, but, obviously, there's a lot of advances  
19 in cancer treatment, especially with the  
20 specialty pharmaceuticals.

21 And if you can combine treatment with  
22 hospice, why are we focusing on where they were,



1     you know, if they were admitted and where they  
2     were? It is more what they received and how  
3     aggressive it was within X days of death. And I  
4     am not a clinician. I don't know whether it is  
5     supposed to be 14 days or some other set of days.  
6     But maybe that is the more relevant measure, and  
7     maybe these other measures should be recommended  
8     to be -- for refinement and resubmission rather  
9     than support, given all the discussion. And it  
10    seems like there is a lot going on in cancer care  
11    right now.

12                   CO-CHAIR PINCUS: Thank you.

13                   So David, do you want to re-vote on  
14    this?

15                   MEMBER BAKER: We could take the time  
16    to do that, but I don't think that there is any  
17    sentiment to change. So I'm fine.

18                   And the other concerns I had, because,  
19    again, these are claims-based measures, it is not  
20    applicable because it is really the issue about  
21    metastatic cancer versus all cancer. I mean,  
22    there still are patients who die in induction

1 chemotherapy, some of which are in the ICU. But  
2 there is not good coding for metastatic cancer in  
3 claims data.

4 So, thanks.

5 CO-CHAIR PINCUS: So we, I think, have  
6 completed going through all the pulled measures  
7 from the Hospital Workgroup. Anybody want to  
8 pull another one?

9 MS. O'ROURKE: Procedurally, I just  
10 want to make sure everyone is clear with where we  
11 are.

12 CO-CHAIR PINCUS: Yes.

13 MS. O'ROURKE: So, this would be the  
14 end of discussing -- let me pull up my list of  
15 programs -- the measures for the Ambulatory  
16 Surgery Center Quality Reporting Program, the  
17 End-Stage Renal Disease Quality Incentive  
18 Program. There were no measures under  
19 consideration for the HAC Reduction Program. We  
20 would have discussed all the measures for the  
21 Inpatient Quality Reporting Program, the  
22 Outpatient Quality Reporting Program. There were

1 no measures under consideration for the  
2 Readmissions Reduction Program, and we have  
3 discussed the measures for the Hospital Value-  
4 Based Purchasing Program. So, those are the  
5 consent calendars before you. And the Inpatient  
6 Psychiatric Facility Quality Reporting Program.

7 So I just want to make sure there are  
8 no additional measures people want to discuss for  
9 any of those programs.

10 CO-CHAIR PINCUS: Yes. So, we need to  
11 cast some official vote?

12 MS. O'ROURKE: If we could just maybe  
13 do a show of hands to make sure we have got --

14 CO-CHAIR PINCUS: Sixty percent.

15 MS. O'ROURKE: That people understand  
16 that the workgroups --

17 CO-CHAIR PINCUS: Yes.

18 MS. O'ROURKE: If you have not  
19 additionally discussed it, the workgroup's  
20 decision would stand. So I just want to make  
21 sure people are --

22 CO-CHAIR PINCUS: So, officially, and

1 by Robert's Rules of Order, you have to vote on  
2 the consent calendar.

3 CO-CHAIR KAHN: I can move it, I  
4 guess.

5 CO-CHAIR PINCUS: Okay.

6 MEMBER BARTON: Second.

7 CO-CHAIR PINCUS: And seconded.

8 All in favor?

9 (Chorus of ayes.)

10 Opposed?

11 Thank you.

12 So just less than a few minutes  
13 talking about gaps in hospitals.

14 Rhonda, do you want to say something  
15 about what the workgroup sort of came up with in  
16 terms of their thinking about gaps?

17 MEMBER ANDERSON: There are lots of  
18 gaps.

19 (Laughter.)

20 WORKGROUP CO-CHAIR WALTERS: There is  
21 a lot of development to be done in a lot of the  
22 programs, and certainly in this one, too. And we

1 have alluded to that a couple of times here.

2 Certainly, the care coordination  
3 between the hospital measures and other types of  
4 programs, we have alluded to in our discussion  
5 here and consideration of what the system is  
6 responsible for and what the hospital is  
7 responsible for. But regardless of that, how can  
8 they coordinate their actions better to get the  
9 care of the patient improved?

10 And then, also, I think we will  
11 continue to look at opportunities to trim down  
12 measures that have topped-out, trim down measures  
13 that aren't quite achieving what they are  
14 supposed to achieve, and look to the other  
15 programs for opportunities to bring into the  
16 hospital.

17 We just talked about one of them, and  
18 certainly cancer care is not unique to those 11  
19 cancer centers. There is an opportunity to  
20 discuss which of those might be appropriate for  
21 hospital inpatient care also, with all the  
22 caveats attached that were mentioned.

1 CO-CHAIR PINCUS: Are there other  
2 comments about gaps?

3 I think, Leah, you had mentioned, yes,  
4 about --

5 MEMBER BINDER: Yes. Would you like  
6 to address that? You were -- I'm sorry.

7 The biggest one that I have heard from  
8 talking to some folks is C-section rates or  
9 maternity in general, I would say. C-sections is  
10 the number one reason for hospitalization in the  
11 United States. So recognizing CMS may not always  
12 have that as a top priority, concern, it  
13 certainly is in the Medicaid program, which pays  
14 for half of the deliveries. So, it is a high  
15 priority from the point of view of purchasers.  
16 We pay the other half. But in general, I think  
17 maternity care is a major area that we should be  
18 looking mor

19 CO-CHAIR PINCUS: Other comments or  
20 suggestions around gaps?

21 (No response.)

22 I mean, beyond what we have so far, I

1 do think that we do need to revisit the substance  
2 abuse measures that we talked about earlier and  
3 think about some better solutions for that.

4 MEMBER BINDER: Yes. So, the other  
5 thing that I heard from a couple of folks is --  
6 and we say this a lot, but I guess it is worth  
7 saying it for the record -- that having more  
8 outcomes measures than we are reviewing today,  
9 and perhaps maybe it is time for us to pursue  
10 more nuanced outcomes than just mortality. So, I  
11 think there is some discontent that we are not  
12 looking at a group of measures that are as robust  
13 as we would hope at this stage in measurement  
14 science.

15 CO-CHAIR PINCUS: Just a comment, just  
16 stepping out of the Chair role, with regard to  
17 both the inpatient psychiatric hospitalization  
18 one and, also, for people that are not  
19 necessarily in inpatient settings. For people  
20 with severe mental illnesses to think about  
21 potential hospital-based measures that look at  
22 the physical comorbidity issues among those

1 people or the potential for their lack of access  
2 to preventive screening and preventive  
3 interventions may be something that is worth  
4 exploring in terms of an area of needed  
5 attention.

6 WORKGROUP CO-CHAIR WALTERS: I would  
7 really like to thank the Committee for having me  
8 here and for their very thoughtful input. It is  
9 a process, sometimes a laborious process, but,  
10 nonetheless, it is a very important process. And  
11 the day we don't go through what we went through  
12 this morning and into the afternoon is the day we  
13 all had better give up.

14 CO-CHAIR PINCUS: Well, thank you,  
15 Ron. We have really appreciated your input and  
16 your being here for this.

17 So now, we can move on to the next  
18 Workgroup report.

19 Oh, Giff?

20 MEMBER GIFFORD: No, just a quick gap.  
21 As a geriatrician, representing nursing homes  
22 assisted living, recognition of dementia in the



1 hospital setting. We are going to see that grow  
2 over time, and I think it is a very vulnerable  
3 population that deserves some special attention  
4 and is overlooked in a lot of the measures in the  
5 hospital setting.

6 CO-CHAIR KAHN: Okay. Now we turn to  
7 another public comment period, now on post-acute  
8 care/long-term care programs.

9 And I guess I ask if there is anyone  
10 on the phone who wants to comment before we get  
11 into a session on that.

12 Please limit your comments to the  
13 post-acute care/long-term care program  
14 recommendations. Limit comments to no more than  
15 two minutes, and make any comments on MUCs or  
16 opportunities to improve the current post-acute  
17 care/long-term care measure set at this time.

18 Actually, I should say, is anyone here  
19 that wants to comment?

20 (No response.)

21 Okay. There is no one in the room  
22 that wants to comment from the public gallery.

1 Is there anyone on the phone?

2 OPERATOR: At this time if you would  
3 like to make a public comment, please press star  
4 1.

5 CO-CHAIR KAHN: And I believe Kim is  
6 also looking at the chatbox.

7 (No response.)

8 Okay, going once, going twice. Anyone  
9 in the chat --

10 MR. HILLMAN: Hello.

11 CO-CHAIR KAHN: Oh, yes?

12 MR. HILLMAN: Hi. This is Troy  
13 Hillman from UDSMR.

14 CO-CHAIR KAHN: Okay.

15 MR. HILLMAN: Is it an opportunity for  
16 public comment?

17 CO-CHAIR KAHN: The floor is yours.

18 MR. HILLMAN: I appreciate it.

19 UDSMR appreciates the opportunity to  
20 have our written comments considered and to  
21 further comment on the pressure ulcer measures  
22 that are being considered by the Committee, and

1 the supporting memorandum that was supplied by  
2 CMS and RTI.

3 While we appreciate the CMS/RTI  
4 response to concerns that were raised during the  
5 PAC/LTC Workgroup, UDSMR would like to note the  
6 following concerns related to this memo:

7 First and foremost, the reliability  
8 and validity analysis and feedback appears to be  
9 based on three resources that have limited  
10 applicability to current inpatient rehab facility  
11 practice.

12 First and foremost, the MBS 3.0 data,  
13 which is collected from skilled nursing  
14 facilities, a discussion from a TEP that was  
15 convened in July 2016, prior to the  
16 implementation of new pressure ulcer items in  
17 October, and PAC-PRD data that was collected and  
18 reported on nearly 10 years ago. Furthermore,  
19 the inter-rater reliability data that is based  
20 upon what are considered equivalent or similar  
21 items, and not the actual items that are  
22 currently being collected for this measure.

1       Because of this, we continue to question the  
2       reliability and validity of the items being  
3       proposed for utilization for this measure.

4               Additional analyses in this memo were  
5       conducted on data from, again, equivalent items  
6       from October 2014 to March 2015, when the IRF-PAI  
7       version was 1.2, and that was in place asking  
8       questions in a different manner, and given  
9       different instructions via the IRF-PAI training  
10      manual. We are currently using IRF-PAI version  
11      1.4, which began assessment in October 2016,  
12      where these pressure ulcer items have been  
13      redefined and the training materials have been  
14      updated with new descriptions.

15             Additionally, later on in the  
16      memorandum, more recent data from October 2016  
17      forward, is utilized and notes that there are  
18      differences between the item sets that are being  
19      utilized, but goes on to recommend that the  
20      M0-300 series of questions which are proposed as  
21      part of this change are more accurate than the  
22      currently-utilized M0-800 items, indicating that

1 the current items are understanding the  
2 incidence.

3 However, review of data within the  
4 UDSMR database on Medicare cases discharged  
5 between October to December 2016 suggests that,  
6 of those cases that are currently identified  
7 utilizing the current items or the M0-800 items,  
8 nearly 114 patients, or 13 percent of those that  
9 are currently identified, would not be identified  
10 utilizing the new items.

11 So, while CMS and RTI are suggesting  
12 that the current items may be underreporting the  
13 measure, it is to be noted that the issue is  
14 present within the changed items as well. We  
15 would encourage the Coordinating Committee to  
16 reconsider the voting on the pressure ulcer  
17 measure for all post-acute care sites and not  
18 just inpatient rehab facilities, with a  
19 recommendation that a refine and resubmit  
20 designation or a do not support recommendation be  
21 provided.

22 We would further suggest that in the

1 feedback to CMS and RTI that they perform a more  
2 detailed medical record review to more accurately  
3 determine which item bank accurately records a  
4 new or worsened pressure ulcer.

5 UDSMR is also concerned that, by not  
6 following the measure selection criteria and  
7 associated decision categories to determine  
8 whether measures are fully developed and tested,  
9 that the NQF MAP process continues to allow CMS  
10 to implement unproven and untested quality  
11 measures that are negatively impacting providers  
12 through the burden of additional data collection  
13 or the publication of inaccurate or inconsistent  
14 values on quality comparison websites that are  
15 available currently to consumers.

16 Furthermore, while CMS staff continues  
17 to suggest during Workgroup deliberations that  
18 the IMPACT Act requires that they implement  
19 various quality measures by certain deadlines,  
20 they fail to acknowledge that the IMPACT Act also  
21 affords the Secretary of Health and Human  
22 Services the ability to suspend or remove

1 measures, especially in circumstances where the  
2 collection of data for a measure may produce  
3 unintended consequences.

4           Given that all post-acute care  
5 measures being considered within the PAC/LTC  
6 Workgroup deliberations have not been fully  
7 tested, CMS should delay the implementation of  
8 these measures until such a time as testing  
9 indicates whether or not providers may experience  
10 unintended consequences as a result of these  
11 measures.

12           We respectfully ask that the  
13 Coordinating Committee consider this and  
14 recognize that the measure selection criteria and  
15 decision categories would reject recommendations  
16 of support or conditional support for all the  
17 measures that have not been fully developed and  
18 tested for the specific quality programs they are  
19 to be considered for.

20           We further ask the Coordinating  
21 Committee recommend that the Secretary of Health  
22 and Human Services utilize the authority provided

1 in the IMPACT Act to suspend or remove measures  
2 that are not fully developed and/or tested until  
3 such a time as adequate development and testing  
4 has been completed and made available to all  
5 appropriate stakeholders.

6 Thank you very much for your time and  
7 consideration.

8 CO-CHAIR KAHN: Thanks.

9 Any other comments on the phone?

10 OPERATOR: Yes, you have a comment  
11 from the line of Caroline Sparks.

12 CO-CHAIR KAHN: Thank you.

13 Would you repeat your name and, then,  
14 give where you are from, and then, go ahead,  
15 Caroline?

16 DR. SPARKS: Okay. I am Caroline  
17 Sparks. However, I did not submit a comment. I  
18 apologize.

19 CO-CHAIR KAHN: No problem. Just  
20 proceed.

21 DR. SPARKS: I didn't have a question.

22 CO-CHAIR KAHN: Oh, oh, I'm sorry.



1 I'm sorry. I thought she didn't give written  
2 comment.

3 Okay. Anyone else on the phone?

4 (No response.)

5 Okay. I guess we can now go into the  
6 session.

7 PARTICIPANT: I'm sorry, I am a  
8 colleague of someone who I know is on the phone  
9 who is an expert in one of these areas. And I  
10 believe that they did have a comment. So, if you  
11 could just give it one more second for them to  
12 register and queue-in their notification of a  
13 comment?

14 CO-CHAIR KAHN: Yes. What is their  
15 name?

16 PARTICIPANT: Her name is Mary Ellen  
17 DeBardleben.

18 CO-CHAIR KAHN: Okay.

19 OPERATOR: Okay, and her line is now  
20 in queue, and I will open her line now.

21 MS. DeBARDELEBEN: Thank you.

22 CO-CHAIR KAHN: Mary Ellen?

1 MS. DeBARDELEBEN: Hello. Can you  
2 hear me?

3 CO-CHAIR KAHN: Yes. If you could say  
4 your name and where you're from?

5 MS. DeBARDELEBEN: Oh, yes.

6 CO-CHAIR KAHN: And then, proceed.

7 MS. DeBARDELEBEN: I'm not sure why my  
8 question didn't go through.

9 Good afternoon.

10 My name is Mary Ellen DeBardeleben,  
11 and I'm the Director of Quality for HealthSouth.

12 My comment relates to the IRF pressure  
13 ulcer measure 16-143 that proposes changing the  
14 measure from using M0-800 items to M0-300 items,  
15 which I will refer to as the existing and  
16 proposed measure from here on out.

17 I would like to thank CMS for the  
18 thoughtful response to the concerns raised by  
19 HealthSouth and other IRF stakeholders regarding  
20 the pressure ulcer measure change. It is obvious  
21 that significant work went into the creation of  
22 this memo, and I respect that time and effort.

1                   We do not believe that the analysis on  
2                   pages 3 through 12 using assessment items from  
3                   2014 and 2015, pulled from prior versions of the  
4                   IRF-PAI, is an appropriate proxy to the changes  
5                   we are discussing today, because the questions  
6                   were different and they were being asked in a  
7                   different way.

8                   We appreciate this analysis, but would  
9                   prefer to focus the Coordinating Committee's  
10                  attention to the analysis that compares the  
11                  specific components discussed here. This  
12                  analysis begins on page 12 of the 17 pages of the  
13                  CMS and RTI memo, and validates the comments from  
14                  the MAP PAC/LTCH meeting last month and public  
15                  comments submitted to CMS in November.

16                  CMS and RTI found that changing the  
17                  pressure ulcer measure from the existing to the  
18                  proposed results in a 33 percent increase in  
19                  pressure ulcers, which is a significant  
20                  difference. Also, while CMS and RTI suggest the  
21                  existing items underreport the incidence, our  
22                  analysis, which has found similar results to what

1 CMS and RTI have presented, show that over 100  
2 patients over the past three months, which are  
3 currently defined as having new or worsened  
4 pressure ulcers, would not be identified using  
5 the new items. So, the suggestion that the  
6 proposed items are more accurate than the  
7 existing items is not necessarily consistent  
8 across the population.

9 I would also like to note that the  
10 voluntary nature of the proposed items listed as  
11 one of the potential reasons for the discrepancy  
12 only applies to the unstageable pressure ulcer  
13 items which were specifically excluded from this  
14 analysis.

15 The CMS and RTI analysis confirms the  
16 significant discrepancy caused by modifying this  
17 measure and offers a few different possible  
18 explanations. However, without further testing  
19 at the measure level using current data, it is  
20 impossible to know if the new measure is accurate  
21 and valid, which is the cornerstone of the NQF  
22 MAP approval.

1           While consistency across providers is  
2     ideal, I would urge NQF MAP to not rush to any  
3     change to any measure with such a significant  
4     change to outcome and would encourage NQF MAP to  
5     vote do not support for measure 16-143.

6           Also, while HealthSouth presented  
7     industry data in lieu of company data in both our  
8     written and verbal comments, we are proud that  
9     the HealthSouth-specific data that CMS and RTI  
10    presented publicly shows that HealthSouth  
11    facilities have fewer new or worsened pressure  
12    ulcers compared to all other IRFs, regardless of  
13    the way the measure is calculated.

14           Thank you so much.

15           CO-CHAIR KAHN:   Okay.   Any other  
16    comments?   Okay.   Thank you for the --

17           OPERATOR:   You have a --

18           CO-CHAIR KAHN:   I'm sorry.

19           OPERATOR:   You have a comment from  
20    Lane Koenig.

21           CO-CHAIR KAHN:   Okay.   Proceed please.

22           DR. KOENIG:   Hi there.   Can you hear

1 me?

2 CO-CHAIR KAHN: Yes, we can.

3 DR. KOENIG: Great. Thank you.

4 My name is Lane Koenig. I represent  
5 the National Association of Long-Term Care  
6 Hospitals.

7 I have a comment on the pressure ulcer  
8 measure, and I just want to reiterate the other  
9 commenters that came before me, that we agree  
10 with many of the comments that were said. And  
11 so, I am not going to rehash some of the things  
12 that have been said.

13 I want to raise one concern that we  
14 have. Others have raised concerns regarding the  
15 switch from the 800 series to the 300 series for  
16 measuring pressure ulcers, particularly from our  
17 perspective on the LTCH care tool. And our  
18 concern is really about the way, the inclusion of  
19 the unstageable wounds, the way it is calculated  
20 in score is that, if you have an unstageable  
21 wound, that, therefore, after treatment is  
22 revealed to be a stage 3, for example, that the

1 way the measure is currently scored, that would  
2 show a worsening of pressure ulcers because the  
3 unstageable pressure ulcer now became stage 3.  
4 And so it would indicate a new stage 3 wound.  
5 And so, we ask that the Committee sort of ask CMS  
6 to revise and correct the coding to deal with  
7 that issue.

8 Thank you.

9 CO-CHAIR KAHN: Okay. Thank you.

10 Any other comments?

11 (No response.)

12 Okay.

13 MR. TILLY: Great. Thank you.

14 I just want to check quickly, is Deb  
15 Saliba on the line? I know we are starting a  
16 little bit later than we planned.

17 WORKGROUP CO-CHAIR SALIBA: I'm on the  
18 line.

19 Jean-Luc is going to present, I think,  
20 for us today.

21 MR. TILLY: That's right, great.

22 Thanks, Deb.

1                   So, the MAP PAC/LTC Workgroup reviewed  
2                   22 measures under consideration for six federal  
3                   programs, the three measures for the IRF program,  
4                   the same three measures for the long-term care  
5                   Hospital Reporting Program, as well as the SNF  
6                   Quality Reporting Program. No measures for the  
7                   Skilled Nursing Facility Value-Based Purchasing  
8                   Program, although we did discuss the existing  
9                   measure set; five measures for the Home Health  
10                  Quality Reporting Program. So, those same three  
11                  for IRF, LTCH, and SNF as well as two others,  
12                  which I will go into in some detail later. And  
13                  eight measures for the Hospice Quality Reporting  
14                  Program.

15                  The overall themes for our meeting,  
16                  the first kind of predominant theme is the IMPACT  
17                  Act and the effect that that has had on measure  
18                  development in the PAC/LTC space. You know, by  
19                  encouraging the alignment of measures across  
20                  settings, we saw that many of the measures  
21                  submitted -- I just described many of the  
22                  measures submitted for this -- were the same



1 across several settings which is by design and  
2 which we hope will standardize measurement.

3 But that also means meeting fairly  
4 challenging deadlines. And so, in the case of a  
5 couple of measures, the measures were not fully  
6 developed before coming to the MAP, which led to  
7 a revise and resubmit recommendation. But I  
8 think the Workgroup strongly agreed that,  
9 overall, the measures submitted were making a  
10 really positive contribution to the program and  
11 were in line with the IMPACT Act recommendations.

12 The MAP Workgroup did highlight,  
13 however, that there were many opportunities to  
14 address quality improvement, so a continuing  
15 opportunity for improvement. And many of these  
16 same themes you saw reflected in the Hospital  
17 Workgroup just now, but, again, an emphasis on  
18 patient-reported outcomes and how key they are to  
19 understanding quality. And, of course, the  
20 presentation on the PROMIS tool was particularly  
21 exciting to the PAC/LTC Workgroup which really  
22 was enthused about the opportunity for

1       groundbreaking measurement there.

2               Other measures of importance, you  
3       know, particularly to patients, we heard  
4       discussion about nutrition measures, care  
5       preferences that extend beyond end-of-life care,  
6       but care preferences around procedural things  
7       such as turning, and finally, measures around  
8       medication management.

9               Finally, the Workgroup emphasized  
10       shared accountability across the care continuum.  
11       So, here where we saw measures of transfer of  
12       information at admission and discharge, that  
13       means that both facilities and hospitals outside  
14       of the PAC/LTC sphere are responsible for making  
15       some effort to either improve their health IT  
16       capacity or their processes of transfer of  
17       information to meet those measures.

18              And then, so we will move into a  
19       discussion of consideration for specific  
20       programs, starting with the Inpatient Rehab  
21       Facility Quality Reporting Program. So, here the  
22       specific new opportunities for measurement cited

1       were CAHPS, or their experience-of-care  
2       assessment.

3               The measures under consideration:  
4       first we have the new or worsened pressure ulcers  
5       measure which received a conditional support for  
6       rulemaking. That is the measure you heard  
7       discussed in the public comments just now.

8               And this recommendation of conditional  
9       support for rulemaking is different than the  
10      recommendation in the other settings, where it  
11      was given a support for rulemaking. Here in the  
12      IRF setting, there was, as you heard from  
13      HealthSouth, a particular concern about how the  
14      measure was being used in the IRF setting and  
15      some data that suggested that there were  
16      questions around the validity there. So, the  
17      condition with the support for rulemaking was  
18      that CMS evaluate the impact of the revised  
19      specifications specific to IRF patients.

20              Public comments we received were  
21      mixed. Some very much supported MAP's  
22      recommendation and others concurred with the MAP

1 that there was a need for possible reevaluation,  
2 even a return to NQF and the CDP for re-  
3 endorsement.

4 CMS submitted a memorandum during the  
5 public comment period to address those changes to  
6 the measure, and which included some findings  
7 from testing that they had done and a specific  
8 examination of HealthSouth's data and how that  
9 applies to the IRF setting.

10 So, the other two measures under  
11 consideration for the IRF QRP were a transfer-of-  
12 information measure at admission and at  
13 discharge. That is two measures there. They  
14 each received refine and resubmit. And the  
15 Committee really underlined that it would be  
16 important to refine the measure to include  
17 transfers between attending clinicians as well as  
18 simply between settings. They asked, of course,  
19 that testing be completed and it be submitted to  
20 NQF for endorsement.

21 And finally, our public comments were  
22 generally supportive of MAP's recommendations and

1 added that there are existing regulations that  
2 may make this measure somewhat duplicative.

3 So, in the SNF Quality Reporting  
4 Program, a lot of the same as in IRF, because,  
5 again, the same measures were submitted here in  
6 terms of opportunities for improvement. We have  
7 had a few other measures to address, the presence  
8 of advance directives and measures of nutrition.

9 For the new or worsened pressure  
10 ulcers measures, we received support for  
11 rulemaking, as I said. But I believe that  
12 measure has been pulled for a re-vote as well.  
13 In fact, I think every pressure ulcer measure has  
14 been pulled for re-vote.

15 And again, the transfer-of-information  
16 measures at admission/discharge received many of  
17 the same comments, in fact, really the exact  
18 same.

19 In the LTCH setting, a little bit  
20 different here. So, in addition to the same new  
21 opportunities for measurement, nutrition, and  
22 CAHPS measure, there were some suggestions around

1 refinement of existing measures already in the  
2 program. So there, where there are infection-  
3 specific measures that exist already that are  
4 addressing a specific infection such as C. diff,  
5 replacing that with a kind of general measure of  
6 infections, and, also, a reconsideration of the  
7 ventilator-associated event measure. There was  
8 some suggestion from the Workgroup that possibly  
9 that measure was no longer needed.

10 And then, finally, for the SNF program  
11 -- and, well, you're familiar with this by now.  
12 Pressure ulcers, support for rulemaking, transfer  
13 of information at admission/discharge, some of  
14 the same comments, transfers between clinicians,  
15 between settings.

16 So, finally, in the Home Health  
17 Quality Reporting Program, a little bit different  
18 there. So, here we had the same measures around  
19 pressure ulcers and transfer of admission, but,  
20 then, we also had a couple other measures.

21 So, here we had a measure, a  
22 functional assessment at admission and discharge

1 together with a care plan. That received a  
2 conditional support.

3 And here, the Workgroup really wanted  
4 the measure developer to resubmit the measure to  
5 NQF for endorsement in new setting. It is  
6 actually not endorsed in the home health setting,  
7 but, rather, only in the long-term care hospital  
8 setting, is my understanding.

9 And then, also, a falls with major  
10 injury measure, where the recommendation was  
11 basically the same. You know, submit to NQF for  
12 endorsement in the setting to which it is being  
13 applied.

14 And public comments generally concur  
15 with the MAP recommendation, although some  
16 suggested expanding the measure to include all  
17 falls and not just those with major injury.

18 So, in the Hospice Quality Reporting  
19 Program, there we had several new opportunities  
20 for measurement. So, medication management at  
21 the end of life, especially after death; the  
22 provision of bereavement services; patient care

1 preferences beyond end-of-life care, and then,  
2 symptom management measures. You know,  
3 currently, the Hospice QRP includes several  
4 symptom management measures around cancer, and  
5 the idea was that we could create other measures  
6 that would be related to other diseases, such as  
7 dementia or other typically end-of-life  
8 conditions.

9 And the idea of the Workgroup there  
10 around the existing measure set was to look  
11 closely at some of the process measures that were  
12 present in that set and to assess their  
13 relationship to actual outcome measures and  
14 patient satisfaction.

15 Eight measures were submitted for the  
16 Hospice Quality Reporting Program, all derived  
17 from the CAHPS Hospice Survey. So, getting  
18 emotional/spiritual support, getting help for  
19 symptoms, getting timely care, the overall rating  
20 of the hospice. They all received a support for  
21 rulemaking, and public comments here were  
22 basically universally supportive. These eight



1 measures actually recently received endorsement  
2 in the Palliative and End-of-Life Care Project.

3 And here, I think I will turn it over  
4 to Erin to talk about the duals.

5 MS. O'ROURKE: Sure. So, again, the  
6 Duals Workgroup convened to provide some cross-  
7 cutting input on the PAC/LTC recommendations. In  
8 particular, they support measures that capture  
9 the degree to which providers and the care they  
10 provide is integrated across settings. They  
11 encourage continued development of the role that  
12 social risk factors play in care delivery as well  
13 as the role they play in performance measurement.

14 In particular, for PRO-PMs, some  
15 considerations include cultural and language  
16 barriers; the person's perspective on whether the  
17 measure is meaningful, understandable, and  
18 achievable.

19 And some additional gaps the Dual-  
20 Eligible Beneficiary Group put forward for  
21 consideration include population health and  
22 transitions from institutional settings to the

1 community.

2 I think, with that, I can turn it back  
3 to Chip for discussion.

4 CO-CHAIR KAHN: First, let me say,  
5 just get this right, that before we go over this  
6 list, which is the next thing to do, the pulled  
7 measures, that Giff added to the pulled MUC16-142  
8 and MUC16-327. And to keep things in order,  
9 let's do MUC16-142 first, and can you bring that  
10 up on the screen, so we know what it is? I  
11 didn't memorize all the --

12 MEMBER GIFFORD: What was 3-something?

13 CO-CHAIR KAHN: Well, I was going to  
14 start with 142 because the next one is 145, 143.

15 MEMBER GIFFORD: No, I think I just  
16 added 142 and 145 to the already-pulled 143 and  
17 144.

18 CO-CHAIR KAHN: Oh, I'm sorry, 145 is  
19 already --

20 MEMBER GIFFORD: Pulled? That's the  
21 home health pressure ulcer one?

22 CO-CHAIR KAHN: Yes, home health

1 patients.

2 MEMBER GIFFORD: I just pulled the  
3 four pressure ulcer ones.

4 CO-CHAIR KAHN: Okay.

5 MS. O'ROURKE: Okay. So, to just  
6 clarify, there are the four pressure ulcer -- it  
7 is essentially the same measure applied across  
8 settings.

9 MEMBER GIFFORD: Yes.

10 MS. O'ROURKE: So, let me just get the  
11 numbers for everybody, just to help clarify.

12 CO-CHAIR KAHN: Okay.

13 MS. O'ROURKE: So, for home health, it  
14 would be MUC --

15 CO-CHAIR KAHN: 145.

16 MS. O'ROURKE: -- 145. For --

17 CO-CHAIR KAHN: Yes, short stay, it is  
18 143.

19 MS. O'ROURKE: Yes.

20 CO-CHAIR KAHN: And inpatient rehab,  
21 and then, I guess the SNF is 142?

22 MS. O'ROURKE: SNF is 144.

1 CO-CHAIR KAHN: Okay. And then, what  
2 is 142?

3 MS. O'ROURKE: Oh, no, SNF is 142 and  
4 LTCH --

5 MEMBER GIFFORD: No, SNF is 142 and  
6 LTCH was 144.

7 MS. O'ROURKE: Giff was right; I'm  
8 wrong.

9 CO-CHAIR KAHN: Okay. And should we  
10 discuss these as a package --

11 MEMBER GIFFORD: Yes.

12 CO-CHAIR KAHN: -- since there is  
13 commonality between those?

14 MEMBER GIFFORD: Yes.

15 CO-CHAIR KAHN: So, Giff, the floor is  
16 yours.

17 MEMBER GIFFORD: And these measures  
18 are all exactly the same measure with some minor  
19 risk adjustment differences between the setting.  
20 Because, recall under the IMPACT Act they have to  
21 have standard measures with standard assessment  
22 tools.

1                   As you heard on the phone, CMS  
2           implemented a standard way of measuring pressure  
3           ulcers consistent with the NPUAP, which I think  
4           most people applauded, which started in all of  
5           our settings, IRF LTCH and PAC, just in October  
6           of last year.

7                   As voiced, there were concerns with  
8           how the measure is constructed from that and the  
9           fact that this is a new assessment tool, that  
10          there is not a good sense on the  
11          reliability/validity of the underlying data yet,  
12          but, also, how the data is collected, making it a  
13          little more difficult to assess change in  
14          pressure ulcers over time when someone is  
15          admitted with more than one pressure ulcer.

16                  And so, again, I find myself in the  
17          awkward position of clearly a topic that is of  
18          grave importance where there's lots of  
19          opportunity in all four settings. And I have  
20          heard from all the different settings prior to  
21          this meeting that they just don't feel this  
22          measure is ready, fully support it, would like to

1 work with CMS on it further.

2 And so, our recommendation would be to  
3 move this from the support category down to  
4 further develop. The other thing is there are  
5 already measures developed and specified last  
6 year by CMS to meet the requirements of the  
7 IMPACT Act. This was the effort to do more  
8 alignment with that, and we just think it is  
9 moving faster than we would like to see it. And  
10 so, our recommendation would be that.

11 CO-CHAIR KAHN: Good.

12 Are there other comments? Input?  
13 Does CMS want to say anything?

14 MS. O'ROURKE: So, I just want to jump  
15 in and point to something in your Discussion  
16 Guide. I know a lot of the public commenters and  
17 Giff was referencing some of the new analyses.  
18 So, if you click on the measure under the IRF  
19 pressure ulcer under the IRF setting, you can see  
20 the comments from HealthSouth, UDSMR, as well as  
21 CMS. And at the bottom of the comments from CMS  
22 there is a link to a memo that has some

1 supporting analyses.

2 And, Pierre, I wasn't sure if someone  
3 from your team wanted to walk through those.

4 DR. YONG: Yes. Thanks, Erin.

5 So, Dr. Alan Levitt or Stace Mandl, do  
6 you want to go through the analysis that we  
7 provided?

8 DR. LEVITT: Sure. This is Alan  
9 Levitt. I'm the Medical Officer in the Division  
10 of Chronic and Post-Acute Care.

11 I mean, really, the summary to look  
12 at, if you could look at, I guess, the attached  
13 item, is really go to page 17, and you can see  
14 both our summary, but, then, also, look at the  
15 items themselves that are being talked about.

16 What we ended up doing, the reason why  
17 we are doing this is really part of our  
18 monitoring and evaluation of this measure and all  
19 the measures that we do, and was supported by the  
20 Technical Expert Panel in the middle of last  
21 year.

22 If you look at the 0300 item, it is an

1 item that essentially is counting the number of  
2 unhealed pressure ulcers. And so, it is counting  
3 it at admission and, then, it is counting it at  
4 discharge. So, it is a real-time count by  
5 usually the nurse, of the number of pressure  
6 ulcers.

7 In addition, on discharge, because it  
8 is possible that a patient may heal an ulcer and,  
9 then, have another new ulcer, we do also ask  
10 whether the count of those unhealed ulcers,  
11 whether or not they were present on admission or  
12 not. And so, that is how that is done. It is  
13 really potentially a real-time count that we do  
14 based on the assessment of a patient.

15 The 0800 items, which, then, come  
16 later on in the assessment tool, the question on  
17 it just asking the number of pressure ulcers that  
18 were not present or at a lesser stage on  
19 admission. So, it is just asking kind of a  
20 number that is asked on the discharged  
21 assessment. That is essentially a retrospective  
22 kind of assessment. It is just asking, well, how



1 many pressure ulcers were not present or present  
2 at a lesser stage?

3 And so, what happened is that the 0300  
4 items in the SNF setting, for example, were being  
5 used for payment, and the 0800 items were being  
6 used for quality. And there was a discrepancy  
7 between those numbers. The numbers that were  
8 being used for payment tended to be high. And  
9 again, you could get paid more, I guess, based on  
10 that, it is possible. And then, the 0800 items,  
11 the number of ulcers were low. And so, again,  
12 that maybe looked favorably, that you had less  
13 pressure ulcers when it came to quality, but more  
14 pressure ulcers when it came to payment.

15 And so, because of that monitoring and  
16 evaluation that we did on those items themselves,  
17 as well as other monitoring and evaluation, that  
18 is why we have the unstageables that have been  
19 added as well, based on that. We did bring it to  
20 the TEP, and the TEP supported us moving towards  
21 the 0300 items.

22 And so, that was done in the SNF

1        setting over this past year. And so now, the SNF  
2        setting is done that way. And what we have  
3        actually done here in terms of bringing these  
4        measures which are already in our programs back  
5        to the MAP was to harmonize this across the  
6        settings, similar to like what we really do want  
7        to do within the IMPACT Act.

8                And also, really to understand that,  
9        look at those M0300 items which count the  
10       pressure ulcers. Those are assessment items that  
11       can be used longitudinally across settings where  
12       you could actually take the counts from one  
13       setting to another. And they are very useful  
14       items, not just for the measure, but also in  
15       terms of the assessment of pressure ulcers.  
16       Whereas, the 0800 retrospective item that is used  
17       only means something in that setting. It doesn't  
18       mean anything from there on.

19               And so, by us going towards an 0300  
20       item that can be used across setting and, then,  
21       modifying it, we could, hopefully, eliminate the  
22       0800 item in terms of any sort of duplication and

1 also get what we would feel to be more accurate  
2 results because they could be based on the actual  
3 real-time assessment that is being done on the  
4 patient both on admission and discharge.

5 And so, we ended up proposing this.  
6 And again, the issue that came up within the  
7 Workgroup was, as was mentioned in the public  
8 comments, that there was a discrepancy when the  
9 calculation was being done between 0800 and 0300  
10 items. And again, that discrepancy really was  
11 representative of why we wanted to do this in the  
12 first place, because there was really an  
13 underreporting of the ulcers when you are using  
14 purely the retrospective item.

15 And what we have showed best, if you  
16 go back on the attachment in terms of table 6, if  
17 you looked at the stage 2 pressure ulcer line,  
18 for example, if you took the difference between  
19 the pressure ulcers at stage 2 from discharge to  
20 admission, and if they were a greater number,  
21 they had to have a new or worsening pressure  
22 ulcer. There is no other way they would have

1       that.

2                   And so, we were able to identify 526  
3       patients that had a greater number. If you  
4       looked at those same patients and looked at their  
5       0800 items, only 336 of them said they had a new  
6       or worsening ulcer. And so, you only got a 64  
7       percent hit by having somebody retrospectively go  
8       and decide whether or not there was a new or  
9       worsening ulcer, which, again, corresponded to  
10      the reason why we were doing this in the first  
11      place.

12                   And I'm not sure if there are any  
13      other questions, but that is really why we did it  
14      and why we feel you should fully support this  
15      measure.

16                   DR. GOODRICH: Thank you, Alan.

17                   CO-CHAIR KAHN: Kate, yes.

18                   DR. GOODRICH: We appreciate it.

19                   No, that's it.

20                   CO-CHAIR KAHN: Okay, Giff, why don't  
21      you --

22                   MEMBER GIFFORD: So, a couple of

1        comments on Alan's comments. I don't disagree  
2        with anything he said, except we see the same  
3        pattern on the SNF side where this is not used in  
4        payment at all. So, the fact that he is alluding  
5        to the differences have to do with something like  
6        payment may be unique to one setting, but the  
7        pattern we are seeing is in other settings where  
8        it is not tied to payment.

9                Second, I think we applauded the  
10       creation of the 300 measures for IMPACT, for all  
11       the things that he described. However, the way  
12       it is constructed, it makes it a little bit more  
13       difficult to measure change during the stay  
14       because you can't link it. It is sort of an  
15       ecologic analysis. You don't know which measure  
16       is tied to change or not. And if there are  
17       changes going on, you can actually look like you  
18       are having worse or not having worse. And so, it  
19       is not fully perfect. So, it is good for  
20       clinical care, good for quality improvement, not  
21       particularly great for measurement. And how they  
22       incorporated the unstageable into the measure

1 calculation also throws the measure off.

2 So, it is not that we object to a  
3 measure here, and this is sort of across all the  
4 PAC settings. So, it is home health, SNF, IRF,  
5 LTCH, all of us had this feeling that the measure  
6 just needs more work. It came out with a new  
7 scale, a new rating system in October, and they  
8 are trying to apply it to a measure. And we  
9 haven't gone back and double-checked to see how  
10 it has done in some of the preliminary data.  
11 And the clinical way suggests that this is not  
12 necessarily accurate at individual facility  
13 level. It might be accurate at a national level,  
14 but at an individual facility level it is not.

15 And so, we would just encourage  
16 further development on this measure.

17 CO-CHAIR KAHN: I mean, how do you  
18 respond? Or any response?

19 MS. MANDL: This is Stace.

20 CO-CHAIR KAHN: Stace?

21 MS. MANDL: Do you want CMS Central  
22 Office to respond or not?

1 CO-CHAIR KAHN: Please.

2 MS. MANDL: Sure. This is Stace  
3 Mandl, and I believe we have RTI, our measure  
4 development contractor on the line as well that  
5 can speak to this. I think those are important  
6 points, and I just want to provide some  
7 clarification.

8 On the M0300 topic that is sort of  
9 being tossed around, it is the assessment of  
10 pressure ulcers at the time of admission or on  
11 interim assessments or at discharge. And as Alan  
12 was describing, it is how many do you have and  
13 how many were present on admission, so as to  
14 remove attribution. Those M0300 items are used  
15 for payment in the run system on the M0300 items  
16 for stages 2 through 4.

17 Another thing I am trying to point out  
18 is that the M0800 item used in the nursing home  
19 version of the measure actually includes even  
20 wounds that have healed. So, part of the  
21 rationale for moving in this direction was to not  
22 include an overcount when using a stay-based

1       measure. So, I just wanted to kind of point to  
2       those two topics.

3               Thanks.

4               CO-CHAIR KAHN: Okay. I don't know  
5       how to resolve this other than I guess to vote.  
6       But, I mean, are there other comments?

7               (No response.)

8               Okay. So, I guess we should vote.

9               Oh, Deb, do you want to add anything  
10      to this discussion?

11              WORKGROUP CO-CHAIR SALIBA: I think it  
12      has been well-covered. The Committee voted to  
13      endorse the measure in three settings. And then,  
14      when the IRF measure was brought up, there was  
15      some public discussion and concerns where  
16      conflicting data was mentioned. And the  
17      Committee's intent in doing a conditional support  
18      was that somebody take a close look at that data,  
19      and CMS generated the memo in response to that  
20      request, looking at the data.

21              I think, you know, from the  
22      Committee's perspective, there is an expectation



1       that the distribution of the item would change if  
2       the item changes, and that part of the reason for  
3       changing an item is that you are going to get a  
4       change in the distribution of the base frequency  
5       responses.

6               So, I think that is why the Committee  
7       was comfortable voting for support in the three  
8       settings, and was really being respectfully  
9       responsive to the public comment in saying, well,  
10      let's look at the data that has been raised. So,  
11      I think Alan has reviewed the data that was  
12      presented by CMS in response to that request.

13              Does anybody have questions that would  
14      help them in terms of deciding on this particular  
15      measure?

16              CO-CHAIR KAHN: We didn't really  
17      generate much in terms of further queries.

18              WORKGROUP CO-CHAIR SALIBA: Okay.

19              CO-CHAIR KAHN: Are there any closing  
20      arguments?

21              Okay. Then, I guess we will go  
22      through all four and close this out.

1                   So, I guess first we will do the SNF.

2                   MS. OGUNGBEMI: Yes. We are now  
3                   voting on application of percent of residents or  
4                   patients with pressure ulcers that are new or  
5                   worsened, short stay, MUC16-142.

6                   Your options are: 1, support; 2,  
7                   conditional support; 3, refine and resubmit; 4,  
8                   do not support.

9                   Voting is open. Ready to read the  
10                  vote?

11                  MS. IBARRA: I'm still waiting for  
12                  remote participants to chat-in their votes. I  
13                  have not received any yet.

14                  CO-CHAIR KAHN: Have you got it?

15                  MS. IBARRA: No. Foster, Doris,  
16                  Steve, Barrett, Brandon, we are waiting. None of  
17                  your votes have come through.

18                  CO-CHAIR KAHN: We're going to give  
19                  you another 30 seconds.

20                  DR. LOTZ: This is Doris. I have sent  
21                  it twice.

22                  MEMBER BROTMAN: Yes, this is Steve.

1 I sent it about a minute ago.

2 CO-CHAIR KAHN: Okay. Thank you,  
3 guys.

4 MEMBER HOTHAM: This is Brandon. The  
5 same situation.

6 CO-CHAIR KAHN: Okay.

7 MS. IBARRA: All right. Well, I'm  
8 going to refresh.

9 MEMBER NOONE: This is Barrett. The  
10 same situation.

11 CO-CHAIR KAHN: Okay.

12 MS. IBARRA: All right.

13 CO-CHAIR KAHN: Then, Kim is going to  
14 have to fix it on our end.

15 MS. IBARRA: Okay, I'm seeing them  
16 now. Okay.

17 CO-CHAIR KAHN: Oh, the votes are in.  
18 The votes are in.

19 Okay, are we ready for a tally of the  
20 vote, everybody? Have you got all the votes?

21 MS. IBARRA: No. Yes.

22 CO-CHAIR KAHN: Okay. Let's tally the

1 votes.

2 MS. OGUNGBEMI: Results are 59 percent  
3 support, 4 percent conditional support, 37  
4 percent refine and resubmit, zero percent do not  
5 support. We reached the 60-percent threshold in  
6 conditional support, and that is for MUC16-142 in  
7 the SNF QRP.

8 CO-CHAIR KAHN: Okay, let's go to the  
9 next one, whichever is the next one that you  
10 want. I guess 143.

11 I think we are going to have to have  
12 an Electoral College here.

13 (Laughter.)

14 MEMBER GIFFORD: These are exactly the  
15 same measures with the same issues in all the  
16 settings. So, I would put on the table as a  
17 motion to accept that, unless people want to go  
18 back and re-vote, because it is the same measure,  
19 the same issues. To have different results on  
20 different measures, I don't understand what that  
21 means.

22 CO-CHAIR KAHN: Okay, so let me

1 clarify.

2 MEMBER GIFFORD: Internally  
3 consistent, not that we seem to require internal  
4 consistency, but --

5 (Laughter.)

6 MS. IBARRA: So, if we have the  
7 decision as conditional support, we do want to  
8 get some clarifications from the Committee on  
9 what those conditions are for the conditional  
10 support.

11 CO-CHAIR KAHN: To me, this is sort of  
12 an awkward situation to have conditional support  
13 when you are at 59 percent and 4 percent, because  
14 the predominance of the body, not the consensus  
15 according to the 60-percent rule, I mean, you're  
16 only one -- you know, does anybody want to change  
17 their vote? We could have another vote. I mean,  
18 because I guess --

19 MEMBER GIFFORD: We didn't do that on  
20 other measures.

21 CO-CHAIR KAHN: No, no, I understand.

22 MEMBER GIFFORD: We came up with the

1 system ahead of time.

2 CO-CHAIR KAHN: I understand. I'm  
3 not --

4 MEMBER GIFFORD: But the initial  
5 support is they can go forward. I think they  
6 have got the feedback from everything here.

7 CO-CHAIR KAHN: Okay.

8 MEMBER GIFFORD: We talked about the  
9 feedback. We have gotten it written, support. I  
10 don't know what else to say, but if you are going  
11 to change it and that, then --

12 CO-CHAIR KAHN: Yes, I'm with you.  
13 I'm with you.

14 MEMBER GIFFORD: Then, we can go back  
15 and re-vote some of the other things that were  
16 close.

17 CO-CHAIR KAHN: I shouldn't have  
18 brought that up. I should not have mentioned it.

19 (Laughter.)

20 Okay, but I guess there is a  
21 suggestion that, since this was the vote on this,  
22 that since the other three are parallel issues,

1       that we would have the same vote. And I guess  
2       the question is, one, is there a motion? And  
3       then, we will see whether there is any objection  
4       in the motion to that effect in terms of taking  
5       the rest en bloc.

6                       So, Giff?

7                       MEMBER GIFFORD: I'll make that  
8       motion.

9                       DR. HUNT: Second.

10                      CO-CHAIR KAHN: Okay. Any discussion?  
11       Is there anyone who objects?

12                      (No response.)

13                      Okay. All in favor say aye.

14                      (Chorus of ayes.)

15                      Anyone object?

16                      Okay, so I guess we would -- oh, good  
17       -- we would give conditional support, then, for  
18       all four of these, with the understanding of the  
19       issues that were raised in the discussion.

20                      Well, no, we can't do that. I mean,  
21       I think Giff was right about that because we were  
22       actually at 57 percent, if I remember, on some

1 earlier ones. So, we were at the same -- I mean,  
2 the issue arises that we really would have to go  
3 back and readjudicate the earlier ones, which I  
4 don't think we want to do.

5 DR. ANTONELLI: But I do think we  
6 should clarify what the conditions are.

7 MS. O'ROURKE: Could I put a  
8 strawperson out, maybe for the Committee's  
9 consideration on what the condition might be?

10 CO-CHAIR KAHN: Okay.

11 MS. O'ROURKE: Perhaps the condition  
12 could be that CMS work with providers to educate  
13 them on the changes to the underlying data  
14 elements and the proper coding procedures, as  
15 well as with the public to help the people who  
16 are using the Compare sites to understand that  
17 the instruments have changed and they may see  
18 shifts due to some of those. So, some education  
19 for both providers and patients around the  
20 changes to the measures.

21 MEMBER GIFFORD: And I guess the  
22 additional add is looking at how unstageable and



1 people with multiple pressure ulcers might be  
2 correctly or incorrectly counted in the measure.

3 CO-CHAIR KAHN: But is that  
4 sufficient, Kate?

5 DR. GOODRICH: That is more helpful  
6 now.

7 CO-CHAIR KAHN: Yes.

8 But, with your question -- just a  
9 moment on it, Giff -- say it again what you said  
10 because I don't --

11 MEMBER GIFFORD: The scenario runs in  
12 when somebody gets admitted with multiple  
13 pressure ulcers, it is harder to figure out what  
14 is getting better and changing, the way the  
15 coding is there. And the way they have  
16 structured the unstageable pressure ulcer in the  
17 measure is causing some confusion out there for  
18 the calculation.

19 So, what I was asking for is -- I  
20 completely agree with what Erin said, that  
21 conditional support would be that CMS explores  
22 with the measure -- I mean, I think they are

1 moving in the right direction. I think there is  
2 general support here. It is just, basically,  
3 going back and validating with those conditions,  
4 how is the measure working there. And that is an  
5 evolution of the measure over time, and  
6 conditional support should not hold them up going  
7 forward in putting this in rulemaking with what  
8 is out there.

9 CO-CHAIR KAHN: So, you can do that?  
10 Okay.

11 MR. TILLY: We will make a note of all  
12 those comments --

13 CO-CHAIR KAHN: Okay.

14 MR. TILLY: -- as the conditions.

15 CO-CHAIR KAHN: Good.

16 We're moving on to the clinician  
17 programs, is that right?

18 MS. O'ROURKE: So, I think if we just  
19 want to do our final call for any --

20 CO-CHAIR KAHN: Oh, I'm sorry. So, I  
21 need a motion for the en bloc, right, vote on the  
22 other measures. And I see a motion from Giff.

1 MEMBER GIFFORD: Motion.

2 MEMBER BRYANT: Second.

3 CO-CHAIR KAHN: And a second over  
4 here.

5 And anybody, any discussion of the en  
6 bloc?

7 (No response.)

8 All in favor, aye.

9 (Chorus of ayes.)

10 Okay. So, the en bloc is now passed.

11 So, does that, then, finish our --

12 MS. O'ROURKE: Any other cross-cutting  
13 conversation?

14 CO-CHAIR KAHN: Any other cross-  
15 cutting conversation, suggestions?

16 CO-CHAIR PINCUS: I guess, also, about  
17 gaps.

18 MS. O'ROURKE: Yes.

19 CO-CHAIR PINCUS: Gaps.

20 CO-CHAIR KAHN: Any gaps?

21 MEMBER GIFFORD: I would just like to  
22 point out the four different PAC settings got

1 through in a third of the time that the hospitals  
2 got through.

3 (Laughter.)

4 CO-CHAIR PINCUS: Actually, in terms  
5 of gaps --

6 CO-CHAIR KAHN: Yes.

7 CO-CHAIR PINCUS: -- Deb, if you are  
8 still on, could you say something maybe about  
9 what the Workgroup received as gaps?

10 WORKGROUP CO-CHAIR SALIBA: I think  
11 the gaps that were highlighted was the need for  
12 increased patient-reported outcome measures, and  
13 that was true across all four of the post-acute  
14 care settings.

15 The need for preferences to also be  
16 accounted for in measurement science better, I  
17 think you have probably heard that not only in  
18 post-acute care, but in all of the other  
19 healthcare settings.

20 One person did bring up nutrition in  
21 each one of the settings, as was mentioned in the  
22 presentation earlier today.

1                   And then, medication reconciliation  
2                   was highlighted as an important area in which  
3                   there are significant opportunities for improving  
4                   care or the lack of appropriate reconciliation  
5                   could lead to harm. And that had a lot of  
6                   consensus within the group, that that would be a  
7                   really important gap to be addressed.

8                   And those were the that I think came  
9                   up across the four settings.

10                  CO-CHAIR KAHN: Thank you.

11                  Anybody from staff or on the phone?

12                  CMS?

13                  (No response.)

14                  Okay, so we will, then, move on back  
15                  to Harold and look at the clinician program.

16                  All right. I guess we want to take a  
17                  how many minute break?

18                  CO-CHAIR PINCUS: Yes, a 15-minute  
19                  break.

20                  CO-CHAIR KAHN: Okay. So, be back  
21                  here at 2:35.

22                  (Whereupon, the above-entitled matter

1       went off the record at 2:20 p.m. and resumed at  
2       2:49 p.m.)

3                   CO-CHAIR PINCUS:   So, first, we want  
4       to hear about public comment on the clinician  
5       programs.   So, first, is there anybody in the  
6       room who wants to make a public comment with  
7       regard to the clinician programs?

8                   So, anybody on the phone wishing to  
9       make a public comment with regard to the  
10      clinician programs?

11                  OPERATOR:   And, once again, to make a  
12      public comment, please press star one.

13                  And there are no public comments at  
14      this time.

15                  CO-CHAIR PINCUS:   Okay.

16                  So, Bruce, Eric, John, do you want to  
17      begin to sort of walk us through some of the key  
18      issues that you discussed?

19                  MR. BERNOT:   Sure, yes, I'll take over  
20      the slides from here.

21                  So, I'm John Bernot, I'm one of the  
22      Senior Directors working on the Clinician

1       Workgroup.

2                   So, go ahead and go to the -- one  
3       more, next slide.

4                   What we're going to do is actually on  
5       this, even though we've not been going over the  
6       actual program summaries, I'm going to spend just  
7       a couple of seconds on the programs, mainly the  
8       MIPS program, because it had so many significant  
9       changes and it's a little bit of a different  
10      animal than the other programs with it, being all  
11      these different specialties.

12                  In addition to that, the clinician  
13      self-select subset of the measures themselves, so  
14      it brings in some different issues than some of  
15      the programs that are all encompassing and every  
16      one's required.

17                  So quickly, this was established by  
18      the MACRA law in 2015 and it was a program that  
19      consolidated all of Medicare's existing incentive  
20      quality reporting programs for clinicians.

21                  In that, there are two different  
22      tracks. One of them is the Advanced Alternate

1 Payment Models and one is the MIPS. And the MIPS  
2 is the specific one that we're talking about  
3 here.

4 Again, they self-select the measures  
5 they're going to submit to CMS. And if they  
6 participate in the advanced APM model, they are  
7 excluded from MIPS.

8 Go ahead, next slide.

9 This does have again, I mentioned,  
10 there's four different things that it looks at.  
11 It's a quality to cost, advance to care  
12 information improvement activities.

13 So specifically there were 18 measures  
14 that we reviewed for the MIPS program.

15 MSSP, this does not have the changes.  
16 This is more of a compare and contrast. This is  
17 looking at the Accountable Care Organizations so  
18 more of the common than what we looked at of the  
19 other programs for this. We had just one measure  
20 for the MSSP program.

21 So I'm going to go over some of the  
22 themes that came out of the two-day workgroup --



1 one of them was this move to high-value measures  
2 and really just the inclusion of the high-value  
3 measures rather than just measures in general,  
4 really taking a consideration for burden.

5 They specifically stated that we want  
6 to make sure that we're addressing the NQF's aims  
7 and priorities.

8 The alignment with other initiatives  
9 that may not be at the clinician or ACO level,  
10 focus on patient outcomes, we've heard that a lot  
11 today and again, sensitivity to the burden.

12 No surprise, more talk about moving  
13 towards the outcomes, composites and we also had  
14 the promise discussion that the workgroup really  
15 found a lot of value in and might be a potential  
16 tool to develop more performance-based measures  
17 for patient reported outcomes.

18 The next one, again also I'll try to  
19 go through this quickly because it's no surprise,  
20 based on what we've heard today but attribution  
21 was a big discussion.

22 And there's a couple of parts to this.

1 One of them is, are we capturing something that  
2 is a team-based measure or a clinician-based  
3 measure?

4 Second point, if it is a clinician-  
5 based measure, is it something the clinician  
6 feels that they're capable of influencing?

7 Timeliness was an interesting issue  
8 that we hadn't talked about a lot. I hadn't seen  
9 that came up with the timeliness of the outcome.  
10 And we'll give a couple examples of that on the  
11 next slide.

12 And then this double-edged sword of  
13 the accountability that there needs to be  
14 consideration for team-based accountability. But  
15 at the same point, it also has to be attributed  
16 to somebody or some entity. So an appreciation  
17 that it can't just follow no one but, it may not  
18 be on an individual person that's going to -- you  
19 can attribute it.

20 So those were the two themes that we  
21 saw. Specific to the MIPS discussions, this is  
22 what the committee had talked about.

1                   Again we mentioned that the high-value  
2                   measures but, in the outcomes there was some  
3                   pretty interesting caveats that came up because  
4                   of the difference in the program that I  
5                   highlighted in the MIPS.

6                   Some of them are specific to the  
7                   clinician level. One of them being, is there an  
8                   adequate sample size? If we're going to look for  
9                   outcomes, it's one thing at a hospital level but,  
10                  at a clinician level did they see -- have enough  
11                  touches to really get up to an adequate sample  
12                  size?

13                  The attribution again, we've talked  
14                  about that a number of times. Very important to  
15                  the -- this is the individual clinicians is  
16                  whether or not that clinician can make an impact  
17                  on the outcome there.

18                  And the last one I thought was  
19                  interesting was the timeliness discussion that  
20                  came up. And I believe it was Erica, one of our  
21                  Chairs who brought up as a breast surgeon, the  
22                  actual time when you'd be able to realize how

1 good of a job he did is not days to months, it's  
2 years and many -- potentially a decade down the  
3 road when you're really seeing that.

4 And is that an outcome that can be  
5 captured? Probably in this setting, we'd say no  
6 but keeping that in mind, the timeliness of when  
7 the outcome would be. So that was a good  
8 discussion, I thought.

9 Also, continuing the partnership  
10 because we have the specialty societies in here.  
11 So measures that might be -- we want outcomes  
12 but, are they outcomes that are the correct one  
13 for a particular specialty? So that's something  
14 we encourage this continued partnership between  
15 CMS and craft and the specialty societies.

16 The last one was because of those  
17 challenges that I just mentioned, when we use  
18 process and when there's a need for process  
19 measures, what can we do? And the use of maybe  
20 considering composite measures or really tying  
21 better process to outcomes on the measures. So  
22 that was a discussion that came up around that.

1                   We can go to the next slide.

2                   Some of these are more of the themes  
3                   that I think we've talked about today so I'll try  
4                   to be brief.

5                   But just addressing the gaps and  
6                   appropriate use was something that we had a  
7                   number of discussions about whether or not those  
8                   were being addressed.

9                   Crosscutting measures, this came up  
10                  because of the specialties or the things that  
11                  would apply to all clinicians that would be good  
12                  markers of performance.

13                  And lastly, I don't believe I've heard  
14                  a whole of discussion about this other than Helen  
15                  did make some comments about measurement science  
16                  in general, was this issue of topped out measures  
17                  again with that focus on a clinician level  
18                  measure that can be self-selected.

19                  So when do these get removed? And  
20                  what's the balancing of these of removing a  
21                  topped out measure and also having a measure that  
22                  might be applicable to a specialty?

1                   And then are these rates a little  
2                   different when you're optional? Because it is  
3                   really the high performers who keep selecting  
4                   those measures? And so is it really as topped  
5                   out across physicians as it might be for just  
6                   that subset who selected it?

7                   And then just considering, would this  
8                   regress if we're not looking at it?

9                   So all of these discussions came up in  
10                  the MIPS program. I think they were good and  
11                  maybe a little bit different than some of the  
12                  other programs.

13                  For the MSSP, this is pretty much in  
14                  line with what we've heard. More outcome  
15                  measures, they would like the care coordination  
16                  focus to be on these outcome measures, especially  
17                  with that ACO level thinking.

18                  They added specific suggestions,  
19                  measures of avoidable emergency department use.  
20                  Since they're really looking at a full spectrum  
21                  for emergency use to inpatient and even the  
22                  outpatient.

1                   They specifically mentioned the desire  
2                   for more of the person and family engagement.

3                   Also the crosscutting, they mentioned the same  
4                   thing about the crosscutting measures, something  
5                   that all clinicians would be represented by and  
6                   linking the quality and appropriate use.

7                   So those are the themes that came up  
8                   with a little different spin from the two  
9                   different programs.

10                  I'll mention just briefly a few  
11                  notable -- we had a few notable discussions. I  
12                  just thought it'd be worth bringing up.

13                  This MUC 16-069, the Adult Local  
14                  Current Smoking Prevalence -- this was actually  
15                  submitted to both MSSP, this was the one measure  
16                  for MSSP as well as one of the 18 measures for  
17                  MIPS.

18                  And there was a lot of discussion  
19                  about this, a lot of good discussion about the  
20                  need to engage the clinicians in this public  
21                  health.

22                  But there was an encouragement that it

1 needs to be refined due to the attribution level.  
2 This was at -- this was proposed at a county  
3 level. And the attribution of this is that  
4 somebody who can actually make a change on this.  
5 And then also trying to look at the accuracy of  
6 the data they had.

7 The next measure on here is MUC 16-  
8 398. This is appropriate use criteria of  
9 electrophysiology. The main reason I wanted to  
10 bring this up well, there was two things.

11 One because appropriate use was a big  
12 topic that came up several times throughout our  
13 discussion. And really wanted to make sure that  
14 the appropriate use is tied into guidelines. So  
15 that was one of the topics that came up when we  
16 discussed this.

17 So that's all on that one, next slide.

18 And, the last one, we had a measure  
19 MUC 16-074. This was a measure about the fixed-  
20 dose combination of hydralazine and isosorbide  
21 dinitrate therapy.

22 This is a specific measure for self-



1 identified black or African-American heart  
2 failure patients who are already on a particular  
3 therapy. This is one that there was an eMeasure  
4 that's been approved for trial use.

5 The workgroup did note that this is a  
6 measure that could address the clinical care and  
7 potential disparities and heart failure because  
8 it would contract the use of a therapy that can  
9 reduce morbidity and mortality in this  
10 population.

11 The workgroup also raised concerns  
12 that it's a measure based on fixed-dose regimen  
13 and the ACC/AHA Guideline suggested individual  
14 components of the combination therapy could be  
15 substituted.

16 So those were the three real big  
17 discussions that took a lot of time and were  
18 heated discussions in the group.

19 The Dual Eligible comments, I'll just  
20 go through those briefly. This is their  
21 perspective on the clinician recommendations.  
22 That the model of care and the incorporation

1 performance measurements of those models must  
2 consider those unique needs and the preferences  
3 also of the various subpopulations.

4 And they wanted to provide the  
5 feedback or data on a regular basis. So I know  
6 that feedback has come up specifically and they  
7 actually asked even so far as to go to the data.

8 And for the PRO-PMS, they really  
9 wanted these cultural language barriers to be  
10 highlighted to the group. So we're thinking  
11 about those and the patients' perspective on  
12 whether this measure was meaningful and  
13 understandable.

14 So with that, we'll go into the  
15 measures. I'll turn it back over to you, Harold.

16 CO-CHAIR PINCUS: Any questions here  
17 in a general way? And also secondly, I know the  
18 Co-Chairs are going weigh in on to elaborate  
19 further.

20 WORKGROUP CO-CHAIR BAGLEY: This is  
21 Bruce Bagley.

22 I think John did a nice job

1 summarizing the discussion. If anybody has any  
2 questions, I'd certainly be glad to attempt to  
3 convey the conversation and some of the reasons  
4 why we came to these conclusions.

5 CO-CHAIR PINCUS: Well, seeing no  
6 hands raised or questions as I understand it,  
7 there were two measures that have been pulled for  
8 further discussion.

9 One is 16-072, Prescription of HIV  
10 Antiretroviral Therapy and 16-073, HIV Medical  
11 Visit Frequency.

12 And these were pulled by Amy Mullins.

13 MEMBER MULLINS: Yes, and I'm going to  
14 speak to both of those kind of as a group because  
15 I pulled them both for the same reason.

16 Both of these measures were included  
17 in the Core Quality Measure Collaborative's Core  
18 Measure Set for HIV and Hep C.

19 And so I believe they should be  
20 included in MIPS with no conditional support or  
21 refine and resubmit.

22 I don't know, anyone -- a show of

1 hands if you're not familiar with the Core  
2 Quality Measure Collaborative work.

3 Okay so Aparna at AHIP and CMS, the  
4 private insurers and, the professional societies  
5 got together and said, we have way too many  
6 measures measuring way too many things in a whole  
7 lot of different ways. We need to come up with  
8 some core sets that we all can agree on.

9 And we got around the table and we  
10 hashed it out over about two years and came up  
11 with core measure sets, one of which was the Hep  
12 C HIV measure set.

13 And our work included these two  
14 measures that I pulled that had not been  
15 supported fully for inclusion into MIPS.

16 So, in the -- this word has been  
17 thrown around today and Doug Henley would be so  
18 happy in the spirit of parsimony and harmony, we  
19 would like to put those on the table for full  
20 support for the MIPS program.

21 So I would like for a re-vote. We can  
22 do one vote on both measures because they are

1 both of the comments for me are the same.

2 CO-CHAIR PINCUS: John?

3 MEMBER HALL: Amy, could you maybe 30  
4 seconds on whether you feel that any of the  
5 concerns raised here have already been addressed  
6 or what the answers might be to the concerns  
7 raised here?

8 MEMBER MULLINS: I feel like we did  
9 hash out all of the concerns over the course of  
10 two years. Amir, Aparna, Kate, do you recall  
11 the specific conclusions that we came to? Is  
12 Kate still down there? I can't see.

13 So he asked if our work at the Core  
14 Measure Collaborative level addressed any of  
15 these specific concerns that the workgroup came  
16 up with? I can't recall the exact answers.

17 CO-CHAIR PINCUS: Yes, could you just  
18 clarify? So what was the vote? The  
19 recommendation from the workgroup? And what were  
20 the concerns?

21 MEMBER MULLINS: So in the 073, MUC  
22 073 was refine and resubmit and 0972 was

1 conditional support.

2 So -- I must be looking at a  
3 discussion group work from two days ago, maybe.  
4 Mine says 07 -- oh, I'm looking at 07 -- I'm  
5 looking at a different one, sorry.

6 So, but, they both were supported and  
7 included in the core measure sets.

8 (OFF MIC COMMENTS)

9 MEMBER MULLINS: So, I pulled 072 and  
10 073, so, yes, so that's 072, yes. Yes, so I just  
11 have them backwards on my sheet.

12 CO-CHAIR PINCUS: Just could we get  
13 just some clarity about what was the  
14 recommendation from the workgroup and what were  
15 the issues of concern that was expressed in the  
16 workgroup? John, do you have it?

17 MEMBER MULLINS: I'm sorry. Oh --

18 MEMBER QASEEM: So, I can -- well,  
19 what I remember, just to chime in over here what  
20 Amy's saying and I'm going to take one by one,  
21 guys. There's so many numbers over here, I'm  
22 getting confused. So, I've been confused all

1 day.

2 So 16-072, that's about the  
3 Antiretroviral Therapy, is that the correct one?  
4 I do remember the discussion we had concerning  
5 the new guidelines that everyone should be  
6 getting the treatment if they follow the current  
7 guideline recommendations. That's the bottom  
8 line summary, if I have to summarize it.

9 So I do think it addresses all the  
10 workgroup concerns. So I'm not really sure why  
11 this was actually -- why it's resubmit?

12 CO-CHAIR PINCUS: What were the  
13 workgroup concerns? That's the question.

14 MR. BERNOT: Yes, I'll go through them  
15 one by one.

16 So there was different concerns on the  
17 two. The first of all --

18 MEMBER QASEEM: So just one by one, do  
19 you mind just taking one by one?

20 MR. BERNOT: I'm going to do one by  
21 one, correct.

22 MEMBER QASEEM: Perfect.

1 MR. BERNOT: Yes, so I'm going to  
2 start with 072.

3 There was two issues on this. The  
4 first one so to clarify, this is the eMeasure  
5 version of the existing claims-based measure.  
6 Both of these are eMeasures.

7 So the concerns were twofold on 072.  
8 The first one was whether this supports  
9 alignment. And in the final rule that came out,  
10 the corresponding non-eMeasure, the claims-based  
11 measure was pulled, the corresponding 072.

12 So it did not support alignment  
13 anymore. That was the first part of the  
14 discussion.

15 The second one was that as it's an  
16 eMeasure, it had not been fully tested as an  
17 eMeasure yet. And so it was to wait until the  
18 eMeasure testing had been complete. So that's  
19 072.

20 CO-CHAIR PINCUS: Could somebody  
21 clarify what's the status of the eMeasure  
22 endorsement process?



1                   MR. BERNOT: So that is it's in the  
2 process right now. Oh, I'm sorry.

3                   MS. MARINELARENA: Hi, Melissa  
4 Marinelarena again.

5                   So I'm working on the infectious  
6 disease project that these measures have been  
7 submitted to. We're in the process of doing the  
8 preliminary analysis. Our in-person meeting is  
9 March 14th, I believe, a one-day meeting. So,  
10 all of the eMeasures will be -- that are new to  
11 us will be evaluated then with recommendations,  
12 including the original paper case measures.

13                  MEMBER QASEEM: So Harold, can I ask  
14 a clarification question? All the measures that  
15 are eMeasures that are reviewed by MAP, aren't  
16 they always tested before they come for our  
17 internal for approval? So why is that an issue?  
18 I mean, that's why, first, this is a two part  
19 question.

20                  The first is are all eMeasure tested?  
21 And, if they're not, then why would this be an  
22 issue with this specific eMeasure? Why do we

1 have to wait?

2 CO-CHAIR PINCUS: We don't have to  
3 wait. We can make a -- we can make whatever  
4 recommendation we want.

5 MEMBER QASEEM: I'm talking about the  
6 workgroup recommendation. They used as a logic  
7 that why did it even come up? What was the --

8 CO-CHAIR PINCUS: But you know, but  
9 eMeasures do have to go through the regular  
10 endorsement process. There's a sort of separate  
11 -- there's kind separate -- a track for it, but  
12 they do have to go through the endorsement  
13 process to get endorsed.

14 MEMBER MULLINS: Point of clarity.  
15 I'm sorry. The numbers are confusing and I was  
16 confused.

17 So, the one that we -- that I should  
18 have pulled, 073 should have pulled. I would  
19 retract my pull of 072 and replace it with 075.  
20 That is the one that I should have pulled.

21 So 073 and 075, I retract 072. 072 is  
22 not in the core set, 075 is the core set, the HIV

1 viral suppression.

2 MS. MARINELARENA: So the status is  
3 the same for that one, the original measure has  
4 been submitted and I believe for that one,  
5 there's the -- this is the eMeasure and that has  
6 also been submitted.

7 MEMBER MULLINS: So, my comments are  
8 the same?

9 MEMBER HIGGINS: Sorry, so, was this  
10 the recommendation on just the eMeasure part of  
11 it or the measure itself?

12 MS. MARINELARENA: This is the  
13 eMeasure that you have before you. So only the  
14 eMeasure version of the paper-based measure was  
15 submitted to the program because the other ones  
16 are the original measures, the paper measures,  
17 are already in the program except for the one  
18 that final rule has removed it from MIPS.

19 But the eMeasures and from an NQF  
20 standpoint, we review eMeasures based on paper-  
21 based measures separately. So we consider them  
22 two separate measures. So you're only looking at

1 the eMeasures right now.

2 They're already endorsed, yes.

3 They're in the core set and already -- yes, in  
4 different programs. One is being removed from  
5 MIPS, as John stated.

6 CO-CHAIR PINCUS: Now let's -- let's  
7 just get clear. So we have the -- so what  
8 you're polling is the 16-073 and 16-075, okay?  
9 And my understanding that for the 075, that is an  
10 eMeasure that is in the queue for evaluation for  
11 endorsement in March.

12 MS. O'ROURKE: 075, isn't that NQF  
13 2082 paper and it's the claims measure?

14 CO-CHAIR PINCUS: Well is it the same  
15 or is it the eMeasure version? Again, just  
16 trying to get clarity.

17 MR. TILLY: So what's in here -- so,  
18 let's just be really specific now.

19 16-075, which is the HIV Viral  
20 Suppression measure, as far as the measure  
21 specifications that are included here, we have  
22 data source includes stated by HHS, the

1 administrative claims data or administrative  
2 clinical data claims, paper records and record  
3 review. That's what I'm -- that's -- and it's  
4 NQF's 2082.

5 CO-CHAIR PINCUS: So --

6 MR. AMIN: John, is that correct? I  
7 just want to be clear because this is not -- now,  
8 we're talking about a new measure, just want to  
9 be specific.

10 CO-CHAIR PINCUS: Well, so, let me be  
11 clear. So this is not an eMeasure and it is not  
12 an already endorsed measure?

13 (Off-microphone comments.)

14 CO-CHAIR PINCUS: Okay, so, yes, so,  
15 I'm trying to get clear about this.

16 WORKGROUP CO-CHAIR BAGLEY: Harold,  
17 this is Bruce Bagley.

18 If I remember correctly, I don't think  
19 the committee had any problem with either one of  
20 these measures as a measure. The real problem is  
21 that they haven't been properly tested and  
22 evaluated in the real life situation.

1                   So I think that's really the only  
2 hurdle.

3                   PARTICIPATE: Their issue that was in  
4 the report was whether a gap existed.

5                   CO-CHAIR PINCUS: Okay. But let's --  
6 before we start getting comments, I just want to  
7 get clarity about what it is -- what's the issue,  
8 okay?

9                   So the issue for -- so let's start  
10 with I guess, 16-075. So the issue here is that  
11 that is -- is that or is that not an already  
12 endorsed measure?

13                  MEMBER BAKER: John, do you mind just  
14 walking through the conditions that are --

15                  CO-CHAIR PINCUS: So wait, let's get  
16 clear. Is it or is it not an endorsed measure?

17                  (Off-microphone comments.)

18                  CO-CHAIR PINCUS: Okay, okay, so, it's  
19 an endorsed measure. And let's not -- and, has  
20 been proposed by CMS is the use of that endorsed  
21 measure, Kate?

22                  (Off-microphone comments.)

1 CO-CHAIR PINCUS: Yes, that -- what  
2 you're proposing in the MUC is the use of that  
3 already endorsed measure? Oh, the eMeasure?

4 DR. GOODRICH: We already have the  
5 non-eMeasure form of these measures in our  
6 programs. This was to put the eMeasure form,  
7 which is in the process of being tested and so  
8 forth by HRSA so that they could be included in  
9 the program as well.

10 CO-CHAIR PINCUS: Okay. So, what  
11 you're proposing is the eMeasure version --

12 DR. GOODRICH: Correct.

13 CO-CHAIR PINCUS: -- to be included.  
14 It's not yet endorsed, but it's in the queue?

15 DR. GOODRICH: It's eMeasure form is  
16 not yet endorsed, right?

17 (Off-microphone comments.)

18 DR. GOODRICH: I'm pretty sure, that  
19 is -- okay, yes. It's coming to you guys soon.

20 CO-CHAIR PINCUS: Okay.

21 DR. GOODRICH: Yes.

22 CO-CHAIR PINCUS: So, we're clear

1 about the current status of it. So what were the  
2 issues that were raised?

3 MR. BERNOT: Okay so I can go through  
4 --

5 CO-CHAIR PINCUS: And was it  
6 conditionally supported?

7 (Off-microphone comments.)

8 MR. BERNOT: So I'll go through those.  
9 There's two different measures. So 07 --

10 CO-CHAIR PINCUS: Let's just start  
11 with the -- let's just do 075.

12 MR. BERNOT: 075, okay. 075 is  
13 conditionally supported. And the issues were  
14 even though the same issues came up, the reason  
15 the committee and Bruce or Erica can weigh in on  
16 this, the reason the committee went with  
17 conditional support on this was because of the  
18 fact that it was an outcome measure and they  
19 wanted to have -- the outcome was one of the  
20 issues that came up.

21 It was the same testing issues though.  
22 It still has not been through and the condition



1 was that it passes the -- or completes the  
2 eMeasure part of the endorsement process. So  
3 that was 075.

4 CO-CHAIR PINCUS: Okay. So let's  
5 discuss that first. So all right, do people want  
6 to discuss that 075?

7 Carl?

8 MEMBER SIRIO: I mean my comments will  
9 be relatively simple. One is, it gets me a  
10 little uncomfortable when we have a group this  
11 size trying to figure out what we're even talking  
12 about. That leads to a potentially disservice to  
13 the work that's been done in terms of the clarity  
14 of the question, to your point.

15 The second thing is, I think that the  
16 testing issue is a real one insofar as -- I mean  
17 that's one of the principles that we have really  
18 upheld over time which is, is that the wisdom of  
19 a process, at least with true testing in a field  
20 where the implications are real.

21 So the bottom line is, I would submit,  
22 that the workgroup did a lot of legwork on this

1 with clarity, I know we support the workgroup for  
2 this and the second measure.

3 CO-CHAIR PINCUS: Other comments?  
4 Rhonda?

5 MEMBER ANDERSON: I think we have seen  
6 this question from a very large number of  
7 workgroups when it's going for e-testing that  
8 they want to be certain that the testing is  
9 completed.

10 A question that I have is, if we have  
11 any data on those that have been already endorsed  
12 on paper and now have gone for e-testing, is  
13 there a correlation or a percentage that with the  
14 e-test issue that they actually are -- they have  
15 issues or problems?

16 I'm not quite sure what the results  
17 have been when they've gone for e-testing. So I  
18 just wondered if anybody has that information?

19 DR. BURSTIN: I don't think we have  
20 any --

21 MS. MARINELARENA: No, we don't. So  
22 that will be a discussion that the standing

1 committee has in March.

2 Now just to make things a little more  
3 confusing, we consider these legacy measures, the  
4 eMeasures. Right? Because they're based on  
5 existing paper-based measures that are in a  
6 federal program.

7 So our testing requirements are a  
8 little bit different. We will not have  
9 performance. They're not in use yet, of course.  
10 We don't have any performance rates for them.

11 I know that HRSA is in the process of  
12 testing them. We will -- we accept only -- we  
13 accept, at a minimal, Bonnie testing or using  
14 synthetic patients. So, I believe that's what  
15 we're going to be looking at. We haven't  
16 finished looking at our preliminary analysis yet.

17 For a legacy measure, that is the  
18 minimum that we require is Bonnie testing. This  
19 is the conversation that standing committees have  
20 every time, if you care to join us about the  
21 correlation between a paper-based measure and an  
22 eMeasure. But that discussion I'm sure, will be

1 had in March. But we don't have that information  
2 right now.

3 CO-CHAIR PINCUS: Aparna?

4 MEMBER HIGGINS: So do we have a sense  
5 for when HRSA might finish their testing or do --

6 DR. BURSTIN: Well it's being -- I  
7 mean, it's being submitted to us for review in  
8 March. So this is eminent.

9 MEMBER HIGGINS: Oh, okay.

10 DR. BURSTIN: And also you know --  
11 again, David can certainly speak to this, but  
12 laboratory data is readily available on a  
13 eMeasure. So I can't imagine it's a huge lift  
14 compared to some other potential eMeasures --  
15 with actually not large requirements because it's  
16 a legacy eMeasure.

17 Now new de novo eMeasures have a much  
18 higher lift than legacy measures.

19 MEMBER HIGGINS: Okay. Well, I think  
20 I just want to -- you know echo what Amy said  
21 about alignment with the Core Measures  
22 Collaborative. And you know -- the importance of

1 making sure that you know -- public and private  
2 programs, we have the same set of measures.

3 So I think there was a question  
4 earlier about gaps in performance, I can't  
5 remember who raised it I mean -- we had -- and  
6 Amy can correct me and Kate as far as these  
7 discussion too, we had some of those discussions  
8 in the HIV Hep C Workgroup when we were going  
9 through the Core Measures Collaborative.

10 We actually had physician  
11 representatives from both HIVMA as well as the  
12 Infectious Disease Society. And, these were  
13 practicing physicians as well and they talked  
14 about how they do see variations in care and  
15 practice and they had cited some studies which I  
16 don't remember right now, which is one of the  
17 reasons why we had included these measures in our  
18 core set.

19 So, I wanted to share that as well.

20 CO-CHAIR PINCUS: So Amy, are you  
21 still proposing that we re-vote on this?

22 MEMBER MULLINS: If this is a

1 conditional support and the condition being that  
2 it passes the eMeasure specs, then I am okay with  
3 that on 075.

4 CO-CHAIR PINCUS: Okay. Sounds like  
5 that's the way it is.

6 MEMBER MULLINS: Okay.

7 CO-CHAIR PINCUS: Okay, Bruce?

8 MEMBER HALL: And I just want to  
9 confirm them because the workgroup did ask  
10 whether performance gaps continue to exist. So  
11 Aparna has weighed in on that and I'm wondering,  
12 does the existing paper legacy measure also weigh  
13 in, that there are still gaps?

14 MS. MARINELARENA: So for the  
15 maintenance measure which is the paper-based  
16 measure, we do require performance over time.  
17 They have submitted that information to us.  
18 We're in the process of doing the initial  
19 analysis and then giving it to the committee.  
20 The committee will talk about it. But without  
21 looking at all of them, there probably is a gap.

22 And then we also asked for, once a

1 measure is topped out often, we'll ask -- we look  
2 at the -- for you know, gender, race, is there  
3 different gaps looking at that? So they've  
4 provided a lot of information, we're in the  
5 process of analyzing it.

6 CO-CHAIR PINCUS: David?

7 MEMBER BAKER: I think that last point  
8 was really important that, for determining  
9 whether a gap exists, it's the old chart-based  
10 measures. Because if we're seeing a gap on the  
11 eMeasures, that's a pseudo-gap. That's a problem  
12 with the eMeasures.

13 And that's what we've seen with some  
14 of the measures that have been submitted on a  
15 pilot basis to the Joint Commission. You know --  
16 organizations that were at 99 percent, 99  
17 percent, 99 percent and then, all of a sudden  
18 they're well less than 95 percent on the  
19 eMeasures.

20 CO-CHAIR PINCUS: So sounds like we  
21 can move on to consider actually 16-073.

22 MR. BERNOT: Sure. I can give the

1       brief introduction.

2               So 073, this is the same situation,  
3       the eMeasure of an existing measure. This was  
4       given a different assignment though. This one  
5       was given refine and resubmit, not the  
6       conditional support that 075 had.

7               So even though it's in the same  
8       situation and again, I'll ask Bruce and/or Eric  
9       if they'd like to contribute but, my  
10      understanding of the discussion was that they  
11      felt that the outcome measure, one -- that they  
12      wanted to get the outcome measure moving. They  
13      wanted to take more time on the process measure.  
14      And that was the difference.

15              Otherwise, it's in the same exact  
16      stage of testing, same time we'll have the  
17      testing data back that Melissa already mentioned.

18              CO-CHAIR PINCUS: So what exactly was  
19      the problem with it as a process measure that  
20      there was some inadequacy of the data in support  
21      of it?

22              MR. BERNOT: No, there's no difference



1 in the adequacy of the data between the two.  
2 That's just my recollection of the discussion.  
3 But again, I'd rather if Bruce or Eric wants to  
4 say anything to make sure that you recall this  
5 the same way that I do.

6 WORKGROUP CO-CHAIR BAGLEY: Yes, this  
7 is Bruce.

8 I think the main thing was that if  
9 you're successful on 075, it's not as important  
10 whether they went once to the doctor or 20 times  
11 to the doctor. If they have viral load  
12 suppression, they had to go to the doctor to get  
13 that done.

14 WORKGROUP CO-CHAIR WHITACRE: This is  
15 Eric.

16 And I do recall that that was the  
17 emphasis of the discussion. I also don't  
18 remember, and I may just have forgotten the issue  
19 about the consensus core set.

20 As I recall, that didn't come up  
21 because we do want to be sensitive to alignment  
22 and other measurement programs. And I just don't

1 remember if that was mentioned.

2 MR. BERNOT: Eric, just to clarify,  
3 that was just for 072 and she withdrew that one,  
4 the alignment issue. So we're okay on that.

5 WORKGROUP CO-CHAIR WHITACRE: Oh, I  
6 see, okay, okay.

7 MS. MARINELARENA: Sorry, this is  
8 Melissa again.

9 And another clarifying, CDP process is  
10 we review the legacy measures first. If it fails  
11 on any of the must-pass criteria such as  
12 evidence, which could be -- you know the case  
13 here or gap, then the legacy or the eMeasure  
14 version would not pass as well.

15 MEMBER MULLINS: Can I move that we  
16 vote on this? And I would like to submit that  
17 this get conditional support much like 075?

18 CO-CHAIR PINCUS: Chip?

19 CO-CHAIR KAHN: This whole discussion  
20 has gotten so much in the weeds, my mind has  
21 trouble getting in there.

22 But I think it really is important

1 here that we just keep in mind two things. You  
2 know -- one thing is, I guess, does it  
3 technically work?

4 And two, beyond it technically  
5 working, which I guess the Bonnie thing  
6 determines whether if it fits the logic, does it  
7 work in such a way that isn't a problem  
8 considering how EHRs work?

9 And I don't know -- I don't have a  
10 complete sense that the second is completely  
11 confirmed in these cases, even if the first is.

12 On the other hand, you know I'll go  
13 with the flow, but I think we have to be very  
14 careful when we're converting or moving from  
15 measures that are accepted and used in one area,  
16 you know, into EHRs because it -- the transfer,  
17 even if all the work is done on the very  
18 technical side doesn't necessarily carry.

19 So I think we have to be really  
20 careful here. But that's all I have to say. I  
21 don't think there's anything else to add.

22 CO-CHAIR PINCUS: Yes so I think for

1       this issue, the question is -- as I see it is,  
2       you know, is it, you know -- if the other  
3       measures or the other viral load measure actually  
4       passes you know, gets endorsement, is this really  
5       necessary?

6                   MEMBER MULLINS:   Yes.

7                   CO-CHAIR PINCUS:   Yes, that's the  
8       issue.

9                   MEMBER MULLINS:   Yes, because it's  
10      core set.

11                  DR. BURSTIN:   Right, but I think MAPS  
12      specifically talked about it in the context of,  
13      if you have an outcome measure, do you still need  
14      the associated process measure? And that came up  
15      multiple times during the earlier MAP work with  
16      their discussions as a MACRA initiative.

17                  CO-CHAIR PINCUS:   So let's let Amir go  
18      and then you, Kate, in case there's a response  
19      you have to make to that.

20                  MEMBER QASEEM:   So this measure has  
21      got problems beyond this. This is not the  
22      current standard anymore. I don't know if you

1       guys noticed or not.

2                   The two CD4 counts is not normal with  
3       the current standard. So I think we need to go  
4       back and look at the basic evidence behind it and  
5       actually look at the newer --

6                   CO-CHAIR PINCUS: Which measure are  
7       you referring to?

8                   MEMBER QASEEM: It's not 16-073?

9                   CO-CHAIR PINCUS: No. Yes, that's  
10      visit frequency.

11                  MEMBER QASEEM: Okay, hold on, let me  
12      just --

13                  WORKGROUP CO-CHAIR BAGLEY: It is  
14      actually viral load and not CD4 count.

15                  CO-CHAIR PINCUS: Yes, right, and  
16      that's what we're discussing.

17                  MEMBER QASEEM: So that's what I'm  
18      talking about that you're not supposed to come  
19      and get the CD4 count on every visit. You're  
20      supposed to actually follow up with a consistent  
21      viral load suppression over the forms or any  
22      other virtual visits or something like that.

1                   This is actually not evidence-based  
2                   measure any more. So it's beyond that discussion  
3                   we are having right now.

4                   DR. GOODRICH: But I think that's a  
5                   discussion for the NQF Endorsement Committee, for  
6                   one. I mean -- I'm not disagreeing with you on  
7                   that, I don't know the evidence at the tip of my  
8                   fingers, but I think that that's --

9                   MEMBER QASEEM: So if we approve this  
10                  measure, then it's going to get implemented,  
11                  right? So, we have to --

12                  DR. GOODRICH: Well I mean, we have a  
13                  condition for NQF endorsement and this one where  
14                  it would be very critical to go because they're  
15                  eMeasures to go through the testing, which is  
16                  what we're waiting on primarily I think before it  
17                  goes through endorsement.

18                  The other comment I wanted to make on  
19                  this one that I recall from the conversation in  
20                  the Core Measures Collaborative, but Aparna,  
21                  correct me if I'm wrong, because this came --  
22                  this issue came up about, if you've got the

1 outcome measure, why do you need this one?

2 I think the points that were made by  
3 people around the table during that discussion  
4 was, for the viral load suppression measure, in  
5 your denominator, you have to have people that  
6 you're seeing and drawing blood on.

7 And there's definitely a quality  
8 problem or a quality gap within the HIV community  
9 and I think a lot of folks felt like this was  
10 particularly the case in FQHCs and other types of  
11 clinics that serve you know, low income  
12 vulnerable populations that just getting people  
13 in to see clinicians to even get tested was just  
14 a major first hurdle.

15 And so, because there was a gap in  
16 that measure, as was described to us at the time,  
17 they felt like that having this measure was still  
18 needed.

19 Now I don't want to quibble with you  
20 over the evidence, you may well be right in that  
21 maybe that we shouldn't go forward with this  
22 measure. But I think we'd need more review of

1       that to understand.

2                   MEMBER QASEEM:   So what I was  
3       suggesting was we can keep it as refine and  
4       resubmit and let the group address this issue  
5       because I don't think we will be able to resolve  
6       it over here.

7                   DR. BURSTIN:   Although that's what we  
8       do conditional support for.  If we know this is a  
9       measure that's coming forward, it could be  
10      conditional.  I think that's the point.

11                   CO-CHAIR PINCUS:   Aparna?

12                   MEMBER HIGGINS:   So to -- I'd echo  
13      with what Kate said and that's exactly the  
14      discussion our HIV Hep C Workgroup had.  And  
15      again, it was a lot of them were clinicians who  
16      you know, specialists who were treating patients  
17      who had seen this and saw this as a problem,  
18      which is why we included both measures in our,  
19      you know, in our core set.

20                   So I would agree with Amy that you  
21      know, given that the other measure was  
22      conditional support and this is going through



1 ECQM testing, we should consider this in the same  
2 way.

3 CO-CHAIR PINCUS: So you're proposing  
4 that we pull it and we re-vote. Now if we're  
5 voting for conditional support, we're talking  
6 about it going -- it is up for review, correct?  
7 As an eMeasure or as a paper measure? Both? As  
8 both?

9 MS. MARINELARENA: But the one before  
10 you right now is the eMeasure for now.

11 CO-CHAIR PINCUS: Right. But it's  
12 coming up for review in March as well. So why  
13 don't we vote with the understanding that that's  
14 the condition, if we vote for conditional  
15 support?

16 MS. OGUNGBEMI: All right, voting is  
17 open. We are voting on MUC 16-073, HIV Medical  
18 Visit Frequency in the MIPS Program.

19 Your options are one, support, two,  
20 conditional support, three, refine and resubmit,  
21 four, do not support.

22 Voting is open.

1                   MEMBER GIFFORD: I'm abstaining from  
2                   voting for a conflict of interest.

3                   MS. IBARRA: Brandon, Dora, Eric,  
4                   Foster and Steve, we received your votes, thank  
5                   you.

6                   MS. OGUNGBEMI: Results are 4 percent  
7                   support, 65 percent conditional support, 26  
8                   percent refine and resubmit and 4 percent, do not  
9                   support.

10                  Our 60 percent threshold is met and  
11                  conditional support.

12                  CO-CHAIR PINCUS: Any further  
13                  discussion about any of the measures on the -- in  
14                  the clinician group?

15                  MEMBER QASEEM: The couple of  
16                  measures, if I can just hear some of the  
17                  comments, one is the 16-398, the Cardiac  
18                  Electrophysiology. I think it's refine and  
19                  resubmit and I just wonder, I wasn't really  
20                  clear, why is that refine and resubmit?

21                  I think it seemed like, at least to  
22                  me, it's a great measure. There's a lot of

1 inappropriate use. It's incredibly expensive.  
2 It's evidence-based based on the current  
3 guidelines by ACC and AHJ.

4 CO-CHAIR PINCUS: Could you repeat  
5 what measure that was?

6 MEMBER QASEEM: It is 16-398.

7 DR. BURSTIN: No testing data has been  
8 done yet, yes.

9 MEMBER QASEEM: The second one I  
10 wanted to ask is just, give me one second, let me  
11 get the right number here, guys. This is -- it's  
12 16-287. It is the, hold on, I'm scrolling down,  
13 it's the bone density one.

14 So that again, is it the duration?  
15 Because again it's -- because it seems like it  
16 would improve clinical outcomes based on the  
17 guidelines as well. It's evidence-based. It's  
18 here, I read as a good measure.

19 MR. BERNOT: There was -- so there are  
20 two issues on that, the data was the big one.

21 MEMBER QASEEM: It's the same issue as  
22 --

1 MR. BERNOT: The second one was the  
2 populations, that whether inclusion or exclusion  
3 of populations were adequate.

4 MEMBER QASEEM: Okay. Sorry, and my  
5 list is long. Sorry guys, but we have until 5:00  
6 to discussion clinical measures right, clinician  
7 measures?

8 16-069, the smoking one -- I was  
9 surprised that it didn't go through. Can you  
10 just tell me what happened?

11 MR. BERNOT: Yes, just the -- this was  
12 the attribution issue, plus testing data. This  
13 was the county level attribution that whether an  
14 individual clinician or, even in the case, so  
15 that was for the MIPS side, could influence that.

16 Or whether the ACO and the MSSP could  
17 effectively be held accountable for that measure.

18 MEMBER QASEEM: Okay. But it is a  
19 MIPS measure though, right?

20 That's it.

21 CO-CHAIR PINCUS: Okay. Now we do  
22 have one public commenter that was unable to get

1 through earlier. And so can we hear from that  
2 public comment?

3 OPERATOR: Okay, and the comment comes  
4 from Soeren Mattke.

5 DR. MATTKE: Hi, can you --

6 CO-CHAIR PINCUS: Hi, Soeren, it's  
7 Harold Pincus.

8 DR. MATTKE: Hi.

9 CO-CHAIR PINCUS: Can you --

10 DR. MATTKE: Hi, Harold.

11 Yes, Soeren Mattke, SRM. We have the  
12 developers of 16-151 which received conditional  
13 support by the workgroup and the conditional  
14 support was pending the clarification of one  
15 question. I wanted to do that.

16 The measure which is NQF endorsed  
17 looks at whether patients receive risk assessment  
18 for febrile neutropenia prior to assumption of  
19 chemotherapy.

20 And the question that the workgroup  
21 had was whether a protocol-based risk assessment  
22 system would meet our criteria? And our answer

1 is yes, if that system gives appropriate  
2 consideration to both patient level and regime  
3 level risk factors.

4 The rationale is that current  
5 guidelines recommend use of CSF prophylaxis to  
6 avoid febrile neutropenia if the expected risk of  
7 febrile neutropenia is greater than 20 percent.

8 That risk depends, on the one hand, on  
9 the inherent toxicity of the chemotherapy regime  
10 but also on patient risk factors like age, prior  
11 treatment and, comorbidity.

12 So you're going to have regimes where  
13 you have an inherent toxicity risk always greater  
14 than 20 percent just because the drugs are that  
15 toxic. But there are also regimes for which the  
16 risk will be above 20 percent only if you are  
17 talking about higher risk patients like elderly  
18 or frail patients.

19 So our answer is, if a protocol system  
20 is able to incorporate both the regimen level and  
21 the patient level factors, it is perfectly  
22 compliant with how we specified the measure.

1                   We want to make one other  
2 clarification. The workgroup correctly pointed  
3 out that the measure will make it more likely  
4 that patients with higher risk receive beneficial  
5 CSF prophylaxis.

6                   But we wanted to emphasize that the  
7 measure will also make it less likely that lower  
8 risk patients receive an extensive treatment with  
9 potential side effects and potentially low value.

10                  And for those reasons, we would  
11 request that you reconsider and re-vote on the  
12 measure to give it full level unconditional  
13 support.

14                  Thank you.

15                  CO-CHAIR PINCUS: Thank you, Soeren.

16                  Is there comment, discussion from the  
17 task force or from the coordinating committee?

18                  Is there a move to make any change?

19                  Okay. Any other comments on any other  
20 issues from the task force, from the coordinating  
21 -- yes, I'm going back to my Medicaid task force  
22 role.

1                   Okay, well, so we pretty much finished  
2 then, the agenda for today.

3                   DR. BURSTIN: We have the consent --

4                   CO-CHAIR PINCUS: Oh, yes, the consent  
5 calendar, right.

6                   So, we'll accept people want to --  
7 anybody want to nominate the acceptance of the  
8 consent calendar?

9                   MEMBER SAKALA: So moved.

10                  CO-CHAIR PINCUS: Okay. All in favor?

11                  (Chorus of ayes.)

12                  CO-CHAIR PINCUS: Opposed?

13                  (No response)

14                  CO-CHAIR PINCUS: Okay so we finished  
15 our agenda for today. So Erin, do you wanted to  
16 discuss what -- how things are going to go  
17 tomorrow?

18                  MS. O'ROURKE: Sure. So for tomorrow,  
19 we are actually going to focus more on some  
20 crosscutting issues that arose from the  
21 workgroup's deliberations.

22                  First, we're going to present some of



1 the findings of NQF's recent attribution expert  
2 panel. As John was noting in his presentation,  
3 we heard a lot of concerns about how MAP should  
4 be handling attribution issues. And in  
5 particular, who has the locus of control for a  
6 measure and a patient's outcome.

7 So we wanted to highlight some of the  
8 findings of that committee to perhaps allow the  
9 coordinating committee to give some more guidance  
10 to the workgroup on concerns about attribution.

11 We also will have an update on the  
12 Medicaid Task Forces. In particular, we're doing  
13 some work to improve that process that we need  
14 approval from the coordinating committee.

15 In particular, John is going to show  
16 you a preliminary analysis algorithm that the  
17 task forces would be using, similar to what the  
18 workgroups used for the pre-rule making  
19 recommendations.

20 We want to ensure that MAP's doing all  
21 of its work as consistently as possible.

22 We will also have presenters from ASPE

1 here to share with you some of the findings from  
2 the Impact Act study.

3 I will also be giving an update on  
4 NQF's trial period for risk adjustment for SDS  
5 factors. And we'll be looking for discussion and  
6 any thoughts the coordinating committee might  
7 have on a potential path forward on that issue.

8 We know we are unlikely to resolve  
9 such a topic but, did want to keep you abreast of  
10 developments in the field and potential  
11 implications for MAPs work.

12 And then finally, in the spirit of  
13 process improvement, we'll be having a session to  
14 get feedback from the committee on what worked  
15 and what didn't and, some areas where we'd like  
16 guidance from the coordinating committee to  
17 improve the process for next year's approval  
18 making work just to get you think about that.

19 In particular, we welcome some  
20 comments on how we can better clarify the  
21 distinctions between the decision categories.  
22 We'd also welcome any thoughts you have on how we

1       could better do the review of the measures that  
2       are currently in the program set in particular,  
3       what's the most useful information that MAP  
4       members need to make recommendations on the  
5       measures that are currently in the sets.

6               And then finally, we'll be sharing  
7       with you some information on the feedback loop  
8       pilot that we tested with the post-acute care,  
9       long-term care workgroup this past fall as a way  
10      to keep MAP up to date on some of the  
11      developments that have happened to the measures  
12      since MAP has made their recommendations as a way  
13      to show that we are getting progress on some of  
14      the refines and resubmits, if you will.

15             So we want to hopefully roll that out  
16      across the workgroups. So we'd welcome input  
17      from the coordinating committee members on how we  
18      can do that most effectively.

19             So that's all for tomorrow but did  
20      want to just put some of those issues in your  
21      minds for mulling over tonight.

22             Helen, anything else?

1 CO-CHAIR PINCUS: So you have a little  
2 bit of extra time. And want to thank NQF staff,  
3 thank the committee, thank my Co-Chair Chip and  
4 also the workgroup Chairs, as well.

5 We will reconvene tomorrow morning at  
6 breakfast at 8:30.

7 (Whereupon, the above-entitled matter  
8 went off the record at 3:40 p.m.)  
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership  
Coordinating Committee Meeting

Before: National Quality Forum

Date: 01-24-17

Place: Washington, DC

was duly recorded and accurately transcribed under  
my direction; further, that said transcript is a  
true and accurate record of the proceedings.

  
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Court Reporter

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NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP  
COORDINATING COMMITTEE MEETING

+ + + + +

WEDNESDAY,  
JANUARY 25, 2017

+ + + + +

The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, NW, Washington, DC, at 9:00 a.m., Charles Kahn and Harold Pincus, Co-Chairs, presiding.

PRESENT:

CHARLES KAHN III, MPH, Co-Chair

HAROLD PINCUS, MD, Co-Chair

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

DAVID BAKER, MD, MPH, FACP, The Joint Commission

MARY BARTON, MD, National Committee for Quality  
Assurance

JOHN BOTT, MSSW, MBA, Consumers Union

MARY BETH BRESCH WHITE, American Nurses  
Association

STEVE BROTMAN, MD, JD, AdvaMed\*

JENNIFER BRYANT, MBA, Pharmaceutical Research and  
Manufacturers of America (PhRMA)

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

FOSTER GESTEN, MD, FACP, National Association of  
Medicaid Directors\*

BRUCE HALL, MD, PhD, MBA, FACS, American College  
 of Surgeons  
 APARNA HIGGINS, MA, America's Health Insurance  
 Plans  
 BRANDON HOTHAM, MPH, Maine Health Management  
 Coalition\*  
 WILLIAM KRAMER, MBA, Pacific Business Group on  
 Health  
 SAMUEL LIN, MD, PhD, MBA, MPA, MS, AMGA  
 AMY MULLINS, MD, FAAFP, American Academy of  
 Family Physicians  
 R. BARRETT NOONE, MD, FACS, American Board of  
 Medical Specialties\*  
 SHAUN O'BRIEN, JD, AFL-CIO  
 AMIR QASEEM, MD, PhD, MHA, American College of  
 Physicians  
 CHRIS QUERAM, MS, Network for Regional Healthcare  
 Management  
 ARI ROBICSEK, MD, Providence Health and Services  
 KORYN RUBIN, American Medical Association (for  
 Carl Sirio)  
 CAROL SAKALA, PhD, MSPH, National Partnership for  
 Women & Families  
 MARISSA SCHLAIFER, RPh, MS, Academy of Managed  
 Care Pharmacy  
 STEVEN WOJCIK, MA, National Business Group on  
 Health\*

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, MS  
 DORIS LOTZ, MD, MPH\*

FEDERAL GOVERNMENT LIAISONS PRESENT:

DAVID HUNT, MD, FACS, Office of the National  
 Coordinator for Health Information  
 Technology (ONC)  
 NANCY WILSON, MD, MPH, Agency for Healthcare  
 Research and Quality (AHRQ)



NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer  
ELISA MUNTHALI, Vice President, Quality  
Measurement  
MARCIA WILSON, Senior Vice President, Quality  
Management  
TAROON AMIN, NQF Consultant  
KIM IBARRA, Project Manager  
YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst  
ERIN O'ROURKE, Senior Director  
DEBJANI MUKHERJEE, Senior Director

ALSO PRESENT:

NANCY DE LEW, ASPE/HHS\*  
KATE GOODRICH, MD, CMS  
RENEE FOX, MD, CMS\*  
KAREN JOYNT, MD, MPH, ASPE/HHS\*  
ROBIN YABROFF, ASPE/HHS\*  
PIERRE YONG, MD, CMS  
RACHEL ZUCKERMAN, ASPE/HHS\*

\* present via telephone

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

9:09 a.m.

CO-CHAIR KHAN: So I think we have the same crew. I think Gif had some family issue or something, had to leave. But pretty much the same crew as yesterday. It's really great having entertainment.

I thank the NQF staff for providing that. I feel like when I was be in high school, I grew up in New Orleans and we would out in August doing football practice, and you know it was like 95 degrees. But, you know, in terms of the real heat it was probably 120.

The coaches would yell and scream that this was fun in the sun. People paid thousands of dollars for this, and we were getting it for free. So since all of you are paying so much to come today, are being paid so much to come today, either way you look at it, we've given you free entertainment up here.

So I hope everybody got their before pictures and we'll see what happens in terms of

1 when the -- we can take a break when the banner  
2 comes down and everybody can go take their after  
3 pictures.

4 So moving on, I think in terms of  
5 yesterday, I guess what is there to say but we  
6 accomplished most of the major areas, and went  
7 through a number of measures and had votes, and I  
8 think successfully completed a good bit of our  
9 task. I don't know what -- do you want to add  
10 anything?

11 CO-CHAIR PINCUS: No, I think we did  
12 a great job yesterday. I think we've gone  
13 through everything, had a complete discussion. I  
14 think the discussion we had yesterday will inform  
15 some of the discussion planned for today, in  
16 terms of thinking about some of issues around  
17 attribution.

18 We're going to get an update about  
19 some of the Medicaid processes which are being  
20 conformed to be more closely with how we've been  
21 operating in terms of the Coordinating Committee,  
22 and we're also going to hear about some of the

1 issues around various risk-adjustment scenarios.

2 CO-CHAIR KHAN: So just without  
3 further ado, why don't we, I guess Harold will  
4 facilitate this, but we go to Erin and Helen now  
5 for the Pre-Rulemaking Cross-Cutting Issues colon  
6 Attribution.

7 MR. AMIN: Great, Chip. Erin and I  
8 will take the lead on the attribution discussion,  
9 and I encourage Helen to jump in as we go  
10 forward.

11 So one of the interesting things with  
12 this attribution work is that, you know, as we  
13 had our conversation yesterday around the  
14 consensus-development process, and some of the  
15 learnings that we've had with the measure  
16 selection process here with the MAP, many of  
17 these measurement science, basic science issues  
18 that emerged through our conversations, and many  
19 times our committees don't really have enough  
20 time to really dig deep into them.

21 We identify them both through the  
22 measure evaluation process and also through the

1 very thoughtful comments of our members and  
2 stakeholders through our commenting process. The  
3 discussion around attribution has been one that's  
4 sort of plagued us for several years and, you  
5 know, there are many of you in the room who have  
6 had the opportunity to be part of these  
7 conversations in many different forums.

8           You know, a few that come to mind,  
9 Bruce your work with the Readmissions Committee,  
10 Amir, all your work with the, you know, the  
11 clinician measures and as we think about, you  
12 know, how do we think about shared accountability  
13 and at the same time be able to have clinician-  
14 level measures that are meaningful.

15           Actually in a lot of ways, Carol, your  
16 work with the linking cost and quality work that  
17 you led several years ago sort of at the same  
18 time led to some of these initial discussions  
19 around how do we think strategically about the  
20 question, the measurement science question of  
21 attribution.

22           And so we embarked on a project over

1 the last year to at least start to really  
2 identify, from the guidance of the NQF Board,  
3 around a path forward for some of the measurement  
4 science issues with attribution. So the purpose  
5 of this morning's conversation is to give you a  
6 summary of some of our discussions, which are in  
7 some ways very preliminary.

8 We've identified that there's, you  
9 know, at a very high level that, you know,  
10 there's a tremendous amount of variation in terms  
11 of attribution models that exist, as Erin will  
12 talk through in some of the environmental scan  
13 undertaken by Andy Ryan's group at the University  
14 of Michigan, who helped support this work.

15 Essentially, we agreed that a good  
16 path forward would be to identify guiding  
17 principles about the evaluation and selection of  
18 attribution models, and then develop a selection  
19 guide to help users, both public and private  
20 users of measures, to identify best practices for  
21 attribution as place to start from.

22 And again, those of you who are

1 measure developers in the room who have been  
2 thinking about this quite a bit and have  
3 struggled with attribution models as you're  
4 developing your measures, we would certainly  
5 welcome your thoughts and feedback as we discuss  
6 the work here.

7           So you know again, some of the other  
8 inputs. Legislation such as the IMPACT Act and  
9 MACRA continue to focus on developing and pushing  
10 forward value-based purchasing programs by  
11 realigning incentives, and again, the question  
12 here as we think about shared accountability in  
13 an environment of pay-for-performance models,  
14 there needs to be a decision made around how and  
15 who to hold accountable for the results of  
16 quality and efficiency measures to ultimately  
17 judge performance.

18           Increasingly as we are looking toward  
19 measuring outcomes, this question of attribution  
20 becomes even more important. When we think about  
21 the question of attribution, it really is the  
22 methodology used to assign patients and their



1 quality outcomes to patients or clinicians, and  
2 helping to identify the patient relationships  
3 that we're trying to measure.

4 And as we again move the system away  
5 from fee for service to alternative payment  
6 models, the question about how we attribute  
7 performance again becomes increasingly important.

8 So this project scope was taking into  
9 account these trends, just moving to the next  
10 slide please, was taking into some of these --  
11 taking into account some of these trends, and our  
12 overarching goal which has come up through the  
13 MAP process over this last several years, and is  
14 one of our guiding principles around shared  
15 accountability.

16 We've brought together a  
17 multistakeholder group to really be able to  
18 advance the measurement science of this area,  
19 first by identifying the key challenges in  
20 attribution that have been identified in the  
21 field, but also have been identified through all  
22 of our work. Again, the MAP selection process

1 and the CDP, develop a set of guiding principles,  
2 identify elements of an attribution model.

3 Again this -- I have to say this was  
4 one of the elements that I thought was one of the  
5 key components that I was really surprised by is  
6 that we look forward into what we describe as an  
7 attribution model, there is a lot of variation in  
8 terms of what's even included in an attribution  
9 model.

10 So it's really setting a foundation of  
11 what are the key elements of what we -- when we  
12 describe an attribution model, what are the key  
13 elements, exploring some strengths and weaknesses  
14 as you're developing tradeoffs, and then  
15 identifying some recommendations for developing,  
16 selecting and implementing attribution models.

17 So Erin will talk us through some of  
18 the project, you know, activities in more detail.

19 CO-CHAIR PINCUS: Taroon, one quick  
20 question. When you say model, what do you mean  
21 by a model?

22 MR. AMIN: I think that's inherently

1        what we were trying to define when we talk about  
2        the elements, and I think we'll get into that in  
3        a moment. Again, we struggled -- actually we  
4        struggled with that particular question quite a  
5        bit through this project.

6                    MS. O'ROURKE: Thanks, Taroon. So on  
7        this side, you can see who served on the  
8        committee. I won't read all the names,  
9        obviously, but just to give you an idea that it  
10       was a multistakeholder committee that included  
11       clinicians, providers.

12                   We tried to get providers from across  
13       the care continuum, in addition to public and  
14       private sector payers, purchasers, a consumer  
15       representative.

16                   It was chaired by Ateev Mehrota from  
17       Harvard and Carol Raphael, a former member of the  
18       MAP Coordinating Committee. So we did want to  
19       make sure someone could share some of the measure  
20       selection challenges the MAP has faced over the  
21       years and bring forward some of the discussions  
22       you've had about attribution.

1           So as Taroon was saying, we started  
2       this project by commissioning an environmental  
3       scan from Andy Ryan and his team at the  
4       University of Michigan, to see what they could  
5       find in the literature about what's currently  
6       being used as far as attribution models go. They  
7       found about 163 models that are either in use or  
8       proposed for use.

9           The vast majority actually were not in  
10      use. Only 70 percent were currently in use. Of  
11      what they found, 89 percent used retrospective  
12      attribution, and 77 percent attributed to a  
13      single provider, generally a physician. As  
14      Taroon was saying, we really struggled on how you  
15      even define an attribution model.

16           Some of the elements that they used to  
17      categorize a model were the stage of the program,  
18      the type of provider that results were attributed  
19      to, the timing of the attribution calculation,  
20      clinical circumstances, the payer or programmatic  
21      circumstances.

22           If the attribution was exclusive to

1 one provider or clinician or was shared among  
2 multiple, which measures they used to determine  
3 who would be responsible, as well as the minimum  
4 requirement to make attribution and the period of  
5 time for which a provider is responsible for a  
6 given patient.

7 MR. AMIN: Erin, before you move on  
8 from this slide, going back to Harold's question,  
9 I think what we tried to actually put forward  
10 here on the left side of this slide was that if  
11 you think about the specifications of a measure,  
12 of a performance measure that's submitted to NQF,  
13 we were sort of thinking about what's on the left  
14 side of the slide as the specifications of an  
15 attribution model.

16 Again, we understand, and Erin will  
17 get into this, there was no best practice. But  
18 these are the elements that we would want to  
19 evaluate as you're looking at -- or, yes,  
20 evaluate as you're looking at an attribution  
21 model.

22 MS. O'ROURKE: Next one. So some of

1 the key findings that we wanted to highlight for  
2 you from the Commission paper, as Taroon was  
3 saying, one of the author's main conclusions was  
4 that best practices for attribution have really  
5 not yet been determined.

6 They found that the existing models  
7 have been largely built off of what was  
8 previously used, without a lot of consideration  
9 of the different tradeoffs and the development of  
10 attribution models that need to be explored and  
11 made transparent to all the stakeholders.

12 They found there's really no standard  
13 definition for an attribution model, and this  
14 lack of standardization really limits the ability  
15 to objectively evaluate the models and compare  
16 them to each other, to eventually get to that  
17 evidence base that would allow us to make  
18 determinations of best practices.

19 So some challenges that the Committee  
20 wanted to start to tackle in this work. First,  
21 greater standardization is needed among the  
22 models so that we can start to make these

1 comparisons and allow best practices to emerge.  
2 They found there's little consistency across  
3 models, but there's actually quite a bit of  
4 evidence that changing the rules of attribution  
5 can dramatically alter the results on how a  
6 clinician or provider might look on the results  
7 of a program or a measure.

8 This lack of transparency on how  
9 results are attributed really means there's no  
10 way to appeal the results of an attribution model  
11 that could wrongly assign responsibility to a  
12 particular clinician or provider.

13 Next slide. So to start to address  
14 these challenges, the Committee came up with a  
15 number of different products in this work, if you  
16 will. They developed a set of guiding  
17 principles.

18 They made a number of recommendations  
19 about attribution models going forward, and they  
20 created a tool for calling the attribution  
21 selection model guide that Taroon will get into  
22 in greater detail.

1                   These products allow for greater  
2                   standardization, transparency and stakeholder  
3                   buy-in. The Committee was aiming that, in the  
4                   future, this would allow for the evaluation of  
5                   attribution models and to start to lay the  
6                   groundwork so that we can develop the necessary  
7                   evidence base to determine what the best  
8                   practices may be.

9                   MR. AMIN: So as we get into the  
10                  guiding principles, before we get any further,  
11                  Helen, is there any other sort of introductory  
12                  sort of comments about the group's work here and  
13                  sort of the importance or the background that you  
14                  want to get into before we go --

15                 DR. BURSTIN: Just to highlight two  
16                 things I think we'll do here shortly, which is  
17                 really surprising there is no gold -- there is no  
18                 gold standards, which is why we thought having an  
19                 approach that everyone could use consistently was  
20                 really important.

21                 And secondly, just there's also a lack  
22                 of transparency in the way the attribution models



1 are discussed, thought about and then shared with  
2 those who would be measured. There's a real  
3 opportunity here to just be very transparent, and  
4 try to have a consistent approach. But a lot  
5 more to do in this phase, for sure. I think this  
6 is really just a way for us to begin working in  
7 this space.

8 MEMBER ROBICSEK: Quick question and  
9 maybe this will become clear as we describe this  
10 more. But in a world where there's no gold  
11 standard, against what sort of reality do you  
12 validate these models against?

13 MR. AMIN: So I think, let's try it --  
14 let me try to get to that through this work,  
15 through the discussion here, because I think the  
16 use and intent is really what we are comparing  
17 the components of an attribution model against.  
18 But again, let's try to get to that and if we  
19 don't hit the mark, this is where we're  
20 interested in the feedback from the group.

21 MEMBER QASEEM: You guys also had that  
22 evidence review done by the Michigan people.

1 MR. AMIN: Absolutely.

2 MEMBER QASEEM: Did you find anything  
3 even in terms of evidence, because you're talking  
4 about the, you know, attribution model evidence  
5 base. It goes back to what Erin was saying. I'm  
6 not sure that there is much there.

7 MR. AMIN: Well, yes. I mean actually  
8 what Erin just described at the beginning of this  
9 around the, you know, the review of all the  
10 attribution models, that was from the evidence  
11 review from the University of Michigan, and  
12 that's what the Committee used as their starting  
13 point.

14 MS. O'ROURKE: And to your point, I  
15 think that's what Andy and the other authors were  
16 really trying to highlight, is people just  
17 developed their models based on what's been  
18 previously done, without any objective evidence  
19 of if it's working or if it's really attributing  
20 correctly.

21 DR. BURSTIN: And as far as evidence,  
22 it's evidence -- there also very little testing

1 of the different models to see their impact. So  
2 that's our key issue too.

3 CO-CHAIR PINCUS: I think there's  
4 somebody on the phone who has a question.

5 MEMBER BAKER: I am still struggling  
6 with this, because I would think you would want  
7 to be able -- the gold standard would be if you  
8 actually looked at the clinical situation, and  
9 said yes, this person was truly responsible for  
10 the care. That would be the gold standard.  
11 That's incredibly hard to do.

12 (Off mic comment.)

13 MEMBER BAKER: That's a good question.  
14 I think, you know, you'd have to. It's the  
15 question of who's responsible. Is this the  
16 primary care physician, for example, who refers  
17 to a specialist, and then the specialist carries  
18 out a variety of things, or the primary care  
19 physician still had some involvement in that?

20 But what about the situation which is  
21 very common, where patients can go to a  
22 specialist, right, and the results are coming

1 back to the primary care physician and the  
2 specialist already did a whole bunch of the  
3 expensive wacky things, right, and some of which  
4 I need to follow up on.

5 This happens all the time in the  
6 emergency department. Somebody comes in, gets a  
7 CT scan. They have multiple incidental findings  
8 and the recommendation from Radiology are follow-  
9 up CT scan every six months for two years, that  
10 these endocrine tracks, and I've just spent  
11 \$10,000 on something that was really the original  
12 test was not appropriate.

13 So that's the type of thing. It's  
14 just really hard to get into, you know, who is  
15 really -- especially I'm thinking about cost.  
16 Who's really the drivers in that?

17 DR. BURSTIN: I think we'll come to  
18 that.

19 (Off mic comment.)

20 CO-CHAIR PINCUS: But I do think it's  
21 a very complex question that seems, because in  
22 some -- and it depends on a number of things.

1       Number one is that in some cases, you know, it's  
2       like a projective test. You know, you talk to a  
3       group of people that are involved with the  
4       patient and you are not necessarily going to get  
5       a unanimous opinion about who's responsible for  
6       what.

7                   DR. BURSTIN: I think that's why  
8       you'll see what we've laid out as a series of  
9       questions that should be part of a dialogue to  
10      begin getting to that. Jack Resnick, who's on  
11      the Committee, who's a dermatologist from UCSF,  
12      gave an excellent example of how he treats a lot  
13      of psoriasis as UCSF.

14                   He tends to see those patients fairly  
15      frequently because they come in for treatments.  
16      So depending on the attribution model, at times  
17      he is labeled as the one who's the person's  
18      principal physician because he seems them most,  
19      and all the costs of their associated CHF,  
20      pulmonary disease, anything goes to him. But he  
21      truly has no actual role in controlling or  
22      thinking about any of that.

1                   So I think when you see the principles  
2                   and the recommendations, let's come back and see  
3                   if we've answered some of these. Go ahead.

4                   CO-CHAIR KHAN: I'd like to propose on  
5                   other thing as we get into the next discussion,  
6                   which is here we're talking about specific sort  
7                   of measures regarding a particular care. Let's  
8                   look at readmissions.

9                   What some of the global measures or  
10                  the cost efficiency measure that's so, to me  
11                  horrendous inside of value-based purchasing, it  
12                  just assumes over a 38 period, or is it 30 days,  
13                  whatever the period is, that the hospital, which  
14                  is going to be judged, is somehow in control of  
15                  those costs.

16                  Now if there's a readmission, maybe  
17                  there was a hack and it's the hospital's fault.  
18                  But you know, in terms of who really is the  
19                  decision-maker, well you know in a voluntary  
20                  medical staff, heavens knows who's the decision-  
21                  maker.

22                  MR. AMIN: Right.

1 CO-CHAIR KHAN: So the trouble is it's  
2 with the global issues as well as --

3 DR. BURSTIN: Absolutely.

4 CO-CHAIR KHAN: On the global  
5 measures, as well as the ones that are --

6 DR. BURSTIN: Correct, and we actually  
7 used that measure as a case study, Chip, in the  
8 report, to work through the decision guide.

9 CO-CHAIR PINCUS: And I just want to  
10 say, I don't think it's more complicated when you  
11 add in the population-based measures that have  
12 been --

13 DR. BURSTIN: Oh yes. We have another  
14 case on that one too.

15 CO-CHAIR PINCUS: Okay, good.

16 MR. AMIN: So I think as we just sort  
17 of wanted to set the foundation, I think as we  
18 talk about this, there's a tremendous amount of  
19 complexity that I think we've just started to  
20 unpack here. But I think what the Committee  
21 wanted to do was to at least set some baseline  
22 sort of parameters, if you will, so guiding

1 principles, first to acknowledge the complexity  
2 and the multidimensional.

3 They were very particular about the  
4 language here, which is why I typically don't  
5 like to actually read the actual language. But  
6 they were very particular about the language, and  
7 I want to make sure that we're all on the same  
8 page or I'm not mischaracterizing it.

9 The multidimensional challenges with  
10 implementing attribution models, as they can  
11 change depending on their purpose and the data  
12 available. They should be grounded in the  
13 National Quality Strategy, as attribution can  
14 play a critical role in advancing these goals.  
15 And again, this is where, you know, we talk about  
16 the importance of measures, measures alignment  
17 and measure selection.

18 But attribution, which can refer to  
19 both the attribution of patients for  
20 accountability purposes and the attribution of  
21 results of a performance measure are both equally  
22 as important.



1                   They also highlighted the absence of  
2                   a gold standard for designing or selecting an  
3                   attribution model, and must understand -- you  
4                   must understand the use and the goals of each use  
5                   case, and then the key criteria for selecting  
6                   attribution are the actionability of the  
7                   accuracy, fairness and transparency.

8                   So as we go to the principles on the  
9                   next slide, the attribution model should fairly  
10                  and accurately assign accountability.

11                 Attribution models are an essential part of  
12                 measure development, implementation, policy and  
13                 program design. Consider choices among available  
14                 data are fundamental in the design of an  
15                 attribution model.

16                 Attribution models are not stagnant,  
17                 and they should be reviewed and updated  
18                 regularly, particularly as data, enhanced data  
19                 assets become available. Attribution models  
20                 should be transparent and consistently applied,  
21                 and attribution models should align with the  
22                 stated goals and the purpose of the program.

1 Again, this is where some of the work as it  
2 relates to MAP comes in.

3 So the second component here of what  
4 the Committee wanted to develop is this  
5 attribution model selection guide, and the  
6 current state here is that there's a tension for  
7 the desire for clarity around an attribution  
8 model's fit for purpose and the state of the  
9 science related to attribution model.

10 There is a desire, and this is a lot  
11 of what we heard through the NQF endorsement  
12 process and a lot of what we heard from the  
13 Board, to clarify which attribution models should  
14 be used in a given circumstance, you know. When  
15 should we hold certain -- some actors accountable  
16 in certain situations.

17 But there is not enough evidence to  
18 support the development of such rules at this  
19 time. So the goals of the attribution model were  
20 really to aid measure developers, measure  
21 evaluation committees and program implementers on  
22 the necessary elements of an attribution model

1 that should be specified a priori, and represent  
2 the minimum number of elements that should be  
3 shared with those being held accountable.

4 So on the next slide, I know this is  
5 really small to read, but I want to just sort of  
6 point out on the next slide. So on the left  
7 side, these are the elements, and I'll walk  
8 through, you know, what the Committee was  
9 actually recommending as you think about  
10 attribution models.

11 So on the left side I'll walk through  
12 what is the context and goal of the  
13 accountability program, and Ari, to your point  
14 earlier, you know, I think this was a key part of  
15 the discussion around what are you measuring  
16 against. The second component is how do the  
17 measures relate to the context in which they're  
18 being used, which is a lot of the conversation we  
19 have in the MAP.

20 You know, as we think about new  
21 measures coming in, what are the current measures  
22 in the set, what are the goals of the program,

1       which units will be affected by the attribution  
2       model, and then how is the attribution performed.  
3       And then so as we go through each box here, the  
4       context and goal of the accountability program is  
5       really what are the desired outcomes and goals of  
6       the program.

7                   Is the attribution model evidence-  
8       based? Is the model aspirational? Are we trying  
9       to incentivize certain delivery system behaviors  
10      through the attribution model? What is the  
11      accountability mechanism of the program? Is it,  
12      you know, is it a pay-for-performance program?  
13      Is it, you know, is there dollars assigned, you  
14      know? How is the program designed with a strict  
15      cutoff in the readmissions example, and which  
16      entities will participate and act under the  
17      accountability program?

18                   The second component, how do the  
19      measures relate to the context in which they're  
20      being used? What are the -- this sort of gets  
21      into some of the measure specification  
22      challenges.

1                   What are the inclusion/exclusion  
2                   criteria, and does the model attribute enough  
3                   patients to draw fair conclusions, and this is  
4                   getting toward the scientific acceptability sort  
5                   of components.

6                   Which units will be affected? To  
7                   which units are eligible for the attribution  
8                   model? To what degree can the accountable unit  
9                   influence the outcomes, and I think, Chip, to  
10                  your point on the readmission discussion, that  
11                  was a key part of the discussion, you know.  
12                  What's the level of influence, and that's a  
13                  little bit of a tradeoff to the aspirational  
14                  question earlier.

15                  Do the units have sufficient sample  
16                  size to meaningfully aggregate, and are multiple  
17                  units to which -- are there multiple units to  
18                  which the attribution model will be applied,  
19                  getting to the shared accountability discussion.  
20                  Then the last component is how will the  
21                  attribution be performed, and this sort of is the  
22                  nuts and bolts, the data that's being used. Do

1 the parties have access to the data? What are  
2 the qualifying events for attribution? What are  
3 the details of the algorithm used to assign  
4 accountability?

5 Were there multiple methodologies  
6 considered, and that should be made transparent  
7 in why and how certain models were selected, and  
8 then the timing of the attribution computation.  
9 So I'll turn it over to Erin to walk us through  
10 the final recommendations of the Committee.

11 CO-CHAIR PINCUS: Taroan, can I just  
12 go through the question about, I guess in some  
13 ways, the model that you described in terms of,  
14 you know, selecting. If we go back, can you go  
15 back one slide?

16 Yes, if you go back one slide. So is  
17 this design to be applied, sort of thinking about  
18 it from different levels of abstraction? Is it  
19 designed to be applied at a program level or at a  
20 measure level? So we talked about that. In some  
21 ways, it's kind of the intersection of both, you  
22 know. We talked about, you know, as we think

1 about selecting measures into programs, but then  
2 also individual measures also include attribution  
3 models in terms of how you're designing the  
4 attribution model within the measure itself. So  
5 we've talked about it at both levels.

6 CO-CHAIR PINCUS: I can imagine a  
7 program that is designed to, you know, like a  
8 quality program that is designed to hold  
9 hospitals accountable, and you could look at  
10 whether or not the assumptions about that program  
11 are correct. But then you also have to look at  
12 each measure, to see whether each measure is  
13 actually appropriate for holding hospitals  
14 accountable.

15 MR. AMIN: In the structure, in the  
16 structure in which the program is designed,  
17 absolutely. Helen, did you have anything else?

18 CO-CHAIR KHAN: And then that gets to  
19 be almost multidimensional chess if you have  
20 composite measures, because then you have the  
21 question of does each measure know? Is the  
22 gestalt really what people assume it is, since

1 simply by smashing a bunch of measures together?

2 (Simultaneous speaking.)

3 CO-CHAIR PINCUS: You can look at, you  
4 know, measure data elements to the extent to  
5 which the source of those data elements actually,  
6 you know, can be attributable.

7 DR. BURSTIN: And part of the reason  
8 for this work is the lack of consistency in this  
9 space, and feeling like sometimes measures bake  
10 in the attribution model. Sometimes it's only  
11 part of the programmatic approach. Sometimes  
12 it's baked into legislation as you know well,  
13 Jim. I mean there's all different ways to do  
14 this.

15 I think the key thing was to try to  
16 add some consistency. We think the questions  
17 will be very useful in terms of developers  
18 developing measures, groups like this looking at  
19 measures in the context of programs. But also  
20 very much so even outside the context of the  
21 federal government, you know.

22 We know a lot of these discussions



1       happen on the ground as well between health  
2       systems and payers. So having again a consistent  
3       way to have that dialogue is really our goal.

4               CO-CHAIR PINCUS: But I think this is  
5       very useful, because it sort of enforces for any  
6       program or measure, it forces the developer or  
7       the person developing the program to be -- to  
8       actually lay out in a purposeful way and a formal  
9       way of here's what we're thinking in terms of  
10      attribution.

11             MR. AMIN: Yes.

12             CO-CHAIR PINCUS: And here's how we're  
13      making that attribution.

14             MR. AMIN: The only other comment I  
15      would make on your question, Harold, is that in  
16      some ways we've walked into the challenge of  
17      attribution both here in the MAP and then also in  
18      the CDP process at the measure level, because all  
19      of this is not really always transparent.

20             And so we've tripped on this question  
21      a number of times because all -- well again, it's  
22      not transparent. So we're hoping that this level

1 of structure will be able -- we will then now be  
2 able to think about how it fits within our two  
3 different processes, and add to this contextual  
4 question.

5 So Erin, can you just walk us through  
6 the remaining part, and I think there's some more  
7 questions on the phone.

8 MS. O'ROURKE: Yes, absolutely. So  
9 building on these, the principles and the  
10 attribution model selection guide, the Committee  
11 made a series of recommendations that they  
12 intended would apply broadly for the development,  
13 selection and implementation of attribution  
14 models in the context of public and private  
15 sector accountability programs.

16 They attempted to recognize the  
17 current state of the science and consider what we  
18 can achieve right now, as well as what would be  
19 the ideal state they'd like to see in the future  
20 as far as attribution goes. The recommendations  
21 really stressed the importance of aspirational  
22 yet actionable recommendations to drive the field

1 forward.

2           Next slide. So their first  
3 recommendation, fairly self-evident -- to use the  
4 attribution selection model guide and to evaluate  
5 the factors to consider in the choice of an  
6 attribution model. Here, they really stress  
7 there's no gold standard. Different approaches  
8 may be more appropriate, depending on the  
9 situation.

10           Model choice should be dictated by the  
11 context in which it is used and supported by  
12 evidence and measure developers and program  
13 implementers should be transparent about the  
14 potential tradeoffs between the accountability  
15 mechanism, the opportunity for improvement, the  
16 sphere of influence of the accountable entity  
17 over the outcome being measured, as well as the  
18 scientific properties of the measure being  
19 considered for use.

20           The Committee noted that attribution  
21 models should be tested. In particular,  
22 attribution models of quality initiative programs

1 must be subject to some degree of testing for the  
2 goodness of fit, scientific rigor and unintended  
3 consequences. The degree of testing may vary  
4 based on the stakes of the program, and  
5 attribution models would be improved by rigorous  
6 scientific testing, and making the results of  
7 this testing public.

8 In particular, the Committee  
9 recommended when used in mandatory accountability  
10 programs, models should be subject to testing  
11 that demonstrates adequate sample size,  
12 appropriate outlier exclusion and/or risk  
13 adjustment to fairly compare the performance of  
14 attributed entities, and sufficiently accurately  
15 data sources to support the model.

16 Next slide. The Committee recommended  
17 that attribution models should be subject to  
18 multistakeholder review, and here they really  
19 highlighted the lack of current evidence and the  
20 lack of a gold standard, so that a stakeholder  
21 perspective could really influence what is the  
22 best approach and maybe, you know, which approach

1 is best maybe in the eye of the beholder.

2 So recommended that attribution  
3 models, selection and implementation in the  
4 public and private sectors should use a  
5 multistakeholder review to determine which  
6 attribution model may best serve their purpose.  
7 Attribution models should attribute care to  
8 entities that can influence care in outcomes.

9 The Committee recognized that  
10 currently, attribution models may unfairly assign  
11 results to entities that have little control  
12 over, influence over the patient outcome. Helen  
13 used the example of a dermatologist being held  
14 responsible for CHF.

15 For a model to be fair and meaningful,  
16 an accountable entity must be able to influence  
17 the outcomes for which it's being held  
18 accountable, either directly or through  
19 collaboration with others. The Committee did  
20 want to highlight the need to get to shared  
21 accountability and attribution as a way to move  
22 us forward.

1           As care is increasingly delivered by  
2       teams and facilities become more integrated,  
3       models should reflect that what accountable  
4       entities are able to influence rather than  
5       directly control.

6           Then finally, attribution models used  
7       in mandatory public reporting or payment programs  
8       should meet minimum criteria. In particular,  
9       they should use transparent, clearly articulated,  
10      reproducible methods of attribution. They should  
11      identify accountable entities that are able to  
12      meaningfully influence the measured outcomes.  
13      They should utilize adequate sample sizes,  
14      outlier exclusion and/or risk adjustment.

15           They should undergo sufficient  
16      testing, they should demonstrate accurate enough  
17      data sources to support the model, and be  
18      implemented with adjudication processes that are  
19      open to the public and allow for a timely and  
20      meaningful appeal by the measured entities.

21           MR. AMIN: Erin, before you move on  
22      from that, I just want to underscore that third

1 to last bullet, undergo sufficient testing at the  
2 level of accountability being measured, which is  
3 again something that we've struggled with at  
4 times with measures. For the goal of aligning  
5 measures across different programs at different  
6 levels of analysis, we want to make sure that  
7 they've been tested at the level of analysis that  
8 they're being implemented at.

9 MS. O'ROURKE: I think with that we'd  
10 like to open up for questions or discussion by  
11 the Committee.

12 CO-CHAIR PINCUS: So we have Chip, we  
13 have Doris on the phone. We have Marissa, we  
14 have Rich, we have Rhonda and we have Andy and we  
15 have John. Aparna, is your -- is your thing up  
16 too?

17 MEMBER HIGGINS: Yes.

18 CO-CHAIR PINCUS: Okay. So Chip and  
19 then Doris.

20 CO-CHAIR KHAN: So what strikes me  
21 about the development here is that we seem to be  
22 at sea a lot over whether measures, when they go

1 through the endorsement process or they go  
2 through our process, are really fit for a certain  
3 purpose. With the discussion this morning, it  
4 seems to me provides is at least one really  
5 important criteria that I'm sure is generally  
6 considered but not necessarily specifically  
7 considered with the depth that you have now sort  
8 of developed, and it seems to me that an  
9 attribution is like one of the --

10 I mean is like a key in terms of  
11 whether -- it may be a great measure, but what's  
12 the purpose? I mean does it fit a purpose and  
13 depending on how it fits in terms of this  
14 attribution, it could be a determining factor.  
15 So I guess my question is, and maybe this is a  
16 question for the end, is where do we go from here  
17 because what you've developed is something that I  
18 think ought to affect the endorsement process and  
19 begin to allow the endorsement process to have  
20 various levels of approval based on a perception  
21 of, you know, what it's fit to do.

22 Because if something is sort of



1 loosey-goosey on meeting your standards in terms  
2 of where the root is of that attribution, then do  
3 we really want that measure being used for pay  
4 for performance, I mean just in the most simple  
5 assessments? So where do we go with this?

6 DR. BURSTIN: Right, and we'll be  
7 happy to come back to this at the end. Obviously  
8 we very much welcome your thoughts about next  
9 steps. So we've been proposing some potential  
10 next steps, one of which is to review and revise  
11 what we already do on the CDP and MAP side, to  
12 consider how this fits in. So we recognize  
13 that's an issue.

14 There are also a lot of unresolved  
15 issues here, so I think there's more work to be  
16 done. I feel like we've scratched the surface of  
17 a really big issue. Somebody recently referred  
18 to attribution to me as the soft underbelly of  
19 value-based purchasing. Like we've got to figure  
20 out how we all agree on this to really move  
21 forward, particularly to move towards population-  
22 based measurement and all the rest of it.

1                   So great questions. Just keep them  
2 coming. We'd love to --

3                   CO-CHAIR PINCUS: Doris on the phone.

4                   DR. LOTZ: I think this is fabulous  
5 work. I agree, Helen. I think this is the soft  
6 belly of, you know, value-based purchasing.

7                   What I'm not hearing in the discussion  
8 yet is, inasmuch as the Committee work, the work  
9 today has talked about differences between who  
10 might actually be the provider of the service or  
11 have ability to implement a measure, being  
12 somewhat different than accountability, I'm not  
13 clearly hearing in the discussion around the  
14 slides how there might be some way of reconciling  
15 different attribution measures, strategies  
16 rather, or having some sort of a hierarchy.

17                   From the position of a payer, you  
18 know, I think that the payer desire is -- and  
19 those of you who again I apologize for not being  
20 able to be in the room -- but I have  
21 accountability for the Medicaid program in New  
22 Hampshire as well. And, you know, the interest

1 is in paying at a fairly high level and then  
2 letting some of the individual decisions around  
3 service utilization or priorities or integration  
4 occur at a smaller unit of analysis, either a  
5 provider group or a geographic level.

6 So if you have different attributions  
7 for different measures, how do you potentially  
8 reconcile them into some more cohesive payment  
9 strategy?

10 DR. BURSTIN: Doris, I think it's a  
11 great question, one we'd love to have more  
12 discussion on. Certainly, I think as we think  
13 about potentially attribution being at a higher  
14 level, and allowing more of that internal  
15 attribution to be ferreted out, that's fine. I  
16 do still think these questions are even useful  
17 internally then, as part of that discussion, even  
18 if it doesn't influence the topic.

19 DR. LOTZ: Yes, agreed. Thanks.

20 CO-CHAIR PINCUS: Amir, then Marissa.

21 MEMBER QASEEM: Just to follow up I  
22 think what Chip just said, and I just wanted to

1 go back to Helen. I mean to a certain degree,  
2 when we're reviewing the measures at NQF level,  
3 we do look at attribution.

4 I mean it's a little bit buried in  
5 there, but the measures that do come forward do  
6 have a very clear attribution there.

7 I think the problem that happens is  
8 that we don't have any of the CMS colleagues  
9 right now here. I would love to get their  
10 feedback. They're somewhere, okay.

11 DR. BURSTIN: They gave a lot of  
12 feedback to this. So this not, you know, this is  
13 work we did --

14 MEMBER QASEEM: No, no, no. My point  
15 is what we endorse the measures for, we do have  
16 it in minds what level we're endorsing the  
17 measures, and then these measures end up getting  
18 implemented.

19 That's where I don't think it's  
20 they're being taken into account the attribution  
21 part, right. Have you had that sort of  
22 discussion with CMS or any of the folks, what

1 happens with attribution?

2 So even when we're reviewing it at  
3 ACP, we come to you guys and we say well, this  
4 attribution is perfectly fine at this level. But  
5 then the measure ends up getting in an expanded  
6 role, and you don't never hear about the  
7 attribution part. So you have had any  
8 conversations or --

9 DR. BURSTIN: Absolutely, and in fact  
10 one of the specific recommendations, and I forget  
11 where it was, specifically said at the level at  
12 which it will be used is that this really needs  
13 to be discussed. So we've been having some  
14 ongoing discussions with CMS, for example, about  
15 the use of the readmission measure and the  
16 physician program, and are working with CMS to  
17 try to get some of the testing done at that  
18 level.

19 But you're right. I mean -- you know,  
20 at least on the endorsement side we clearly  
21 require that. Testing is required at the level  
22 at which the measure will be used, and I think we

1       need to understand how that relates to the  
2       attribution when it's not as clear.

3               MEMBER QASEEM:   And just to wrap up on  
4       it, I think you guys did a very good job with  
5       this attribution paper.   I really, really enjoyed  
6       it and I think you have pretty much taken into  
7       account some of the major principles.   But it's  
8       still very high level.   I think it's a lot how  
9       it's going to get operationalized.

10              I think it will be still be good that  
11       if you very clearly state in there that the  
12       clinician or whoever is being measured, they  
13       should have some sort of influence on the process  
14       or the outcome that's being measured.   I still  
15       feel like after reading that report it's really  
16       buried in there.   It does not come out as clearly  
17       in some of the principles, but thanks.

18              CO-CHAIR PINCUS:   Marissa.

19              MEMBER SCHLAIFER:   First just thank  
20       you for starting this work.   It's definitely  
21       something very important and some of my comments  
22       are from participating in the American

1       Pharmacists Association Policy Committee meeting,  
2       where we were talking about the pharmacists' role  
3       in value-based purchasing, and spent some time  
4       talking about attribution.

5               Not trying to like solve anything, but  
6       talking about it as an issue. I think one of the  
7       things to -- that I'm sure you thought about,  
8       that I should point out, as David talked about,  
9       he talked about, you know, when you see  
10      physicians and specialists, with primary care  
11      physicians and specialists, there's some kind of  
12      handoff potentially.

13             Those times where there's truly shared  
14      responsibility with no -- with several providers  
15      that may not even know that the other exists, and  
16      specifically as we get into more and more  
17      medication of care and medication management type  
18      measures, obviously the physician or NP or PA has  
19      a very important role.

20             At the same time, a pharmacist is  
21      doing their role in making sure that the patients  
22      are taking medications appropriately in maybe the

1 medication adherence space. It may be in  
2 identifying gaps in therapy and notifying the  
3 prescriber about those gaps in therapy.

4 It also may be in those potentially  
5 bad handoff situations, as a patient goes from  
6 hospital back to outpatient and there's a  
7 pharmacist that identifies, you know, the  
8 medication misadventures that often happen there.  
9 So I think as you go through your work and I  
10 don't have any answers, it's more questions, you  
11 know, thinking about when there's definitely  
12 shared attribution or there needs to be shared  
13 attribution, and this is something especially I'm  
14 sure to many of the allied health professions,  
15 you know, it's important.

16 Right now it's pharmacies talking.  
17 Pharmacists aren't providers under Medicare Part  
18 D today but hope to be in the not-too-distant-  
19 future. But also as pharmacists are contracting  
20 with ACOs and with physician groups, when we look  
21 at improvement in ACO measures and MSSP measures  
22 or MACRA measures for physicians, PAs and nurse



1 practitioners.

2 While pharmacists may not be getting  
3 paid by Medicare, they're looking at how they can  
4 identify to those medical groups that they have  
5 had a role. So I think this is something that's  
6 very important to the pharmacy profession and I'm  
7 sure others also. Is there any chance we can get  
8 these slides? That would be nice. They are in  
9 there? Okay. If they are, okay.

10 CO-CHAIR PINCUS: Rich.

11 DR. ANTONELLI: I also want to  
12 acknowledge and thank you guys for setting this  
13 work on this path. I usually restrict my  
14 comments to strategic framing, but I'm actually  
15 going to get into the grassroots with this. So  
16 to the degree, the couple of comments that I'd  
17 make, one is the attribution model versus a  
18 process.

19 For those of us, and right now in the  
20 name of Romneycare in Massachusetts, we are going  
21 forward with serious ACO development.  
22 Conversations of attribution are happening

1       literally in real time. I don't know that that's  
2       something that has really any relevance for this  
3       body, in terms of being prescriptive about what  
4       needs to happen, because we still have to develop  
5       what the evidence is in that space.

6               So what I want to call out to people  
7       is, and I think the example that we raised about  
8       the readmissions work, right. Here's the  
9       measure. If we had spent a lot of time in this  
10      room and in the MAP thinking about attribution, I  
11      don't think we would have made as much progress  
12      as we did.

13             So the way I would think about an  
14      approach, maybe not the singular approach to  
15      attribution but an approach to attribution is  
16      thinking about attribution at the tactical level.  
17      This is going to have significant implications,  
18      and I think, Marissa, you raised an issue that  
19      we're thinking about a lot in pharmacy, is still  
20      at the level of implementing a model of care.

21             So for example, pharmacy is relatively  
22      easy because it's still in the medical silo.

1 We're starting to get into some serious work on  
2 the Massachusetts and several other states that  
3 I'm providing some support for in integration,  
4 around social determinants and community so-  
5 called CPs or community partners, long-term and  
6 social, LTSS subpopulations.

7 I think for the MAP to actually think  
8 about measures and attaching attribution  
9 methodologies or worse, an attribution model,  
10 would slow the process down. So I just want to  
11 call that out. I think this is great. This will  
12 inform our work at a tactical level.

13 But the same thing that works for SDOH  
14 intervention in Roxbury, Massachusetts may not be  
15 how it's going to play out in Indianapolis. And  
16 so -- and then the last thing I'd like to react  
17 to is the notion of the measure developers being  
18 mindful of attribution. To the degree that  
19 that's desirable, that's okay. But frankly,  
20 especially thinking about being responsive to the  
21 Vital Signs report of the NAS/IOM, where we're  
22 actually talking about things beyond singular

1 medical resources.

2 I would like to have the ability to  
3 think about attribution across a community. So  
4 please, please let's not make attribution a  
5 component of endorsement, if we're trying to get  
6 to some of those holistic community-based  
7 population health measures. Not at all saying we  
8 shouldn't discuss it, but I for one would not  
9 care about, you know, endorsing if we haven't  
10 worked out the attribution methodology de novo.

11 DR. BURSTIN: One quick response. I  
12 think the Committee intentionally said the model  
13 can be labeled as aspirational, and then the  
14 discussion can proceed.

15 But at least it's labeled as such,  
16 recognizing that some of this may not be within  
17 the current purview but there's a recognition  
18 that's where people want a signal to go, and then  
19 you would logically think through the next set of  
20 steps, perhaps with a slightly different eye,  
21 knowing it's aspirational. We intentionally put  
22 that in there.

1 DR. ANTONELLI: Yes, and thank you for  
2 that. I think the optics. So I'm very mindful  
3 of what comes out of this Committee, and the NQF  
4 in general often gets -- I'll even use a somewhat  
5 provocative term on purpose -- over-interpreted  
6 in the street. Well Rich, why would we want to  
7 use that measure out here in the XYZ Medicaid  
8 program? It's not NQF-endorsed.

9 So I think if NQF and the MAP in  
10 particular could manage the optics of  
11 conversations around attribution because they are  
12 aspirational, hugely important by the way. But I  
13 do think some of these measures that get into  
14 LTSS and get into population health and social  
15 determinants, there is no a priori way, there's  
16 no -- there's no best model for that yet.

17 So Helen, I think if we can capture  
18 the spirit of what you just said and have that be  
19 attached to discussions around attribution, that  
20 would actually be very helpful.

21 CO-CHAIR KHAN: To respond, I think  
22 you really need to discriminate between your

1 measures, because when you're shooting with real  
2 bullets on a CMS basically fee-for-service  
3 measure, or set of measures, and I would argue  
4 value-based purchasing is a fee-for-service  
5 aspect of Medicare for hospitals, I don't think -  
6 - I think this really is an essential component  
7 to whether or not we go, you know, of any kind of  
8 design of the set of measures.

9 I agree. You don't want to hold up  
10 necessarily looking at a global situation, but  
11 everything isn't a global situation. So I think  
12 that's why I really think in the endorsement  
13 process, you may want to discriminate as to the  
14 -- and this goes back to fit for purpose -- what  
15 is the purpose of the measure?

16 If it's a population-based measure, it  
17 may have a different purpose and attribution may  
18 be dealt with at a different level than it would  
19 if we're talking about measures that are going to  
20 be used in either a real, either a fee-for-  
21 service environment or even, I would argue,  
22 you've got to be a little bit careful about your,

1       you know, beautiful ACOs on the hill environment,  
2       because not all that's population.

3               A lot of that is simply, you know,  
4       moving a fee-for-service measure into a different  
5       environment and it's basically the same thing,  
6       and you've got to make sure that it's fair.  
7       Because at the end of the day, it's three things:  
8       transparency, accountability and improvement. If  
9       it really can't be used for improvement, then so  
10      what to transparency and accountability?

11             CO-CHAIR PINCUS: Rhonda.

12             MEMBER ANDERSON: I would underscore  
13      what Chip has said. I think there is a balance  
14      there between what Rich and Chip have said. So I  
15      hope that we consider both, because I was going  
16      to comment on the endorsement piece. So Chip,  
17      thank you for that.

18             But the question, other question that  
19      I had for Helen is you alluded to the fact that  
20      to do a little testing with one of the measures.  
21      I was wondering if any additional testing really  
22      has been done, based on the principles and if

1       that you could share that with us?

2                   DR. BURSTIN:  Yes.  I mean again, I  
3       think what Andy Ryan was able to find with his  
4       colleagues was this, there's actually very little  
5       testing done of attribution models per se.  I  
6       think we've been trying to make sure that as  
7       measures are in use perhaps at different levels  
8       that are originally intended.  Sometimes the MAP  
9       has referred to it as off label measure use.

10                   We want to make sure there is in fact  
11       the ability to make sure it's tested at every  
12       level it's used for scorecard purposes.

13                   MEMBER ANDERSON:  And as we, and I  
14       really want to commend you, because this is such  
15       a difficult area.  But it's so important.  
16       Somebody used the underbelly; I use the elephant  
17       in the room concept.

18                   But the question I guess then I have  
19       is as you bring this forward, and it maybe goes  
20       to the next steps, will you select a few measures  
21       and if I look at what our conversation was  
22       yesterday, we had the opioid discussion; we had



1 the alcohol and substance abuse discussion, and  
2 there were a lot of questions about attribution,  
3 et cetera.

4 Will you take a couple of those and  
5 try to do some of our own testing, so that we get  
6 some of that information back to us about the use  
7 of the principles and how this -- how you at NQF  
8 have found those principles to be usable and  
9 maybe some changes even to them?

10 CO-CHAIR PINCUS: Aparna.

11 MEMBER HIGGINS: I'm actually going to  
12 -- she put up her card before me. I don't know  
13 if you noticed, but I'd have Amy go first.

14 CO-CHAIR PINCUS: Okay.

15 MEMBER HIGGINS: She had her card up  
16 before I did.

17 MEMBER MULLINS: So thank you for the  
18 work here. Thanks, Aparna, for that. One of the  
19 things primary care physicians get frustrated  
20 with is the duplicity and all the measures they  
21 have to report on, and likewise all of the  
22 attribution methodologies that come with all the

1 programs they participate in.

2 So, much like we have core measure  
3 sets, I think that there is something to be said  
4 for maybe some core methodology around  
5 attribution. So I'm hoping that this is where  
6 this work is going.

7 I think that one of the things, the  
8 conversation from me is getting a little  
9 confusing, because I don't think we attribute --  
10 we don't need to attribute measures. I think we  
11 need to attribute patients and people.

12 So when I think of attribution, I  
13 attribute patients to physicians and providers.  
14 I don't attribute measures to programs. So for  
15 me, it's kind of -- the conversation kind of took  
16 a turn, because attribution is for patients.  
17 It's not for measures. So for me, that's kind of  
18 weird how we were speaking about it.

19 Perhaps attribution is for measures.  
20 I don't know. But for me as a provider,  
21 attribution is for patients to providers. I  
22 don't know when the discussion, when the

1 Committee was having the discussion if they  
2 considered all the methodology that was written  
3 into the final rule with comment for MACRA around  
4 provider codes, patient codes that where  
5 providers can -- is everyone in the room familiar  
6 with this? Am I just being redundant?

7 Providers can assign a code to their  
8 patient to describe the relationship that they  
9 have with them, to prevent the confusion around  
10 how much responsibility they have in order to get  
11 the cost correct. So if that was taken into  
12 account, I'd like to hear a little about that.

13 DR. BURSTIN: I'll answer the second  
14 part first. It was literally coming out as the  
15 Committee was meeting. So there was nothing to  
16 reflect on. I think it was out for comment I  
17 think at the time. So I think the Committee  
18 recognized that was something to keep an eye on  
19 as something potential.

20 In fact, there have been other things  
21 written as well, and in fact with Healthcare  
22 Learning and Action Network, sort of more look

1       towards a patient-based attribution model. We  
2       looked at all of those different models. Again,  
3       not having a gold standard is one of the  
4       difficult things.

5               But in terms of your first point, it  
6       is very much -- you can go back to the definition  
7       of attribution. It is all about assigning  
8       patients. It is not about measures. But the  
9       idea is the way measures are used and the concept  
10      of value-based purchasing is you are essentially  
11      assigning patient results to providers.

12             So that's what we were thinking. But  
13      actually one of the key things that came out, and  
14      we just did our member webinar last week and  
15      Carol said this really eloquently is at the end  
16      of the day, the most important thing here is that  
17      the patient is true north. We want to do nothing  
18      that hurts the patient by having everybody go  
19      it's their responsibility, it's their  
20      responsibility and nobody takes responsibility.

21             So that is truly the true north, is  
22      making sure everybody is really making sure

1 somebody's accountable at the end of the day, but  
2 also trying to do it in a way that there is at  
3 least an assessment of fairness.

4 MEMBER MULLINS: Yes and I would just  
5 -- and I totally agree with that. I would just  
6 caution against trying to bake methodologies or  
7 attribution methodologies into measures, because  
8 then you would have different methodologies in  
9 different measures, and then you have a mess when  
10 you try to report different measures with  
11 different methodologies built into them, because  
12 reporting is already a burden enough, and if you  
13 have to report using different methodologies for  
14 attribution, then I can see this becoming a mess,  
15 even bigger than it already is.

16 CO-CHAIR PINCUS: Aparna.

17 MEMBER HIGGINS: So I just want to  
18 build on some points that Amy and Rich and Amir  
19 have made. So I want to apologize for being  
20 late. I got stuck with the whole drama outside  
21 the window with the traffic, and I know I missed  
22 a lot of the conversation earlier. So if I'm

1 saying something somebody already discussed, I  
2 apologize for that.

3 So I want to build on what Amy said.  
4 I think in my mind too, I always think of  
5 attribution of a patient not a measure. I  
6 understand and I feel like maybe there's sort of  
7 two concepts here that we're trying to address.  
8 One is who's accountable for the patient, which  
9 is the attribution piece, and more and more the  
10 field is moving towards using patient attestation  
11 as the gold standard for that.

12 So you no longer use, relying purely  
13 on claims-based. So I think at some point, a  
14 patient's going to say yes, so and so is my  
15 physician and you don't have to be here talking  
16 about attribution.

17 I think so -- and then the other  
18 concept to me, at least as we've been discussing,  
19 and Rich I heard you sort of bring it up, is the  
20 fit for purpose, which is, is it, you know, is it  
21 useful for QI, it is useful for public reporting,  
22 it is useful for payment.

1                   To me, attribution is patient-level  
2                   accountability and fit for purpose is is the  
3                   measure useful for payment? Is the measure  
4                   appropriate for, you know, public reporting,  
5                   which in my mind are sort of two different  
6                   things. Also I think, you know, would agree with  
7                   both Rich and Amy that, you know, I don't think  
8                   it's a good idea that attribution be part of the  
9                   measure endorsement process that you want to have  
10                  the measure be evaluated for.

11                  It's already being evaluated for a  
12                  number of scientific criteria, including as Amir  
13                  mentioned, you know, sort of the level of  
14                  analysis, which tells you what the appropriate  
15                  setting is.

16                  One of -- a couple of other things I  
17                  want to bring up. I know Amy brought up the  
18                  MACRA. The LAN has obviously done a lot of work  
19                  on attribution, so I don't know where the  
20                  Committee, you know, what kind of input they had  
21                  or review they did of the LAN papers.

22                  You know, they've put out a model for

1 attribution which I think, you know, kind of got  
2 broad input. They went through a public comment  
3 period. As part of that, they had actually  
4 talked to people who had tested various  
5 attribution models empirically, and had included  
6 some of that data work in their paper.

7 You know, so okay. So there is quite  
8 a bit of empirical testing that's ongoing, in  
9 terms of trying to figure out what the optimal  
10 methods are. So I just want to make sure we're  
11 not reinventing the wheel. I think that was sort  
12 of my set of comments.

13 CO-CHAIR PINCUS: John.

14 MEMBER BOTT: Yes. I actually  
15 submitted comments on the draft report when it  
16 was out, so if you can bear with me, I'll just  
17 read what my general comments were on that, and  
18 then I will probably tack on one comment. But an  
19 excerpt from one of my general comments on the  
20 draft report, which are still germane to the  
21 final report in having read it, is a large  
22 portion of the report is dedicated to relaying



1 the attribution model selection guide.

2 This guide is followed by several  
3 recommendation, where the first suggests using  
4 the guide to evaluate attribution models.  
5 However, the guide is less of set of evaluation  
6 criteria and more of a set, a list of nice to  
7 know facts about a methodology.

8 These facts solicited about a given  
9 methodology do not add value, to truly evaluate a  
10 given attribution methodology. Of the questions  
11 posed in the guide, I would estimate that less  
12 than half would be of utility in the evaluation  
13 of an attribution model. So I'd recommend that  
14 if indeed we want the guide to serve in an  
15 evaluation capacity tool to revisit and refocus  
16 the questions comprising the selection guide.

17 Just one thought on that to try to be  
18 helpful. I really liked a couple of the past NQF  
19 reports where they -- where it was posed here's  
20 the NQF-given criteria, and here's how the  
21 composite measures and PROMs fit within those  
22 evaluation criteria. So I liked when criteria

1       were discussed in relation to the NQF criteria.  
2       That might be helpful here.

3               And just one other thought is about a  
4       year ago, CMS had a measure and NQF endorsement  
5       process and it largely was voted down if you sit  
6       there and read like I do, the steering  
7       committee's rationale, and it was largely shot  
8       down because of the attribution methodology.

9               You know, we all know this is a very  
10      contentious area, and I thought the criticisms  
11      were rather soft and not well-founded. So if I  
12      were to put myself in CMS' shoes, to say oh  
13      great, here's some guidance coming out, this  
14      really -- if I was CMS and I'm not speaking on  
15      behalf of CMS, I don't really see this as going  
16      nearly far enough as helping a measure steward,  
17      measure developer in guiding them on what's  
18      acceptable and what's the parameters for  
19      evaluation principles.

20              So while maybe this is a nice start,  
21      a nice part one and addresses a number of issues  
22      about attribution, I guess I would encourage, as

1 Amir hinted at, some more specificity and perhaps  
2 a part two report. Thanks.

3 CO-CHAIR PINCUS: Thank you. So Carl,  
4 then Jennie, then David, and then I have a  
5 comment.

6 MEMBER QUERAM: Just a quick one,  
7 since much of what I was going to say has been  
8 said. But I want to pick up on just the Amir-  
9 David-Chip kind of thread, when compared to some  
10 of the threads on attribution that have said,  
11 well, maybe not so much.

12 Alan, to the point, if we were to look  
13 forward, given the comments you made about  
14 aspiration, what do you anticipate we would see  
15 in this conversation a year from now when we look  
16 at next year's measures, as some practical,  
17 tangible changes to the process that we would  
18 actually feel and see?

19 DR. BURSTIN: That's a super question,  
20 Carl. I don't know that we know that yet. I  
21 think part of what we'd like to think through  
22 with you today is at least part of the question.

1       So that I agree: they didn't go far enough. They  
2       weren't specific enough, and frankly, as you  
3       guessed, there's not enough out there on which to  
4       base additional principles or recommendations, to  
5       be perfectly frank at this point.

6               I think the question would be, does  
7       some of that get baked into at least the  
8       discussions that we have here about measures? Do  
9       we at least perhaps, as part of our preliminary  
10      evaluation of measures, go through some of the  
11      elements of the guide to answer some of those  
12      questions to again try to have a more -- have a  
13      discussion that's perhaps more informed?

14             Again, not the intent to say more  
15      measures go down; really, the intent is to say,  
16      to have a very transparent discussion, and then  
17      the Committee should make a decision based on  
18      having that information on hand. But we'd  
19      welcome your thoughts on that as we finish this  
20      discussion.

21             CO-CHAIR PINCUS: Jenny.

22             MEMBER BRYANT: Thanks. This has been

1 a fascinating conversation for me. It's my first  
2 meeting, so I'm now exposed to the -- how far we  
3 have to go in the science related to attribution.  
4 One thing that -- I mean many of the things I was  
5 going to say have been said.

6 But one thing that occurs to me as we  
7 think about sort of next steps in the work would  
8 be that if you go -- if you think back to the  
9 principles that you articulated in selecting  
10 attribution models, they're very -- my sense  
11 based on the conversation is there can be very  
12 challenging -- it's challenging to meet, right.

13 So most folks who are developing an  
14 attribution model won't be able to meet all of  
15 those principles. So they're by themselves  
16 really aspirational, and it struck me that it  
17 could be useful to begin to articulate where the  
18 risks are higher and lower of being successful.

19 So you know, it's sort of -- I think  
20 it builds on and gets related to some of John's  
21 points of something about it being more tactical  
22 thinking about this, and taking it down to the

1 next level so that folks who are developing  
2 attribution models in some ways could have a set  
3 of -- a set of, I don't want to say criteria, but  
4 it's almost like warning signals.

5 If you're dealing with a measurement  
6 problem that has these characteristics, you're  
7 much more likely to not be able to satisfy these  
8 principles. So beginning to parse the principles  
9 and the challenges a little bit more finely,  
10 because I think talking about it at the 100,000-  
11 foot level does a disservice to the level of  
12 thinking that you have actually already done.

13 So you're going to find very different  
14 challenges when you're talking about attribution  
15 for clinician models than when you're talking  
16 about attribution of outcomes in the hospital  
17 setting, and it will be worth talking about the  
18 specific pitfalls, since I think that's where we  
19 are, is realistically we're going to be doing a  
20 lot of work on attribution, and we need to do it  
21 better.

22 So I think setting sort of some

1 incremental goals about how to improve  
2 attribution models which are clearly imperfect  
3 and not well-tested at the moment would be a  
4 place to start.

5 I was, say, also really struck by the  
6 conversation about how this relates to fit for  
7 purpose, and it does seem that there's an  
8 inherent tension here with the notion of  
9 fostering shared accountability across the system  
10 and moving to team-based care, and a desire to  
11 drive toward pinpoint attribution. And maybe was  
12 just worth acknowledging that the biggest  
13 challenges we have in the system are around hand-  
14 offs, where attribution is going to be really  
15 contentious.

16 So I think that gets to why it might  
17 be important to continue to, in the endorsement  
18 process, identify places where measures are  
19 critical to develop but almost unattributable,  
20 and not then decide that they're not -- that that  
21 means that they're not important measures, but  
22 that it might mean that we have IT challenges,

1 infrastructure challenges that need to be focused  
2 on as a way of making progress on those measures.

3 You know, I think there is a -- there  
4 is a rush to using every measure for payment that  
5 does a disservice to the development of the  
6 measures. I think it's important in the  
7 endorsement process. I think maybe this is part  
8 of what Rich was saying, like to not assume that  
9 they only have one purpose.

10 CO-CHAIR PINCUS: David.

11 MEMBER BAKER: So I think that you  
12 don't want it to be rigid, but I do think this  
13 should be part of the endorsement process, at  
14 least to have the measure developers give some  
15 idea of what their intent is, and I'll give a  
16 couple of really concrete examples.

17 One really simple one are diabetes  
18 measures. When we were doing the group physician  
19 reporting option, if you looked at our  
20 endocrinology practice at Northwestern in general  
21 medicine we did really well. But we had all  
22 these people with diabetes who are coming in to



1 see dermatologists, orthopedic surgeons, and you  
2 said, well everybody with diabetes who touched  
3 the system, we weren't doing well at all, right.

4 And for the developers to say, you  
5 know, there has to be some way of identifying  
6 those physicians who are truly responsible for  
7 caring for that patient's diabetes, that would  
8 help us tremendously. Another example is for  
9 some of these measures that were designed for  
10 hospitals, to apply those to an individual  
11 hospital was well. Most patients who are cared  
12 for by hospitals are cared for at least two,  
13 sometimes by three, and sometimes with input by  
14 the primary care physician.

15 So you know, it's really problematic  
16 to apply some of those things to an individual  
17 physician. So just for developers to give some  
18 statement of their philosophy, not necessarily a  
19 detailed model and not something that's  
20 prescriptive and says, you know, it can't be used  
21 in these other settings. But just to at least  
22 begin that conversation, I think, would be

1 helpful.

2 CO-CHAIR PINCUS: I had a couple of  
3 comments that I wanted to make, actually three.  
4 So one is, you know, we've been thinking about  
5 attribution as a binary concept, but it's not.  
6 It's really in many ways proportional, and I  
7 think it gets to some of the points, David you  
8 made and Jennie made, in terms of the  
9 determination of that proportionality is very,  
10 very difficult and may not be even possible in  
11 many cases.

12 So that's one issue to think about in  
13 terms of how to do that. I mean the typical  
14 example I think about is in terms of shared  
15 accountability. If I have a patient with  
16 schizophrenia and diabetes, at some level I'm  
17 responsible for both the schizophrenia and  
18 diabetes, and I should be thinking about the fact  
19 that there's this comorbidity. And while I'm  
20 primarily focused on treating the schizophrenia,  
21 if I see that the patient's gaining weight  
22 because of the medication I'm using, I need to

1 think about what kind of intervention.

2 I need to certainly communicate with  
3 their primary care physician or their  
4 diabetologist. So that that's a -- so how to  
5 think about that is complicated.

6 Number two is, when the report talks  
7 about testing, I'm trying to think about what do  
8 we mean by testing. How does one determine the  
9 validity of an attribution model? What would be  
10 the methodology for doing that? Would you  
11 convene all the providers and say, you know, well  
12 what do you think is your responsibility?

13 You know, how would you actually test  
14 the validity of the assumptions in a formal way?  
15 I think some work, further work on what are some  
16 of the research methodologies for assessing the  
17 assumptions about attribution would be sort of a  
18 worthwhile endeavor.

19 Then third, I think that -- so I'm  
20 sort of in between in terms of whether you would  
21 include attribution as a criterion or not. I  
22 think it would vary by the kind of measure or

1 program you're looking at. I think, for example,  
2 for a structural measure, there obviously is  
3 accountability that is quite clear, and for many  
4 process measures, that would be the case.

5 For outcome measures, it's much more  
6 complicated certainly. So those are the kind of  
7 things in terms of how -- you know, so that it  
8 would -- but certainly I agree with David and I  
9 think Jennie that there should certainly be a  
10 discussion about assumptions being made about  
11 accountability, both in terms of the endorsement  
12 process and also in terms of the MAP process in  
13 that way.

14 DR. BURSTIN: And just quickly this  
15 time, we have a list, a running list of the  
16 issues we've not -- we weren't able to really  
17 resolve as part of that, and certainly this  
18 question of what is attribution model testing?  
19 What are the methods? How would you interpret  
20 the results?

21 The data issues, we didn't talk a lot  
22 about that today, but it was a big cornerstone of

1 the discussion of the Attribution Committee. If  
2 you're looking at claims versus paper records  
3 versus patient attestation versus physician or  
4 other clinician attestation, how does that all  
5 come together? What's the integrity of the data  
6 source? This whole issue of team approaches, and  
7 Marissa raised this earlier, is something we've  
8 not really -- particularly around non-physicians  
9 came up a lot.

10 And then the attribution challenges in  
11 special settings and special populations.  
12 Patients with multiple chronic conditions are a  
13 whole lot harder than a patient who primarily  
14 sees one specialist for their one given disease.  
15 Then one of the things we did include, there was  
16 something about an ability to have adjudication  
17 or feedback, and how that even gets  
18 operationalized.

19 Again, many of the things we think we  
20 just didn't get to but I think are important  
21 questions.

22 CO-CHAIR PINCUS: Bruce, Amir and

1 Nancy and Rhonda.

2 MEMBER HALL: Thank you. I'll build  
3 on a couple of comments. Harold, I think  
4 ultimately the way we judge whether the  
5 attribution works is whether the feedback of  
6 information improved care, and we rarely ever  
7 reach that point with any measure anymore.

8 Having read this document a couple of  
9 weeks ago, I think it's a fantastic opening  
10 gambit. I agree with John and others that  
11 there's much more than we need to dive into, but  
12 it's a great opening gambit. I would just argue,  
13 and I'll sort of go even farther and harder than  
14 David did a minute ago.

15 I would argue that attribution has to  
16 be explicitly concretely specified in a measure.  
17 You don't have a measure if you haven't  
18 attributed. In the document itself, we talk  
19 about some related principles that are not all  
20 exactly attribution. The document talks a little  
21 bit about eligibility of data for a measure. Are  
22 these data points eligible to be in this measure?

1 And those data points may represent people or  
2 other pieces of information.

3 And then are these providers eligible  
4 for this measure, and those are sort of issues of  
5 accrual into the measure. Then inside of the  
6 measure, you decide how you attribute cases or  
7 information to the units you're evaluating,  
8 whether those units are individual providers,  
9 groups of providers, institutions or whatever  
10 they might be.

11 And then once you've done that, you  
12 have to return to the issue of fit for purpose,  
13 which several people have raised. But I would  
14 argue you cannot discuss and contemplate fit for  
15 purpose until you have a measure, and you don't  
16 have a measure until you've attributed the  
17 information internally in the measure and done  
18 the modeling.

19 I think the real challenges, one of  
20 the biggest challenges will be how, at what level  
21 of testing do we require a measure to be  
22 evaluated in the measure development process?

1       Because you can have very different measures,  
2       very different performance if you simply  
3       attribute the results of your calculations to an  
4       individual versus to a group.

5               I would argue that each of those  
6       levels has to be separately contemplated and  
7       tested, evaluated, approved, whatever. The  
8       history of what we've done here at the NQF,  
9       having contributed to these processes myself for  
10      15 years or more as well, was that at first, we  
11      used to say we refuse to talk about that. That's  
12      an implementation issue. That's not in our  
13      scope.

14             Then we evolved towards saying we'll  
15      specify measures at different levels. The  
16      individual provider, the institution, the system.  
17      So that was an advance forward.

18             I think where we're heading now is to  
19      say we're realizing that the measurement science  
20      argues that until you've clearly said how you're  
21      going to accrue, attribute and then use, you  
22      can't do the evaluation of that measure in its



1 complete, in its completeness so to speak. So  
2 thank you.

3 CO-CHAIR PINCUS: Thanks. Amir,  
4 Nancy.

5 MEMBER QASEEM: So I'm just going to  
6 come back to what's already been said, and I  
7 think Chip started this discussion. He hit the  
8 nail on the head in terms of these measures are a  
9 high stakes game at this point right, and this  
10 report is very good. You guys did a great job.  
11 But I still think this report is not even at  
12 10,000-foot level. This is like at hundreds of  
13 thousand foot level, because the practical  
14 applicability, there's -- I have some concerns  
15 about it.

16 And then -- and Chip again is  
17 absolutely right. The transparency, you have  
18 that as a principle. It's not going to really  
19 matter if you cannot really apply some of these  
20 principles, and I'll give you an example of that.

21 You have a principle in there,  
22 considered choices among available data are

1 fundamental in the design of attribution model.  
2 After I heard Helen talk about the discussions  
3 about the current limitations of the data and the  
4 availability of the data, that kept on coming up  
5 in the work core measure set confidence as well.  
6 All the time, right?

7 But there was -- seems like there was  
8 very rich discussion during that meeting, Helen,  
9 but if you read that principle and underneath the  
10 text underneath the principle, it does not even  
11 mention the issues with the data availability and  
12 the limitations of the data, and that concerns  
13 me.

14 Now I'm coming to a point of, yes, I  
15 really like the report. But again, that's why I  
16 said 100,000-foot level or feet level. I think  
17 again, you need to remember it is a high stakes  
18 game. Look, I mean CMS is using them for  
19 reimbursement and all that purpose, something  
20 what Bruce has just mentioned I think. We need  
21 to start keeping that in mind, and I think we  
22 need to really look into this report, now that --

1 is it -- how can it practically applied.

2 The first step is going to be make  
3 attribution part of the endorsement process  
4 before we can even go beyond that. And then go  
5 from there.

6 CO-CHAIR PINCUS: Nancy and then  
7 David.

8 DR. WILSON: Well, I'll be quick. I  
9 want to weigh in on agreeing with Rich and Aparna  
10 and Amy that I see attribution as a person-  
11 centered function. And I remember ten years ago,  
12 Mark McClellan, remember Mark McClellan, saying I  
13 just want to know who the team is that's taking  
14 care of the person. I don't care how they  
15 distribute the money that we're going to give  
16 them.

17 I mean, and I hope he doesn't mind me,  
18 because I am paraphrasing a little. But it was  
19 basically, who's caring for the person? Who's  
20 caring for the community? Who's caring for ---  
21 you know, I tend to think of it as ZIP codes and  
22 counties and things like that for the social

1 services, et cetera.

2 Being very person-centered and that  
3 gets you into a provider attribution model for  
4 payment. But I think that really focusing on  
5 people, the person and the patient as opposed to  
6 even providers is where we need to -- is the gold  
7 star. I think that part of what Mark was saying  
8 and I agree with is that it is tactical to figure  
9 that out.

10 I thought it was great to see the  
11 principles and what are kind of the things that  
12 should be in an attribution model. If I were  
13 trying to -- if I were sitting in a seat trying  
14 to create one for whatever the entity is that I'm  
15 trying to create it for, I'd run through that,  
16 because it would be -- I never remember  
17 everything that I should think of, and here's  
18 this astute body that came up with all these  
19 things.

20 So I see this being very useful, but  
21 translating and operationalizing it I think has  
22 to be at a very tactical level, depending on what

1       you're talking, who you're talking about.

2       Thanks.

3                   CO-CHAIR PINCUS: David. Rhonda, did  
4       you put yours down? Okay. Okay, David.

5                   MEMBER BAKER: So Bruce and Amir  
6       talked about that this should be part of the  
7       endorsement, and I'd just like to hear what that  
8       means. I think testing actually the attribution  
9       model is just a step way too far, particularly  
10      like you were talking about. I mean, we don't  
11      even know how to do that accurately or what the  
12      best practice is.

13                   So what do people mean when they talk  
14      about that, as opposed to again, saying that you  
15      should be -- it's interesting. You think about  
16      the testing, and when organizations do testing of  
17      their measures, they're making assumptions about  
18      the attribution, just by who is in that  
19      population.

20                   So I think for them to make a  
21      statement of the philosophy and explain why they  
22      chose the test population is one thing. But I

1       just wanted to hear from the two of you whether  
2       you really think there should be any testing of  
3       the accuracy of the attribution, because I think  
4       that will be very difficult.

5               MEMBER HALL: Well I support what you  
6       just said. I think in almost all cases when  
7       we're sitting at the measure development level  
8       and we're evaluating a measure, you're actually  
9       evaluating -- whatever the testing's been done,  
10      it's been done at some level by those developers.  
11      I think most developers develop a measure  
12      thinking it will be applied at one level or the  
13      other. It's true, some measures come through and  
14      they might say this could be applied at  
15      physician- or system-level.

16              But I think almost all the information  
17      that I've seen over the years that will come in  
18      on a measure will represent testing at some  
19      level, and that's why I said until you've  
20      attributed, until you've accrued, attributed, and  
21      sort of stated what your intended purpose is, you  
22      don't have a measure to evaluate.

1                   Maybe the intended purpose is the one  
2                   that is the softest, because people might feel if  
3                   they get through all those preliminary steps,  
4                   then that they're then approved to use it for  
5                   different purposes. I would argue against that.  
6                   And I would say that usually when we're doing  
7                   measure development evaluation, we are looking at  
8                   results that a developer has done at a particular  
9                   level.

10                   So they have attributed it at a  
11                   particular level, at a particular unit of  
12                   performance, individual, group, system, you name  
13                   it, and that's usually what we're contemplating.  
14                   That's probably -- that should be the extent of  
15                   the approval, unless they've truly submitted,  
16                   here's how this measure performs on individuals,  
17                   where the reliability will be an entirely  
18                   different picture than it is for groups.

19                   So I think your question reaffirms my  
20                   feeling, which is, you don't have a measure until  
21                   you've specified those things, and usually when  
22                   we're evaluating a measure, those things have

1       either been implicitly or explicitly specified.  
2       I would argue that's the level the approval  
3       should sit at.

4                   MEMBER QASEEM:   Just to add to that,  
5       what I'm trying to get to, David, you already  
6       nailed.  I'm trying to avoid the off-label use of  
7       the measure that's happening a lot, and I think  
8       we need to start acknowledging there is a  
9       fundamental problem with the current measures.  
10      We all know that.

11                   I think this seems like we're  
12      oversimplifying the process and how they're  
13      getting used and becoming a high stakes game.  
14      We're all aware of it, but I think we need to be  
15      aware of it and start investing resources to  
16      understand how we can improve the whole  
17      performance measures process.  The point is to  
18      improve the quality of our patient.  You keep on  
19      hearing, Amy mentioned patients.  We're all  
20      providers over here.

21                   If that's not happening, what's the  
22      point?  I mean are we just -- it starts feeling



1       like it's checkbox. And I know CMS is  
2       struggling, and they have to meet certain  
3       requirements and all the law and all that. But  
4       you don't want to make it, again, a checkbox,  
5       just we implemented the measures.

6               We need to be fundamentally behind to  
7       improve the quality of our patient care. If  
8       that's not happening, we need to start looking at  
9       it. I think, sometimes I feel like when I sit at  
10      these meetings, it seems so oversimplified that  
11      these measures are going to go, and we endorse  
12      them, and now certainly patient care is going to  
13      change.

14             We endorsed a lot of measures  
15      yesterday. Do you really guys believe that some  
16      of those measures are going to improve the  
17      quality of care? I'm not sure. I can actually  
18      list some of the measures, and without going  
19      back, and I know you guys are going hate me if I  
20      start extracting the measures again. But that's  
21      essentially the point.

22             I think I absolutely agree with Bruce,

1 and I think we need to start investing resources  
2 to learn a little bit more.

3 DR. BURSTIN: Sometimes there's also,  
4 it's interesting. Somebody said sort of implicit  
5 versus explicit attribution. So we oftentimes  
6 hear from committees when they look at health  
7 plan-level measures, for example, and I'm sorry  
8 Mary left the room, that we keep reminding them  
9 it's only at the health plan-level of analysis.

10 We frequently hear, particularly from  
11 the providers at the table is, well, you say  
12 that, but then the health plan sends those  
13 results to me at my level and expects me to  
14 respond. But again, we've not looked at the  
15 measure at that level. So I think the explicit  
16 versus the implicit is something we want to make  
17 sure we understand, too.

18 MEMBER BAKER: For those physicians,  
19 if something's in the measure set that shouldn't  
20 be applied at the physician level, right?  
21 Because they may go ahead, the organizations may  
22 go ahead and do it anyway, but at least, you

1 know, you could come, and physicians could say  
2 this isn't supposed to be applied at my level.

3 CO-CHAIR PINCUS: It sounds like, in  
4 terms of this issue of a criterion for  
5 endorsement that there's pretty much a consensus  
6 about it should certainly be discussed and  
7 detailed. Whether it should be a checkbox or not  
8 is a whole other issue. But it certainly  
9 requires some degree of intense discussion.  
10 Aparna.

11 MEMBER HIGGINS: I don't feel like  
12 we're -- there's different set of -- so there's  
13 the measures and then what I think of as the  
14 measurement methodology. And so part of that is  
15 the attribution, the small numbers issues, all of  
16 the things that we were all familiar with.

17 I feel like some of the comments that  
18 have been made here fall in this sort of -- some  
19 of it is small numbers issues, because I know the  
20 concept of reliability was brought up, and I  
21 think that's important to address if we're going  
22 to use a measure for a particular purpose.

1                   I feel like a lot of what we talked  
2                   about is fit for purpose, and how do you move  
3                   measures and identify measures that are good for  
4                   particular kinds of purpose, and not so much  
5                   attribution, because that's still, as Nancy said,  
6                   it's the patient, and who does this patient  
7                   belong to.

8                   I think the challenge of putting it in  
9                   the endorsement process also is that, to Amy's  
10                  point, it's not just different methods from  
11                  different developers, but could be slightly  
12                  methods depending on what payment model you're  
13                  talking about. So now you're talking about a  
14                  measure that could be applied in a specialty  
15                  setting; it could be applied in a population  
16                  setting. And then you've kind of, sort of even  
17                  multiplied that complexity even further.

18                  I just worry that we're going to get  
19                  away from evaluating measures for their  
20                  scientific properties, and then also looking at  
21                  sort of what's the appropriate level of analysis,  
22                  which is part of the current endorsement process.

1 CO-CHAIR PINCUS: So Helen, Taroon,  
2 Erin. Do you want to sort of summarize your own  
3 thoughts at this point?

4 MR. AMIN: So this was a very, very  
5 rich discussion. We really appreciate all the  
6 thoughts related to this conversation. As a  
7 recap, we embarked on the work of the attribution  
8 effort because of our experience, both in the  
9 measure endorsement process -- and I think Bruce  
10 characterized a lot of the challenges that we  
11 have in that sort of structure very well -- and  
12 also within the MAP process.

13 So this effort was to be a first step,  
14 to understand the state of the science first, and  
15 then second to characterize what the elements are  
16 that we may want to consider. I think the  
17 conversation we had today was very rich in terms  
18 of providing input about how the endorsement may  
19 consider the elements of an attribution model,  
20 and then how we might consider this going forward  
21 in the MAP process.

22 I think we're going to still have to

1 take this back and try to figure it out.

2 Operationally, I think we heard this very loud  
3 and clear in terms of making this tactical in  
4 terms of what are the expectations of both of  
5 these processes. I think we quite frankly  
6 haven't yet done that work, and I think that's  
7 clearly the next step.

8 There's also been this underlying  
9 conversation around what are some of these  
10 scientific components around testing? What does  
11 that mean in the context of attribution? And  
12 again, that's partially what we're going to have  
13 to go back and think about in the next phase of  
14 work for these activities if we're really going  
15 to be including them in the next phase of  
16 evaluation.

17 Helen, are there any other sort of  
18 high level takeaways that you have? I mean  
19 obviously there's a lot of rich discussion here,  
20 and we'll make to represent it in the discussion  
21 and as we think about our next steps. Also, if  
22 there's any thoughts from CMS in particular, we

1 welcome those as we close up the discussion.

2 DR. BURSTIN: Just a great discussion.  
3 It gave us lots to think about. I think we'll be  
4 kind of bringing back a lot of these issues to  
5 our CSAC and other groups as we think through  
6 next steps.

7 MEMBER QASEEM: Can I ask a  
8 clarification question? So right now the testing  
9 is happening at a certain level right?

10 MR. AMIN: Yes.

11 MEMBER QASEEM: So maybe I'm not  
12 really get it. Going back to what Bruce said,  
13 wouldn't that be a low-hanging fruit to implement  
14 what Chip just said? So if the testing is  
15 happening at a clinician level, or whatever level  
16 it's happening, that it becomes a requirement?  
17 What's there to discuss for this one? I mean why  
18 can't we just really quickly move on this?

19 MR. AMIN: Well, so there were some  
20 discussions around testing different attribution  
21 models, and the criteria of what we would be  
22 looking at there, I think, is still not

1 completely clear. The second, and I don't mean  
2 to speak for Bruce, but I think where we're not  
3 going all the way to the level of testing the  
4 reliability and validity sort of cut-offs that  
5 are included in the context of the program that  
6 it's being used.

7 And that's sort of hinted at in some  
8 of these components that have been laid out here,  
9 which is, a lot of it is the measure evaluation  
10 context of the program. That's a step that we  
11 haven't taken yet. It's not that it's difficult  
12 to do. It's just whether it's the, you know, the  
13 next step that we should take.

14 MEMBER QASEEM: So what I'm asking, I  
15 mean that's going to take a while to do all that,  
16 and since we have -- we have a little bit of a  
17 simplified performance measure evaluation process  
18 right now in place in the country anyways. What  
19 I'm asking is if a measure is being endorsed at a  
20 certain level right now, and I know NQF already  
21 does that, why can't we move that little bit  
22 forward, that that's going to become one of the



1 criteria?

2 At this point, more knowledge that if  
3 the measure has been tested at this level, this  
4 is what is being endorsed right now. It's buried  
5 in the text when you're endorsing the measure.  
6 But what I'm saying is that because one of the  
7 criteria that this is all we're endorsing it for.

8 MR. AMIN: So technically that is the  
9 way the current endorsement works.

10 MEMBER QASEEM: But it's buried.

11 MR. AMIN: Yes. I mean we definitely

12 --

13 MEMBER QASEEM: It's buried. It is  
14 there. What I'm asking is to make it your  
15 criterion.

16 MR. AMIN: Yes, and make this whole  
17 off-label use, meaning if it's used at different  
18 levels, more transparent and clear. There's  
19 obviously what we could do that. And you're  
20 right. It is straightforward. It's not what the  
21 testing supports. So we could certainly bring  
22 that back.

1 DR. ANTONELLI: I promise this will be  
2 30 seconds. In terms of language, so I know at  
3 the IOM or NAS, whatever we're calling it now,  
4 earlier this month, they were talking about child  
5 health measures. In fact, some of those measures  
6 are actually readiness for kindergarten, high  
7 school graduation, so really community measures.

8 So to the degree that you bake into  
9 your discussions use of the term patient versus  
10 person, I would really appreciate it.

11 CO-CHAIR PINCUS: Okay.

12 DR. ANTONELLI: Because when I think  
13 about population health, you're a person who  
14 happens to become a patient. I recognize that in  
15 this group, because we're thinking about CMS all  
16 the time, your ticket to the dance is that you're  
17 a patient. I actually am excited about this  
18 attribution discussion, because of the potential  
19 bridge it builds into the world of true  
20 advancement of health.

21 So could you bake in some components  
22 of your language going forward around person, not

1 just patient.

2 CO-CHAIR PINCUS: Yes, yes. We  
3 realize that we did not leave room for public  
4 comments on this, so just at this point, let's  
5 open it up. Are there any comments from the  
6 public participants in the room?

7 (No audible response.)

8 CO-CHAIR PINCUS: Any comments from  
9 public participants on the phone?

10 OPERATOR: At this time if you'd like  
11 to make a comment, please press star then the  
12 number one.

13 (No audible response.)

14 OPERATOR: There are no public  
15 comments at this time.

16 CO-CHAIR PINCUS: So why don't we take  
17 a break now and reconvene at 5 to 11:00.

18 (Whereupon, the above-entitled matter  
19 went off the record at 10:39 a.m. and resumed at  
20 11:04 a.m.)

21 MS. O'ROURKE: While we reconvene, I  
22 did want to just kind of jump in for a few

1 minutes for some of our newer MAP members, who  
2 actually may not be familiar with the work of the  
3 MAP task forces, and to give some background that  
4 MAP does have responsibilities outside of the  
5 pre-rulemaking rule.

6 So obviously the pre-rulemaking work  
7 that we've done over the past two days  
8 constitutes one of MAP's largest charges, but if  
9 you recall from the org structure that we show  
10 during the orientation, we do also have the  
11 ability to convene time-limited task forces to  
12 tackle particular challenges or to do work  
13 outside of the scope of pre-rulemaking.

14 So historically, we've looked at a  
15 wide range of topics. We've provided some input  
16 on the health insurance exchange's quality rating  
17 when that was getting set up. We also created  
18 families of measures around the different NQF  
19 priorities, and one of the more enduring task  
20 forces has been the work of the Adult and Child  
21 Medicaid Task Forces, to provide input on the  
22 core sets of measures used by the states.

1                   So what we're hoping to do today is to  
2                   shift the focus of the Coordinating Committee for  
3                   a bit to the process that the Medicaid Task  
4                   Force, forces I should say, have been using to  
5                   make those recommendations, and to help us  
6                   continually improve them and perhaps bring the  
7                   more in line to the way that MAP makes its pre-  
8                   rulemaking recommendation, so that CMS and others  
9                   can see a consistent process and product from MAP  
10                  and to know that all the recommendations are made  
11                  equally rigorously. So, I think, Taroon, if you  
12                  have anything to add or --

13                 MR. AMIN: No, just to say that this  
14                 next conversation obviously builds on the  
15                 conversation we had in September, related to the  
16                 preliminary analysis algorithm. So you'll find  
17                 the goal here is to create more alignment in the  
18                 approach that's being used across the work  
19                 groups. So that is the purpose of today's  
20                 discussion.

21                 CO-CHAIR PINCUS: And actually let me  
22                 just say a word. In some ways and I may be

1 wrong, but in some ways the first meeting of the  
2 group that reviewed the Medicaid measures  
3 actually predated the MAP process. In that way,  
4 it became kind of the model for how MAP operated.

5 I was there at that meeting and  
6 participated in it, and it was really sort of an  
7 interesting process to see how one does that,  
8 that came out of the CHIPRA rules, and so it's  
9 kind of come full circle now to now sort of get  
10 more joined up with the MAP process. So Debjani.

11 MS. MUKHERJEE: Thank you. So I would  
12 like to thank Harold and everybody, and  
13 especially the MAP Coordinating Committee for  
14 this opportunity to present some of the MAP  
15 Medicaid process refinements here today, and what  
16 I'll do first is provide a background, and my  
17 name is Debjani. I'm the Senior Director for the  
18 Medicaid Adult and Child Core Set, and I'd like  
19 to acknowledge our chairs here today.

20 Harold is the chair for our Medicaid  
21 Adult Task Force, and which is -- Rich Antonelli  
22 is the chair for our Child, and he's our new

1 incoming chair, replacing Foster Gesten. So with  
2 that, what I'd like to do is, the first couple of  
3 slides will be foundational, providing some  
4 background on the core sets and sort of the task  
5 force charge and sort of the goal of the core  
6 sets.

7           Hopefully, that will set some context  
8 for the ensuring discussion about the preliminary  
9 analysis. So the Adult Core Set came out of the  
10 Affordable Care Act, and sort of that was the  
11 genesis of creating an initial Adult Core Set,  
12 and since then it has been updated annually with  
13 recent iterations reflecting the input from MAP.

14           Similarly, the Children's Health  
15 Insurance Program Reauthorization Act of 2009  
16 provided for the identification of a core set for  
17 children enrolled in Medicaid and CHP. And the  
18 CMS and AHRQ, Agency for Health Care Research and  
19 Quality, jointly came together with a group of  
20 experts and created the initial core set in 2009,  
21 and just a point about this core set.

22           The measures cover children ages 0 to

1 18, as well as pregnant women to get pre- and  
2 post-natal care needs. So the core sets must be  
3 updated annually, and the way this happens is the  
4 Medicaid Task Forces come together. They discuss  
5 potential recommendations for addition, as well  
6 as measures for removal from the core set.

7 These recommendations are sort of  
8 blessed by this MAP Coordinating Committee in  
9 August. Then they are sent forth to CMS HHS,  
10 where they get feedback from their various  
11 internal/external stakeholders, and the final  
12 annual updates for that year to both the core  
13 sets are published in December.

14 So what is the core set's  
15 charge/purpose? The purpose is to get states'  
16 experiences in implementing and reporting on the  
17 core set measures, and in a way, that functions  
18 as a feedback loop and gives us experiential data  
19 regarding sort of the feasibility and sort of the  
20 difficulties with respect to implementing.

21 The core set purpose is also to sort  
22 of gather concrete recommendations for



1 strengthening and sort of addressing measure  
2 gaps, potential measures that should be  
3 considered, as well as measures that are  
4 ineffective and should be removed.

5 Together, the input provided helped  
6 CMS formulate strategic sort of direction and  
7 sort of policies with respect to Medicaid.

8 So as mentioned before, the task  
9 forces are time-limited bodies, and it's an  
10 interesting point, because the Medicaid task  
11 forces have been around for a couple of years,  
12 and what they -- what the goal of the task force  
13 is is to come together, provide guidance on a  
14 very specific topic, and then they get disbanded.

15 Just because of their annual updates,  
16 the Medicaid task forces have been around for a  
17 while, and one of the caveats is that the task  
18 force membership is drawn, has to be drawn from  
19 the current MAP work groups, as well as the  
20 Coordinating Committee. This is also another  
21 reason why that the Medicaid work happens off-  
22 cycle, so that we can let the MAP pre-rule work

1 be completed before we start tapping the same  
2 individuals for the Medicaid work.

3 So the core set data or sort  
4 of reports on measures from the core set are used  
5 to create a snapshot of quality across Medicaid  
6 and CHP. The data is provided annually in the  
7 Health Quality Report. There are two reports,  
8 one for child, one for adult. There's also a  
9 chart pack that has state-specific data and other  
10 analyses, and altogether all of this, again, is  
11 used to inform policy and program decisions.

12 Again, a quick recap of the task  
13 force's charge. Review states' experiences in  
14 reporting measures to date; refine; identify  
15 measure gaps, and sort of, usually it's growing  
16 the measure gap on a yearly basis; recommend  
17 potential measures for addition to the set; as  
18 well as recommend measures for removal based on  
19 loss of endorsement and/or ineffectiveness within  
20 the program.

21 This provides you with a quick time  
22 line. The Medicaid work again is off-cycle. It

1 starts in March with a web meeting. Then the in-  
2 person meeting always happens in May, late May.  
3 Report development happens June through August.  
4 Mid- to late August is when all the  
5 recommendations as well as comments are brought  
6 forth to the MAP Coordinating Committee for  
7 review and approval.

8 The final reports are completed by  
9 August 31st on a yearly basis, and then the core  
10 set updates are provided usually by December of  
11 that year.

12 So the project evolution. The whole  
13 point of sort of undertaking this process  
14 improvement is to sort of align with the  
15 expansion of Medicaid and sort of the impact in  
16 importance of Medicaid and health care,  
17 standardize the work flow, as well as the  
18 assessment of measures and recommendations across  
19 project tiers, as well as systematically review  
20 measures.

21 The current processes of document  
22 review considers the gaps within the Medicaid

1 population and sort of the needs of the  
2 population, as well as being guided by the  
3 measure selection criteria. What is being  
4 recommended and sort of put forth for discussion  
5 today is the introduction of a standardized way  
6 of discussing potential measure recommendations  
7 based on a Medicaid-specific algorithm and  
8 preliminary analysis.

9 And just to note that what staff has  
10 done is take the MAP pre-rulemaking algorithm and  
11 preliminary analysis and has adapted it for  
12 Medicaid on core sets. Hence, the edits are not  
13 drastic. It's more sort of a clarification of  
14 what Medicaid needs might be and how they might  
15 be different from MAP pre-rulemaking Medicare  
16 needs.

17 So in the next couple of slides, what  
18 I want to do is quickly talk about some of the  
19 Medicaid decision criteria before I go into the  
20 actual edits of the algorithm, and the  
21 preliminary analysis tool with the edits has been  
22 distributed. It's a draft copy. So everybody

1       should have a copy of it at your table right now.

2               So the decision criteria starts with  
3       support, and support criteria basically addresses  
4       a previously identified measure gap, measures  
5       that are ready for immediate use and promotes  
6       alignment across programs and settings. The  
7       other decision criteria is conditional support,  
8       and that's for measures that are pending  
9       endorsement from NQF, pending change by the  
10      measure steward, pending CMS confirmation of  
11      feasibility of implementation reporting, and  
12      other such considerations, practical  
13      considerations.

14              And finally, the do not support  
15      criteria are for measures and/or measure focus  
16      that are inappropriate are a bad fit for use for  
17      the Medicaid core sets. There's a duplication of  
18      efforts, resource constraints, which is a big  
19      issue, and Medicaid agencies at the state level  
20      will need to tweak and/or vary the level of  
21      analysis to increase measure adoption and  
22      implementation.

1                   So with that, the next couple of  
2                   slides talk about where changes have been  
3                   introduced to the MAP pre-rulemaking preliminary  
4                   analysis tool. So for the first couple of  
5                   assessments, all we have done is add high impact  
6                   area with a focus on the Medicaid population. So  
7                   that's more of a clarification. And then the  
8                   major adaptations or deletions are, if you want  
9                   to follow along in the paper copy that's been  
10                  handed out for Assessment Number 5.

11                  The Assessment Number 5 for pre-  
12                  rulemaking says the measure can be feasibly  
13                  implemented. For Medicaid, it has been changed  
14                  to operational feasibility because we want to  
15                  make sure that it's implementable. From reports,  
16                  sorry, the pre-rulemaking says reporting  
17                  feasibility. The Medicaid one says operational,  
18                  because we want to make sure that it can be  
19                  implemented and operationalized before we get to  
20                  sort of the reporting aspect.

21                  And then the final one is number  
22                  seven, which for the pre-rulemaking is sort of

1 asking for end user feedback on measures that are  
2 already implemented in other programs, and that  
3 has been deleted for the Medicaid.

4 That's one of the questions I have for  
5 the MAP today: should this assessment still be  
6 done? Because the Medicaid program is unique in  
7 having the data of how feasible -- or sort of  
8 user feedback from PQS and some other program, I  
9 don't know if that's going to be very helpful for  
10 the Medicaid-specific core set.

11 But if this group feels like it should  
12 be put back, all we'll do is just add it back.  
13 With that, those were the only two sort of big  
14 edits done. I want to open it up to say what  
15 other factors or considerations should be added  
16 to this Medicaid-specific preliminary analysis?  
17 Any additional edits? Any additional comments?  
18 Sort of your thoughts on sort of adapting  
19 something that's for pre-rulemaking to something  
20 that's for Medicaid.

21 I just want to keep this to this part  
22 brief so that we can have time for discussion.

1 Harold.

2 CO-CHAIR PINCUS: So any comments, any  
3 thoughts? I know, you know, Rich, you are coming  
4 into the process. You've been involved in the  
5 process, but coming in as chair, and Carol's been  
6 very involved as well. And others have been  
7 involved in the Medicaid Task Forces.

8 So maybe we could -- people would have  
9 some thoughts in terms of some of these changes.  
10 Important points about, just to reemphasize, is  
11 that it's interesting in that this is a voluntary  
12 program, and so that states have the option of  
13 participating in it or not participating in it.  
14 States also have the option of choosing which  
15 measures they want to implement.

16 So there's a balance in terms of  
17 thinking about both what are individual state  
18 needs? What are the needs across the Medicaid  
19 program? What capacity states, individual  
20 states, have in terms of the implementation of  
21 these programs. And also there's a real  
22 opportunity to have very good interactions



1       between people involved in running state Medicaid  
2       programs, as well as other stakeholders in  
3       getting some of the back and forth about how they  
4       -- the difficulties and barriers they have in  
5       implementing some of the measures, but also in  
6       terms of how they're using the measures within  
7       their states to improve care.

8               So it really provides an interesting  
9       sort of laboratory of what actually goes on in  
10      other areas of other programs that MAP oversees.  
11      So comments. Rich, did you want to say  
12      something?

13             DR. ANTONELLI: I have a couple of  
14      comments, but I'm going to anticipate a question.  
15      Debjani, could you say a little bit more about  
16      the rationale for deleting number 7?

17             MS. MUKHERJEE: Sure. So I think from  
18      sort of the staff perspective, we wanted it to be  
19      as Medicaid-focused as possible and sort of  
20      really attuned to the specifics of needs of the  
21      Medicaid population. And from our point of view,  
22      we didn't know if looking at other federal

1 programs that have already implemented the  
2 measure, whether that sort of information is  
3 translatable to the Medicaid population.

4 So if it worked in some sort of pay-  
5 for-performance, is it going to sort of translate  
6 easily to sort of the Medicaid population? And  
7 Medicaid is voluntary. Also, a lot of the issues  
8 we hear in Medicaid as resource constraints are  
9 political, sort of, will-related issues. I don't  
10 know if that, especially the political will  
11 issue, is going to be captured in sort of the  
12 states' experience in reporting.

13 And that's why I said staff is open to  
14 putting it back in if the MAP Coordinating  
15 Committee thinks that it is something we should  
16 at least hear from and consider, even if it's not  
17 directly relatable or translatable.

18 DR. ANTONELLI: So thank you, and I  
19 don't know whether Foster is listening in today,  
20 but I have huge shoes to fill. But I'm honored  
21 to be asked to be able to do this, and I'll make  
22 a couple of comments. I'll keep them brief. So

1 first of all, I think in general, the document,  
2 the tool that you've shared with us for comments,  
3 I think aligns very nicely with being able to  
4 look at some of the core principles around  
5 validity and parsimony harmonization, usability,  
6 and feasibility.

7 Last year what we did is we had, for  
8 the child and the adults, actually there was like  
9 a three day meeting with overlap between the  
10 child and the adult for two of those three days.  
11 So I really liked that, and one of my core  
12 principles with respect to care coordination and  
13 integration measures is to try really hard to  
14 promote a single approach to integration that is  
15 not age-specific.

16 So I really like this approach, and I  
17 like the criteria. This will be especially  
18 important as we try to identify and then promote  
19 measures to fill gaps in the area around  
20 behavioral health assessment and integration as  
21 an example. So I really appreciate the ability  
22 to have the child and the adult task forces to

1 co-convene, and to look at experience.

2 The other piece though that I found  
3 valuable last year, and I wanted to bring up with  
4 our CMS colleagues in the room, we have  
5 qualitative experience from selected states that  
6 will come in to talk a bit about their measures.  
7 I want to make sure that that continues. That's  
8 very helpful.

9 It also would be really helpful for us  
10 to be able to see some data from the states that  
11 actually are using some of these measures. What  
12 I'm particularly mindful of is, because a state  
13 isn't using a measure, if I don't have any more  
14 information than that, I don't know is that was  
15 because of lack of resources, lack of political  
16 will, or whether in fact it speaks to the  
17 usability, feasibility, or applicability of the  
18 measure.

19 So I think if CMS could consider  
20 getting some data to the task forces when we have  
21 that component of measure review, that would make  
22 our -- that would inform our deliberations that

1 much more. Then I think it would be -- I'm also  
2 keen to hear a little bit about Item 7. Full  
3 disclosure, this is the first time that Harold,  
4 Debjani and I are talking about this.

5 But I am mindful, being a provider  
6 myself. There may be measures that I have  
7 experience with that aren't necessarily in the  
8 Medicaid space yet. So while I agree with the  
9 need to have relevance and comparability, we may  
10 want to have some criteria by which we will  
11 either rule in or rule out the content, if you  
12 will, for Element 7, or make sure that those  
13 comparability criteria fold into another element.  
14 Those are my, those are my comments.

15 CO-CHAIR PINCUS: Carol?

16 MEMBER SAKALA: Yes. So I've been  
17 through this process for three rounds and heading  
18 toward a fourth. I'd like to second what Rich  
19 says I think about the structure, which I think  
20 is really valuable and rich to have the task  
21 force members, NQF staff, people from CMS. Very  
22 rich presentations, feedback from the states,

1       which do give some of the feedback about measure  
2       use issues in the context of Medicaid.

3               And also, having a day of overlap  
4       where the child and adult groups meet together.  
5       So I think it's really fundamentally a very  
6       excellent process, and I support the effort for  
7       continued alignment with the overall, the MAP  
8       process. I just wanted to follow up. Leah made  
9       a comment yesterday that I think might have  
10      seemed a little strange. She mentioned maternity  
11      and cesarean in the context of a conversation  
12      which is framed around Medicare.

13             Last year we had the VBAC measure, but  
14      it wasn't an all-payer measure. So I just wanted  
15      to share a little bit of -- like be sure that  
16      everyone's aware of what I would call an  
17      imbalance right now, because the Medicaid is  
18      really, there are facility measures, clinician  
19      health plan, but they're aggregated to the state  
20      level.

21             So the potential for improvement is  
22      very different from the Medicare measure. So I

1 just wanted to be sure that everyone understands  
2 that, and as Harold said, it's voluntary, and it  
3 is at the state level. And it's also  
4 confidential, so that we don't even get the state  
5 performance results there. And the three aims  
6 are that over time, more states should be  
7 collecting -- more states should be involved.

8 States should collect an increasing  
9 number of measures, and states should use them  
10 for quality improvement. But that is very  
11 different from the various federal programs that  
12 we've been talking about, and there were some  
13 public comments this time around directed to the  
14 hospital draft report, saying that on the model  
15 of the elective delivery measure, that is an all-  
16 payer measure that is in the inpatient quality  
17 reporting program and in Hospital Compare.

18 Maybe it's time to think about how we  
19 might fix this imbalance between the two  
20 programs. So in the context of discussing  
21 Medicaid, I just wanted to rise that, because  
22 conditions that apply to younger populations,

1       pediatric, maternity, other things, really are  
2       pretty left out of the federal programs.

3               CO-CHAIR PINCUS:   Marissa.

4               MEMBER SCHLAIFER:   So some of my  
5       comments very much mirror Rich's comments and  
6       Carol's comments.  I'm only -- I've been through  
7       just two years going on Year 3, and one thing I  
8       just want to reiterate, the importance of having  
9       the Medicare/Medicaid program directors, state  
10      directors here to share information.

11              There's some of us on the Committee  
12      who have strong managed Medicaid background and  
13      not fee-for-service Medicaid background, and I  
14      think explaining the feasibility of why things  
15      can't be collected.  I think I learned so much  
16      over the last two years about why measures that  
17      made sense to me don't really make sense, or make  
18      sense in the managed Medicaid world and don't  
19      make sense in the fee for service Medicaid world.

20              So I just would encourage that, and  
21      that's originally what I thought this question  
22      was, and now I'm understanding I guess that it's



1 more people that are non-Medicaid. I just wanted  
2 to say that.

3 One question, and I don't expect it to  
4 be answered here, but I think that came up  
5 briefly at the end and Kate, I don't know that  
6 this is something that CMS has gotten to yet.  
7 But one of the interests that I know on the  
8 management Medicaid plans have is with the new  
9 managed Medicaid quality measures that will be  
10 rolling out in I think 2021, and we are still  
11 pretty far away, I think trying to --

12 One of the questions that was asked at  
13 this past go-round of the meetings was whether a  
14 MAP or MAP-type entity would have input on those  
15 managed Medicaid measures, and whether those  
16 managed Medicaid measures could be -- we would be  
17 assured that they would mirror the state Medicaid  
18 measures.

19 So I think that's just something that  
20 hopefully we can talk about a little more at the  
21 upcoming this year's meetings, and maybe CMS will  
22 have had time to think about that by then.

1 CO-CHAIR PINCUS: Other comments? I  
2 just have a few. Oh, Doris.

3 DR. LOTZ: Yes, thanks. A couple of  
4 general comments. I wouldn't want too much  
5 departure from the MAP process, you know,  
6 inasmuch as the MAP process we've just discussed,  
7 you know, evolves the contribution about  
8 attribution. Other conversations we've had over  
9 the last day and a half, applying those to any  
10 approach taken for Medicaid to me would be, you  
11 know, should be done.

12 I think there are some unique aspects  
13 of the Medicaid population, you know, the  
14 population, some of the services maybe. But as  
15 far as measurement is concerned, I would strongly  
16 encourage just keeping the same approach, the  
17 same standards, maybe with a few additional  
18 standards, but without substitution.

19 You know, the past physiology is the  
20 same. We're moving more and more towards  
21 integrated payer models, where Medicaid is most  
22 effectively affecting changes to population when

1 thinks its service delivery across payers, and  
2 not as some sort of unique payer. So you know,  
3 the ACO models, some of the models that came out  
4 of SIM, these are looking for Medicaid to partner  
5 with the commercial sector and with Medicare.

6 If we create too different a set of  
7 standards for measurement, we're going to have a  
8 hard time, you know, introducing payment models  
9 and some assessment of value and change. That  
10 said, I do think we need to think about some  
11 unique needs of the populations. But I see that  
12 almost as, you know, secondary to creating the  
13 gold standard in a measure so to speak, that I  
14 kind of like to think of coming out of this  
15 process.

16 I think absolutely feedback on  
17 measures, though, is good. So I'm not, I'm not  
18 clear, and I don't have the full document. I  
19 only have the slides that were distributed. But  
20 number seven it says regarding feedback, delete  
21 number seven regarding feedback.

22 I would speak against that. I've had

1 a chance to talk to the Medicare MAP group a  
2 couple of times in my capacity as CMO for  
3 Medicaid, and pointing things out that, you know,  
4 we have a good portion of our population going to  
5 places called Institutes for Mental Disease,  
6 which are the state psychiatric facilities or  
7 otherwise, you know, psych facilities that are  
8 dedicated primarily to the public sector.

9 Historically, these were taken out of  
10 the payer mix so Medicaid didn't pay for them.  
11 They were primarily funded through other state  
12 reimbursements. But as we've kind of evolved our  
13 Medicaid practices, we look at, you know, the  
14 measures that deal with discharges from mental  
15 health facilities, certain follow-up criteria, et  
16 cetera, as definitely applying to the IMDs or the  
17 Institutes of Mental Disease.

18 So this is a variation in Medicaid  
19 that I think enhances the use of the measure, and  
20 that the MAP process ought to be familiar with.  
21 But it certainly doesn't require a different  
22 approach to creating that measure, and certainly

1 not a different measure.

2 So I would speak against deleting the  
3 feedback, and I'm also similarly befuddled about  
4 why separating operational feasibility from  
5 reporting feasibility. As been said before it's  
6 voluntary, so where there's politics, where there  
7 might be resource constraints, that's on the  
8 states to sort through.

9 To take them somehow formally out of  
10 the discussion, it seems prematurely to take them  
11 out of there because politics and resources  
12 change, and you know, I would rather see for  
13 Medicaid a robust set of measure sets. It allows  
14 us to capture local opportunities and capture  
15 integration where we can, rather than to have  
16 them sort of presorted before the measure set is  
17 complete.

18 So I know that was a lot, but 15 years  
19 I've been working with the Medicaid program  
20 primarily with quality improvement and  
21 specifically with measures. I would rather at a  
22 philosophic level have the measure set reflect,

1       you know, the general delivery of medicine, as I  
2       said, the pathophysiology that we're trying to  
3       address, rather than have it be some sort of  
4       separate set of criteria that leads to Medicaid  
5       measures. I'll go back on mute now.

6                   CO-CHAIR PINCUS: Thanks, Doris. I  
7       had a -- oh, Aparna.

8                   MEMBER HIGGINS: Sorry, I had a quick  
9       question. On the operational feasibility aspect,  
10      are there -- I know when we do our MAP selection  
11      criteria, we have subcriteria. So is that  
12      something? That's actually a question? So do we  
13      have subcriteria in terms of how the Committee  
14      looks at operational feasibility? So I mean kind  
15      of looking at it --

16                  CO-CHAIR PINCUS: And maybe explain  
17      the difference between operational feasibility  
18      and implementation and reporting.

19                  MEMBER HIGGINS: Reporting, yes.

20                  CO-CHAIR PINCUS: What are the --  
21      because it seems like a fuzzy mentality there.

22                  MEMBER HIGGINS: And then I have a

1 comment after that, after I get an answer to my  
2 question. So go ahead.

3 MS. MUKHERJEE: So the way we were  
4 looking at it is can it be adopted as specified  
5 without additional resources being needed at the  
6 state level, and if additional resources are  
7 needed, does the state have access to that? Also  
8 we're looking at the implementation. Is it at  
9 the state level, at the plan level and sort of  
10 what is the feasibility of doing that?

11 But again, all of this is up here  
12 today for sort of input, refinement. So if  
13 anybody has other thoughts, other subcriterias  
14 that should go other than sort of the level of  
15 analysis, operationalizing at the level of  
16 analysis, and sort of the resources of adopting  
17 it as specified, I think we're open to any and  
18 all suggestions at this point.

19 MEMBER HIGGINS: Because one thing I  
20 would -- I mean this probably came up in  
21 discussion is the availability of data, right,  
22 for calculating all the measures. Depending upon

1       how the state defines the benefit, you know, some  
2       states carve in behavioral health, some don't.  
3       You know, it's just going to vary in terms of  
4       what states are going to be able to do.

5               So you probably want to make that  
6       explicit. I think I'll say the same thing as  
7       what Doris said for seven. I think it's still  
8       useful to get feedback from current measure  
9       users, because if say implementing the measure in  
10      the commercial population they run into some  
11      challenges, I think it would be good for the  
12      committee to understand those.

13             People might say oh yes we have the  
14      same problem because we don't have X, Y or Z. So  
15      I think there's value in that. And then just to,  
16      you know, sort of comment on what Marissa said  
17      about Medicaid managed care, and looking at what  
18      the states are doing, you know, I mean there's  
19      variations on a theme.

20             I mean I think we're all familiar with  
21      the buying value project. We looked at use of  
22      measures at the state level and there were, you



1 know, over 1,000 measures and variations on those  
2 as well. I think, and again it's also driven by  
3 the benefits and what the states decide to do.  
4 So that's -- I mean it's a huge challenge and I  
5 just say more power to the committee so --

6 CO-CHAIR PINCUS: So just a couple of  
7 comments. One is with regard to the two issues  
8 about the changes, it seems to me that, you know,  
9 one of the sort of real things I like about the  
10 program is the fact that it is voluntary, and it  
11 allows, you know, more flexibility in a sense in  
12 terms of how one applies this.

13 There's always going to be a balance  
14 between having the flexibility versus having  
15 standardization, you know. While, you know, at  
16 some level the goal is to have every state report  
17 on every measure, there's also an understanding  
18 that every state's going to be very different,  
19 and if you look at where the Medicaid program is  
20 heading, there's going to be even more  
21 variability.

22 So that, you know, during this period,

1 especially when there's going to be this  
2 transition, I think having flexibility may be  
3 important. So that different states applying  
4 different models having different capacities can  
5 get their feet wet in reporting in some way. At  
6 some levels, we want to encourage people to come  
7 in, states to come into this.

8 And they may -- with the understanding  
9 that they may not be able to report on every  
10 measure, but still to participate and to begin to  
11 be able to sort of evolve over time, particularly  
12 from the point of view of what they find useful  
13 in participating in this.

14 Because one can think of feasibility  
15 from a number of different perspectives,  
16 feasibility in terms of reporting, actually  
17 collecting the data. But also feasibility of the  
18 ways in which they might use the data. They have  
19 different capacities to do that.

20 So I would, you know, be more general  
21 in terms of thinking about, in terms of  
22 Assessment 5 to say that that's something that

1     should be explored, but it should be, you know,  
2     with not, you know, we shouldn't set the lowest  
3     possible capacity to do that as the standard,  
4     that we should have some, you know, allow some  
5     flexibility.

6                 With regard to Item 7, you know, I  
7     think that it's always useful to have this kind  
8     of information. I don't see a reason to exclude  
9     this kind of information. So you know again,  
10    it's input and it's useful and I think, you know,  
11    members of the task force think about these  
12    things anyway, because they may have been exposed  
13    to the use of these measures, you know, in other  
14    ways.

15                So we should probably be explicit  
16    that, you know, we welcome this kind of  
17    additional information. But I think, you know,  
18    as I said before, given the current political  
19    issues going on around Medicaid, this is going to  
20    become, you know, increasingly important as a  
21    program. I think we also want to sort of  
22    generate as much interest as possible from the

1 states themselves, in understanding as they move  
2 towards these more, you know, potentially more  
3 flexible and potentially more innovative  
4 arrangements, how they can sort of understand  
5 where they are in relationship to other states  
6 and how they, you know, can use this kind of  
7 program to improve what they're doing and learn  
8 from the experiments that are going on.

9 MS. O'ROURKE: Could I jump in with a  
10 perhaps suggestion of a path forward? So it  
11 sounds like from Doris' comments and Aparna's,  
12 perhaps maybe we want to adopt the same seven  
13 assessments for both pre-rulemaking and the  
14 Medicaid work, and then allow for the necessary  
15 customization in the definition of those  
16 assessments, so that now we'll have a consistent  
17 preliminary analysis algorithm across the board  
18 when you look at the overarching assessments that  
19 every measure will be subject to.

20 And then versus pre-rulemaking versus  
21 the Medicaid at work, there will be the need for  
22 the customization. Again, just to highlight why

1 we're bringing this to you, is we want the  
2 Coordinating Committee to feel comfortable with  
3 the process, that the task forces will now go use  
4 to make their initial recommendations to you,  
5 because we'll be bringing the findings of the  
6 task force to you at your August web meeting, to  
7 finalize. Similarly to the charge of the  
8 Coordinating Committee to finalize the pre-  
9 rulemaking recommendations.

10 So again like we discussed in  
11 September, the process for pre-rulemaking, we  
12 want you all to feel comfortable with the process  
13 the task forces are about to embark on for their  
14 work. So we would perhaps put that suggestion  
15 out for the Committee's consideration as a  
16 potential path forward.

17 CO-CHAIR PINCUS: I think that makes  
18 a lot of sense. Rich.

19 DR. ANTONELLI: Yes. I don't know  
20 whether our CMS colleagues didn't respond to the  
21 Medicaid MCO, or whether you were just being  
22 polite. So I would absolutely respect you not to

1       feel comfortable, but I'd love to hear what you  
2       would say about, you know, what would the lines  
3       of sight be between this work and the Medicaid  
4       MCO measure sets.

5               DR. GOODRICH: I think we need our  
6       Medicaid colleagues to answer that question up  
7       here. We need our Medicaid colleagues to answer  
8       that question. Peter and I work on the fee for  
9       Medicaid service side. I don't know if there's  
10      anybody on the phone.

11             MS. O'ROURKE: Oh okay, okay.

12             DR. GOODRICH: So if we have somebody  
13      from CMS on the phone who can answer that.

14             MS. MUKHERJEE: Renee, are you on the  
15      phone? Gigi, Renee?

16             DR. FOX: Debjani, can you hear me?

17             MS. MUKHERJEE: Yes, we can hear you.  
18      Do you hear the question? Do you want to take  
19      sort of an --

20             DR. FOX: So I'm going to -- I'm not  
21      the managed care rule guru, and I'm going to  
22      defer the question. I think we would be happy to

1 discuss it in the -- maybe we can add that to the  
2 agenda for the MAP meeting in March.

3 CO-CHAIR PINCUS: That makes sense.  
4 I mean it's certainly something that we want to  
5 discuss and --

6 DR. FOX: Great. We'll make sure that  
7 --

8 CO-CHAIR PINCUS: And we can prepare  
9 for that.

10 DR. FOX: Yes. Thank you.

11 (Off mic comments.)

12 CO-CHAIR PINCUS: Other comments,  
13 other questions? Any other comments from the CMS  
14 Medicaid participants?

15 (No audible response.)

16 CO-CHAIR PINCUS: Okay. So why don't  
17 we move on to the next section. Is there any  
18 other -- that's good. Let's move on. Let's move  
19 on to the next section. So there's an  
20 opportunity for public comment on this Medicaid  
21 presentation. Okay. Are there any comments on  
22 the sort of Medicaid task forces discussion that

1 we just had from the public in the room?

2 (No audible response.)

3 CO-CHAIR PINCUS: What about the  
4 public on the phone?

5 OPERATOR: If you want to make a  
6 comment, please press star then the number one.

7 (No audible response.)

8 OPERATOR: There are no public  
9 comments at this time.

10 CO-CHAIR PINCUS: Okay, thanks. So  
11 Chip, I think we're going to move on to  
12 discussions about process improvement of the work  
13 that we've been doing over these two days.

14 (Pause.)

15 MS. O'ROURKE: Sure. So we can -- the  
16 presenters from ASPE can be available at one  
17 o'clock.

18 CO-CHAIR KHAN: Okay. Well then let's  
19 barrel through. So I'll turn to Kim to present  
20 this process.

21 MS. O'ROURKE: Thank you. Do you want  
22 to at this -- sure. So again, this is something



1 we've done with the Coordinating Committee every  
2 year. We want to hear your feedback on what  
3 worked about the pre-rulemaking process, both  
4 what the process, the work groups used to make  
5 their recommendations, as well as the process for  
6 the Coordinating Committee's meeting.

7 So Kim's going to be taking you  
8 through an exercise there. She's also going to  
9 be highlighting a few areas where we'd really  
10 love your feedback on some potential ways to do  
11 this a little better next year. In particular,  
12 we're looking for feedback on the decision  
13 categories. If you need to further clarify the  
14 differences between the refine and resubmit and  
15 the conditional support, and if the Committee  
16 thought that having these four categories worked  
17 for this year.

18 We also want any input you might have  
19 on building out the process to look at the  
20 measure that are currently finalized for the set,  
21 any ideas about data we could bring into the  
22 Committee for their consideration, potential

1 sources for that data.

2 Kim's also going to give you a  
3 refresher on the feedback loop that we've piloted  
4 with the PAC/LTC group and some suggestions from  
5 the Coordinating Committee would be most welcome  
6 as we roll that out across all the MAP work  
7 groups.

8 DR. GOODRICH: Thanks, Erin. So we'll  
9 do a warm-up process improvement exercise. It's  
10 the round robin plus delta. This is something  
11 that the Clinician Work Group used. Yes, the  
12 Clinician Work Group used in their December  
13 meeting. So what we'd like to do is to go around  
14 the room and have each Committee member talk  
15 about something that worked really well over  
16 these last two days, and what could be improved.

17 NQF staff will be taking notes and  
18 we'll use this to help inform the process that  
19 happens next year.

20 MEMBER BAKER: I thought the decision  
21 categories worked well. I particularly liked --  
22 for the conditional support, I thought all of the

1 groups did a good job at saying what were the  
2 conditions that needed to be met. I thought that  
3 was really helpful.

4 In terms of what could be improved, I  
5 think just to be able to come up to that higher  
6 level and be able to understand the existing  
7 measure set and what niche does this fill. I  
8 think we need to get more information on that, a  
9 couple of very concrete things. We talked about  
10 some of the measures for end stage renal disease  
11 and how --

12 It wasn't apparent from the materials  
13 that they were -- you had a dig a little bit to  
14 see that they were addressing specific problems  
15 in some of the existing measures, and the same  
16 with one of the other ones, where you were  
17 shifting, essentially replacing ECQMs, chart-  
18 based measures with new ECQMs. So just to be  
19 able to give that higher level view I think would  
20 be helpful.

21 DR. GOODRICH: So I think the prep  
22 materials and having this online, which we've had

1 now for a couple of years for me works very well.  
2 I felt like there was a button missing this year  
3 that allowed you to get back to the top really  
4 easily. So a tiny little thing, but I just  
5 thought I'd say that. I looked for it a couple  
6 of times. I remember it being there before.

7 The one thing that for me was a  
8 little, I don't know if it came out in previous  
9 years or not, but was the process by which when  
10 you had multiple votes in multiple categories,  
11 that it would roll down to the, you know, to get  
12 to the 60 percent. Sometimes we saw a couple of  
13 examples of this yesterday.

14 That was just awkward, because you  
15 ended up having most in one category, but you did  
16 have a couple of like in refine and resubmit sort  
17 of roll down to refine and resubmit, which didn't  
18 always make sense for the measure if it was fully  
19 endorsed, fully specified.

20 So I would just think through that a  
21 little bit for next year. So that's one area I  
22 would point out. I feel like we struggle with

1       this every year, like what does consensus mean,  
2       you know. Should it just be a simple majority?  
3       Now we've come to the 60 percent, and I know why  
4       we got where we did each time. It continues to  
5       be a struggle. I do not have a suggestion. I'm  
6       sorry.

7               DR. YONG: So along with Erin and  
8       Helen having sat here now for eight days of MAP  
9       meetings, over the course of the past two months.  
10      Just from my own observations, I think -- I think  
11      the -- at the work group level and at the  
12      Coordinating Committee level, I think what has  
13      worked really well is both having a chance to dig  
14      into the measures on the MUC list.

15             But then also having these cross-  
16      cutting conversations even at the work group  
17      level, I think they -- we've heard a lot of  
18      comment, feedback that that worked. The members  
19      really appreciated that opportunity to think  
20      about sort of broader cross-cutting issues.

21             I also agree with Kate. I think the  
22      prep materials have been really helpful too, and

1 so I really appreciate the work the staff has  
2 done just to get those done and out to the  
3 Committee.

4 MEMBER ROBICSEK: On the plus side, I  
5 felt like the chairs did a very good job of  
6 stimulating conversation, helping it move, making  
7 everybody wanting to comment and feel comfortable  
8 doing so. I also thought the materials that were  
9 prepared were very thorough. On the delta side,  
10 I did feel like the kind of relative proportion  
11 of discussion about procedural things and  
12 discussion about the kind of material that we're  
13 talking about was maybe not as favorable as it  
14 could have been.

15 There was also I felt like, at least  
16 for me maybe, because I'm new, ambiguity about  
17 what was the what that was in scope for us to be  
18 talking about? What would be excessively  
19 duplicating work that was already done by the  
20 work groups, and what's discussion that should  
21 happen here?

22 So kind of what level? Should we stay

1 at that 100,000 foot level? Should we get down  
2 into the details that again, at least as a -- for  
3 a newbie wasn't totally clear.

4 And then I just want to reemphasize  
5 David's point about it would be helpful to see  
6 what the existing measure set is, so that we can  
7 know where this fits in.

8 MEMBER FLAMM: So I would just, I  
9 guess, pile on on the positive side about the  
10 materials. A lot of information, very easily  
11 accessible. So I think that worked well from my  
12 perspective as well. On the opportunity to  
13 improve piece, perhaps and others have mentioned  
14 this, that is getting clearer around the category  
15 purposes and definitions for conditional versus  
16 refine and resubmit.

17 I know we kind of touched on that, and  
18 I noticed when we were reviewing the MAP Medicaid  
19 Task Force, they only had the conditional  
20 category. As we're looking to kind of align  
21 these processes, maybe there is another  
22 opportunity to really clarify whether we really

1       need both and how to -- do we use them at the  
2       same time or not, you know.

3                   DR. ANTONELLI: I can make this quick  
4       because three of the things will be affirmations.  
5       But I guess I'll start first by once again  
6       complementing the staff. You guys are just  
7       amazing and thank you for the prep and your  
8       positive energy and support in general. It's  
9       wonderful to work with you.

10                   The voting thing I found a bit  
11       disturbing as well. I think we have to discuss  
12       and decide, you know, do we need to achieve  
13       consensus on things because sometimes the  
14       outcomes didn't really make sense. This one I  
15       think that you just raised, Carol, is also key.  
16       Indeed, the deny is sort of was reflected in the  
17       conversation I think we had yesterday about would  
18       we want to send a statement about opioid  
19       dependence or assessments. So there should be a  
20       refine and resubmit.

21                   But it was really a significant pivot  
22       from what the spirit of the measure was. And



1       then I think the other one that I'd like to  
2       reflect on, and this may actually come -- I don't  
3       know if it's going to land here at the MAP or  
4       not, but I was really mindful of how important  
5       the conversation was about the quality of the  
6       informed consent for the elective surgical  
7       procedure.

8               There was a sentiment in the room that  
9       that's a process measure that may or may not  
10       reflect the patient experience. I really was  
11       quite impressed by Bruce Hall's notion of the  
12       relationship between the surgeon and the patient  
13       and family et cetera. I reflected on that. The  
14       measure developer put a lot of thought into that,  
15       and by the time it lands here a lot of us said  
16       but that's not really where we want to go.

17              So I don't know, you know. If we're  
18       identifying a gap here, how does that information  
19       get out there to the world of people that provide  
20       resources and do measure development, because I  
21       really -- I don't know if the measure developer  
22       was expecting to get the pushback they got from

1       us. I think we landed in the right place.

2                       Probably several years' worth of work  
3 went into something that kind of came in here and  
4 hit the wall. So I don't know what I'm calling  
5 out. Maybe it's an issue of better alignment or  
6 synchronization around gap identification and  
7 work that's being done to actually fill those  
8 gaps.

9                       MEMBER ANDERSON: I will just say that  
10 I appreciate all my colleagues' comments, so I'm  
11 not going to reiterate those. But I am going to  
12 add just a couple. One is in reflecting on all  
13 the materials which I felt were very well done,  
14 it seems as though in some of our discussions,  
15 when we pushed a little bit more with our  
16 questions, the group's decision in what they were  
17 putting forward was not fully articulated in that  
18 comment.

19                       We found out more about what the  
20 group's discussion and decision was and why. So  
21 if we could refine that a little bit, I think it  
22 would help us in an overall discussion. I know

1       this was hard because it's probably our fault as  
2       members. But having the pulled measures at  
3       really the eleventh hour was very difficult. To  
4       then do all the cross-referencing and everything.

5               But that's our fault. So we need to  
6       respond to you a little earlier, and make certain  
7       that we get those pulled measures in when you ask  
8       for us to pull them, and I think I'll apologize  
9       for all of us. But it isn't -- we can't have the  
10      same in depth discussion if we're at the last  
11      minute trying to do all the cross-referencing.  
12      So I would just add those comments.

13             MEMBER HIGGINS: So just like everyone  
14      else, I want to, you know, thank the staff and  
15      congratulate all of you on great work, and having  
16      been at the MAP from the very first year, I think  
17      we've come a long way in terms of our tool kits  
18      and discussion guides, and I think it's so much  
19      easier now than it was when we first started  
20      doing this so we've learned a lot.

21             So I want to echo some of the things  
22      others have said. So I agree with Kate in terms

1 of the decision to have a voice in voting up and  
2 voting down. We're a small group so one person  
3 could really lost the vote, I think. I don't  
4 have the answer to it just like she said, but I  
5 think that's a concept we need to come back to  
6 just like she said, so it's what the majority of  
7 us think to some extent.

8 And then I kind of want to echo what  
9 Ari said about trying to figure out what's the  
10 right level for us as the Coordinating Committee  
11 and not wanting to relitigate all the discussions  
12 at the work group level. I think it's  
13 challenging sometimes, you know, but we're  
14 getting better at it but I think we should pay  
15 more attention to.

16 MEMBER MULLINS: I agree with  
17 everything Aparna just said, so I'm not going to  
18 restate all of that. I do appreciate not  
19 carrying about three or four big huge white  
20 binders of information to everyone in these  
21 meetings. That's great. Completely different  
22 subject on things that were great. The hotel was

1 within a wonderful walking distance of the office  
2 so yay on that decision.

3 One thing that I thought was a little  
4 confusing for me, it was hard to about the pulled  
5 measures. I think it was hard to see what the  
6 whole measure list was and then which ones had  
7 been pulled for discussion. Then when you're in  
8 the measure index on the discussion guide, the  
9 measures were arranged by alphabetical order and  
10 not numerical order.

11 But then we were talking about them in  
12 numerical order and not alphabetical order. So I  
13 got confused. I think several other people may  
14 have gotten confused. So maybe numerical order  
15 might work better for us. I don't know. It  
16 would have worked better for me.

17 MEMBER KRAMER: Thanks. Just to  
18 reiterate, I agree with all the comments that  
19 were made so far. I wanted to quickly point out  
20 I thought the co-chairs did a great job of  
21 managing the discussion and the process. This is  
22 a big room, complicated topics, and I appreciate

1 all the work you did to keep it on track and get  
2 us to decisions.

3 One suggestion I had would be around  
4 the agenda. We've talked about this offline. We  
5 just kind of slid around a little bit and just  
6 keeping everyone informed, and making sure that  
7 we get everything done at the right time with the  
8 right people. It's important. I hope we can do  
9 that better the next time.

10 MEMBER HALL: Yes. From the top down,  
11 I really appreciated the conversation management  
12 by the co-chairs, and the pre-work done by all  
13 the working groups was phenomenal. The  
14 organization of that pre-work by NQF staff again  
15 was phenomenal.

16 The organization of the materials was  
17 great. The one thing I kept looking for, and  
18 I've already talked to Erin and Taroon about  
19 this, I kept looking for that one link that said  
20 here's the conceptual picture. Here are all the  
21 measures in this program or here are the ones  
22 you're thinking about and how they would relate

1 to this program, even to the level to say hey,  
2 there were 18 here. Two got full support, four  
3 got conditional support. All the rest got, you  
4 know, do not support or whatever. Just the big  
5 picture. Even to the point of like a super-  
6 graphic that ties all the programs together with  
7 some lines. That's the one piece of context I  
8 was struggling to really assemble. So all good  
9 on the organization of the materials, but for  
10 that one small nitpick.

11 Even better if I think we, and others  
12 have said this, if we could maintain our focus in  
13 this conversation on the suitability for  
14 rulemaking, and not be revisiting measure  
15 development. I think the measure development was  
16 done even before the work groups and if anything  
17 was reexamined in the work groups. So we should  
18 try to maintain that focus.

19 And then the only other big question  
20 I had was is there any role for us thinking about  
21 removal of metrics? Again I think maybe the big,  
22 big conceptual picture of what metrics and what

1 programs would help us think about the questions  
2 of removal of metrics.

3 But I don't think we went anywhere  
4 into a conversation about metrics that are in  
5 programs that should be discussed for removal,  
6 you know, metrics that we've put forward in the  
7 past but at this point might want to reconsider.

8 I don't know if that's in our scope or  
9 not in our scope, but we didn't -- we certainly  
10 didn't get that far. Thank you.

11 MEMBER BOTT: On the positive side, I  
12 was really happy and really impressed with the  
13 responsiveness of NQF staff when I asked a myriad  
14 of questions in that last week before the  
15 meeting. People were very quick to get back in  
16 touch. So that was really appreciated with the  
17 chart and the time we had to review materials.

18 On the potential improvement side  
19 would be I am a devil in the details kind of guy,  
20 but it would have been nice at least in the  
21 initial version that I primarily used to prepare,  
22 would be to have a link to the technical



1 specifications, such as if the measure had a  
2 completed NQF endorsement form it would really  
3 help.

4 Sometimes it would help in review  
5 because you see what the comments were from the  
6 work group and sometimes you don't have enough  
7 context. I know there's a summary of the  
8 numerous and denominator. Also sometimes  
9 measures get labeled as a process measure and  
10 sometimes it's confusing. Is this an  
11 inappropriate/overuse measure or is this a  
12 process measure in that the higher numerator rate  
13 the better, and sometimes you just a quick look  
14 at the specifications can get to that.

15 Oftentimes, a description of the  
16 measure, like in the Excel file, doesn't  
17 necessarily reveal that. Also I think having the  
18 full tech specs may have helped truncate some of  
19 these conversations we're having in this precious  
20 time we have together, where people ask about  
21 what's the data source. Is this risk-adjusted or  
22 not and then other people have to be pulled in

1       who are down at that detail level.

2               If we would have readily had that, we  
3 might have been able to avoid taking this meeting  
4 time with those conversations to fish around to  
5 find the specifications. One other comment on  
6 the documents. So we're, especially on Day 2,  
7 we're referring to several reports. So I had to  
8 root around to find the reports.

9               So I had to root around and find the  
10 reports. It would have been nice to just simply  
11 have a link to them. It would save some time and  
12 save calls to NQF staff on where is the final  
13 report. So thanks.

14              MEMBER BRESCH WHITE: This is my first  
15 meeting, so I'm feeling a little underwater, just  
16 in terms of trying to -- the learning curve is  
17 huge. But I do want to thank the staff and  
18 commend them for the great work and keeping the  
19 conversation going. I thought they were very  
20 articulate and clear explaining particularly the  
21 change in the rule process for voting. The  
22 online access was very helpful.

1 I agree with David's comments about  
2 understanding, particularly on the dialysis part,  
3 why we were looking at that measure. If we had  
4 understood that at the beginning, it would have  
5 limited our conversation.

6 I agree with Rich in terms of the  
7 voting. I thought it was a little awkward, and I  
8 thought sometimes that the way the votes came out  
9 didn't legally mesh with the conversation in the  
10 room. So and that's it. Thank you.

11 MEMBER BRYANT: Thanks. Also my first  
12 time through this process, and I'll just pile on  
13 and say really the staff work, sorry the staff  
14 work providing us with background materials was  
15 really impressive I've got to say. It sort of  
16 sets a very high bar for how to get detailed  
17 feedback from a group of disparate folks quickly.  
18 Maybe not at lightning speed, but effectively.

19 So I think in terms of things that  
20 could make it work even better, I'd just like to  
21 reinforce the things that have already been said  
22 about attention to the broader context. So the

1 summary information about the measures that we're  
2 looking at and what the work group  
3 recommendations were I think that Bruce was  
4 alluding to, but also the interaction between the  
5 measures we're looking at and the existing set  
6 and to what extent --

7 I mean just even a few sentences about  
8 to what extent the measures we're looking at  
9 would change the emphasis of the existing set,  
10 would make big changes, small changes. Just  
11 frame a little bit the context or magnitude of  
12 change we might be looking at.

13 You know, in that vein I'd note that  
14 it's particularly challenging to sort of think  
15 holistically about the measure set which I  
16 understand MAP wants to be doing more. When  
17 you're thinking about say MIPS, where there are  
18 multiple pathways for reporting, including the  
19 QCDR measures which I don't even -- I assume  
20 we're not making decisions about those measures  
21 but we don't even have a list of what has been  
22 considered or might be coming up through other

1 pathways, you know, around those data registry  
2 measures.

3 So but obviously as part of the  
4 context, we're thinking about what the changes  
5 that we're looking at here. So this is an  
6 example of how more context, so that we can put  
7 in, we can have the right frame for what we're  
8 looking at.

9 MEMBER LIN: Well ditto, ditto, ditto  
10 to everything that's been said but, let me say  
11 something in addition. I don't think we can ever  
12 over-compliment enough the work of the staff, and  
13 I've been seen this for a number of years and the  
14 time frames in getting materials out so we  
15 commend them.

16 Number two, I want to commend the  
17 chairs for what I'm going to call their unbiased  
18 chairing. We really appreciate that, and that's  
19 very important. Materials are good. We've said  
20 all that already. One of the things I suggest is  
21 on the agenda is that perhaps staff could stamp  
22 every agenda before the agenda comes out the day

1 before with draft.

2 I came with five agendas at this  
3 meeting and I had to figure which one I really  
4 wanted to pay attention to. So, and I know  
5 there's, you know, 5.1, 6 point, you know, 10  
6 point whatever but --

7 CO-CHAIR PINCUS: Sam, the agenda is  
8 changing as we speak.

9 MEMBER LIN: Yes sir, I appreciate  
10 that. I appreciate that.

11 (Laughter.)

12 CO-CHAIR PINCUS: Even what we're  
13 doing now.

14 MEMBER LIN: Okay, sorry. But I would  
15 suggest just a simple way to solution is a quick  
16 optic or visuals, stamp them all draft until the  
17 one that comes out the day before, and probably  
18 the one we'll bring along to the meeting.

19 I think having decided to attend, sit  
20 through in December at least two of the work  
21 groups, where the granular activity takes place,  
22 I have to, you know, compliment those work groups

1 on the directions they took. Best as I could  
2 tell in reading through the materials, you know,  
3 it really did capture the essence.

4 It's not easy to capture all of it.  
5 The chairs, of course, did a good job and Ron in  
6 particular on the hospital. So I have to  
7 encourage it, and as a group here we are sort of  
8 at the 50,000 foot level. But if you really want  
9 to hear some of the nitty-gritty and the  
10 intricate materials, if you can, you know, listen  
11 in or attend one of the work groups.

12 The thing that I noticed, particularly  
13 starting with the work groups was that we are  
14 moving a little more towards the trend of patient  
15 experience or patient outcome or patient  
16 empowerment, whatever word is, you know, the hot  
17 one of the day. That's good, because that sort  
18 of is going to keep pace with something called  
19 outcomes which is, as we all know, you know,  
20 structure and process are wonderful and  
21 important, but the patient cares about outcomes.

22 They expect us to do structure and

1 process. So I would encourage, certainly from  
2 CMS, to be thinking more of sending us things  
3 where there is the patient experience, since we  
4 now sort of understand that the patient actually  
5 has a role in their own care.

6 Yes, I was going to say just lastly,  
7 the logistics is always, at least within the  
8 room, not outside in the streets, but in the room  
9 has been excellent. Again I thank staff, and I  
10 don't think we can over, ever over-compliment  
11 staff. Thank you.

12 DR. HUNT: Well, I think I'm going to  
13 be a bit of a contrarian. I've been to a lot of  
14 these types of meetings before, and I find it  
15 singularly unhelpful that we can't scapegoat or  
16 blame the staff, because any problems we have  
17 then falls back on the Committee itself. So I  
18 think we should change that in some way.

19 (Laughter.)

20 DR. HUNT: The prep materials were  
21 absolutely great. I think links to the current  
22 NQF endorsement status of a particular measure



1       may be helpful, as well as the full tech specs.  
2       It can be arranged to have it in a hyperlink,  
3       such that if we wanted to look for it, we could.

4               I was completely impressed with the  
5       pace of the meeting yesterday at 10:30. I never  
6       would have dreamed that we would have left by  
7       6:00, and it picked up. So I think that goes to  
8       the co-chairs in particular.

9               I don't know what to do as far as the  
10       voting, but not having the skin in the game for  
11       voting, it does seem unsatisfying sometimes when  
12       things don't work out. We might want to  
13       beforehand consider something like two rounds of  
14       voting when a clear yes or no wasn't decided, in  
15       which case the category that got the least amount  
16       of votes was thrown out and perhaps you would  
17       tend towards something more definitive. But  
18       again, I'm no expert in this. That's just my two  
19       cents.

20              DR. WILSON: Well, I have to echo that  
21       the work of the staff and the chairs is  
22       phenomenal, and I also really appreciate that the

1 Committee takes its role so seriously. This  
2 Committee takes its role so seriously. I will  
3 say that this is the first year where I actually  
4 listened all day, each day to every work group  
5 and man, is that very helpful.

6 So I think that -- I mean it's huge  
7 commitment of time, but listening in on the work  
8 groups or attending in person is very, very  
9 helpful, and I think helps us with the let's not  
10 rehash what the work group did, because I --

11 There were moments yesterday when I  
12 thought well this is like the old days with the  
13 CSAC and the Board, you know, where we're  
14 rehashing with the CSAC, and of course, you know,  
15 we eventually said CSAC rules. So just throwing  
16 that out.

17 And I had it written on my piece of  
18 paper too about thinking procedurally about,  
19 before we start. Well, do we want to do two  
20 votes? Do we want to revote? Do we -- how do we  
21 handle it when it gets a little awkward? So  
22 again, I go with David. You know, that's a

1 procedural issue for you guys to think through.  
2 But we couldn't do it when we needed to do it,  
3 when we wanted to do it because we hadn't done it  
4 all day, you know. So which I think was the  
5 right decision.

6 I think just a little bit of clarity  
7 on, you know, like okay. Like here's the whole  
8 current list or a link to the whole current list,  
9 and now we're going to look at these four  
10 substantive measures. We're going to talk about  
11 all four of them, so you're going to have to  
12 really pay attention.

13 Whether it's 172 or 173 or, you know.  
14 But having the conversation as a group, and being  
15 able to think about how those either work for, as  
16 additions to the current stat or replace them.  
17 That kind of thing would be really helpful. So I  
18 love the idea of being able to kind of link to  
19 the current set of measures. That's it.

20 MEMBER SAKALA: So again, kudos to the  
21 overall quality from staff and co-chairs, and  
22 also of the materials. I want to echo what Bruce

1 and others have said about the -- getting to the  
2 high level of a view, bringing a view in this  
3 room of the federal programs, their composition  
4 and how we might be altering them with the work  
5 that we do over these two days.

6 I think that would be, you know, very  
7 -- a very helpful frame for us, and I think that  
8 is consistent with our charge. I felt during the  
9 hospital work group discussion yesterday a little  
10 bit like we were swimming in molasses, and I  
11 don't know how to fix some of that because there  
12 are so many factors that come to bear that came  
13 into that conversation.

14 But it was frustrating and yes, people  
15 were saying I'm not going to know their evening  
16 plans, notifying people that there are going to  
17 be changes. And also the tension between the  
18 voting and the qualitative comments that, you  
19 know, maybe we need to smooth out the voting, but  
20 also to realize that it's all good.

21 And just one more thing, the  
22 attribution discussion was extraordinary. I

1 thought very helpful and rich, and advancing my  
2 knowledge and also I think the process moving  
3 forward. It's the right time for the iterative  
4 step, so thank you for that.

5 MEMBER SCHLAIFER: I'll just start out  
6 by reiterating the attribution comment. It was  
7 definitely the fun part of, you know, hearing  
8 what was going on there and being able to --  
9 having it explained in a way that we can take it  
10 back to others that have been very interested in  
11 what you're doing here I'm very excited about.

12 First just want to say yes, thank you  
13 to the staff and thank you for all the process  
14 improvements over the years. I know the staff  
15 that prepared this, you know, five-six years ago  
16 put just as much work into it, but it wasn't as  
17 easy to use. Having the links and being able to  
18 jump back and forth between the programs and  
19 measures, especially for those of us that when  
20 we're talking about programs that I know nothing  
21 about, you know, when it gets to inpatient  
22 psychiatric care or something that I know nothing

1 about, it really helps to be able to jump back  
2 and forth that way, especially for those  
3 programs.

4 I mean all of us are very into certain  
5 programs and not so much into others. So having  
6 the existing measures, especially in those  
7 programs we're not as familiar with would be  
8 very, very helpful. So that would be the only  
9 one improvement I would say with all the links  
10 and everything there.

11 I think as far as the voting, just a  
12 couple of really -- some that's been kind of  
13 measured to get into the weedy parts of it, and  
14 from someone who -- as speaker of the house for  
15 various pharmacy associations, very into the  
16 minutiae of Roberts Rules of Order, we're looking  
17 for consensus.

18 So I think when someone said, you  
19 know, we can't revote. Well in a consensus  
20 discussion, you can keep discussing until you get  
21 to consensus. So I think I would suggest that  
22 when we got to a point where we had a vote we

1 weren't comfortable with, that it would have made  
2 sense to revote until we got to a vote that we  
3 were comfortable with.

4 Not that you want to do that often,  
5 but there's -- I don't think there's any rule  
6 that says we can't revote. So that's just a  
7 suggestion. I think it would have gotten us to  
8 where we wanted to be. I also just wanted to  
9 mention there was one comment at one point about  
10 why are we pulling measures when we're not going  
11 to vote on them and we're not going to change the  
12 recommendation?

13 And I think that the pulling of  
14 measures to get to the discussion to make  
15 everyone comfortable to support what the work  
16 group did serves a purpose, and I think we should  
17 continue to be comfortable with that and not  
18 think you can't pull a measure if you don't  
19 disagree. I don't know if I just said that or  
20 whatever. I think you know what I meant there.

21 So I just -- just thanks again for all  
22 the pre-work. It was just fabulous to be able to

1       jump back and forth and get to exactly what we  
2       need.

3                   MS. RUBIN: Koryn Rubin. I'm filling  
4       in now for Carl for the AMA. Thank you for all  
5       the pre-work and, as someone who's been  
6       intimately involved with this process for several  
7       years and having a seat on the Coordinating  
8       Committee since the inception, it's gone a long  
9       way. I think we got the materials maybe like one  
10      day earlier than last year, which is always  
11      helpful. The more time the better to prepare.

12                   With the -- in general, I think the  
13      new categories were effective. But at the --  
14      whether it's here at the Coordinating Committee  
15      or at the work group, there are sometimes some  
16      inconsistencies based on like the approved kind  
17      of definitions in terms of what can and cannot  
18      apply. So if there's a way, you know,  
19      preliminarily to, you know, highlight which  
20      categories apply based on the status.

21                   So you know, this has NQF endorsement  
22      so it, you know, falls into two of the three



1 categories as opposed to four of them. Then also  
2 in terms of with the pulled measures, it would be  
3 helpful if they can be more easily identified.

4 So maybe they just even go in the head, the email  
5 that said, you know, these are the measures that  
6 were pulled. If you could just put it front and  
7 center and then also who pulled the measure.

8 There was a little inconsistency with  
9 pulled measures from last year to this year. I  
10 recall last year there were some kind of rules to  
11 the road in terms of pulling measures, and you  
12 had to provide a little bit of an explanation  
13 with your pulled measure. That would be helpful,  
14 especially since that information comes late, so  
15 that you're aware of what you're looking at and  
16 can come a little bit more prepared in a short  
17 time frame.

18 MEMBER QUERAM: Thank you. Going this  
19 late in the process, I reminded of a saying that  
20 others have used when they're in this position.  
21 Just about everything that can possibly be said  
22 about the subject has been said, but not

1 everybody has had a chance to say it.

2 So I will just align myself with  
3 comments about the quality of the staff and  
4 quality of the materials, and Marissa's comments  
5 about the voting procedure.

6 MEMBER BARTON: I'm going to pile on  
7 my thanks for the staff and the chairs, and about  
8 the measures. I've heard, you know, we have  
9 things sorted by title and the suggestion maybe  
10 sort them by number, and this is just like a  
11 radical idea. There may be some software  
12 solution out there that would allow this to be.

13 You know, I'm thinking Excel but I'm  
14 old, right. So where you could sort it several  
15 different ways and you could have a field for if  
16 it was pulled and field for how it had been voted  
17 by the work group, and then we could sort them  
18 however we wanted.

19 MEMBER QASEEM: Well, let me just  
20 start out by what works. I think it's -- I have  
21 to agree with everyone that NQF staff, it's  
22 amazing under the leadership of Helen and Alyssa.

1 But I have to say that Erin, Taroon and Yetunde  
2 sitting next to me really kept me on track, and  
3 she has promised me that I'll always sit next to  
4 her, because I didn't know what measures or what  
5 are we doing. So it is my seat guys. No one can  
6 take this one. And then of course thanking Harold  
7 and Chip.

8 (Off mic comments.)

9 MEMBER QASEEM: Harold and Chip, you  
10 guys ran an amazing meeting, keeping us on time.  
11 They always say the best meetings are the ones  
12 that finish ahead of time. I think we're heading  
13 in that direction. So I'm not going to get into  
14 the numerical orders and all that. I already  
15 mentioned it to you guys. I think that's an easy  
16 fix.

17 Two suggestions that I'd like to make  
18 are one is I'm still struggle with this whole  
19 revise and resubmit category and do not approve  
20 category. You guys saw the struggle yesterday,  
21 and we're not going to of course come up with a  
22 solution right now. But I'd really strongly

1 encourage you guys to look into this, as to how  
2 we can differentiate, because I don't think that  
3 the measures we voted, we were inconsistent  
4 ourselves, right. This is something to really  
5 start thinking about.

6 And the MAP Coordinating Committee  
7 voting, I've been thinking about it. I feel like  
8 that, you know, many of us are on various  
9 governance committees and all. Maybe we should  
10 just have a thumbs up and thumbs down vote, and  
11 let me tell you why. I think that the subgroups  
12 of MAP are spending really ample amount of time.

13 We do not spend that much amount of  
14 time when we're discussing those measures. They  
15 have all the detailed information in front of  
16 them, and I really hesitate overturning their  
17 decision without really having full knowledge of  
18 depth of knowledge what's going on.

19 I think what we need to start thinking  
20 about as a Coordinating Committee is that we  
21 discuss the measure. I'm not saying that. But  
22 we vote just thumbs up and down, and if it's a

1 thumbs down and essentially which means it's to  
2 be sent back to the Committee. They heard the  
3 concerns from this Coordinating Committee and  
4 what do you think based on these comments? Do  
5 you still stand by those?

6 I just don't think we spend enough  
7 time over here, and I don't think we should be  
8 turning thumbs, giving thumbs up or down to any  
9 of the measures that were here unless we do have  
10 all the information and we start reviewing the  
11 measures in detail. I'm very uncomfortable with  
12 this process, to be honest with you, in  
13 overturning the --

14 I think the hospital group and all the  
15 clinician group, they spend like almost --  
16 because I have been in those groups and Amy you  
17 too, right. So you guys end up spending like  
18 maybe 45 minutes to an hour on just one single  
19 measure.

20 I think it's just unfair. Then why do  
21 we even have those subgroups if we don't trust  
22 their judgment? So something to think about,

1       that maybe we need to revise our policy in terms  
2       of voting.

3                   CO-CHAIR KHAN:  Anyone I guess on the  
4       phone?  So it's Doris and --

5                   DR. LOTZ:  Yes.  My travel was  
6       cancelled at the last minute, and it may have  
7       been a matter of routine for staff to be so well  
8       prepared to integrate folks remotely into the  
9       meeting.  But they did a fabulous job, so I want  
10      to thank them for that.

11                   But also specifically thank the  
12      chairs.  I never felt like I wasn't part of the  
13      discussion, and sometimes that also happens when  
14      you're working remotely.  So I really appreciate  
15      that.  Also, the folks around the room.  I always  
16      feel like more meaningful content will come from  
17      a large gathering like this when people are  
18      comfortable disagreeing with each other and  
19      speaking their mind, and I felt like that was the  
20      case as well, so many thanks to go around the  
21      table there.

22                   With respect to doing things a little

1 bit differently or contemplating kind of how  
2 things could be otherwise, I think about our  
3 title as being that of the Coordinating  
4 Committee, and yet it seems like we approach  
5 things still in their programmatic silos.  
6 There's a tremendous amount of imperative to look  
7 for some economies in measurement.

8 I think that's, you know, looking to  
9 purge the structural process measures, to look  
10 for outcome measures. One mechanism to go about  
11 doing that would be, you know, we talked a little  
12 bit about feedback on implementation in the  
13 Medicaid space. But it seems to me that feedback  
14 on implementation could be good across the whole  
15 board, and perhaps it's done.

16 But I didn't, I didn't see it if it  
17 was there in the preparatory materials. And  
18 also, you know, it's very hard, I think, for  
19 maybe the work groups to think about what to  
20 eliminate. I totally concur with what everyone  
21 said about them being subject matter experts  
22 around the table.

1                   But I'm wondering if to be  
2     deliberately provocative, to suggest in advance  
3     of the work groups. Perhaps it has to come out  
4     of a balanced committee like this; perhaps it  
5     comes from NQF staff to say have some substantive  
6     discussion about the elimination of the following  
7     measures. Are they still serving their purpose?  
8     Are they being used appropriately?

9                   Maybe the sword in that discussion is  
10    just to wholesale think about eliminating all  
11    structural and process outcomes. That's very  
12    provocative, I realize that. But some way of  
13    getting their input in that regard, and then  
14    expanding the Coordinating Committee role in  
15    looking across programmatic silos. Someone  
16    mentioned already, and I'm really sorry. I don't  
17    know voices and names, so it's hard to  
18    coordinate.

19                  But the idea of taking more of a  
20    patient perspective was mentioned. That's, I  
21    think, a very good way to think across measure  
22    sets, to look at the patient experience, which



1 wouldn't necessarily compartmentalize things to  
2 outpatient hospital, inpatient hospital, renal  
3 disease, that sort of thing. That might be a way  
4 to also become both more meaningful and to have a  
5 more strategic measure set that, you know, could  
6 be adopted broadly and implemented broadly, and  
7 hopefully be meaningful as well. So thank you  
8 for that.

9 CO-CHAIR KHAN: Thanks. Barrett.

10 MEMBER NOONE: Hello. Can you hear  
11 me?

12 CO-CHAIR KHAN: Yes.

13 MEMBER NOONE: I just wanted to echo  
14 what everyone has said. I think that the staff  
15 deserves a lot of credit, especially when we are  
16 tuning in remotely and they've been terrific in  
17 following this whole conversation.

18 Congratulations to the leadership and  
19 chairs of the committees who have really guided  
20 us through these two days of deliberations. So  
21 thank you very much for letting me participate  
22 remotely.

1 CO-CHAIR KHAN: Thank you so much.  
2 Foster.

3 MEMBER GESTEN: Thanks Chip. Again,  
4 I just, you know, want to put my thumb down on  
5 all the positive things that were said about  
6 staff and you Chip and Harold as co-chairs. The  
7 one thing I didn't hear that in terms of a  
8 suggestion going forward was in terms of getting  
9 this larger picture, what I called sort of the  
10 20,000 foot view, all the measures in the program  
11 which would help understand what the place is of  
12 new suggested measures or perhaps invite  
13 conversations about eliminating measures, the one  
14 thing I think that would be useful is to better  
15 understand what happened to previous suggestions  
16 to CMS, and get that feedback about measures that  
17 were maybe recommended that weren't taken up, or  
18 measures that were recommended to not be taken up  
19 that were taken up.

20 Again, I don't think it has to  
21 necessarily change the process or the criteria  
22 that the Coordinating Committee or the groups use

1 in evaluating the measures. But I think  
2 sometimes it's -- I know we found it helpful in  
3 the Medicaid Task Force to better understand how  
4 CMS was thinking and using and what some of the  
5 constraints were.

6 I think that might be just useful  
7 context, you know. If it comes out in some  
8 fashion that I've always missed, then you know,  
9 my apologies. But it always feels like a bit of  
10 an unknown to me.

11 CO-CHAIR KHAN: Thanks. Steve Wojcik.

12 MR. WOJCIK: Yes, hello. I agree with  
13 most of the comments. I just had one and I  
14 apologize. I had to go away for ten minutes to  
15 talk to a reporter, so I hope this wasn't  
16 covered. But following up on the reaching  
17 consensus, I'm wondering if when the process,  
18 when we don't reach 60 percent and our decision  
19 then is contradictory to or especially if it's  
20 the exact opposite of what the work group  
21 recommended, I wonder if we should treat that  
22 somewhat differently than where we don't reach

1 consensus but it's in the same direction or the  
2 same recommendation as the work group, because I  
3 believe that might have happened once yesterday  
4 towards the end. I can't remember which measure,  
5 and it was treated the same way as one where it's  
6 in the same direction.

7 It just seems to that that's a bigger  
8 issue than if our failure to reach consensus just  
9 is settled around confirming or close to what the  
10 work group decided. Apart from that, I thought  
11 it was great and I was glad to be able to  
12 participate and have the opportunity. Thank you.

13 CO-CHAIR KHAN: Thanks. Brandon.

14 MEMBER HOTHAM: Yes, can you hear me?

15 CO-CHAIR KHAN: Yes.

16 MEMBER HOTHAM: Okay, yes. I will  
17 echo a huge thanks to you, the staff. My travel  
18 was also cancelled at the last minute due to  
19 inclement weather and they were exceptional in  
20 helping me to actively participate remotely. So  
21 I greatly appreciate that. I will also, in terms  
22 of a delta, agree on the voting process.

1                   You know, I think there's been some  
2                   mention of, you know, a possibility of moving to  
3                   a structure that allows maybe getting rid of one  
4                   of the categories that got the lowest volume of  
5                   support.

6                   I would just agree with reevaluating  
7                   the voting process to make it more clear in terms  
8                   of category truly gets consensus from the group.  
9                   But other than that, you know, I agree with all  
10                  the comments that have been made by the rest of  
11                  the Committee members, and thanks.

12                 CO-CHAIR KHAN: Thanks, and finally  
13                 Steve Brotman.

14                 MEMBER BROTMAN: Hi Chip, thanks.  
15                 There are so many things that worked well and  
16                 they continue to just get better each year.  
17                 Integrating us remotely, this is the first time  
18                 I've been remote and it was actually a great  
19                 experience. I appreciate from the staff. They  
20                 did everything they could and really worked very  
21                 hard on it.

22                 We had wonderful discussions around

1 the room, very robust discussions around the  
2 room. I was very impressed this year. The  
3 decision guide with links this year was  
4 excellent. The link the NQF status would be  
5 helpful, but other than that kudos to the staff.  
6 It's really a hard thing to do. It's very much  
7 appreciated from our point of view.

8 Decision categories worked fairly well  
9 with some hiccups, you know. But it's still, I  
10 think, a work in progress. So but that's going  
11 to continue to evolve. Also there was great  
12 flexibility to pull measures for discussion ad  
13 hoc and have the measure developers available for  
14 questions. That was really appreciated. The  
15 work of you guys the co-chairs was truly amazing,  
16 and you really deserve tons and tons of credit.  
17 Thank you for everything.

18 The attribution presentation was  
19 excellent. That was one of the best  
20 presentations we've seen, I think, and on the  
21 side of what could be improved, I parrot the  
22 remarks about the consensus process, but I don't

1 have any. Those comments were made early. I  
2 don't have any direct solutions.

3 And also, this is probably a new  
4 comment that I haven't heard. When a measure is  
5 pulled, it would be helpful and this happened  
6 most times but it wasn't always consistent, and  
7 that is what is presented should be a concise  
8 history of the measure issues that the work group  
9 had and some clear questions from the onset of  
10 when it's being pulled.

11 So maybe there's a structural  
12 organization way to address this, to state that  
13 point of contention when a measure is being  
14 pulled, so that everybody is on the same page  
15 from the get-go and there's not a lot of  
16 discussion, and then the contention points come  
17 afterwards. One piece of advice I have for new  
18 members, since I've been doing this for quite a  
19 number of years.

20 I would wholeheartedly recommend that  
21 new members sit in as much as possible or listen  
22 to the individual work groups. Over the years,

1 I've found that to be one of the best ways to  
2 sort of integrate into the Coordinating Committee  
3 and just come with your feet ready to run, so  
4 that all the issues are not new to discuss. It  
5 really helps out a lot.

6 I would also encourage to pull,  
7 continue to pull measures for discussion even if  
8 there's no vote, because that's a great  
9 opportunity to provide additional information and  
10 flag some issues, and other than that, I want to  
11 thank everyone. This was a wonderful cycle.

12 CO-CHAIR KHAN: Thanks, Steve.

13 CO-CHAIR PINCUS: So I have a couple  
14 of comments. Number one is the staff is  
15 incredible, I mean in terms of the way in which  
16 they facilitate and helped this and put together  
17 behind the scenes so much material and  
18 information and condense it. Yetunde, Ken, Erin,  
19 Taroon, Helen. Just really remarkable.

20 Also, I think the engagement of the  
21 members of the Coordinating Committee is really  
22 incredible. I mean really people feel passionate



1 about a lot of these things, and they're willing  
2 to discuss it intensively and intelligently.

3 I think that's really important, and  
4 obviously also the work group members as well,  
5 and also CMS has really, you know, engaged in  
6 this process fully and receptive to the  
7 discussions and engages in discussions, I think.  
8 So it's a very, very productive process that we  
9 have.

10 A couple of things in terms of  
11 improvements. I think what people have suggested  
12 in terms of having some way of displaying sort of  
13 each program, the overall context in terms of the  
14 measures, what's been added, what's been removed,  
15 what's been the response, you know, as opposed to  
16 sort of the response to previous suggestions.

17 I mean we get that in the Medicaid  
18 Task Force. We sort of get that. It's only one  
19 program so it's easy to do. But to sort of get  
20 that succinctly over time would be very helpful.  
21 I think the voting is a problem, but you know,  
22 I'd like -- it would be useful to hear back from

1 CMS about what would be helpful to them in terms  
2 of the vote.

3 How much does the vote really matter,  
4 especially the fact whether it reached the  
5 consensus on support versus these other  
6 categories that are less than support. How  
7 important are these distinctions, because it's  
8 not a, you know, there's not really a strict  
9 threshold for those, I mean for the conditional  
10 one.

11 It's clear that if you know  
12 specifically what you want, and we can try to get  
13 that done. But for the revised use of NIT, which  
14 is a replacement for the support direction, you  
15 know, it gives a little bit more specificity but  
16 it's, you know.

17 And maybe just having that it may give  
18 consensus for support and if not, here's the  
19 distribution across the other categories. That  
20 may be sufficient, I don't know. But that's  
21 something that would be helpful to get CMS'  
22 response to.

1                   Having a discussion about a cross-  
2                   cutting issue like accountability was incredibly  
3                   useful. I think it would be useful to have  
4                   something like that, more specifically something  
5                   -- I'm not totally satisfied with how we deal  
6                   with gaps.

7                   I think having some way of addressing  
8                   gaps, both within programs but across programs  
9                   and linking that to a more in depth discussion  
10                  about what is in process within the development  
11                  process that CMS is doing would I think be a  
12                  useful thing to have, almost in the same vein as  
13                  the accountability discussion we had, and so I  
14                  would make that suggestion.

15                  CO-CHAIR KHAN: Okay. Well I'll close  
16                  out, I guess. We got everybody in terms of the  
17                  members commenting and, you know, just restate  
18                  our appreciation, I think the whole Committee's  
19                  appreciation to the staff for really making the  
20                  meeting possible, by lining everything up in a  
21                  way that could be comprehended and discussed.

22                  Second, I know it's always an issue

1       whether a body above the bodies that spend a lot  
2       of time on a matter should have the power to, in  
3       a sense, veto.

4               But on the other hand, I think if we  
5       look at the number of measures considered  
6       overall, and we look at the focus that we put on  
7       really, except for the hospital area but even  
8       there very few regarding the total end, and I  
9       think we do have a fairly expert group here, and  
10      you know, even though it might not have been as  
11      explicit enough, there was a sense for the  
12      context that most of us had.

13              I guess I think I would err on the  
14      Coordinating Committee taking action, although I  
15      do think we need to reexamine the vote. I think  
16      if you look at the votes, and this is only my  
17      head which is by its very nature not scientific,  
18      we sort of had two kind of votes.

19              We had a vote that was completely  
20      flat. It was like -- like it was just spread  
21      across the four, or we had these votes, and I  
22      think we had at least two if not three that were

1       above 55 percent for one. On that last one, when  
2       the one was 57 percent and we went and took the  
3       four percent below it, I thought wow. That just  
4       doesn't look right.

5               I think we need to reexamine that, and  
6       I'm not saying that 60 is the wrong threshold, or  
7       maybe we should just be voting, you know, it  
8       should be binary. I don't know, but I think we  
9       do need to reexamine that, and whether we have a  
10      vote like that where you're within shouting  
11      distance of 60, whether we take the vote again  
12      just to see whether anybody would change,  
13      considering where we are. Maybe that's what we  
14      do.

15             But other than that -- oh, let me say  
16      one other thing. No one, I don't think anyone  
17      else has commented on this. Gerry Shea and I  
18      many, many years ago chaired a strategic planning  
19      committee for the MAP, and I can't even remember  
20      which year it was now, and one of the major  
21      recommendations we made was the, I guess it  
22      manifests on the slide that Helen talked about,

1 the feedback loop.

2 I think just as with the gaps, I don't  
3 think we're there yet in terms of a process for  
4 identifying it clearly that we can all feel  
5 comfortable with. I think, I'd like to stress  
6 that I think that this notion of the feedback,  
7 like what's really happening with all those  
8 things that are out there that we can get our  
9 teeth around.

10 I'm working on a presentation right  
11 now on the Medicare fee-for-service, pay-for-  
12 performance and other programs for a speech I'm  
13 giving in Israel, and I'm having really -- and  
14 I've asked a number of people to help me look at  
15 the literature. There's not much of a feedback  
16 loop in terms, you know. There's great stuff  
17 about how readmissions we're reducing, but  
18 there's not that much literature about what that  
19 really means.

20 And then with the other metrics, we  
21 can just go on and on. So I think that that  
22 feedback loop is something we really need to work

1 on, and I'm not sure that this is the place that  
2 can be done, but that we need to think about. So  
3 with that, I'll conclude. It's now 20 minutes to  
4 1:00. I think we're going to reconvene at 1:00,  
5 is that right?

6 MS. O'ROURKE: If everyone could come  
7 back a few minutes before 1:00. We have some  
8 hard stops at 1:30 and ASPE is a 30 minute  
9 presentation. So we want to get to a few people  
10 before Karen and Nancy begin their presentations.  
11 So maybe if we --

12 CO-CHAIR KHAN: Okay. So why don't we  
13 say literally 15 minutes, which will get us back  
14 here about three or four minutes before 1:00, and  
15 then we'll start there. So get your lunch and  
16 we'll see you in a few minutes.

17 (Whereupon, the above-entitled matter  
18 went off the record at 12:39 p.m. and resumed at  
19 12:55 p.m.)

20 CO-CHAIR KHAN: If everybody could  
21 return to their seats, and we'll get started with  
22 the last part of our program, and we're going to

1 have -- Nancy's coming.

2 MS. O'ROURKE: She'll be here at one.

3 (Off mic comments.)

4 CO-CHAIR KHAN: Okay. So just I guess  
5 for 30 seconds, I will -- before we go to that,  
6 just say that this process is very important to  
7 me, and I really appreciate everybody's  
8 participation. I guess back many years ago, it  
9 was probably mine, but other people's brain child  
10 was this meeting and this process that we have  
11 today, when we -- when Jordy Cohen and Dick  
12 Davidson and I many, many years ago formed the  
13 Hospital Quality Alliance.

14 That was sort of a multistakeholder  
15 group, but still has been started by the  
16 hospitals. We envisioned a process like this,  
17 working with CMS and hopefully with other payers,  
18 and it's great to see it actually in place and  
19 working. In the -- obviously it had to find  
20 another home, and NQF was the logical home.

21 And so some of us, I think, you know,  
22 want to see this continue, and we are going to



1 actually need to get funding at a point in the  
2 near future, because we're at the point of the  
3 cycle again.

4 And so to help that process and to  
5 inform people, because I don't think it's always  
6 clear to everyone, even though we've got so many  
7 hundreds of people that are very active in the  
8 NQF committees and task forces and work groups  
9 and then -- and the board, I'm not sure the  
10 outside world every really understands quite what  
11 NQF does.

12 So the Federation is funding a project  
13 with Kristine Martin Anderson and her team that  
14 Booz Allen's going to undertake, to do sort of an  
15 analysis of how NQF does meeting its various  
16 missions, and also what the cost of achieving  
17 that should be going forward, and hopefully when  
18 that's completed in about two months, it will be  
19 helpful.

20 So I don't know whether any of you  
21 necessarily will be interviewed. Some of you may  
22 be, because they will be talking to some of the

1 stakeholders in the process of doing the survey,  
2 or they will be surveying people. So you may be  
3 queried and if you do, I hope you'll be  
4 cooperative and obviously open about your point  
5 of view, but cooperative.

6 So I just wanted to let you know that  
7 we're doing that, and that we will be beginning a  
8 process. There's a thing called Friends of NQF  
9 that I hope all of you will be active in in the  
10 upcoming months, as we gear up to make sure that  
11 the funding continues. So with that, let me pass  
12 it over to Erin and let her start.

13 MS. O'ROURKE: Thanks Chip, and thanks  
14 to all of you for sticking with us for one more  
15 session, and having a working lunch that  
16 hopefully we can let you out a little bit early.  
17 But we did want to bring up one more cross-  
18 cutting issue, obviously a topic we've spent a  
19 lot of time grappling with over the years.

20 In particular, we're looking for some  
21 guidance from the Coordinating Committee on the  
22 consideration of sociodemographic factors, as we

1 move to an era of value-based purchasing and  
2 there's obviously strong sentiments across the  
3 stakeholder spectrum on this issue, and how MAP  
4 can really do its work most effectively and  
5 ensure that we're making fair recommendations  
6 that will really work to improve health care for  
7 everyone.

8 We know this is a very challenging  
9 topic. We don't expect any solutions to come  
10 here today. But rather we want to just keep you  
11 abreast of some developments in the field, and  
12 look for any guidance you might have on how we  
13 should consider some of these new findings and  
14 new research as we continue to do the pre-  
15 rulemaking work.

16 So I think we with that, we are going  
17 to have a presentation from ASPE on the findings  
18 of the IMPACT Act study. But before that, we  
19 have a few Committee members with hard stops that  
20 we want to hear from, so Bill, if I could turn to  
21 you and then Pierre and Kate, if you wouldn't  
22 mind giving a brief update on the 21st Century

1 Cures Act and some of the implications of that  
2 law.

3 MEMBER KRAMER: Thanks very much,  
4 Erin. This is a little bit out of order. I'm  
5 reacting to a presentation that we haven't seen  
6 yet. But I did read the ASPE report, so I'm  
7 reacting to that, as well as the discussions  
8 we've had about this at NQF Board and many, many  
9 committee meetings and so on over the last  
10 several years.

11 First, I want to express appreciation  
12 for the excellent work that ASPE did, as well as  
13 the great work that Helen Burstin and her team  
14 have done here at NQF, and the work that Kate  
15 Goodrich and her team at CMS have done on this  
16 issue over the last several years.

17 I think the ASPE study makes a  
18 significant contribution to our understanding of  
19 the interplay between lower socioeconomic status,  
20 clinical risk factors and disparities in care. It  
21 occurred to me in reading this that the deeper we  
22 go into this issue, the more we realize that it's

1 very complex and in some ways the solutions now  
2 are less clear than we may have thought  
3 previously. But our understanding of the issues  
4 and therefore what we should do about it  
5 hopefully is advanced.

6 In the discussion of this issue, one  
7 topic keeps coming up that is a very sensitive  
8 one, but I think needs to be addressed head on,  
9 and that is -- the question is often framed what  
10 factors are within a provider's control?

11 It's often stated that providers  
12 should not be held accountable for factors not  
13 entirely within their control and I understand  
14 this. It's a very natural human response. I  
15 just had my performance review meeting with my  
16 boss, and we had this exact discussion. How much  
17 were we able to influence CMS regulations?

18 So but I'm concerned that framing the  
19 issue this way may be a dead end, and I'd like to  
20 suggest some alternatives. In a patient-centered  
21 health care system we should be asking instead  
22 whether the patients got the care and services

1       that they needed.

2               For example as we know, some low  
3       income patients live in neighborhoods that have  
4       poor public transportation. They might not have  
5       access to a car. They might not even -- so it  
6       makes it more likely they'll miss a follow-up  
7       appointment after hospitalization.

8               Should the provider say well, too bad,  
9       that's not my problem? Of course not. Most  
10      providers are going to do whatever they can to  
11      try to provide those -- arrange for those  
12      additional services that would help them get the  
13      care that they need.

14              Is that totally within their control?  
15      No, that's the wrong question to ask. The  
16      question asked is what can we do to encourage and  
17      support physicians who are trying to do the right  
18      thing for their patients, and that includes those  
19      kind of supports that they need, in addition to  
20      the immediate and direct clinical care.

21              So my concern is that narrowing the  
22      focus into things that are just under the direct

1 control of providers, what is the risk of  
2 overlooking the other services that may be needed  
3 to provide care to patients, taking into account  
4 their special circumstances?

5 So I would recommend that we shift the  
6 conversation from is this in the provider's  
7 control to is the patient getting the services  
8 she needs, and figure out how to do that, solve  
9 that problem.

10 One of the important findings in the  
11 ASPE study was the point they made about the  
12 work, the existing state of the art in terms of  
13 clinical risk indicators, and the observation  
14 that while we've relied on these for years, there  
15 in fact still needs to be improvement in the  
16 science of clinical risk indicators and clinical  
17 risk factors. So I strongly encourage us to  
18 support that.

19 I wanted to make sure we're all clear  
20 that there's a fundamental difference between  
21 socioeconomic factors and clinical risk factors.  
22 While the statistical analysis of those has some

1 similarities, there are fundamental differences.  
2 For clinical risk factors, we accept the fact  
3 that sicker patients have worse outcomes. We  
4 understand that, we accommodate that and we  
5 adjust for -- we adjust some things for that  
6 appropriately.

7           However, for socioeconomic risk  
8 factors, I believe we should not and do not  
9 accept that people of different socioeconomic  
10 categories should get different outcomes. Now we  
11 observe that they do get different outcomes, but  
12 I don't think they should. I don't think anyone  
13 believes that they should get different outcomes,  
14 so it's a fundamental difference.

15           So we should not automatically say  
16 since there are differences, we should adjust for  
17 them in the measures the way we do for clinical  
18 risk factors. They need to be treated  
19 separately. Even though the statistical methods  
20 might be similar, they're fundamentally different  
21 in what we, I think all of us as involved in the  
22 health care system believe should be done.



1                   Finally, I was pleased to see the  
2                   recommendation regarding financial support for  
3                   providers, to achieve better outcomes for  
4                   beneficiaries with socioeconomic status risk  
5                   factors. This makes sense to me. We recognize,  
6                   I think, that caring for disadvantaged patients  
7                   probably requires additional resources, and we  
8                   ought to pay providers accordingly.

9                   The last thing we want to do is make  
10                  it more difficult for the outstanding providers,  
11                  physicians, nurses, hospitals and so on who are  
12                  doing good things for these patients. The flaw  
13                  in the current system is in the payment models,  
14                  not in the measurements. So accordingly, I think  
15                  we ought to be focusing on fixing the payer  
16                  models explicitly, rather than trying to do it  
17                  indirectly through the risk adjustment of the  
18                  measures.

19                  So the bottom line, my recommendation,  
20                  my recommendation based on my understanding of  
21                  the issues and further enhanced by this ASPE  
22                  study is that we ought to keep the measures pure,

1 so that we can clearly observe disparities in  
2 outcomes. Understand what's causing those  
3 disparities and address them.

4 Second, that we risk adjust the  
5 payments to providers to recognize the higher  
6 cost of caring for disadvantaged patients.  
7 That's obviously beyond the scope of MAP's work,  
8 but we can make that recommendation to somebody  
9 who's working on the payment models. I think we  
10 ought to all be working explicitly, as ASPE  
11 recommends, on the goal of improving health  
12 equity.

13 I'll speak, I can speak I believe on  
14 behalf of most if not all consumers and  
15 purchasers here and outside this room, that we  
16 would be very happy to work with physicians,  
17 hospital systems and others on the payment models  
18 to get this right, so to make sure people get the  
19 care they need.

20 CO-CHAIR KHAN: Thanks, Bill.

21 MS. O'ROURKE: Pierre, did you want to  
22 give people just a quick update on the 21st

1 Century Cures Act?

2 DR. YONG: Sure. Thanks Erin, and I  
3 think the comments beforehand actually nicely  
4 lead into just this quick update for folks who  
5 aren't familiar with the Cures Act, which was  
6 passed in December of last year. There is a  
7 provision in Cures Act which addresses SES in  
8 particular relative to the hospital readmissions  
9 reduction program.

10 What it says is that -- it says that  
11 the HRRP program, which includes all the  
12 readmission measures which are not currently risk  
13 adjusted for SES, they'll have been part of the  
14 NQF pilot, that the program be restructured a bit  
15 so that we group hospitals into like groups. So  
16 you may have heard of the stratification sort of  
17 approach, which MedPAC put forward a couple of  
18 years ago as a recommendation.

19 But essentially you stratify providers  
20 or hospitals in this case by full eligible dual  
21 status. So the proportion of full eligible dual  
22 seen by that provider. So you are then comparing

1 hospitals with similar, seeing similar  
2 proportions of dual eligibles. So it's this like  
3 compared to like sort of approaches, as some  
4 people call it.

5 So that's what it's done. It says we  
6 can also consider the ASPE recommendations  
7 relative to risk adjustment of the measures, but  
8 the first sort of step forward is this  
9 stratification in terms of assessing the  
10 penalties not on the measure side. The other  
11 piece of this is also that the program and this  
12 adjustment is done in a payment, in a budget-  
13 neutral fashion.

14 So there's no change in the overall  
15 sort of penalties assessed on providers at the  
16 overall program level, compared to the current  
17 approach. There are also some other provisions  
18 in there. MedPAC is required to do a study  
19 relating to readmissions, but the main pieces are  
20 what I described so --

21 CO-CHAIR KHAN: Thanks. I guess just  
22 in response to Bill, I think in an ideal world or

1 a world where we had confidence that there would  
2 be an ongoing reconsideration of policy, I agree  
3 with you. But I think in the reality of what is,  
4 I think that the last thing you want to do in an  
5 admission policy that's fixed is penalize the  
6 very people you want to be reaching out, and  
7 worrying about the social determinants of health  
8 of their patient population, as well as worrying  
9 about the care inside the four walls of the  
10 hospital.

11 So I think, you know, in an ideal  
12 world it's great to talk about having risk  
13 adjustment that includes social determinants on  
14 DRGs, but that ain't going to happen any time  
15 soon and we have to deal with the reality of are  
16 we penalizing the wrong hospitals in the way that  
17 readmissions work.

18 So I agree that it's good to have the  
19 pure measure, because we don't know necessarily  
20 why certain hospitals are being penalized. I  
21 mean whether or not it's what they do inside the  
22 four walls or because of the situation of these

1 other patients. But they do tend to be patterns,  
2 and I think we need to recognize that in the  
3 current policy mix, which can be done under  
4 current authorities if CMS chose to do it.

5 That's sort of the problem we face.  
6 I mean it worries me too not to have, you know,  
7 everybody sort of measured the same way in terms  
8 of readmissions. But I think -- I think  
9 considering realities, I guess that would be the  
10 position that hospitals would take, and I think  
11 it's a sensible one considering that we don't  
12 have a process to do what you described yet.  
13 That's just sort of my response. But what do we  
14 do next?

15 MS. O'ROURKE: So we should have Karen  
16 Joynt and Nancy De Lew on the line. They're  
17 going to provide an overview of the findings from  
18 ASPE's study that came out of the IMPACT Act.  
19 Karen and Nancy, do we have you?

20 MS. DE LEW: Yes. It's Nancy De Lew.  
21 I'm on the line. Karen, you're on?

22 DR. JOYNT: Yep, we're both here.

1 MS. DE LEW: Terrific. We're in  
2 different parts of the country, so we're not  
3 sitting next to each other. I want to thank you  
4 all for welcoming us to the conference today, to  
5 the meeting today.

6 I'm going to start, do a couple of  
7 slides. Then I'm going to turn it over to Karen.  
8 We also have other members of our team who are  
9 with us, and I know that we may well have folks  
10 who helped us on this report.

11 We had a number of people participate  
12 on our technical expert panels as we pulled this  
13 material together, and if any of those  
14 participants are on the line, we want to thank  
15 them as well.

16 So I want to start. Let's go to the  
17 next slide please. I want to start by talking  
18 about the big picture, why social risk is  
19 important as we move to value-based purchasing in  
20 the Medicare program, a topic that many of you  
21 are very familiar with, and know intimately.  
22 Social risk factors we all know, play a major

1       role in health.

2                   As we began this work, we were  
3       thinking about some of the discussion that's  
4       taken place about social risk factors. You see  
5       several of those items on the slide right here.  
6       Some people have thought that beneficiaries with  
7       social risk factors have worse health outcomes,  
8       because the providers they see provide low  
9       quality care, that value-based purchasing could  
10      be a powerful tool to drive improvement in care,  
11      and to reduce disparities. That's one argument  
12      that we've heard.

13                  We've had others argue that if those  
14      beneficiaries have worse health outcomes due to  
15      factors beyond providers' control however, the  
16      value-based purchasing could inappropriately  
17      penalize providers that care for them, or could  
18      result in providers becoming reluctant to care  
19      for these populations.

20                  CO-CHAIR KHAN: I'm sorry. Could you  
21      all speak into the phone, because we're having a  
22      little trouble on this end.



1 MS. DE LEW: Sure. So I'll try to  
2 speak a little louder. Is that a little better?

3 CO-CHAIR KHAN: Yes.

4 MS. DE LEW: Okay. So as we began  
5 this work, we know that these relationships need  
6 to be better understood, so that we can align  
7 payments and ensure that the value-based  
8 purchasing programs we have achieve their  
9 intended goal. So that's the big picture as we  
10 began this work.

11 Next slide, please. The Congress in  
12 the IMPACT Act asked ASPE to provide a series of  
13 empirical analyses and provide considerations for  
14 providers, for policymakers, I'm sorry. The  
15 study that we're going to report on today, the  
16 IMPACT Act had several different pieces, and  
17 we're going to talk to you about Study A today.

18 What I just want to review here for a  
19 moment is the various provisions in the IMPACT  
20 Act and tell you where we are in our work, and  
21 what's coming over the next number of months and  
22 years. So Study A, the study that we'll report

1 on today, is looking at the impact of  
2 socioeconomic status on quality and resource use  
3 in Medicare, using existing data. So I want to  
4 just underline that word "existing data." That's  
5 what we'll be talking about today.

6 Study B will tell you a little bit  
7 about our thoughts for Study B. We will welcome  
8 your input for those today, as well as we've got  
9 a mailbox set up. We would welcome your input  
10 later as well, about our thoughts for Study B.  
11 So in Study B, the Congress has asked us to look  
12 at measures using data that we don't tend to use  
13 right now in our program, looking at measures  
14 like education, health literacy.

15 We'll be looking at income at both  
16 the individual income as well as income of the  
17 area where that person resides. So that will be  
18 our work on Study B. Again, we'll invite your  
19 input both now and later. The Congress also  
20 asked us to do qualitative analyses of potential  
21 data sources, and looking at the broader context  
22 surrounding defining socioeconomic status.

1                   The Congress asked us to develop  
2       recommendations and determine payment adjustments  
3       drawing upon all of that work that I just  
4       outlined. So a final report is due to the  
5       Congress in October of 2019. So what I want to  
6       just underline is that the report that we've made  
7       available, that we're going to be talking about  
8       today is Study A, and then we have additional  
9       work that we'll be doing and we welcome your  
10      input.

11                  So with that, I'm going to ask Karen  
12      to start walking through the report.

13                  DR. JOYNT: Great. Thank you so much.  
14      I've never been accused of talking quietly, but  
15      if you can't hear me tell me to -- tell me to  
16      speak up. Okay. So I'm going to give an  
17      overview of what we did in the report, and I'm  
18      going to try to give sort of a mix of a broader  
19      review, where we saw similar themes, and as well  
20      as some specifics to give you sort of a flavor  
21      for what we did on each program.

22                  I would invite you to look in the

1 report and the appendix for any specifics you  
2 might want on any particular program. So the way  
3 that we set up the project was to take a  
4 consistent set of social risk factors, and to  
5 examine the relationship between those factors  
6 and performance under the measures that  
7 constitute each of the Medicare payment programs  
8 you see there on the slide.

9           The programs certainly vary, and the  
10 number of measures they have and then how those  
11 are translated into payments. But we tried to be  
12 as consistent as possible in our analyses across  
13 programs. You can see here we grouped them into  
14 hospital programs. So the very familiar  
15 readmissions reduction program, value-based  
16 purchasing and hospital-acquired admission  
17 reduction programs are three programs that  
18 contain a number of very similar ambulatory  
19 quality measures.

20           So the MA Quality Star Rating Program,  
21 Medicare Shared Savings Program and the new  
22 Physician Value-Based Program which will sunset

1 and be replaced by MIPS in a few years, and then  
2 three programs in the facility setting, doctor  
3 office facilities, nursing facilities and home  
4 health agencies and home health agencies, with  
5 the caveat that the nursing facility and home  
6 health agency program are in the measurement and  
7 not payment phases. So we only looked at  
8 measures for those and didn't have programs to  
9 evaluate.

10 Next slide, please. So across our  
11 analyses, we had really two main findings. I  
12 think the consistency of our findings is  
13 important. We found that across most measures,  
14 beneficiaries with social risk factors, excuse  
15 me, had worse outcomes than quality measures,  
16 regardless of the providers they saw. Meaning we  
17 are looking predominantly within provider  
18 analyses, and dual enrollment status was the most  
19 powerful predictor of poor outcomes.

20 So typically dual status explains a  
21 fair amount of the racial and economic  
22 disparities, for example, intended to dominate

1 most of the measures though not all.

2 Our second finding, moving to the  
3 provider level, was that providers that  
4 disproportionately served beneficiaries with  
5 social risk factors also tended to have worse  
6 performance on quality measures, even after  
7 accounting for their beneficiary mix. Under all  
8 five value-based purchasing programs in which  
9 penalties are currently assessed, these providers  
10 experienced somewhat higher penalties than did  
11 providers serving fewer beneficiaries with social  
12 risk factors.

13 So as I think was set up quite nicely  
14 by these pre-comments, I think we had gone into  
15 this set of analyses thinking we might find a  
16 simple answer, that this would be a beneficiary  
17 issue. There would be a very specific quality  
18 signal we could relate directly to the  
19 beneficiary characteristics, or that it would be  
20 a provider issue and the poor outcomes we see  
21 would be all about provider quality.

22 And instead, really across settings,

1 we found that those are true, and you'll see that  
2 echoed in the way we sort of took this in terms  
3 of next steps. But also you'll see it in the  
4 analyses that we'll walk through in a moment. We  
5 did not find a simple answer, but rather that  
6 this is a complex combination of both beneficiary  
7 and provider characteristics and performance.  
8 Next slide, please. Rachel, do you want to do a  
9 slide or two here?

10 MS. ZUCKERMAN: Sure. So I will sort  
11 of walk through these two findings in some of the  
12 readmissions program, and then I'll go back to  
13 Karen. So this first finding that beneficiaries  
14 with social risk factors had higher readmission  
15 rates, regardless of the providers they saw, and  
16 we found that dual enrollment status was the most  
17 powerful predictor of a higher rate of  
18 readmission, as Karen just explained.

19 So if we look -- if you're looking at  
20 this table here, in the first column we're  
21 looking just at the social risk factor alone, and  
22 you can see that the odds ratio is highest for

1 dual status. Dually enrolled beneficiaries have  
2 a 24 percent higher odds of being readmitted,  
3 just looking at the raw readmission rates.

4 Then if we go to the middle column, we  
5 also adjusted for the medical risk that is  
6 contained in the readmission measure, and we see  
7 that the odds of readmission for duals goes down  
8 to 13 percent greater odds. And then finally  
9 when we adjust for other social risk factors,  
10 that drops to ten percent greater odds.

11 So we do see that each of these  
12 things, the social risk factors and the medical  
13 risk, decreased the odds of readmission, and that  
14 across the board dual status is the strongest  
15 predictor and in fact once we adjust for both  
16 medical and social risk, only dual status and  
17 urban beneficiaries were more likely to be  
18 readmitted.

19 So if we go to the next slide. Can we  
20 go to the next slide please? Yes, thank you. So  
21 the second finding is looking more at the  
22 provider side of things. So this looks very



1 similar in terms of the odds ratio, but here  
2 we're looking at providers treating beneficiaries  
3 with social risk factors, and in this case for  
4 the hospital measures, we looked at hospitals  
5 with the highest 20 percent, the highest 20  
6 percent of hospitals based on their  
7 Disproportionate Share Hospital or DSH index.

8 Just looking at this first row, heart  
9 attack, we see that hospitals -- these safety net  
10 hospitals had a 20 percent higher readmission  
11 rate than other hospitals, or sorry,  
12 beneficiaries. Yes, beneficiaries going to these  
13 hospitals had a 20 percent higher readmission  
14 rate, and then when we adjust the comorbidities,  
15 that goes down to 14 percent, and again adjusting  
16 for safety net status brings it down to nine  
17 percent.

18 So patients who are at safety net  
19 hospitals have five to nine percent higher odds  
20 of readmission after controlling for all measured  
21 medical and social risk factors. So this is  
22 similar to what we saw at the beneficiary level,

1 looking at the provider level.

2 Go to the next slide. Then when we  
3 look at how the program affects this, we're  
4 comparing safety net hospitals, again top 20  
5 percent of the disproportionate share, and that's  
6 to all other hospitals, and we see that a larger  
7 proportion of hospitals are penalized, and their  
8 penalties were slightly higher, about \$40,000  
9 higher over the year.

10 So safety net hospitals were more  
11 likely to be penalized and had slightly higher  
12 penalties than other hospitals. So again, we see  
13 that the -- in this case, the program itself has  
14 a much smaller impact than the measure, and that  
15 sort of changed throughout. The findings at the  
16 measure level were consistent; the findings at  
17 the program level depended on the program itself.

18 Go to the next slide. And I'm going  
19 to hand it over back to Karen at this point.

20 DR. JOYNT: Thanks, Rachel. So if we  
21 think those three slides that Rachel just talked  
22 through, and we sort of have equivalent ones in

1 the report for all of the programs, we ended up,  
2 as we mentioned at the beginning, with pretty  
3 consistent findings. We found, for example, the  
4 odds associated with readmission to be consistent  
5 across ACO analyses, physician group analyses and  
6 hospital analyses.

7 We found that hospitals that we  
8 considered to be the safety net were more likely  
9 to be penalized in the hospital readmissions  
10 reduction program, in the hospital-acquired  
11 condition reduction program and the value-based  
12 purchasing program. So we found consistent  
13 findings across the programs, and again, we'll  
14 defer to the report for details in the interest  
15 of time.

16 But overall, we found that  
17 beneficiaries of social risk factors have poor  
18 health outcomes regardless of the providers they  
19 see, and providers serving these beneficiaries  
20 have poorer performance regardless of the  
21 patients they serve. Of course now we come to  
22 the complexity, which is that these analyses

1       can't determine why patterns exist.

2               As was brought up in the speakers  
3       prior to us, beneficiaries may have poorer  
4       outcomes due to higher levels of medical risk,  
5       worse living environments, challenges in  
6       adherence and lifestyle or bias, and providers  
7       may have poorer performance due to fewer  
8       resources or a mismatch between resources and  
9       clinical workload, lower levels of community  
10      support or worse quality of care.

11              Unfortunately, many of these factors  
12      on both the beneficiary and provider side are not  
13      easily measured with our current data.

14              Next slide, please. So what are some  
15      potential policy solutions? And I'll just walk  
16      through a few here to set up some of our  
17      simulations. As many of have discussed, we can  
18      simply adjust the quality and resource use  
19      measures, which some would argue could make  
20      comparisons more equitable and reduce the risk of  
21      decreasing access to care for high risk  
22      beneficiaries.

1 Others might argue that that makes it  
2 more difficult to track and address disparities  
3 by varying the disparities within the measure,  
4 and could excuse low quality care if the  
5 adjustment is done broadly. Here, there's  
6 clearly no right answer. We simulated it anyway,  
7 so we'll show you that. But the answer here  
8 likely differs by measure.

9 Another adjusted solution has been to  
10 stratify measurement or payment, which largely  
11 has the same pros and cons in terms of  
12 potentially making comparisons more equitably,  
13 but running the risk of making it difficult to  
14 address disparities or excusing low quality care  
15 if done broadly.

16 Finally, creating bonus opportunities  
17 for improvement if a program does not already  
18 have such an opportunity, or equity, or anything  
19 else that one might want to do to sort of tweak  
20 the structure of value-based purchasing in a way  
21 that's felt more -- perhaps to add on some  
22 opportunities to address some of the social risk

1 factors.

2 Next slide, please. Some of the  
3 policy options that have been proposed were  
4 already mentioned. So MedPAC has proposed  
5 stratifying hospitals into ten groups by social  
6 risk, and in the 21st Century Cures Act, as  
7 Pierre noted, it suggests stratification into  
8 groups by proportion of fully and dual enrolled,  
9 and also has a consideration about the IMPACT  
10 report, and excludes certain patients and certain  
11 readmissions, to try to make the measure a little  
12 bit more precise.

13 Next slide, please. Well here, I'm  
14 going to talk through what we did in the report  
15 in terms of simulations, without placing any  
16 value judgment on any of these three options for  
17 now. I'm going to show you an example of each of  
18 those three types of solutions.

19 So if you start in the first column  
20 there, you can see the current average HRRP  
21 penalty in thousands of dollars, that the state  
22 committed 191,000 and all other hospitals at

1 150,000 and the difference on the bottom there in  
2 bold at 41,000.

3 Adding dual status to the risk  
4 adjustment model, which is Simulation 1, narrows  
5 the gap between safety net and all other  
6 hospitals to about \$16,000. Stratifying  
7 hospitals into ten groups, which is similar to  
8 what MedPAC had proposed and similar, although  
9 not with quite the same variables, as is in 21st  
10 Century Cures.

11 Simulation 2 you can see actually  
12 flips the penalty difference between safety net  
13 and all other hospitals because it's by  
14 definition distribute the penalties across the  
15 very different groups of hospitals, and  
16 Simulation 3 in this case was simulated adding an  
17 improvement bonus, in which we allowed each  
18 hospital to buy down its penalty based on its  
19 improvement in the prior year.

20 You can see that all hospitals were  
21 able -- not all. On average, hospitals were able  
22 to buy down a penalty a little bit with both

1 groups dropping.

2 So the safety net dropping from 191 to  
3 176 and all other hospitals dropping also, that  
4 did not reduce the difference between safety net  
5 and all other hospitals, because the safety net  
6 was not in fact improving faster than other  
7 hospitals were.

8 Next slide, please. Here we're  
9 showing a very similar set of simulations, this  
10 time in the Medicare Advantage Program. So the  
11 Medicare Advantage Program rewards quality stars  
12 based on performance across a wide array of both  
13 patient level and contract level measures, and in  
14 the current program, the average star rating for  
15 a high dual or low income subsidy status  
16 contract is 3.48 stars, which you can see in the  
17 left-most column.

18 Below that you can see the average  
19 star rating for all other contracts, which is  
20 3.78 stars. Now with four stars, you get a  
21 bonus. So in the Medicare Advantage Program,  
22 about 26 percent of the contracts in the highest



1 group of duals compared to 53 percent of other  
2 contracts actually meet that four star threshold.

3 So again, an example of a difference  
4 in performance that correlates with proportion  
5 dual. As we can see at baseline, there's about a  
6 .3 star difference between those two. If you go  
7 to Simulation 1, in which the adjusted measures,  
8 only the clinical measures, not the contract  
9 level measures for dual status, you can see that  
10 it narrows the gap only minimally, in part  
11 because those measures only make up a subset of  
12 the scores that go into this program, and in part  
13 because the differences on many of the measures  
14 were fairly small.

15 If you move one more column to the  
16 right to Simulation 2, you can see the  
17 categorical adjustment index, which is an  
18 adjustment index that takes into account both  
19 dual status and disability status, as the  
20 original reasons for Medicare entitlement, and  
21 that will be implemented as an interim adjustment  
22 in Plan Year 2017.

1                   You can see that narrows the gap a  
2                   little bit also, by giving a small bounce to the  
3                   high duals or LIS contracts. In the third  
4                   column, you can see a simulation for adding an  
5                   equity bonus, which I will say right now we made  
6                   up as sort of a back of the envelope idea, in  
7                   which we measured the disparity, the average  
8                   disparity on the clinical measures, and awarded  
9                   contracts extra stars if they had a low average  
10                  disparity.

11                  You can see here that that led to a  
12                  narrowing of the gap to some degree, with more of  
13                  an extra equity bonus being received by the high  
14                  dual contracts than the other contracts.

15                  Next slide, please. But, and herein  
16                  lies the complexity that was presaged in the  
17                  comments prior to us and then brought up by Nancy  
18                  as well, one solution will not address all the  
19                  causes. We can talk about certainly the  
20                  multitude of factors that lead to beneficiaries  
21                  with social risk factors having worse outcomes.

22                  I had mentioned those before, but

1       they're on this slide again. If we think about  
2       how pervasive, persistent and deep-seated of a  
3       problem this is, I think it becomes pretty  
4       apparent that just talking about adjusting the  
5       measures probably misses the opportunity sort of  
6       inherent in value-based purchasing, to think  
7       about how these both measures and programs might  
8       be leveraged in a way to really to start to  
9       change that conversation.

10               So the next slide, please. As a  
11       result, we came up with the help of our CMS  
12       colleagues and lots of other folks around the  
13       department, with sort of a broader strategy and  
14       how we can start thinking through how to account  
15       for social risk in Medicare payment programs.

16               These are much more considerations for  
17       future development and discussion than they are  
18       highly specific recommendations, but we do hope  
19       that they dovetail with a lot of what you all  
20       have been thinking as well. So the first part of  
21       the strategy is to measure and report quality for  
22       beneficiaries and social risk factors, which is

1 very germane to this group.

2 The second is to set high, fair  
3 quality standards for all beneficiaries, again it  
4 will feel familiar to this group. The third is  
5 to reward and support better outcomes for  
6 beneficiaries with social risk factors. So I'll  
7 walk through each of those in turn.

8 Next slide, please. So the first  
9 strategy is to measure and report quality for  
10 beneficiaries with social risk factors. The  
11 first consideration is to consider enhancing data  
12 collection, developing statistical techniques to  
13 allow the measurement and reporting of  
14 performance for beneficiaries with social risk  
15 factors on key quality and resource use measures.

16 We realized in doing this that we've  
17 created a, I don't know, 600 plus page document  
18 full of really an enormous amount of information,  
19 that could be really instructive to track over  
20 time and to help us understand the changes in the  
21 patterns of quality and of disparities. We felt  
22 like this shouldn't be a one-off, but rather sort

1 of a start in thinking through how, what we might  
2 need to do from a data and statistics standpoint,  
3 to make it feasible to actually see what our  
4 disparities are and what our performance is for  
5 these beneficiaries.

6 The second consideration is to  
7 consider developing and introducing health equity  
8 measures or domains into existing payment  
9 programs, to measure disparities and incent to  
10 focus on reducing them. I'll again admit that we  
11 don't know what this means or what it looks like,  
12 but we'll very much look to input and guidance  
13 from all of you.

14 And third, to prospectively monitor  
15 the financial impact of Medicare payment programs  
16 and providers disproportionately serving  
17 beneficiaries with social risk factors. As these  
18 programs continue to broaden and as they move  
19 into multiple different types of beneficiaries in  
20 different types of specialties and models,  
21 keeping this front of mind will be important.

22 The second component is to set high

1 fair quality standards for all beneficiaries.  
2 First, measures should be examined to determine  
3 if adjustment for social risk factors is  
4 appropriate, and the determination for any  
5 measure will depend on the measure and its  
6 empirical relationship to social risk factors,  
7 which is exactly what NQF has been leading the  
8 charge in doing.

9 Certainly, all measures should not be  
10 considered to be the same when it comes to this  
11 particular consideration. So we sort of leave  
12 this here as an invitation for continued  
13 discussions on this issue.

14 The second component we've also  
15 brought up before, which is that the measure  
16 development community should continue to study  
17 program measures to determine whether differences  
18 in health status might underlie some of the  
19 historic relationships between social risk and  
20 performance, and whether perhaps adjusting for  
21 health status might improve the ability to  
22 differentiate true differences in performance

1       between providers.

2               That would be things like frailty,  
3       functional status, disease severity, things in  
4       which there are likely differences between  
5       subpopulations and the better we can understand  
6       them both, the more equitable the measures and  
7       programs can be, and the better idea we'll have  
8       about the types of beneficiaries that might  
9       benefit the most from quality improvement and  
10      intervention.

11             Next slide, please. Finally, the  
12      third strategy is to reward and support better  
13      outcomes for beneficiaries with social risk  
14      factors. The first consideration is to consider  
15      creating targeted financial incentives within the  
16      value-based purchasing program, to reward the  
17      achievement of high quality and good outcomes or  
18      significant improvements among beneficiaries with  
19      social risk factors.

20             Certainly, we've seen some encouraging  
21      news, I think, from the hospital readmission  
22      reduction program for the Massachusetts

1       Alternative Quality Contract, suggesting that  
2       perhaps beneficiaries with social risk factors  
3       might gain the most from these programs. And so  
4       kind of really leveraging that could be an area  
5       with a lot of promise.

6               The second consideration would be to  
7       consider using existing or new quality  
8       improvement programs to provide targeted support  
9       and technical assistance for providers that serve  
10      beneficiaries with social risk factors. For  
11      example, one thing that we found in a few  
12      programs, particularly the physician value-based  
13      payment modifier program is that physician groups  
14      serving high risk populations were less likely  
15      even to successfully report.

16             So if their infrastructure needs or  
17      technical assistance or support needs to even  
18      make sure that all providers that serve  
19      vulnerable beneficiaries can be part of these  
20      programs, there really may be some things that  
21      using the existing technical support resources  
22      could potentially really help some of these



1 groups.

2 Third, considering developing  
3 demonstrations or models focusing on care  
4 innovations may help achieve better outcomes for  
5 beneficiaries with social risk factors. We need  
6 to know more about how we can do the things that  
7 these beneficiaries need, and some of those may  
8 require some creativity and innovation that sort  
9 of aren't easy within current systems that might  
10 be more feasible within demonstration models.

11 And finally, further research to  
12 examine the cost of achieving good outcomes for  
13 beneficiaries with social risk factors, to  
14 determine whether current payments adequately  
15 account for differences in care needs, and this  
16 is certainly the idea behind DSH payments, for  
17 example, and could be an important area to learn  
18 more about in the future, particularly under  
19 alternative payment models.

20 We'll turn now to Robin to tell you a  
21 little bit for our next piece of work.

22 MS. YABROFF: Great. Thank you,

1 Karen. Hi, this is Robin Yabroff, and I'm going  
2 to give you a very quick overview of some of our  
3 plans for Impact Study B. As a reminder, this is  
4 -- the goal of this study is to evaluate social  
5 risk factors and performance using new measures  
6 of social risk, new data sources.

7 So to give you a quick overview, we  
8 plan to build on the first report to Congress,  
9 the framework that Karen has described so well.  
10 We'll be looking at a number of different social  
11 risk factors at the beneficiary, provider and  
12 program level, and we will use the conceptual  
13 framework in a series of recommendations for data  
14 sources and measures from reports from the  
15 National Academies, and there's a series of five  
16 reports the picture is showing here on the right  
17 side of this slide, Accounting for Social Risk in  
18 Medicare Payments.

19 We will also explore new measures of  
20 social risk, and this is part of the conceptual  
21 framework that the National Academies came up  
22 with, which include things like socioeconomic

1 position, race-ethnicity, gender, social  
2 relationships and residential and community  
3 context. We will also be evaluating medical or  
4 social risk factors that are prevalent in dually  
5 eligible beneficiaries, things like frailty and  
6 disability, and then finally examining program  
7 impact and policy solutions.

8           Next slide, please. So just to give  
9 you a better sense of exactly what we will be  
10 doing within our evaluation of new measures of  
11 social risk, we have a series of survey database  
12 projects using the Medicare current beneficiary  
13 survey, which is about 15,000 beneficiaries a  
14 year, and also the American Community Survey,  
15 which looks at both the individual and area  
16 levels.

17           We'll be doing a series of parallel  
18 analyses to evaluate which social risk factors  
19 are the strongest predictors of poor outcomes.  
20 We'll also be evaluating interrelationships  
21 between individual and contextual measures of  
22 social risk and outcomes, to give us a better

1 sense of how well these measures correlate, but  
2 also which -- where it's most important to  
3 include these sorts of measures, and then how the  
4 risk factors influence provider performance.

5 We're also going to be doing a series  
6 of claims-based data projects, where we are going  
7 to be identifying and validating new measures of  
8 medical risk factors that are prevalent in dually  
9 eligible beneficiaries, and then similarly  
10 assessing relationships with outcomes and  
11 evaluating the influence on provider performance.

12 Next slide, please. So with that, I  
13 want to open it up for questions. I also want to  
14 note that I just sent a note to everyone, which  
15 includes the contact information for any feedback  
16 you might have on this report or any other  
17 suggestions you have, and that is [aspeimpactstudy](mailto:aspeimpactstudy@hhs.gov)  
18 at [hhs.gov](mailto:hhs.gov).

19 So that is a new mailbox we recently  
20 started that we'll be using to collect feedback  
21 from anyone who has comments. So with that, I'm  
22 looking forward to your feedback and questions.

1 Thank you.

2 CO-CHAIR KHAN: Thank you so much,  
3 guys. Okay who? I see David and Harold right  
4 now.

5 MEMBER BAKER: This is David Baker.  
6 I just want to thank you for a really incredible  
7 presentation. It was just so clear and  
8 thoughtful. So my first comment is you talk  
9 about these unmeasured health factors, and I  
10 can't stress how important that is. There is  
11 incredibly robust literature on the importance of  
12 health status.

13 You talk about frailty, but even self-  
14 reported overall health. As simple as that one  
15 question is, it's an incredible predictor of  
16 hospitalization, mortality, et cetera. Before  
17 you do a lot of research, you should look at the  
18 studies that have been done using the health and  
19 retirement study, and I'd be happy to share some  
20 of the work that I've done and that others have  
21 done using that, because that's a great source of  
22 data for looking at this.

1 MS. YABROFF: Thank you very -- this  
2 is Robin. Thank you very much. I appreciate  
3 that, and certainly we'd be interested in you  
4 forwarding those studies. And when you refer to  
5 this, the simple one item question how would you  
6 rate your health; excellent, very good, good,  
7 fair, poor, correct?

8 MEMBER BAKER: Exactly.

9 MS. YABROFF: Yes, yes.

10 MEMBER BAKER: But you know, it's just  
11 a start obviously, but it's so important to  
12 recognize that a lot of these measures that  
13 you're using for socioeconomic status, they are  
14 almost certainly, as you pointed out nicely,  
15 they're proxy measures for differences in health  
16 status. If you look at patients, for example,  
17 with diabetes and what proportion of patients,  
18 you know. You adjust for comorbidities.

19 But what's the prevalence of  
20 microvascular disease in those patients? Again,  
21 huge differences. When we were using the health  
22 and retirement study data about 15 years ago, we

1       were looking at people who are sort of in the ten  
2       years before hitting Medicare, and overwhelmingly  
3       the most important predictor of their health  
4       outcomes we're looking particularly at race-  
5       ethnicity but also socioeconomic factors.

6               Overwhelmingly, it's a baseline health  
7       status, right. So if you don't have that  
8       information, you know, really you're missing the  
9       boat on ability to adjust, and really understand  
10      what the differences in this is.

11             MS. YABROFF: Yes. Thank you for that  
12      suggestion. It is something that we are  
13      considering, and we do in fact have, that  
14      question in the Medicare current beneficiary  
15      survey.

16             MEMBER BAKER: Oh great.

17             MS. YABROFF: Yes, and we plan on  
18      using it. So yes, go ahead.

19             MEMBER BAKER: Just the other things.  
20      You talked about rewarding achievement, and  
21      that's great. But I'll give an example of Mount  
22      Sinai Hospital in Chicago. One time their CEO

1 said that they measure their cash on hand not on  
2 days but sometimes in hours. So you know, to  
3 reward organizations for performance improvement,  
4 they don't have the cash up front to implement  
5 the programs, many of which are evidence-based  
6 programs, community health workers and such.

7 They don't have the money to implement  
8 those, to be able to get the bonuses later on.  
9 Which gets to Bill's comment right at the start,  
10 you know, about the need to have adjustment for  
11 the payments right up front. So you know, I  
12 applaud that idea, but the reality is much  
13 different.

14 CO-CHAIR PINCUS: Really an incredibly  
15 sophisticated approach that you've used to this,  
16 and I'm really thinking through all, both the  
17 scientific and the policy questions in a really  
18 good way. One question I had, both in the I  
19 guess Study A and your plans for further studies.  
20 To what extent did you look at the extent to  
21 which behavioral health conditions had an impact  
22 on this, both behavioral health conditions that



1       were identified in claims, but also ones that  
2       were not -- that were or might not be identified?

3               DR. JOYNT: This is Karen. That's a  
4       great question. We didn't in quite the sense  
5       that you ask. We certainly noted when we  
6       examined patient characteristics based on claims  
7       across programs, that typically most of the  
8       individuals with social risk factors have  
9       significant higher proportions of prevalent  
10      mental health diagnoses in claims.

11             My recollection is two to three times  
12      higher in the dual versus non-dual group. I  
13      believe some of the quality measures incorporate  
14      some pieces of that, but certainly not in the  
15      kind of detail that you're asking, and we didn't  
16      do any additional looks at other data sources in  
17      terms of where one might find that information  
18      outside of claims.

19             But I think it's a tremendously  
20      important area to think about, especially as we  
21      think more about many of the alternative payment  
22      models and other systems, really thinking about

1       how to integrate behavioral and medical type  
2       health services. So it's a great point.

3                   MS. YABROFF: Hi, this is Robin. I  
4       just want to add to that and say that it is a  
5       great point and your timing is perfect, in that  
6       it is something we can think about carefully as  
7       we start exploring some of the different measures  
8       of not only self-rated health but different  
9       measures of a lot of our other health status  
10      measures.

11                  CO-CHAIR PINCUS: Just to say that  
12      we'd be glad to talk to you further about it.  
13      We've recently been just completing a  
14      Commonwealth Fund study around kind of the  
15      interface between behavioral health and general  
16      health, and some issues around quality  
17      measurement.

18                  MS. YABROFF: Hi, this is Robin again.  
19      I just want to make sure. Could people please  
20      announce their names when they're asking  
21      questions? So it make it a lot easier for us --

22                  CO-CHAIR PINCUS: This is Harold

1 Pincus at Columbia, okay.

2 MS. YABROFF: Got it. Thank you.

3 CO-CHAIR PINCUS: Aparna.

4 MEMBER HIGGINS: Okay, thanks. This  
5 is Aparna Higgins. So I have a couple of  
6 questions and one suggestion, so I'll kind of go  
7 through them. So I think one of the earlier  
8 slides you had presented, you had talked about  
9 how after adjusting for some of the provider  
10 characteristics, you still found differences -- I  
11 mean so after adjusting the beneficiary  
12 characteristics, you still found differences in  
13 the performance of these hospitals.

14 So when you looked at the data, do you  
15 see a lot variability among hospitals that had a  
16 higher proportion of DSH? And I have a follow-up  
17 question to that, based on your first -- answer  
18 to that first question.

19 MS. YABROFF: Sorry. Can you say that  
20 one more time? So did we find a -- are you  
21 asking the disparity difference across hospitals?

22 MEMBER HIGGINS: Right. So if you

1 look at hospitals that have, you know, a higher  
2 proportion of DSH patients, you know, at usually  
3 the 20 percent threshold. So I'm wondering if  
4 you looked along a continuum, did you see, you  
5 know, if it's five percent versus 20 percent  
6 versus, you know, 50 percent? You know, do you  
7 see a lot of variability in terms of when you  
8 move that threshold like you were -- I don't know  
9 if you modeled it, but I was curious.

10 MS. YABROFF: Yes. So I'll answer  
11 that in a couple of ways. It differed a little  
12 bit by programs. So there's a couple of graphs  
13 in the report looking at either DSH index or a  
14 proportion of dual as a continuous variable and  
15 relating that to performance.

16 And perhaps from a value-based  
17 purchasing, or if you look at a combined  
18 performance across the three hospital programs,  
19 which is at the beginning of the hospital  
20 section, it's a reasonably linear relationship.  
21 There's not an obvious threshold where we made  
22 the cut for DSH index, use a presentation of

1       having a specific group. But the relationship  
2       was visible across the entire spectrum.

3               One thing we found that was very  
4       interesting was that in the Medicare Advantage  
5       Program, the line was instead shaped a little bit  
6       like a swoosh, for any Nike enthusiasts out  
7       there, in that there was clearly a negative  
8       relationship between proportion of dual and  
9       performance out to the end, and then it did seem  
10      like at the highest proportions of dual low  
11      income subsidy individuals, there was really an  
12      uptick in performance, suggesting that perhaps  
13      the contract that had really focused on providing  
14      the types of services or interventions or  
15      whatever that these folks might particularly  
16      benefit from have had some success in doing so.

17             Certainly that will be, I think, an  
18      interesting area for us and others to learn more  
19      about in the future. In terms of the disparity,  
20      we did look in a couple of settings to find out  
21      if disparity varied by proportion duals with high  
22      or low disparities. That was -- that was pretty

1 all over the map. We didn't find a very obvious  
2 connection between proportions or quality and the  
3 magnitude of the disparity.

4 MEMBER HIGGINS: Okay, thank you.  
5 Then just real quickly, I think you mentioned  
6 your Study B, you were going to be looking at  
7 survey measures. You mentioned MCBS. I think  
8 the other you might be looking at this already on  
9 the MA side is the HOS survey, where they do ask  
10 questions about, you know, health status. So  
11 something you might want to think about.

12 MS. YABROFF: Yes, thank you. We  
13 looked at performance on those measures in the  
14 Medicare Advantage Program, but we didn't use  
15 those to examine other measures, if that makes  
16 sense. So we sort of took the first step into  
17 the medical and/or what is it, physical and  
18 mental health measures and looking at them, and  
19 certainly differences by dual status, but did not  
20 apply those to other measures within MA. That's  
21 a terrific idea.

22 MEMBER HIGGINS: Okay.

1 CO-CHAIR KHAN: Okay, other questions?  
2 Do you have any other questions?

3 DR. ANTONELLI: This is Rich Antonelli  
4 from Boston Children's Hospital. This is -- if I  
5 was empowered to give out an Oscar, you guys  
6 would get it. Congratulations. Thank you for  
7 the inspiration and the good work. This is  
8 something that we're thinking about a lot in  
9 Massachusetts, where we're developing  
10 methodologic approaches to embedding social  
11 determinants of health into our Medicaid program  
12 across the age spectrum.

13 That said, I'm especially interested  
14 in your comparison about the provider performance  
15 on certain measures. To the degree that we could  
16 get data, that you could get some data that isn't  
17 necessarily the same Medicare population, I'm  
18 wondering what's the impact on a delivery system  
19 that has a Medicare service line and a non-  
20 Medicare service line? Does this caring for this  
21 population, if there's a substantial commercial  
22 presence, in fact elevate performance across the

1 board or drag it down?

2 It would be interesting to see the  
3 comparability and then also I want to build on  
4 what Bill's wisdom was at the beginning. It  
5 isn't just an issue of giving more money to the  
6 providers; we have to think very creatively  
7 because a one-size-fits-all intervention won't  
8 work. So I'll stop there, but I wonder if you  
9 can comment about that.

10 MS. YABROFF: Yes no. We appreciate  
11 that. Certainly Massachusetts has had -- has  
12 been the home of a number of very interesting  
13 programs and efforts to try to think through  
14 this. I think -- I honestly don't know the  
15 answer to your question, but it sure would be a  
16 great thing for someone to figure out.

17 You know, there's efforts within the  
18 Department to try to harmonize and think through  
19 what multi-payer programs would look like, or how  
20 we could have a system -- quote-unquote system in  
21 which various incentives from various purchasers  
22 sort of augment one another.



1 I don't know that we have the data  
2 right now to know what those patterns look like.  
3 We certainly don't. I don't know if other folks  
4 do, but it's certainly a tremendously important  
5 area. You can imagine that depending on what  
6 proportion of your practice is Medicare/Medicaid,  
7 a whole slew of different private purchasers,  
8 whether or not those are in Medicare Advantage or  
9 not, whether or not they're in alternative  
10 quality contracts could really change the benefit  
11 for investing in the kind of systems it might  
12 take to do some specific interventions.

13 So that's obviously -- that was the  
14 great comment, and if you know the answer, please  
15 tell us.

16 DR. ANTONELLI: Well I have a  
17 suggestion, and it actually is to build on a  
18 comment I made to the NQF staff at the break, and  
19 we were -- a study was done with the  
20 Massachusetts Blue Cross/Blue Shield alternative  
21 quality contract, and the headline was that this  
22 approach in fact reduced disparity.

1                   But the problem that I had with that,  
2                   and I wasn't connected with the study although I  
3                   am a clinician in Massachusetts, the problem is  
4                   that those patients were able to be commercially  
5                   insured to begin with. So to the degree that you  
6                   can reduce disparities for a commercially insured  
7                   population, that's wonderful. But you know, I  
8                   really have significant concerns about the  
9                   representativeness of low resource populations  
10                  that are commercially insured versus a vulnerable  
11                  population.

12                 So here's my suggestion. If your  
13                 analytic team could actually look at some of the  
14                 data elements that were reported in the BCDS  
15                 Massachusetts AQC, to see if any of those things  
16                 cross-walk into the measures that you were  
17                 looking at. It wouldn't be definitive, but it  
18                 may be directional.

19                 MS. YABROFF: That's a terrific idea.  
20                 I saw that study, and I will go back and look at  
21                 the details with that eye.

22                 CO-CHAIR KHAN: Okay, Bruce. Okay,

1       Bruce.   Oh Mary?

2                   MEMBER BARTON:    Hi.   This is Mary  
3       Burton from NCQA.   I was curious that on the  
4       slide where you mentioned the pros and cons of  
5       risk adjustment, you said that the issues with  
6       stratification would be the same.   That strikes  
7       me as not immediately apparent, why presenting in  
8       a group just to a straw person, you know, all the  
9       high duals I'll say health plans, because that's  
10      my world, and comparing them to each other and  
11      creating benchmarks within that pool, would not  
12      have the effect of showing -- it would still show  
13      everybody's actual rate, but you would be going  
14      to pay because of the way that, you know, the  
15      payments are based on benchmarks on -- with a  
16      different threshold.   So that you would not be  
17      changing the measures, but you would be  
18      facilitating a change in the payment.

19                   So I'm curious, how do you see that as  
20      being subject to the same cons as risk  
21      adjustment, which by itself would obscure the  
22      actual performance?

1 MS. YABROFF: That's a great point.  
2 I think the devil is in the details, and that is  
3 to say that when and where you adjust versus pay  
4 versus compare, do you report unadjusted  
5 performance, do you report relative performance?  
6 How you operationalize any of these fixes could  
7 address some of the cons and augment some of the  
8 pros, and I would suspect there are better and  
9 worse ways to implement many of these things.

10 So that is to say it would depend how  
11 it were done. Certainly if you gave everyone  
12 just a score, a within stratum score or something  
13 like that, that would be very different, showing  
14 actual performance within strata. So I think it  
15 would depend how these things would be  
16 operationalized, which is obviously a much bigger  
17 challenge in many ways.

18 CO-CHAIR KHAN: Thanks. Bruce.

19 MEMBER HALL: Bruce Hall from the  
20 American College of Surgeons. Thank you all,  
21 Robin and Karen and Nancy and teams for doing  
22 this work. Fantastic work, generating important

1 insights for all of us. These are topics that  
2 all of us measurement folks worry about and lose  
3 sleep over.

4           You said at one point early on, I  
5 forget which piece of the presentation it was,  
6 that you noticed that even after adjusting for  
7 beneficiary mix, providers still had -- these  
8 providers still had some performance gaps. But  
9 then you correctly, I think, go on to say those  
10 may be associated with other resource issues and  
11 other operational issues.

12           I think that's correct, and I think  
13 what that shows us is that, you know, maybe we're  
14 at a time where we should flip this paradigm  
15 around. So those of us who are measurement  
16 wonks, we always think that some day we're going  
17 to be able to tease out enough factors that once  
18 we've adjusted for all those factors, we'll be  
19 left with some true performance gap for that  
20 provider, showing, proving to all of us that that  
21 provider was, you know, a bad person to begin  
22 with.

1                   It's just a matter of teasing out what  
2                   the proportions of different populations are and  
3                   whether they have resources or not. But the end  
4                   of the day, the numbers that are left are going  
5                   to be the residual, and that residual is going to  
6                   indicate that that provider was bad.

7                   If we could just flip from the start  
8                   and say to ourselves whenever we notice  
9                   performance isn't reaching a benchmark, we're  
10                  going to assume that those are good people, good  
11                  teams who don't have the resources, and then we  
12                  start teasing out the ways they don't have the  
13                  resources.

14                 They don't have the resources to  
15                 address dual eligibles. They don't have the  
16                 resources to address literacy, so on and so  
17                 forth. We would find ourself in a very different  
18                 policy position. We'd be finding ourself wanting  
19                 ways to correct for those deficiencies, instead  
20                 of trying to make sure that we've removed enough  
21                 factors that we justfully penalize somebody.

22                 So that my pie in the sky comment.

1 Now I'm going to switch to a granular comment  
2 that's concrete. As the recent chair of the  
3 Readmissions Standing Committee, along with  
4 Sherrie Kaplan, and I'm still on that committee  
5 but no longer chair, we had a number of our  
6 measures in the recent round go through the SDS  
7 trial period.

8 For those of you who noticed the  
9 announcement, only a couple, only I think two of  
10 the measures ended up with any SDS adjustment in  
11 the final version. But I want to make it clear  
12 to everyone in this committee and everyone  
13 listening that I think that's because the  
14 available metrics tested just weren't on the  
15 mark.

16 I think everyone acknowledged that.  
17 There just wasn't a lot of data at that time  
18 easily available to roll into that trial period,  
19 and so we didn't see a lot of factors with big  
20 influence on those metrics. But that's because  
21 there just, I think, wasn't a fully developed  
22 approach. It was the opening salvo.

1                   But those results should not be viewed  
2                   as the Readmissions Committee or anyone in NQF  
3                   saying SDS adjustment is not important. That  
4                   would be the wrong message. The message should  
5                   be we tried it this first round. We weren't  
6                   sophisticated enough to really show the impact.  
7                   That work is ongoing and continues, and it is not  
8                   a statement that SDS adjustment is not important.

9                   The final -- the final approvals for  
10                  the readmissions and other measures recently  
11                  came along with four qualifications or  
12                  recommendations from CSAC, and I think those are  
13                  important for everyone to read and think about.  
14                  But still at the end of the day, they are mostly  
15                  centered on the measurement challenge, on the  
16                  work challenge of did we get all the factors we  
17                  could have gotten.

18                  I would ask all of us to go back to  
19                  either Karen or Robin's Slide No. 72, which  
20                  showed this multicolored circle with six, you  
21                  know, different circles and different colors  
22                  around it. Go back maybe one more or yes,



1 something like that, which shows that, you know,  
2 risk adjustment is just a little piece of what we  
3 should be shooting for here, and until we can get  
4 the policy support to be paying attention to all  
5 of these colors, I think we're going to be  
6 falling short of our charge for our patients.  
7 With that, I will shut up.

8 CO-CHAIR KHAN: Okay. Rhonda.

9 MEMBER ANDERSON: I really appreciate  
10 the work that's been done, and this follows up  
11 actually. My question was going to -- my comment  
12 was going to be what Bruce made about the trial  
13 period. But my question is I think probably to  
14 Helen or someone from NQF, in terms of these  
15 findings and this work to date, how is it going  
16 to affect the work that you have been doing, and  
17 maybe an extension of the trial period. I'm not  
18 exactly sure of the next steps.

19 MS. O'ROURKE: Sure. We actually had  
20 a couple of slides that we put together. If you  
21 could go to Slide 84, which shows some of the  
22 results of our trial period. 83's a background

1 on the trial period.

2 DR. BURSTIN: Basically for those of  
3 you who aren't aware, we've been doing this trial  
4 period now for about a year and a half, I think,  
5 overall looking and actually it's at all measures  
6 that come before NQF, to consider whether there's  
7 both a conceptual and empiric basis for  
8 adjustment.

9 We were actually very heartened to  
10 see, I think, that the IMPACT report said that  
11 same mantra, conceptual plus empiric. I think  
12 what we generally found though is that many  
13 measures for which there was a conceptual basis,  
14 vis-a-vis saying it in English, a logical reason  
15 why you think social class, social risk could be  
16 a factor, we have not seen very many measures  
17 where the empiric data supports that.

18 Meaning the available variables, as we  
19 just heard from Bruce, and I think eloquently  
20 described by the ASPE folks, are not yet  
21 available to show some of that difference. And  
22 so as you could see this here, very few of the

1 measures to date have gone through with  
2 adjustment, you know.

3 One example, there was a measure that  
4 looked at the coordination of care for children  
5 with special health care needs, where the  
6 education of the parent was such a critical  
7 factor in it. That measure was in fact adjusted  
8 for that. There was a SNF measure that adjusted  
9 for marital status and insurance status.

10 So there were a couple where it did  
11 logically come through. So I just want to put up  
12 these four statements that Bruce had mentioned.  
13 So when those -- the readmission measures in  
14 particular came through recently, the CSAC and  
15 then ultimately the executive committee of the  
16 board recommended that those endorsements, move  
17 forward with these four statements attached to  
18 them.

19 The first was that we recognized this  
20 is not a closed door, as I think you just heard.  
21 As better data get, become available, we do see  
22 it as something that, as part of the annual

1 update process that measures come forward,  
2 measures that had a conceptual basis, that didn't  
3 have an empiric basis will be asked to consider  
4 what new adjusters can you potentially update  
5 your analyses?

6 The second thing is that I think we  
7 actually put this forward a while ago, but I  
8 think very much bolstered by the IMPACT report as  
9 well, is this idea that it's really time to think  
10 very much about this next generation of risk  
11 adjustment broadly, considering better clinical  
12 factors, clinical complexity, health status. We  
13 very much want to take that and we'd love to do  
14 that in partnership obviously with our federal  
15 partners.

16 I think the third is that given the  
17 concerns about the potential unintended  
18 consequences on the safety net, and this was  
19 before the 21st Century Cures Act came out, we  
20 specifically wanted to encourage MAP and the NQF  
21 Board to consider other approaches like payment,  
22 again very clearly outlined in the IMPACT report.

1                   Measurement and risk adjustment is not  
2                   the only approach here to fix concerns about  
3                   unintended consequences, but it is one certainly.  
4                   And then finally, as some of you know, we have a  
5                   Disparity Standing Committee actively doing work,  
6                   creating a measurement road map to think about  
7                   how you can reduce disparities through  
8                   measurement.

9                   One of the things they've been  
10                  specifically tasked with is considering some of  
11                  these questions that kept coming up with our  
12                  committees, about should you potentially adjust  
13                  for hospital or community level factors. So we  
14                  will, we will tee that up for them. In terms of  
15                  next steps for the Disparities Committee, they  
16                  will have a formal review of all the measures  
17                  that have been part of the trial period at their  
18                  May-June in person meeting.

19                  We'll then have them make a  
20                  recommendation to the NQF Board for their meeting  
21                  in July, as to whether NQF would make this a  
22                  permanent change to our policy, to allow measures

1 to be considered for social risk factors. At  
2 least in talking and very much supported by the  
3 IMPACT report, it seems that we have not seen any  
4 evidence of a down side to necessarily allowing  
5 the discussions to happen.

6 I think our bar is probably pretty  
7 high, given how difficult it's been for measures  
8 to get through. But that will be a final change  
9 in July. But I do think, just as a take-home for  
10 us at least, the IMPACT report was very, I think,  
11 affirming, that our approach of requiring both  
12 conceptual and empiric basis was right.

13 I do think though, which we've also  
14 agreed with, that it can't just be about  
15 measurement and risk adjustment. You've got to  
16 think about the payment levers, and whatever  
17 other levers could be done. And then finally  
18 something else we'll ask the Disparities  
19 Committee to address, and this committee as well  
20 if you'd like, is one of the other really  
21 important recommendations I think of the IMPACT  
22 report is the idea that we need a set of health

1 equity measures.

2 That's something we're going to have  
3 the Disparities Committee really begin to help us  
4 think through. We've done some of this work over  
5 the last several years. But I, you know, very  
6 much would welcome your thoughts about what would  
7 be an important starter set of what those health  
8 equity measures would look like, as we continue  
9 to move forward in this.

10 CO-CHAIR KHAN: I guess thank you  
11 Helen, and I guess it's, you know, the whole  
12 thing is very troubling, as Bruce pointed out,  
13 and as the study showed. The lower income tend  
14 to have a double whammy. They tend to be sicker  
15 and they tend to go to institutions that, at  
16 least right now, are not as good -- don't have as  
17 high quality care as other institutions treating  
18 other populations of Americans. So a lot to do  
19 with -- we need to do to improve on that. So  
20 with that, have we I believe done our work?

21 MS. O'ROURKE: We're done.

22 CO-CHAIR KHAN: Okay. I think with

1 that, we're done. I want to thank ASPE -- are  
2 they still on the phone?

3 MS. O'ROURKE: Yes, they're still on  
4 the phone.

5 CO-CHAIR KHAN: Okay. I want to thank  
6 them for super work, and we'll look forward to  
7 the next edition of your work. Obviously some  
8 people have made suggestions here, and I think  
9 everyone here now is really keyed in.

10 So I'm sure you'll be getting cards  
11 and letters and suggestions, as well as hopefully  
12 maybe some other gifts of -- to help you along as  
13 you do the next part of your task. So with that,  
14 Harold anything else? Oh I'm sorry, I'm sorry.  
15 I forgot about public.

16 CO-CHAIR KHAN: Any public comment?

17 OPERATOR: At this time, if you'd  
18 like to ask a comment, please press star one.

19 (No audible response.)

20 OPERATOR: And there are no public  
21 comments at this time.

22 CO-CHAIR KHAN: Okay. I'll pass the



1 baton to Harold.

2 CO-CHAIR PINCUS: Well again, let me  
3 just thank certainly ASPE staff, NQF staff, and  
4 probably most of all the members of the  
5 Coordinating Committee, because it's been a very  
6 efficient and substantive and I think effective  
7 way in which we've met our mandate. So thank you  
8 all. Safe travels.

9 DR. BURSTIN: I'll just add my thanks  
10 to everybody as well. We recognize you're  
11 volunteers. You put an incredible amount of work  
12 on your plates and I'm just delighted that all of  
13 you are willing to participate. Your suggestions  
14 for improvement are really heartwarming to us.  
15 We continue to want to make this a better  
16 process.

17 In fact, we did some things with the  
18 work group we'll need to bring to you, including  
19 the holistic review of the measure sets. We made  
20 sure of that to follow, since that will be in the  
21 final report. Not in the spreadsheets, but in  
22 the final report that we put forward to CMS. So

1 we'll make sure all of you have an opportunity to  
2 review that, and we'll think about ways to  
3 incorporate that further into the process for the  
4 Coordinating Committee going forward. So thank  
5 you all and safe travels.

6 CO-CHAIR KHAN: Great. So I guess we  
7 are adjourned. Thank you.

8 MS. O'ROURKE: I just want to jump in  
9 and thank you so much, Chip and Harold, for your  
10 leadership over the past two days in getting us  
11 through this incredible volume of work.

12 I echo my thanks on Helen's for all of  
13 the work all of you have done over the past few  
14 days. We greatly appreciate it, and safe travels  
15 home and our next meeting will be in August, to  
16 review the work of the Medicaid core set task  
17 forces. That will be a web meeting, and then we  
18 will keep you updated on the release of the pre-  
19 rulemaking reports in the coming weeks. Thank  
20 you.

21 (Whereupon, the above-entitled matter  
22 went off the record at 2:11 p.m.)

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This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership  
Coordinating Committee Meeting

Before: National Quality Forum

Date: 01-25-17

Place: Washington, DC

was duly recorded and accurately transcribed under  
my direction; further, that said transcript is a  
true and accurate record of the proceedings.

  
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Court Reporter

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