

NATIONAL QUALITY FORUM

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MAP COORDINATING COMMITTEE

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WEDNESDAY

JANUARY 15, 2020

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The MAP Coordinating Committee met at the
National Quality Forum, 5th Floor Conference
Room, 1099 14th Street, N.W., Washington, D.C.,
at 9:00 a.m., Bruce Hall and Chip Kahn, Co-
Chairs, presiding.

PRESENT:

BRUCE HALL, Co-Chair, BJC Healthcare
CHIP KAHN, Co-Chair, Federation of American
Hospitals
DAVID BAKER, The Joint Commission
MARY BARTON, National Committee for Quality
Assurance
LEAH BINDER, The Leapfrog Group
SCOTT FERGUSON, American Medical Association
DAVID GIFFORD, American Health Care Association
ELIZABETH GOODMAN, AHIP
EMMA HOO, Pacific Business Group on Health
LIBBY HOY, Patient and Family Center Partners*
REBECCA KIRCH, National Patient Advocate
Foundation
ESTHER MORALES, Health Care Service Corporation
CHERYL PETERSON, American Nurses Association
HAROLD PINCUS, Columbia University
AMIR QASEEM, American College of Physicians*
CHRIS QUERAM, Wisconsin Collaborative for
Healthcare Quality*
MISTY ROBERTS, Humana, Inc.
JEFF SCHIFF, Consultant*
RONALD WALTERS, University of Texas-MD Anderson
Cancer Center
STEVE WOJCIK, National Business Group on Health

FEDERAL LIAISONS:

SUSAN ARDAY, CMS*
MIA DeSOTO, AHRQ
REENA DUSEJA, CMS

TAMYRA GARCIA, CMS

NICOLE HEWITT, CMS*

MICHELLE SCHREIBER, CMS

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and CEO
TAROON AMIN, Consultant
KATE BUCHANAN, Senior Project Manager
APRYL CLARK, Chief of Staff
AMY CHAUDHURY, Project Analyst
AMY MOYER, Director*
ELISA MUNTHALI, Senior Vice President, Quality
Measurement
SAM STOLPE, Senior Director
MAHA TAYLOR, Managing Director

ALSO PRESENT:

BRUCE BAGLEY, Clinician Workgroup Co-Chair*
HEIDI BOSSLEY
ROB FIELDS, Clinician Workgroup Co-Chair*
LISA HINES, Pharmacy Quality Alliance*
GERRI LAMB, PAC/LTC Workgroup Co-Chair*
KURT MERKELZ, PAC/LTC Workgroup Co-Chair*
KORYN RUBIN
MARIA SCARLATOS

* present by teleconference

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

2 9:02 a.m.

3 CO-CHAIR KHAN: So we're going to start
4 now. We want to open up the meeting. This is our
5 annual coordinator committee meeting. I'm going
6 to co-chair this morning. Bruce will be here a
7 little bit later this morning and we'll pair off.

8 And to get things started, I'm going
9 to hand over the baton over to Sam to go through
10 the logistics before we get into the meeting
11 substance itself.

12 MR. STOLPE: Wonderful, thank you so
13 much, Chip, and welcome, everybody, on behalf of
14 the NQF staff, we're delighted to have you here
15 at this our 2019/2020 measure applications
16 partnership coordinating committee in-person
17 meeting.

18 So just a few housekeeping items
19 before I hand it over to our CEO, Shantanu
20 Agrawal, to cover a couple of items. First up,
21 we're going to be using a voting platform that
22 I'm hoping many of you have familiarity with at

1 this point, it's called Poll Everywhere.

2 Has everybody had access to that at
3 this point? If not, please put your tent up like
4 so, and we'll have some NQF staff come by to help
5 you out and make sure that we have you ready to
6 vote, since that's what we're all here to do.

7 Next, meeting materials. We have all
8 of those available at public dot qualityforum dot
9 org. I think you're, we're all familiar with the
10 convention that we have in general. If you wish
11 to speak, not now of course because your tent
12 cards are up for a different reason. But just
13 place your tent card up in, as you have it. And
14 those on the web platform should raise your hand
15 using the chat comment box, or jump in when
16 possible.

17 One important item, when you came in,
18 you likely noted that there are restrooms near
19 the elevator doors, those are just right past the
20 reception desk. So when you need a break, that's
21 the direction that you go.

22 Couple of more items. One, please

1 mute your cellphones if you have not already.

2 And a couple of items to note related to quality
3 measures that were on the MUC list that have been
4 removed, MUC-110 and 112, emergency department
5 utilization and acute hospital utilization. Both
6 have been removed for consideration but will
7 remain on the list, so to speak.

8 And lastly, we do have these
9 microphones at your desk. If you wish to move
10 them closer to you, please use the base rather
11 than the neck. You will actually asphyxiate and
12 strangle to death the microphone. They actually
13 pull out pretty easily, so please be careful.

14 With that, I'll hand it over to
15 Shantanu to do some welcomes and provide some key
16 updates.

17 MR. AGRAWAL: Sure, Sam, thank you.
18 So I won't take much time, I just want to thank
19 you all for being here and welcome you to our new
20 space. I also want to thank Bruce and Chip for
21 their leadership, I know Bruce will be joining us
22 later today.

1 And actually, I think that's it.
2 We've got a really robust agenda. The various
3 work groups I think have had, even though the
4 volume of measures has been lower, frankly the
5 quality of the dialogue has been really
6 excellent. And I've enjoyed being part of the
7 whole cycle this year. And I think you'll have
8 some really robust discussion I'm looking forward
9 to. So again, thank you and we will get this
10 started.

11 CO-CHAIR KHAN: Okay, so I'm going to
12 just open up with our objectives. We're going to
13 finalize recommendations to HHS on measures for
14 use in federal programs. Oh.

15 MR. AGRAWAL: I committed a process
16 foul. I'm going to actually turn it over first
17 to Kathleen Giblin, and then Elisa Munthali will
18 also provide introductions from the NQF.
19 Katherine.

20 PARTICIPANT: So you don't want me to
21 begin with the DOIs?

22 CO-CHAIR KHAN: Some meeting objectives

1 and DOIs.

2 MR. AGRAWAL: You do it, you do it.
3 Sorry, again, I screwed up the situation. Okay.

4 PARTICIPANT: Let's do the DOIs.

5 MS. GIBLIN: Do those first. Okay,
6 very good. Okay, thanks, everyone.

7 I'm Katherine Giblin, Senior Vice
8 President for Quality Innovation. And to get us
9 started with the DOIs, first off, we're going to
10 combine the disclosures with introductions. So
11 we'll dividing the disclosures of interest into
12 two parts, because we have two types of work
13 group members today, organizational and subject
14 matter experts.

15 So we'll begin with the organizational
16 members. Organizational members represent the
17 interests of a particular organization. We
18 expect you to come to the table representing
19 those interests. Because of your status as an
20 organizational representative, we've asked you
21 only one question specific to you as an
22 individual.

1 We ask that you disclose if you have
2 an interest of \$10,000 or more in an entity that
3 is related to the work of this committee. Please
4 tell us who you represent and if you have
5 anything to disclose.

6 And then let's just start. We'll go
7 around the table with the organizational members
8 only first, so that we'll begin to my left. I
9 think Misty from Humana is our first. If you
10 would begin, Misty.

11 MEMBER ROBERTS: Hi, I'm Misty Roberts
12 Associate Vice President Enterprise Clinical
13 Quality.

14 PARTICIPANT: Please use your
15 microphones. Thank you.

16 MEMBER ROBERTS: Hi, Misty Roberts,
17 Associate Vice President Enterprise Clinical
18 Quality at Humana.

19 And in terms of disclosure, from other
20 potential committees and measurement committees,
21 I do participate on a couple committees, the NCQA
22 Committee for Performance Measurements, as well

1 as Kentucky Health Collaborative Performance
2 Measures Alignment Committee, and the CQMC work
3 groups. But nothing from a financial perspective
4 to disclose.

5 MS. GIBLIN: Great, if we could just
6 keep going down the line there for the
7 organizational representatives.

8 MEMBER WOJCIK: Yes, I'm Steve Wojcik,
9 National Business Group on Health. I'm the Vice
10 President of Public Policy, and we have no known
11 financial disclosures, no financial disclosures.

12 MEMBER MORALES: Hi, I'm Esther
13 Morales, representing Healthcare Service
14 Corporation, and I have no financial disclosures.

15 MEMBER HOO: Emma Hoo, Pacific
16 Business Group on Health. Also no financial
17 disclosures.

18 MEMBER BAKER: David Baker, Joint
19 Commission, no disclosures.

20 MEMBER GIFFORD: David Gifford, I'm
21 the Chief Medical Officer and Senior VP for
22 Quality at American Healthcare Association. We

1 represent nursing homes. I have a lot of money
2 in a 401(k) retirement account, and I have no
3 idea what it's invested in.

4 We are measure stewards for ten post-
5 acute measures, none of whom are coming to the
6 committee today. And I'm an Advisor to CDC on
7 their NHSN measures in the post-acute space, none
8 of them related to the measures coming before us
9 today.

10 MEMBER PETERSON: Good morning, I'm
11 Cheryl Peterson, Vice President for Nursing
12 Programs at the American Nurses Association, and
13 we have no disclosures.

14 MEMBER FOSTER: Good morning, I'm
15 Nancy Foster, I'm the Vice President of Quality
16 and Patient Safety policy at the American
17 Hospital Association. I have no financial
18 disclosures.

19 MEMBER FERGUSON: I'm Scott Ferguson,
20 I'm a member of the Board of Trustees of the
21 American Medical Association, and also a board
22 member of PCPI.

1 MS. GIBLIN: Okay, and I believe we
2 have some folks on the phone. So if we could
3 begin perhaps with Chris Queram. Okay, how about
4 Libby Hoy? And if you're speaking, you're on
5 mute, just a click. Jeff Schiff? Okay, so.

6 PARTICIPANT: I don't think they can
7 hear us.

8 MEMBER BARTON: Mary Barton
9 representing the National Committee for Quality
10 Assurance. I'm Vice President of Performance
11 Measurements.

12 MS. GIBLIN: Okay, so we'll move on to
13 the individual subject matter experts. So I'll
14 thank you all for the organizational disclosures.
15 But now for the subject matter experts, because
16 subject matter experts sit as individuals, we ask
17 you to complete a much more detailed form
18 regarding your professional activities.

19 When you disclose, please do not
20 review your resume. Instead, we are interested
21 in your disclosure of activities that are related
22 to the subject matter of the work group's work.

1 We're especially interested in your disclosure of
2 grants, consulting, or speaking agreements, but
3 only if relevant to the work group's work.

4 Just a few reminders before we begin.
5 You sit on this group as an individual, you do
6 not represent the interests of your employer or
7 anyone who may have nominated you for this
8 committee.

9 I also want to mention that you are
10 not only, we're not only interested in your
11 disclosures of activities where you were paid.
12 You may have participated as a volunteer on a
13 committee where the work is relevant to the work
14 of the task force. So we are looking for you to
15 disclose those activities as well.

16 Finally, just because you disclosed
17 does not mean that you have a conflict of
18 interest. We do oral disclosures in the spirit
19 of openness and transparency, so please tell us
20 your name, who you're with, and if you have
21 anything to disclose.

22 If you're on the phone, I'll call your

1 name so that you may disclose as well. So we'll
2 begin, so why don't we begin down this way. I
3 think we have Harold.

4 MEMBER PINCUS: So I'm Harold Pincus,
5 I'm at Columbia University, where I'm Vice Chair
6 of Psychiatry and Co-Director of the Irving
7 Institute for Clinical and Translational Science.

8 So I have several disclosures, I
9 guess. One is I'm on the Behavioral Health
10 Measurement Advisory Panel for NCQA. I'm an
11 adjunct staff member at the Rand Corporation.
12 I've been a consultant for Mathematica, and I'm
13 on the clinical advisory Board for Bind Health
14 Plan and AbleTo.

15 And I have grants from NIH and from a
16 member of different foundations that are not
17 specific to this work.

18 MS. GIBLIN: Great, thank you. So I
19 guess we'll, so Ron.

20 MEMBER WALTERS: I'm Ron Walters, I'm
21 a medical oncologist at MD Anderson. Somehow
22 I've managed to get through a 41-year career with

1 no grants, no significant money crossing my
2 hands. I think my Sunshine Act consistently has
3 about \$18 on it that I don't know where that came
4 from.

5 The, I serve as the Chair of the
6 National Comprehensive Cancer Network Board.
7 They are not a measure developer yet. I also am
8 on the board of the TMF QIN-QIO, which is not a
9 measure developer, they're an implementation arm
10 for six states.

11 And I founded the ADCC, the Exec
12 Cancer Center Quality Committee. They have
13 developed a measure. All I did was come up with
14 the idea of how great it'd be to have a
15 readmission measure that was cancer-specific. I
16 don't have any other conflicts.

17 MS. GIBLIN: Great, thank you.

18 PARTICIPANT: I guess the people on
19 the phone are not being heard, are we?

20 PARTICIPANT: They're working on it.

21 MS. GIBLIN: So we'll finish up then.
22 So we have Chip, you would be next. And then

1 we'll move to the rest of the organizations.

2 CO-CHAIR KHAN: So I, as an individual
3 member then.

4 MS. GIBLIN: Right, as a subject
5 member.

6 CO-CHAIR KHAN: Yeah, as a subject
7 matter member, I don't have anything to disclose
8 I think that's relevant.

9 MS. GIBLIN: Great.

10 CO-CHAIR KHAN: Other than my day job.

11 MS. GIBLIN: Thank you. Okay, so we
12 had some folks join us. So Leah, if you could.

13 MEMBER BINDER: Good morning, nothing
14 to disclose, if that's the question.

15 MS. GIBLIN: Okay, and Rebecca.

16 PARTICIPANT: I'm sorry, Kathleen, but
17 could we have Leah introduce herself.

18 MS. GIBLIN: Yes, sorry.

19 PARTICIPANT: I have the pleasure but
20 not everyone does.

21 MEMBER BINDER: Thank you. I'm Leah
22 Binder from the Leapfrog Group.

1 MS. GIBLIN: And Rebecca.

2 MEMBER KIRCH: Good morning, I'm
3 Rebecca Kirch for the National Patient Advocate
4 Foundation.

5 MS. GIBLIN: So we have the need for
6 some folks on the phone, so as soon as they're
7 available, we can have that.

8 CO-CHAIR KHAN: Since that's not,
9 we're going to proceed, and wait and then we'll
10 just add them, deal with the when we're back in
11 operation.

12 MS. GIBLIN: Yes.

13 CO-CHAIR KHAN: So now we'll review
14 the objectives for today, if that's correct.
15 Finalize, we have to finalize the recommendations
16 to HHS on measures for use, federal programs for
17 the clinician, hospital, and post-acute longterm
18 care settings, consider strategic issues that
19 span across the MAP work groups, and discuss
20 potential improvements to the pre-rulemaking
21 process.

22 And it's always a little difficult for

1 me, and I hope we get warm during the day,
2 because it's a one time a year thing. But I
3 better get warmed up, because this is the only
4 day we have this year. So all eyes are on the
5 Chair, I'm sure, so I'll be very careful to keep
6 us moving.

7 So keeping us moving, next we have
8 Michelle Schreiber with, we'll hear from CMS.
9 She is the QMVG Director from CMS, and the
10 coordinating committee particularly in recent
11 years has had a wonderful working relationship
12 with CMS in terms of our consideration of
13 measures for recommendation to them.

14 And we look forward to Michelle's
15 comments and remarks. And then when she
16 finishes, if there are questions for her
17 representing CMS, she will be happy to entertain
18 them, and I will moderate. Michelle.

19 MEMBER SCHREIBER: Wonderful. Well,
20 first of all, thank you and good morning. I
21 wasn't introduced in part of the introductions,
22 but just formally, I have nothing to disclose.

1 MS. GIBLIN: Yes, thank you.

2 MEMBER SCHREIBER: And I am the
3 representative from CMS today. Sort of abandoned
4 by my two colleagues here.

5 So they should be here later. Reena
6 Duseja, I will introduce them now, is the Chief
7 Medical Officer and Tamyra Garcia is the deputy.

8 So just to clarify my role at CMS and
9 how we are here and how this very important
10 committee works with us, I am the Director of
11 QMVG, which is the Quality Measures and Value-
12 Based Incentive Group. That is one of six groups
13 as part of CCSQ, the Center for Clinical
14 Standards and Quality, led by Kate Goodrich.

15 We do a great deal of the measure
16 development, but clearly we don't develop all
17 measures. There are many other measure
18 developers and stewards. But we also develop and
19 write the regulation for many of those value-
20 based programs that you all know and love,
21 Hospital Stars, for example; MACRA; meaningful
22 use/promoting interoperability for post-acute

1 care standards.

2 Not all of them, but a large majority
3 of those, it is. But there are other value-based
4 programs obviously within CMS, not only the CMMI
5 innovation programs, but Medicare shared savings,
6 the Stars Program for MA. So those are sort of
7 separate within CMS, just to kind of clarify that
8 for people, because sometimes people wonder where
9 everything sits.

10 But QMVGIG houses the vast majority of
11 this in terms of measures development and in
12 terms of the value-based programs.

13 Our partnership with both NQF and this
14 committee in particular is extraordinarily
15 important. So as you know, every year, the first
16 thing that happens is starting now, but early in
17 the year we open up our sort of line, so to
18 speak, it's Gira (phonetic), but we open up for
19 measures under consideration. And anybody can
20 submit measures to CMS, and we are happy to
21 consider them.

22 From that, we narrow down a list of

1 measures that we really think might be important
2 in the value-based programs, and we bring those
3 then to the measures application team. And as
4 you know, in December we have meetings with,
5 separately with the hospitals, with clinicians,
6 and with post-acute care, and the result of all
7 of those comes to you in a summary, which you
8 will be voting on final recommendations to HHS
9 today.

10 I do want to clarify that we take your
11 consideration and your consensus statements very
12 seriously. And the feedback really from these
13 committees has been important, and has indeed
14 changed the direction of policy, and it's changed
15 measures, actually, as you will see today.

16 And a very good examples, since Dr.
17 Pincus is sitting very close to me, was the cost
18 measure last year for behavioral health that was
19 opposed and actually was not then put forward in
20 the rule. So you should know that was your
21 impact quite honestly and the impact of the
22 committee. So we really do take this to heart.

1 That all being said, you probably know
2 what I'm going to say next, and that's this is an
3 advisory statement to HHS, and CMS does have the
4 final say. That does not, however, mean this is
5 not significantly important to all of us.

6 You know, you've seen the trend of
7 fewer and fewer measures, and I'm going to talk
8 about that in a moment with meaningful measures.
9 And so the list is relatively shorter. We had,
10 because of that, an opportunity to really have
11 some more robust discussions about where there
12 may be gaps in measure areas or some of the
13 programmatic implications.

14 And I am happy to talk about those and
15 to entertain questions in the hour that I've been
16 given, because I certainly don't have slides for
17 that. And I hope that this time that we have
18 this morning can be more of an interactive
19 conversation back and forth, hearing what your
20 thoughts and concerns are so that we can be
21 carrying those back to CMS and again, listening
22 to those important stakeholder concerns.

1 There's been a lot of work in this
2 past year. So many of you know last year I had
3 just started when I arrived here. I have now
4 survived a year at CMS, I'm very pleased by that.

5 Wish you all a happy new year. It has
6 been an absolute joy and privilege to work with
7 many of you and your organizations, actually, in
8 the various programs and the measures that we
9 deal with. And so my thanks really to each and
10 every one of you and to your organizations.

11 I want to spend -- I'll get to
12 Meaningful Measures 2.0 in a moment, but I just
13 want to refresh your memory that in this past
14 year, we've actually had a lot of developments,
15 and we look forward to engaging all of you around
16 those developments as well.

17 One, as many of you are intimately
18 familiar with, is the update to the Hospital
19 Stars Program. The updates for this year should
20 be out shortly. But also, following on the heels
21 of that, sometime in the spring, and I certainly
22 don't have a final date on this, will however be

1 the IPPS proposed rules that come out and detail
2 exactly CMS's recommendations for modifications
3 to the Stars Program.

4 And I will say they will be
5 significant, they will not surprise any of you.
6 These are things that have been talked about over
7 and over again, and we've had significant
8 stakeholder engagement, including a meeting led
9 by NQF, actually, on Stars. And that weighed
10 heavily into our decision making. So again, I
11 thank you for your input on that, and hopefully
12 you will see the fruits or not of that when you
13 see the rulemaking in the spring.

14 I offered at the other MAP meetings
15 and will offer to you as well that if you're
16 interested through NQF after the rule proposal
17 comes out, we're happy to work with NQF and
18 convene another committee if there is interest in
19 doing that and you wanted to provide further
20 input. And obviously I know that many of you
21 will be providing input as well.

22 The other thing that we've been

1 working on is some updates and modifications with
2 transforming MIPS. We released this year the
3 proposal for shifting MIPS to MIPS value
4 pathways, which are meant to answer the question
5 of how confusing this is and how many measures
6 people are reporting, to really developing a
7 coherent set of related measures that sit
8 together as a bundle.

9 So that it's easier for a physician to
10 say, for example, I am a primary care physician,
11 here is my primary care bundle. And it become
12 laid out much easier. They are related, they are
13 important to specialties.

14 What's particularly exciting about
15 this is how we have engaged the specialty
16 societies, because we are looking to co-produce
17 these MIPS value pathways with the specialty
18 societies.

19 And we've actually already engaged a
20 number of them, in particular the American
21 College of Surgeons, the American College of
22 Physicians, and several others, Ophthalmology,

1 American, the College of Thoracic Surgeons.

2 So there are several who are kind of
3 willing to be early adopters and partner with us.
4 So we are actually looking forward to this. We
5 don't have the final answers, but we are
6 certainly exploring this and very committed to
7 producing these along with the specialty
8 societies, because who knows better what's
9 important for them than they do. So that will be
10 very exciting.

11 Ron's sitting right in front of me.
12 Oncology actually is another that we've reached
13 out to, and they have had some tremendous ideas,
14 as a matter of fact. So if you've been involved
15 in those, they've really done some great work.

16 Pardon? Indirectly? They've really
17 done some great work and some wonderful ideas, so
18 thank you for that.

19 And I also want to put a little plug
20 in for the CMS Quality Conference, which is at
21 the end of February. So if any of you have
22 interest in hearing more details, it tends to be

1 a little bit technical sometimes about our
2 programs, but just recognize that on your
3 calendar. And of course, I will put a plug in
4 for NQF's Quality Conference that is in March.

5 Again, in thanks, I would like to
6 thank not only all of you, but Chip for being a
7 chair, a co-chair of this committee. It's hard
8 work, and thank you for that. And to NQF,
9 obviously your expertise is always very welcome.
10 Welcome to your new space, we're excited to see
11 microphones. But this is actually wonderful and
12 a good move forward, so thank you.

13 Do we have the slides that were in the
14 pack? Can we start displaying them, please? Oh,
15 I'm sorry, I'm looking there. Are we like --
16 okay, thank you. I'll have to be sure to pay
17 attention over there and not to the ones that are
18 right in front of me.

19 So I want to talk just a little bit
20 about Meaningful Measures and Meaningful Measures
21 2.0, which is really what is in development. I
22 don't have specific slides on Meaningful Measures

1 2.0, because frankly we haven't even come to
2 consensus yet, and there aren't slides that have
3 gone through clearance.

4 But I will walk through some of the
5 key concepts, so that hopefully you'll see some
6 of the directionality of what we're thinking.
7 And I really, sincerely welcome comments.

8 As you know, CMS's primary goal in the
9 patients over paperwork is to make sure that we
10 are reducing burden, that we are committed to not
11 only patient-centered care, and certainly
12 improving beneficiary outcomes, but we're also
13 interested in reducing burden for clinicians.
14 And we have been working very hard, actually, to
15 that end.

16 We have reduced the number of
17 measures, as many of you have seen. You see that
18 in the reduced number of measures that are coming
19 before you as the MAP Coordinating Committee. In
20 the past we used to bring 100 measures at a time,
21 and it would be days of going through them. And
22 we have relatively limited numbers. It fits on

1 one page, as a matter of fact. And I think that
2 will likely be a continuing trend.

3 In the IQR program for hospitals, for
4 example, we've reduced the number of measures in
5 that program by 60%, and we've reduced the number
6 of MIPS measures by almost 25%. And we did that
7 by de-duplication, by looking at topped out
8 measures and eliminating them, and looking at
9 those measures that really had some overlap and
10 trying to pick the one that was most effective.

11 So I hope that you are really seeing
12 the sincere commitment to reducing measures and
13 having the right measures in place. Next slide.
14 I'm sorry, I don't control the slides.

15 Just a reminder, many of you have
16 probably seen this slide, this is the CMS
17 overarching strategic priorities. A little bit
18 hard to read, but you should have them in
19 advance. Most importantly, patients are at the
20 center of everything that we do. And the key
21 strategies are really focusing on results,
22 empowering patients, and unleashing innovation.

1 And in this, of course, quality and
2 safety remains paramount. The Administrator
3 always emphasizes that we have to maintain and
4 improve and continue to improve quality and
5 safety at the same time we're bending the cost
6 curve to promote affordability for patients and
7 certainly, reducing the span that we all see in
8 healthcare. Next slide.

9 So the original Meaningful Measures
10 Initiative, if you recall, because you all heard
11 it, was launched in 2017. And its goal was of
12 course to improve outcomes for patients, to
13 reduce the data burden, and to focus on CMS's
14 sort of quality measurement and improvement to
15 choose those domains that were most important.

16 And then within those domains, those
17 measure areas that were most important, so that
18 we can strategically focus on those. Next slide.

19 In addition to that, it had some
20 cross-cutting themes, which included addressing
21 high impact areas, making sure that measures were
22 patient-centered and outcomes-based, as opposed

1 to process-based. Although I will continue to
2 say there are important process measures as well.

3 Fulfilling, obviously, the program
4 statutes, minimizing burden, we've spoken of
5 that. Identifying significant areas for
6 opportunity, in other words, making sure that
7 there's variation and we're not just topped out
8 in measures. Addressing measures for a
9 population basis, and aligning with programs and
10 other payers.

11 I want to spend a moment on the
12 aligning part, because there's been a
13 considerable amount of work here, and I know that
14 there are members in this room who are
15 participating in the CQMC, which is a
16 collaborative of CMS AHIP, America's Health
17 Insurance Plans, thank you very much. And NQF,
18 thank you very much for being the convener of
19 this.

20 To really try to unite on a set of
21 core measures that will be used by all payers so
22 that we can be aligned around a single set of

1 core measures. And we've had some progress,
2 although I have to say it's slow, bringing
3 everybody to consensus is sometimes interesting.

4 But we have had committees doing work,
5 and I'm going to forget some of them, so you guys
6 can help me. HIV/Hepatitis C, gastroenterology,
7 cancer oncology, orthopedic surgery, primary
8 care. I know I'm forgetting two, so you can look
9 up the two that I'm forgetting. Cancer I think
10 is one of them, and then there's -- which one?

11 PARTICIPANT: Neurology.

12 MEMBER SCHREIBER: Neurology, okay, so
13 we got all of them. And this year we're actually
14 pleased to announce that we are adding behavioral
15 health and, wait, OB/GYN was one of them. So
16 what's the other new one? So we've got them all,
17 okay. And endocrinology is the new one, right,
18 okay. So mental health and basically diabetic
19 care, but it's endocrine.

20 So slowly we are adding important
21 topic areas and generating this consensus of what
22 are the important quality measures. And for the

1 most part, the group is landing on about five to
2 six measures per group, which really provides
3 then an important parsimonious -- I hate that
4 word, but still -- parsimonious list of measures
5 per sort of specialty that we can all as all
6 payers agree on.

7 And I think that would be a huge and
8 welcome step forward. So I'm very excited about
9 that work. Next slide.

10 The current Meaningful Measures
11 framework, and many of you have seen this slide
12 before, I know because I showed it last year,
13 really is these domains of care, including
14 effective communication, prevention and treatment
15 of chronic disease, working with communities to
16 promote best practices of healthy living, making
17 care affordable, making care safer, ensuring that
18 we're strengthening the patient and the family
19 engagement as partners in their care.

20 And under those you can see the 19
21 specific areas. And this has worked well so far.
22 We have used this actually in looking at measures

1 evaluation, for example, measures that come on
2 Gira and are being candidates for the MUC list.
3 We look and see how they align with the
4 Meaningful Measures framework.

5 We look at the measures already in our
6 programs to see how they align with the
7 Meaningful Measures framework, that's one of the
8 elements that we use in determining whether or
9 not measures should go forward. But we're
10 looking at refining this framework to really
11 focus particularly on driving value.

12 So with that, and here's where I don't
13 have slides, but I'm just going to talk a bit,
14 the domain areas, which are those six that we're
15 looking at, we are thinking of, and I say
16 thinking of because this is truly under
17 discussion and consideration, there is nothing
18 that's even wet concrete at this point.

19 But the domain areas that we're
20 thinking of are very similar to these, but we've
21 added a few. And I would love feedback on
22 whether or not you think directionally we're

1 going in the right direction.

2 So the first domain remains patient
3 safety, doing no harm. The second domain is, I'm
4 calling it patient voice, but that's really
5 patient engagement and making sure that patients
6 are partners in their care.

7 The third domain is cost and
8 affordability, which clearly remains there. The
9 fourth is chronic care management and
10 coordination. So we actually put coordination in
11 with chronic disease management.

12 The fifth is somewhat new, although
13 you've seen it there. It's seamless
14 communication through interoperability. So
15 you're going to start seeing this theme of really
16 aggressively promoting not only interoperability,
17 but electronic quality measures, which I'll get
18 to in a moment.

19 The next is prevention and wellness.
20 And the two new ones that we have added, one is
21 mental health, to make sure that it has a
22 separate domain, recognizing how important it is

1 to overall quality and outcomes of care.

2 And the last one, which actually was
3 an idea that was based on comments from the
4 earlier MAP meetings in December, is employee
5 engagement. Because I don't think you can have
6 quality programs if we don't have staff that
7 aren't burned out and that have reasonable staff
8 ratios or work-life, or work-life balance. And
9 so it's really an attempt to focus on that.

10 So those are the eight areas. Now,
11 one that we are sort of trying to strategically
12 place is the concept of equity. So is equity one
13 of these domains, or is equity the lens through
14 which you look at measures, making sure that
15 measures are in their outcomes being looked at
16 from either race, ethnicity, language, or
17 whatever you want to use for equity and social
18 determinance.

19 But to make sure that care is
20 equitable. So I don't know and I certainly
21 welcome comments on that.

22 So that's what we're really looking

1 forward to is in terms of these domains. In
2 terms of measures, over time sort of what's the
3 role of government in measures. And there are
4 some people who will say you've got way too many
5 measures. There are other people who say you
6 don't have enough measures, there should be lots
7 of measures.

8 And really, there isn't a consensus on
9 this. But what's the role of government? Is it
10 the role of government to have a thousand
11 measures, or is it the role of government to have
12 a list of fewer measures? And many people would
13 say possibly fewer.

14 So should we then be working more
15 towards measures that are of those domains that I
16 talked about? And I'll take patient safety for
17 example. So could a sort of encompassing measure
18 for patient safety be a national serious safety
19 event, right? Or could it be something else?
20 You can think of other broad, like a single,
21 broad encompassing measure or several of them.

22 And you can think of the key

1 components that that would be, sort of a roll-up
2 of healthcare-acquired infections, a roll-up of
3 complications. A roll-up of electronic medical
4 record safety, for example. A roll-up of
5 diagnostic accuracy. So you could think of what
6 are those key components to that domain and sort
7 of have branch logic to the measures.

8 What we've been developing for many
9 years are the measures that are sort of at the
10 end of that branch logic, you know, if you keep
11 going. So if you have a composite infection,
12 then as part of the composite you have CLABSI,
13 CAUTI, so forth and so on. And then if you think
14 of CLABSI, it's what are line days and are you
15 compliant with insertion protocols, and so forth
16 and so on.

17 So you can think of all of those
18 branch points, and a lot of our measures have
19 been sort of at the distal end of those branch
20 points. Should we be sort of thinking of broader
21 outcomes where clearly you're going to have to
22 understand those branch points if you're a

1 system. You have to know that you've got to be
2 compliant with line insertion that tracks your
3 CLABSI rates and goes back.

4 But should our measures for outcomes
5 be earlier on in that cascade? So that's just a
6 thought process that we're considering. I am not
7 telling you that this is anything baked in stone,
8 I'm just sharing with you some conversations.

9 So there are some operational
10 strategies behind Meaningful Measures 2.0 that
11 I'd also like to share. The first is this
12 question of sort of cascading measures. Another
13 way to put that that most all of us have dealt
14 with at some point in time is big dot versus
15 little dot, and which one do you focus on, and
16 which ones do you measure, and which ones go into
17 a value-based program, for example.

18 So if you really want to avoid the
19 thousand measures, which are at the end of the
20 branch points, you have to move it up. So that's
21 one, is focusing on outcomes that really will
22 move value.

1 And the ones that we outlined we think
2 are the ones that will help drive value. And
3 will also sort of help connect the dots for
4 providers and organizations to understand what
5 really is important and what it takes to be
6 performing well in those areas. So that's one.

7 A second operational strategy that I
8 want to talk about that's very important, and
9 frankly we've been doing a tremendous amount of
10 work on this, is how do we eventually get to
11 fully or near fully as best as we can digital
12 measures.

13 And I specifically say digital
14 measures as opposed to just electronic quality
15 measures because the traditional eCQM, for
16 example, by definition, are those that have their
17 data source coming out of the electronic medical
18 record.

19 There are other digital sources, for
20 example, census, okay, death rolls, social, not
21 social security numbers, but social determinants
22 that may come from other places. So you can

1 imagine there are other digital ways of getting
2 information. So digital quality measures with
3 eQMs really almost being a subset of that. But
4 you're getting the idea of really moving towards
5 electronic measures.

6 There's a small group of us, and NCQA
7 is here, they're in the room, and they've been
8 partners with us. We've also had ONC, some of
9 other people who are sort of near and dear to
10 this conversation working on what might that look
11 like and what might a blueprint look like that
12 accelerates that path.

13 And when might be a reasonable time to
14 sort of put a stake in the ground and say, CMS
15 for example is only going to accept digital
16 measures. Or we're going to move to this point
17 in the future where we envision that most of our
18 measures will be digital.

19 We recognize that it will be hard for
20 some places really to implement that fully.
21 There were organizations and parts of the
22 continuum of care that didn't get meaningful use

1 dollars, for example, post-acute care space, in-
2 patient psychiatry, for example.

3 And we recognize that there -- we
4 can't move too fast because we can't leave people
5 behind. But nonetheless, I think you're getting
6 the gist of the movement towards digital
7 measures.

8 And the reason for this is not just
9 because we've all spent billions of dollars on
10 electronic medical records, which we have. But
11 what is kind of that visionary end state of why
12 we did it. And it's to move data seamlessly with
13 interoperability, full interoperability, so that
14 there's information at the point of when it's
15 needed by whom it's needed, and that includes the
16 patients. It includes the providers, it includes
17 the payers, okay.

18 And also, when it's electronic, it
19 gives the opportunity for rapid cycle feedback
20 loops, as opposed to my quality data is three
21 years old and I've blown past that already. You
22 can only have rapid cycle feedback loops if

1 they're electronic. And it also provides the
2 opportunity for what I'm going to call big data
3 analytics.

4 So define that however you will, but
5 you all understand the outcome, that when you
6 have big data like that, you can do things like
7 looking at outliers, you can do things like
8 predictions. But you can only do that when it's
9 electronic, and that's why CMS likely will be
10 putting a stake in the ground, and you will be
11 hearing more and more about this, about the
12 transformation to digital measures. So that's
13 strategy number two.

14 Strategy number three that we think is
15 very important is unleashing the voice of the
16 patient. We think that if we really are
17 dedicated to hearing from our patients, from
18 unleashing their voice, from truly focusing on
19 patient-reported outcomes in a meaningful way, be
20 that the health outcome survey or the promise
21 tool, or other things that are developed around
22 patient-reported outcomes.

1 Think about how that would change the
2 quality measurement space when we're hearing from
3 the patient how they're doing, when we're hearing
4 from the patient what is important to them. And
5 so that is another sort of operational strategy
6 that is under discussion.

7 The other operational strategies,
8 you've heard a little bit about alignment.
9 Obviously we talked about that earlier. You've
10 all seen the commitment to transparency. Some
11 happy with it in some cases, some not. But
12 insuring that whatever we do is fully
13 transparent.

14 Some things that I will share with you
15 is there will likely be some important updates to
16 the compare sites coming later this year that
17 will be much more user-friendly. And we're very
18 excited about that going forward.

19 And finally, the concept of using all
20 payer data. Many of the measures are built right
21 now on Medicare fee-for-service data. Medicare
22 fee-for-service numbers are declining. As a

1 matter of fact, there are some states where
2 Medicare fee-for-service is actually a minority
3 of the payer. And so we can't have our measures
4 continue to be built just with Medicare fee-for-
5 service data.

6 So how do we make that transition? We
7 can't quite honestly force the private payers to
8 join, but across even CMS, you have Medicare fee-
9 for-service data, you have marketplace data, you
10 have Medicaid data, you have MA data.

11 We have lots of data, even within CMS,
12 so how can we even pivot towards using more
13 robust data, which then gives you much more
14 robust, valid, and reliable information, as
15 opposed to just a slice of the population.

16 So those are some of the operational
17 thoughts behind Meaningful Measures 2.0. And I
18 will pretty much rest there. Let me just go
19 through the rest of the slides and make sure I
20 covered everything. The next slide, Meaningful
21 Measures area we've talked about already. The
22 next slide. The future I have talked about, but

1 next slide. I think I've covered most of this.

2 I do want to point out that some very
3 specific areas that CMS is focus on, and I'm sure
4 you've sort of seen these themes coming through.
5 We've talked about patient-reported outcomes,
6 electronic quality measures. But obviously, high
7 on our priority list are opioids and the
8 avoidance of harm from substance abuse.

9 Nursing home infections and nursing
10 home safety. Maternal mortality, you will hear
11 more of that this year. Sepsis, and I would also
12 add to this ESRD. There's obviously the very big
13 kidney care initiatives and transplantation, as
14 well as cost. A continued focus on cost, because
15 in addition to quality, we have to bend the cost
16 curve. Next slide.

17 And the future of Meaningful Measures,
18 I've spoken to most of these already. Developing
19 the APIs to quality data submission. That kind
20 of goes along with this transformation to digital
21 or electronic quality measures and what's the
22 standard for developing those. In more and more,

1 FHIR appears to be the standard that will be
2 used, with the transmission done through FHIR-
3 based API.

4 And we have actually been piloting a
5 fairly substantial amount of work with this,
6 including the development and publication of
7 standardized data element libraries, the
8 publication of how to kind of build electronic
9 measures.

10 And we are now testing at least three
11 quality measures, and we do this sort of through
12 connect-a-thons where -- this is way above me
13 technologically, so please don't ask me questions
14 about connect-a-thon.

15 But where people come together and
16 they're actually testing the interfaces of these
17 to make sure that you can transmit data this way.
18 So we are well into doing a fair amount of this
19 work, hoping that we're paving the pathway
20 towards the future.

21 We have talked about harmonizing
22 measures already, including across registries.

1 So, many of you have seen within the MIPS program
2 some of the proposals around registries, ensuring
3 that we really have stronger data within
4 registries, and that they are harmonized, as
5 well. Timely, and actually we'll feed back to
6 providers, I talked about, and I talked about the
7 opportunities to use big data.

8 I think that may be the end of my
9 slides, is that correct? Yes. So with that, I
10 think we're scheduled till 10:15, but I will also
11 guess that nobody will mind if they have some
12 time back. But, Chip, I turn this back to you to
13 moderate any kind of discussion you would like
14 for the committee.

15 CO-CHAIR KHAN: Thank you, Michelle,
16 that was really, really helpful to get that
17 overview.

18 Questions or comments?

19 MR. STOLPE: Just can we pause for a
20 moment? Sort of a operational issue, you know,
21 we've had some trouble with people getting
22 through on the phone. Can we double check that

1 we are able to hear people on the phone, please?

2 CO-CHAIR KHAN: Could the people on
3 the phone speak up?

4 PARTICIPANT: Hello.

5 CO-CHAIR KHAN: Okay, good. Maybe
6 before we start then, go on a round of
7 introductions on the phone, and then also if you
8 could respond to the disclosure. Maybe we start
9 with Chris Queram and then other, Amir and others
10 speak up after that.

11 MEMBER QUERAM: Sure, hi Chip, good
12 morning, everyone. My name is Chris Queram, I
13 represent the Network for Regional Healthcare
14 Improvement. I'm on the coordinating committee,
15 and I have no disclosures.

16 MEMBER QASEEM: Good morning,
17 everyone, this is Amir Qaseem, American College
18 of Physicians. Sorry I couldn't be there in
19 person. And I was a little worried, I thought
20 that Michelle and Shantanu abandoned me from NQF
21 and CMS this morning.

22 CO-CHAIR KHAN: Others?

1 MEMBER HOY: Good morning, everybody,
2 this is Libby Hoy with PFCP Partners. We are a
3 patient- and family-driven organization. Happy
4 to be here today, I'm sorry that I couldn't be
5 there in person. I have no disclosures.

6 MEMBER SCHIFF: Hi, this is Jeff
7 Schiff, can you hear me?

8 CO-CHAIR KHAN: Yes, we can hear you.

9 MEMBER SCHIFF: This Jeff Schiff. I
10 am a consultant and former Medicaid Medical
11 Director in Minnesota. I have served as a
12 consultant with Mathematica on the Medicaid and
13 CHIP quality and ratings for health plans. And I
14 am the Co-Chair of the Opioid Technical Expert
15 Panel that just concluded with NQF on a national
16 set of opioid measures and priority gaps.

17 CO-CHAIR KHAN: Great.

18 MEMBER DESOTO: Hi, good morning,
19 everybody, I apologize, I missed doing my
20 disclosure. I am Mia DeSoto, I work at the
21 Agency for Healthcare Research and Quality at the
22 Center for Patient Safety and Quality

1 Improvement. I direct the AHRQ Quality
2 Indicators Program, and I have no disclosures.
3 Thank you.

4 CO-CHAIR KHAN: Okay, anyone else on
5 the phone?

6 MEMBER HEWITT: Hi, this is Nicole
7 Hewitt from CMS. I'm the core on the MIPS MCC
8 and ACO MCC measure.

9 CO-CHAIR KHAN: Thanks. Anybody else
10 on the phone?

11 MS. SCHWARTZ: Yes, Carol Schwartz at
12 the CMS. Thank you, no disclosure.

13 CO-CHAIR KHAN: Great, any others?
14 (Simultaneous speaking.)

15 PARTICIPANT: CMS.

16 MS. GIBLIN: I'm not catching these,
17 I'm from CMS. Could they repeat?

18 CO-CHAIR KHAN: Sorry, could our CMS
19 people repeat?

20 (CMS telephonic introductions.)

21 CO-CHAIR KHAN: Okay, have we gone
22 through everyone on the phone, either on CMS or

1 members of the coordinating committee? Great,
2 thank you so much. I think we need to do one
3 more disclosure, Rebecca.

4 PARTICIPANT: Rebecca introduced
5 herself.

6 CO-CHAIR KHAN: You need to respond to
7 the disclosure.

8 MEMBER KIRCH: Sure, Rebecca Kirch,
9 National Patient Advocate Foundation, no
10 disclosures.

11 CO-CHAIR KHAN: Okay, so now we'll go
12 back to the matter at hand, and I think Nancy
13 Foster was the first up with questions. Oh, I'm
14 sorry, Bruce. Disclose

15 CO-CHAIR HALL: My apologies,
16 everyone, for waltzing in late. Bruce Hall, I'm
17 the Vice President at BJC Healthcare in St.
18 Louis, an operating surgeon. I'm a consulting
19 director for the NFCIB for the American College
20 of Surgeons, which is a prior measure developer,
21 but has no business in front of the NQF here
22 today. I have no other disclosures, thank you.

1 MS. GIBLIN: Chip, I'm sorry, we have
2 one who joined us too.

3 MEMBER GARCIA: Good morning,
4 everyone. Good morning, everyone, my name is
5 Tamyra Garcia. I am here representing the
6 Centers for Medicare and Medicaid Services. And
7 I am the Deputy Director of the Quality
8 Measurement and Value-Based Incentives Group.
9 And I have no disclosures.

10 MS. GIBLIN: So we have one last
11 statement to make, and then we'll have the team
12 introduce themselves, and then we can go forward,
13 if that's okay.

14 CO-CHAIR KHAN: Okay.

15 MS. GIBLIN: Thank you. Just wanted
16 to take some time to remind folks that if you
17 believe that you might have a conflict of
18 interest at any time during the meeting,
19 obviously please speak up. You may do so in real
20 time at the meeting, you can approach your chair,
21 who will go to the NQF staff, or you can go
22 directly to the NQF staff.

1 If you believe that a fellow committee
2 member may have a conflict of interest or is
3 behaving in a biased manner, you may point this
4 out during the meeting, approach the chair, or go
5 directly to NQF staff.

6 If you have any questions or if you'd
7 like to discuss any of the disclosures made
8 today, please let us know. And if not, we'll
9 have the NQF staff do a quick introduction of
10 themselves and continue the meeting. Thank you
11 for your patience as we work through several
12 glitches this morning.

13 CO-CHAIR KHAN: Okay, so do we want to
14 start with staff?

15 MS. GIBLIN: Okay, so, I'd introduce
16 Katherine Giblin.

17 MS. MUNTHALI: Elisa Munthali, Senior
18 Vice President for Quality Measurement.

19 MR. AMIN: Taroon Amin, NQF
20 consultant.

21 MR. STOLPE: Sam Stolpe, Senior
22 Director.

1 MS. CLARK: Apryl Clark, Chief of
2 Staff.

3 MS. BUCHANAN: Kate Buchanan, Senior
4 Project Manager.

5 MS. CHOGAN: Ameerah Chogan, Project
6 Analyst.

7 MS. TAYLOR: Good morning, Maha
8 Taylor, Managing Director for our framework
9 projects.

10 CO-CHAIR KHAN: Now, have we concluded
11 --

12 PARTICIPANT: We are set.

13 CO-CHAIR KHAN: All the introductions.
14 Is there anyone in the universe who has given us
15 their name, serial number, and all their
16 conflicts of interest?

17 MEMBER MORALES: This is Esther
18 Morales from HCSC, I want to modify my previous
19 one, because I remembered that I do have some
20 stocks from United Healthcare that I bought in
21 the 80s that I've never touched again. So I just
22 want to modify my disclosures.

1 CO-CHAIR KHAN: We are extremely happy
2 that you did that. And we're happy for you.

3 (Laughter.)

4 CO-CHAIR KHAN: Because I know a
5 little bit about the value of United, and I'm
6 sure you've done well over time.

7 So let's --

8 MEMBER GOODMAN: I'm Liz Goodman with
9 AHIP.

10 CO-CHAIR KHAN: Oh, good, I'm sorry.
11 So now really we have everyone's stuff. Okay.
12 Now, let's go to Nancy for questions for Michelle
13 or comments.

14 MEMBER FOSTER: Thank you. And gosh,
15 I hope I remember what I was going to say.
16 Michelle, thank you for describing what's been
17 extremely exciting set of changes that are being
18 contemplated at CMS. I'm very interested to hear
19 more and to think more about what you can do.

20 Just a couple of quick comments. One,
21 I'm glad you further explained what you meant by
22 the interest in patient voice, patient

1 experience.

2 A number of our members, hospital
3 system members, think that getting patient-
4 reported outcome measures several months out from
5 hospitalization will be extraordinarily helpful
6 as they work diligently to try and better
7 coordinate care and ensure that patients return
8 to the life they wanted to when they undertook
9 their hospitalization. So that's exciting.

10 There probably are some folks we could
11 put you in touch with that are experimenting with
12 things that might be of use in that regard.

13 Love the fact that you've expanded
14 from just talking about EHR-generated measures to
15 talking about digital measures. There is a
16 wealth of information out there. And in part,
17 some of the information you alluded to, census
18 data and others, may help with the other you
19 raised around equity.

20 We, too, have struggled with the
21 question of whether equity is an issue unto
22 itself to be measured separately, or is it part

1 of the core of everything we should be doing.

2 We landed on keeping it as part of the
3 core, because it should be so central to
4 everything we think about when we're talking
5 about quality improvement, quality measurement.
6 And by doing so, it allows us to think critically
7 at each stage, what are the specific groups that
8 may be particularly disadvantaged by how care is
9 done or may have particular issues in getting
10 equal access or equal interventions.

11 And so just that piece of advice, and
12 thank you for presenting. Chip, back to you.

13 CO-CHAIR KHAN: Good. I think Cheryl
14 was next.

15 MEMBER PETERSON: Good morning, Cheryl
16 Peterson, American Nurses Association. Thank
17 you. I was particularly pleased at the
18 conversation going on in the, out of the two
19 domains of mental health and employee engagement.

20 I think that we are finding that
21 employees are also being harmed at work, and we
22 need to figure out how to take that into account.

1 So we would be very pleased to partner in any way
2 on that effort.

3 I would agree on the equity piece,
4 probably more of a lens or core to everything.
5 And agree on the patient voice and thinking about
6 how to bring that in. The Nursing Alliance for
7 Quality Care is looking at that same issue of how
8 do we look at beyond patient engagement but
9 actual voice. So thank you very much.

10 CO-CHAIR KHAN: Great. Okay, David.

11 MEMBER BAKER: Thanks, Michelle, that
12 was great. I wanted to build on some of the
13 comments about the equity. But I agree that most
14 of the issues around equity are cross-cutting; we
15 want to be thinking about this.

16 But there are still specific issues,
17 language barriers being one. Use of interpreters
18 is still extremely problematic. So there are
19 some specific issues that focus in on equity
20 issues that are not part of that overall picture
21 of cross-cutting work.

22 The other thing I'll just bring up

1 again is, you know, access to care is a major
2 problem. And so much of our work when we're
3 looking at measures because we're looking at
4 people who are actually able to get into the
5 healthcare system. And there's just a growing
6 number of problems, out-of-pocket costs are
7 increasing, so that's probably something else
8 that we should be thinking about.

9 CO-CHAIR KHAN: David.

10 MEMBER GIFFORD: I was very encouraged
11 by the discussion moving to digital-type
12 measures, I think. And as you're pushing for
13 care coordination RA, I guess I would just put a
14 plug in for CMS to start looking at how the rate
15 of the payment and regulatory and other sides as
16 well.

17 Because some are moving towards away
18 from digital into claims. And some are
19 developing their own measures separate from
20 payment issues, so you end up with multiple
21 measures. In our sector, we had three different
22 re-hospitalization measures. And so it would be

1 helpful to figure out how to align that better.

2 CO-CHAIR KHAN: Harold.

3 MEMBER QASEEM: Chip and Bruce, this
4 is Amir over the phone, at any point if you can -
5 -

6 CO-CHAIR KHAN: Yeah, I'm going to --

7 MEMBER QASEEM: People who want to
8 have coaching.

9 CO-CHAIR KHAN: Right. Jeff, and I
10 think Jeff's on, and Amir wanted. I'm going to
11 finish around the table here, and then come to
12 the phone. So just hold on for just a moment and
13 I'll be to the phone.

14 MEMBER PINCUS: I was going get
15 actually to David and Nancy's point that none of
16 those domains are really mutually exclusive.
17 They've overlapping all the way. And so I would
18 add sort of disparities in equity as of this, you
19 know, as a distinct domain, but recognizing that
20 none of them are mutually exclusive.

21 And, but I thought it was a terrific
22 overview. I think one of the issues, though, is

1 that, you know, and this gets communicated more
2 broadly, it's not always clear sort of the
3 rationale for the different changes that are made
4 from year to year, the priorities.

5 And it's really important to --
6 because the way in which you describe it, your
7 thinking behind how you did it is very important.
8 There are -- people just look at the overall
9 list, it, you know, it sort of passes them by.
10 So I think it's really important to have that
11 kind of backup to it.

12 CO-CHAIR KHAN: Leah.

13 MEMBER BINDER: Thank you. Michelle,
14 I just want to -- this is Leah. I want to convey
15 how appreciative we are of this vision for the
16 future of Meaningful Measures. I think it's
17 extremely exciting to hear about the direction.

18 I was very excited about patient-
19 reported outcomes and the move to address
20 maternal mortality. There's so much that you
21 just outlined that has such vision and such
22 boldness, and I just really commend the

1 administration for this.

2 I also, I just want to add one key
3 point about Meaningful Measures from our
4 perspective. The metric that I think that you
5 should be proud of yourselves as you move forward
6 with Meaningful Measures is not the number of
7 measures. And certainly parsimony, that's not
8 much of a vision.

9 The measures should be, the outcome
10 that we should be seeking is meaningful. Are we
11 actually spending our efforts collecting and
12 reporting measures to such an extent that they
13 actually move the dial, change things, improve
14 things. You are definitely outlining a vision
15 that will do that.

16 But the number of measures means
17 nothing in and of itself. If we collect only
18 five measures but they're not very meaningful
19 then the groups fails completely on Meaningful
20 Measures. I really urge you to focus on meaning.

21 And in terms of cascading measures,
22 which I think is a good idea, I would also urge,

1 and it's extremely important to us from a
2 purchaser perspective as well, that they cascade
3 to the patient first. Make sure that we still
4 have publicly report measures that patients and
5 other aligned payers can use at a granular level
6 to compare among providers on extremely important
7 measures.

8 So the example that you outlined of
9 like a global infection rate, that's a great idea
10 to put that together into strategic categories.
11 But then also preserving the public reporting by
12 facility of individual infections, such as
13 CLABSI, for example.

14 And then finally I just want to add
15 one little point that I think you may have
16 incorporated already, but is important to put on
17 the table.

18 Over 60 percent of all surgeries are
19 done either in an outpatient hospital unit or in
20 an ambulatory surgery center. It is extremely
21 important that we make sure that we get into
22 better measure quality in those settings. And I

1 just want to make sure that that is part of the
2 thinking as well.

3 CO-CHAIR KHAN: Michelle, do you have
4 any --

5 MEMBER SCHREIBER: Is there somebody
6 else?

7 CO-CHAIR KHAN: No, I'm going to, if
8 you have any comments on what Leah's --

9 MEMBER SCHREIBER: Oh, no, just to say
10 thank you, actually, for the comments.

11 CO-CHAIR KHAN: Okay, great. Misty.

12 MEMBER ROBERTS: Hi, Michelle, Misty
13 Roberts from Humana. First of all, thank you for
14 sharing your strategy, your vision. I think this
15 is very exciting. A couple things I want to
16 comment on.

17 First, love to talk to you offline
18 about using all payer data. That's something
19 that I think is important in terms of really
20 getting that robust, complete picture of quality.
21 So these are things that we've been thinking of.
22 I know it's not something that you think we've

1 been thinking of, but I would love to talk to you
2 offline more about that.

3 MEMBER SCHREIBER: Any time.

4 MEMBER ROBERTS: Second thing, the
5 digital measures I think is very important and
6 really thinking about it beyond, you know, just
7 the electronic health records. But I think it's
8 something that is probably still challenging.
9 And we would really like to understand how you
10 all are thinking about removing some of those
11 barriers and challenges, if you have thought that
12 far or if right now it's just kind of a vision.

13 MEMBER SCHREIBER: You know, I, you've
14 all seen some of the work that CMS is doing along
15 with ONC for interoperability and trying to pave
16 some of those paths. And we certainly are asked
17 over and over again are there new incentives,
18 what can you do to have people, you know, sort of
19 get on the bandwagon. And those are all things
20 that are under discussion.

21 But I think the biggest thing is
22 really trying to set a clear path, because right

1 now people are confused. Even to, you know, are
2 we doing FIRE standards or are we doing something
3 else. Are we doing QRDA1 or 3, or you know, I
4 think some people really would just like clarity
5 so that they can start building and get on board.

6 And I think that's part of the work to
7 this. The policy work in framing incentives is a
8 really broad question and with no answers right
9 now.

10 CO-CHAIR KHAN: Okay, Esther.

11 MEMBER MORALES: I just want to add on
12 to what Misty said. We've been working at HCSC
13 for years trying to increase interoperability, to
14 be able to use EMR systems, to be able to work
15 with the EMR systems.

16 We've worked in Oklahoma with their
17 health information exchange for the last four
18 years and we still can't use the data. So I just
19 want everybody to understand how complicated this
20 is to get this set up.

21 And the vision needs to include
22 realistic time frames, because we spent a huge

1 amount of resources to try to make this work, and
2 we've always been disappointed. So I just want
3 everybody to understand that reality.

4 CO-CHAIR KHAN: Let me go to Scott.

5 MEMBER FERGUSON: And I will pile on
6 and say I read the vision going forward and thank
7 you for the comments. Beforehand I'd mentioned,
8 so I just thought I'd mention before the group as
9 well, about alignment of payers on measures.

10 I've got family practice doctors that,
11 you know, you're supposed to report on six or ten
12 measures, and they'll have 80, 90, and 100
13 measures because different payers are not aligned
14 and not harmonized. And it is a great burden.

15 If we're going to truly put patients
16 over paperwork and reduce the burden, someone
17 with the clout needs to convene the payers to
18 make sure that we are all working on the same
19 measures. And I think they'll be more meaningful
20 as well.

21 The thing on interoperability,
22 everybody knows how important that is, and I

1 appreciate the thoughts going forward on digital
2 collection as well.

3 MEMBER DESOTO: Hi, thank you, Mia
4 DeSoto from AHRQ. I'd first of all like to thank
5 my CMS colleagues. I really like the vision that
6 you have presented. It has a lot of depth, and I
7 really appreciate and congratulate you on all the
8 hard work that you do. You really have a hard
9 job.

10 With that said, I also want us all to
11 collectively think about, I agree with Leah that
12 parsimony is not a word that I like either. We
13 need to understand that this is a multi-billion
14 dollar industry. It is going to take a lot of
15 work for us to strike that balance between what
16 is needed and what is wasteful and what we can
17 let go of.

18 So I just want us to keep that at the
19 back of our minds. It's a lot of work, and I
20 think collectively we can make a change.

21 CO-CHAIR KHAN: Great. Let me go to
22 the phone, I'll come back to you, David. But now

1 I think we have Jeff was first, then Libby, and
2 then Amir. Jeff.

3 MEMBER SCHIFF: Thanks. Hey, I just,
4 yeah, I think you can hear me, I have a little
5 bit of an echo.

6 CO-CHAIR KHAN: We can hear you fine.

7 MEMBER SCHIFF: I wanted to tie along
8 about the fact that this is a good vision. I
9 wanted to talk about a couple things here. One
10 is that we need to address the issue of cascading
11 measures and the fact that a lot of times, the
12 responsible party for the higher tier measure is
13 not the same as somebody who's responsible for a
14 measure at the end of the branch chain.

15 I have an echo so I'm talking slowly.
16 What I'd like to suggest to you is that we ask
17 responsible parties for the branch chain to still
18 keep track of the overall, overarching outcome.
19 For example, an opiate overdose outcome has many
20 parts underneath it, including prescribing and
21 retention and treatment.

22 And those people are not individually

1 responsible -- those people are not individually
2 responsible for the opioid overdose, but they
3 need to be responsible for their parts
4 underneath, and they should be aware of their
5 impact on the overall outcome. Otherwise what we
6 have is what we have now, which is a lot of
7 individual process measures.

8 I want to also suggest that the equity
9 component be infused everywhere, but suggest two
10 things. One is we have really very poor
11 standards or not adequate commonality of
12 standards around collection of data and what
13 measures are reported by race and ethnicity. We
14 need to up our game around that.

15 And then the last part of that is that
16 it would be really worthwhile to go to some of
17 our communities that are, have disparate outcomes
18 and ask them to be involved in measure selection
19 as well.

20 Last part, last comment is around
21 collection of data. I think that we need to move
22 forward with the collection of patient-reported

1 data through new mechanisms. And I'm thinking of
2 just the use of cell phones and other surveys and
3 other mechanisms that are much faster and can
4 give feedback much more quickly than some of our
5 more antiquated methods. Thanks.

6 MEMBER SCHREIBER: Thank you.

7 CO-CHAIR KHAN: Thanks. So Amir.

8 Going once. Amir, are you on mute?

9 MEMBER QASEEM: Yes, I'm sorry. Good
10 morning, everyone. Hi Michelle, wonderful
11 presentation. Couple things, you and me touched
12 major differences with things, the stakeholders
13 really appreciate all of your hard work.

14 Two things. One is performance
15 measures are the building blocks of all this
16 framework that you have presented. I love the
17 framework.

18 But my concern continues to be that
19 the inter performance measures variability
20 continue to exist. The standards for
21 performances measure was called into a
22 performance measure. The things that we have

1 been discussing for a while, that's why MAP is
2 there, to give measures thumbs up or down. That
3 is not still getting addressed, right?

4 So until we start fixing the building
5 blocks that go into the theoretical model, the
6 successful theoretical model will get, will be an
7 issue. And I don't know if CMS has been thinking
8 about it or what you guys have in mind. That's
9 one question.

10 And the second question I have with my
11 MAP hat on, I know we are an advisory body, and
12 this is something that came up in the past as
13 well, I absolutely expect that CMS will take
14 over. And you do take over comments under, when
15 you're selecting the measures.

16 I think what will be very helpful is
17 sort of a feedback loop, because for me a good
18 learning for MAP as well that at the end of the
19 meeting, let's say there are 20 measures and we
20 give 15 measures the thumbs up, or some of the
21 measures we say that here are the things that
22 need to change.

1 What happens? Because then I think
2 that feedback loop is still broken. Because I
3 don't know when I was at the meeting last year
4 and we gave, provided a lot of comments, I mean
5 it's a group of really smart people here, what
6 happens to those comments?

7 Did you guys adopt our comments? Did
8 the measures change in any way? And without that
9 feedback loop, the problem is that we will not be
10 able to learn, we meaning MAP, in terms of what
11 we are doing. Are we on the right track, are we
12 completely missing the mark. So two questions
13 here, Michelle.

14 MEMBER SCHREIBER: Chip, can I respond
15 to that one?

16 CO-CHAIR KHAN: Yes, please.

17 MEMBER SCHREIBER: Thanks. So Amir,
18 thank you as always for your comments. I'm not
19 going to address the first one now, and we've had
20 conversations. I will, however, say that we have
21 in beta testing what we're calling the, correct
22 me if I'm wrong, Quality Measure Index, where we

1 have a very clear set of parameters by which we
2 will be testing measures to test their
3 performance, are they good measures or not good
4 measures.

5 And we hope that it's actually pretty
6 standardized, very data-driven. And we'll
7 compare it against yours, Amir.

8 The second question, though, is
9 important, and thank you. So I tried to
10 highlight earlier as I was speaking some of the
11 changes, even from last year, of how we changed
12 our approach. For example, the cost measure on
13 behavioral health.

14 But what we can do, and actually I
15 apologize that we didn't do it this year, but we
16 will commit for next year, is we'll take the list
17 of measures, and we will bring it back next year,
18 maybe at the beginning of the meeting. We'll run
19 through what we did with them, if that would be
20 something that you're interested. So you guys --

21 CO-CHAIR KHAN: Well, I think that
22 would be really great.

1 MEMBER SCHREIBER: -- can hold us
2 accountable for that, okay?

3 CO-CHAIR KHAN: Yeah, that would be
4 really, really useful. It helps us one, in two
5 ways, it shows whether we have any impact.

6 MEMBER SCHREIBER: Right.

7 CO-CHAIR KHAN: But it also gives us
8 feedback on the process, to see how we've helped
9 or not helped.

10 MEMBER SCHREIBER: Happy to do that.

11 CO-CHAIR KHAN: Great. I think Libby.
12 Oh, I'm sorry.

13 MEMBER GIFFORD: It's on this very
14 point.

15 CO-CHAIR KHAN: Okay, David.

16 MEMBER GIFFORD: I believe we've asked
17 for this two years in a row, and we've not gotten
18 whether the measures that came out of this were
19 actually incorporated into regulations or not and
20 how they were modified or used based on our
21 feedback. So it would be very helpful to have it
22 next year. Because three strikes you're out.

1 CO-CHAIR KHAN: Let's look forward to
2 the future. And we appreciate it, Michelle, and
3 we hope that we can, we will have it next year.
4 Libby.

5 MEMBER HOY: Good morning, can you
6 hear me okay?

7 CO-CHAIR KHAN: Yes, perfectly.

8 MEMBER HOY: Great. Good morning,
9 Michelle, thank you so much for such a
10 comprehensive overview, it was really helpful.
11 I'm certainly very excited to hear, echo the
12 commitment to a person-centered approach. In our
13 organization's view, equity is a person-centered
14 approach.

15 So, like others have said, there is a
16 great deal of overlap between the domains. And
17 maybe just highlighting the ways that the domains
18 sort of relate to each other and integrate might
19 be useful.

20 The idea of equity being sort of
21 across domains is of course very important and
22 relevant, and I love hearing Nancy's organization

1 and how they're thinking about it. I would
2 caution, though, to keep that as a centerpiece of
3 the domain, rather than sort of absorbing it.
4 Because I just, I'm not quite sure that the
5 environment overall is ready for that. I think
6 they still kind of need to be front and center.

7 And then actually building on the last
8 comment and Jeff's comment, I would really
9 encourage that as we think about ways to measure
10 outcomes for people experiencing inequity of
11 care, that we really make space for that patient
12 voice to inform those measures as they get
13 developed, so that we're ensuring that we are
14 developing outcomes measures that are outcomes of
15 importance to those groups experiencing inequity.

16 Our organization is very focused on
17 this and making space and raising voices to be
18 part of codesign across healthcare activities and
19 look forward to partnering and supporting your
20 efforts in that way, so thank you very much.

21 CO-CHAIR KHAN: Thanks a lot.

22 Michelle, any other comments, or?

1 MEMBER SCHREIBER: No, I just want to
2 once again echo my thanks and appreciation for
3 all of these really wonderful comments. This is
4 something that is truly conceptual at this point,
5 so we were kind of pleased to share as you hear
6 our thoughts going forward, and this will help
7 shape them, so thank you very much.

8 CO-CHAIR KHAN: Great, thank you.
9 Anybody else on the phone? Anybody have any
10 other comments here?

11 Okay, great. So we'll move on now,
12 and I'm going to recognize Kate Buchanan to talk
13 about the pre-MAP pre-rulemaking approach.

14 MS. BUCHANAN: Thank you so much,
15 Chip, really appreciate it. So these are a
16 similar process that you all saw earlier this
17 fall, but we do want to reiterate it because
18 we're now getting to the practice. And review
19 some of the background information to what has
20 informed the materials to date.

21 So for our preliminary analyses, this
22 is conducted by staff.

1 PARTICIPANT: Excuse me, I'm sorry to,
2 can you just speak up a little bit? It's hard to
3 --

4 MS. BUCHANAN: Oh, my apologies. Is
5 this better? Great, thank you.

6 So the preliminary analysis is
7 intended to provide MAP members with a succinct
8 profile of each measure and serve as a starting
9 point for MAP discussions. This is utilized by
10 the MAP workers during their December in-person
11 meetings. And the algorithm with which the staff
12 used has been approved by the MAP Coordinating
13 Committee.

14 So if we go and look into the
15 algorithm, it has seven components. I'm not
16 going to go through each of the definitions, but
17 did want to highlight what each of these, each of
18 the components are. So first, that the measure
19 addresses a critical quality objective not
20 adequately addressed by the measures in the
21 program set.

22 Two, the measure is evidence-based and

1 either is strongly linked to outcomes or is an
2 outcome measure. Three, the measure addresses a
3 quality challenge. Four, the measure contributes
4 to efficient use of measurement resources, and/or
5 supports alignment of measurement across the
6 programs.

7 The fifth component is that the
8 measure can be feasibly reported. And on the
9 next slide we have the last two, which are that
10 the measure is applicable to and appropriately
11 specified for the program's intended care
12 settings, level of analysis and population.

13 And finally, if the measure is in
14 current use, no unreasonable implementation
15 issues that outweigh the benefits of the measure
16 have been identified.

17 So moving on, and I'm going to spend
18 some time on the MAP voting decision categories,
19 because I think that this is a really important
20 thing to have clarity on. So here, I apologize
21 for the small text, but here we have the four
22 different decision categories. They are the same

1 that were used last year.

2 But I want to go through and review
3 each of them, because I think that there's always
4 an opportunity to provide additional clarity. So
5 the first decision category is support for
6 rulemaking. And the definition of this is that
7 MAP supports implementation with the measure as
8 specified, and has not identified any conditions
9 that should be met prior to implementation.

10 So the evaluation is that the measure
11 is fully developed and tested in the setting
12 where it will be applied and meets the
13 assessments 1 through 6 of the algorithm. And
14 then also 7, which is no unintended consequences
15 that outweigh the benefits, which is assessment
16 7. So that is support for rulemaking.

17 The second voting category is
18 conditional support for rulemaking. The
19 definition of this is that MAP supports
20 implementation of the measure as specified, but
21 has identified certain conditions or
22 modifications that would ideally be addressed

1 prior to implementation.

2 And so if you look at here, it says
3 the measure meets assessments 1 through 3, and 1
4 through 3 are critical quality objective,
5 evidence-based, and addresses the quality
6 challenge. And that there may be some elements
7 of the other additional criteria that the
8 coordinating committee or work group would like
9 to abide by.

10 The third category is do not support
11 the rulemaking with potential for mitigation.
12 And when MAP selects this, it means that MAP does
13 not support implementation of the measure as
14 specified. However, MAP agrees with the
15 importance of the measure concept and has
16 suggested modifications required for potential
17 support in the future.

18 Such modification would be considered
19 to be material change to the measure. So any
20 modifications recommended under this category are
21 considered to be material changes.

22 (Music plays.)

1 MS. BUCHANAN: Oh, great, thank you so
2 much. Sorry, when people put us on hold, this
3 happens.

4 So what we define a material change is
5 any modification to the measure specifications
6 that significantly affects the measure result.
7 And so the difference between this do not support
8 for rulemaking potential for mitigation and
9 conditional support is under conditional support,
10 the MAP supports the implementation of the
11 measure as specified, but has some ideal changes.

12 For do not support for rulemaking with
13 potential for mitigation, the MAP does not
14 support the implementation of the measure as
15 specified and has some recommended material
16 changes.

17 The fourth category is do not support
18 rulemaking, and it just means that MAP does not
19 support this measure. It doesn't believe that
20 there are material changes that could be made
21 that would lead to a potential support in the
22 future.

1 Chip, I didn't know if you wanted to
2 take any questions on this, or if you wanted me
3 to move to the voting process, I don't know.

4 CO-CHAIR KHAN: Let's go through the
5 whole thing and then see if anybody has any
6 questions.

7 MS. BUCHANAN: Okay, thank you. So if
8 we move on to the key voting principles. So
9 quorum is defined as 66 percent of voting members
10 in the committee present in person or by phone
11 for the meeting to begin. Just wanted to update
12 everyone. We have 22 voting members on this
13 committee, 21 are in attendance, we needed 14 to
14 meet, or sorry, we needed 15 to meet our quorum
15 to begin. So we are good.

16 So one of the things is that once
17 quorum is established, we can move forward. But
18 if at any time during the meeting if a MAP member
19 believes that we've lost quorum, they can ask to
20 do a recount.

21 And so MAP has established consensus
22 threshold of greater than or equal to 60 percent

1 of voting participants voting positively, and a
2 minimum of 60 percent of the quorum figure voting
3 positively. And what we mean by that is we just
4 don't want to have so many abstentions that we
5 end up with too few people voting. But it's 60
6 percent greater than or equal to 60 percent of
7 voting participants voting positively.

8 Every measure under consideration will
9 receive a decision. And if we move on. So staff
10 will provide an overview of the process for
11 establishing consensus.

12 PARTICIPANT: Which has led at least

13 --

14 MS. BUCHANAN: Which we've done. And
15 then we will go through each program. So the
16 staff will provide opening comments, and then we
17 will have programmatic discussion, voting will
18 begin. Measures will be divided into the related
19 groups, so we'll be going through hospital,
20 clinician, PAC LTC.

21 Each matter for consideration has been
22 subject to a preliminary staff analysis as well

1 as a work group recommendation.

2 On the next slide we actually have a
3 breakdown of the step-by-step process. And so
4 the staff, the first step is that staff will
5 review the work group decision for each measure
6 under consideration. We are also lucky enough to
7 have some of the work group co-chairs be able to
8 join us via phone various times, so they will be
9 able to provide additional context for any
10 questions.

11 The co-chairs will ask clarifying
12 questions from the committee and compile the
13 committee questions. This is where we'll have an
14 opportunity for either members of the work group
15 co-chairs to provide clarification, or the
16 developers if they've been able to join either in
17 person or on the phone to provide any
18 clarification. And staff will respond to any
19 process questions.

20 So the first thing we do is we vote on
21 acceptance of the work group decision. And so
22 that's the, if a work group voted support for a

1 measure, we would vote on their decision. And if
2 we get greater than or equal to 60 percent on the
3 work group decision, then that becomes the
4 coordinating committee's decision.

5 If in an instance the coordinating
6 committee does not have agreement and -- on the
7 work group decision, it opens up for discussion.
8 So if we go on to the next slide. So everyone
9 should have received information on lead
10 discussants. So if the coordinating committee
11 does not vote on the work group recommendation,
12 then we open it up for discussion.

13 The lead discussants provide their
14 oversight. We also have petitional discussants.
15 Co-Chair will open it up for discussion. And you
16 know, because we are reviewing three programs
17 within one day, we want our committee members to
18 make their opinions known. But we want to also
19 be efficient. So not repeating points already
20 presented but saying that you are in agreement.

21 After discussion, the Co-Chair will
22 open them up for a vote. NQF staff will

1 summarize the major themes of the committee's
2 discussion, and the co-chairs will determine
3 which decision category will put to a vote based
4 on potential consensus emerging. If co-chairs do
5 not feel that there is a consensus position, then
6 they will begin from the top and go down. So
7 support, conditional, do not support, mitigation,
8 et cetera.

9 And then will we tally the votes. So
10 if a decision category put forward by the co-
11 chairs receives greater than or equal to 60
12 percent of the votes, the motion will pass and
13 the measure will receive that decision. If no
14 decision category achieves greater than 60
15 percent to overturn the work group decision, the
16 work group decision will stand.

17 And I'll turn it over to our co-chairs
18 to facilitate any questions.

19 CO-CHAIR KHAN: Thanks, Kate. So
20 we've really spent over at least my tenure and I
21 guess with Harold as co-chair and then now with
22 Bruce, a lot of time on these voting categories.

1 And I hope we're at a point at which they work
2 for everyone. I think we have gotten to that
3 point, but it's really been difficult over time,
4 but I think we're there.

5 Harold, do you have a question or
6 comment?

7 MEMBER PINCUS: Actually, I wasn't --
8 much more than what you just said. I think it's,
9 you know, there are subtle differences here, and
10 I think ultimately, you know, individual people's
11 conscience about how they put them into these
12 categories, especially between the two middle
13 categories, you know, the mitigation and the
14 conditional support.

15 And it's really a, it's sort of a
16 sense of, you know, the degree to which you have
17 some concern in the measure. And again, you
18 can't make it an absolute barrier between the
19 two. It's up the individual voter's perception.

20 CO-CHAIR KHAN: I think this is very
21 important. This is very important. I mean, the
22 moral equivalent I guess is the Senators at

1 impeachment, where each one is really deciding --

2 (Laughter.)

3 CO-CHAIR KHAN: What is the
4 definition, but I won't go on with that.

5 (Laughter.)

6 MEMBER GIFFORD: You know, I would
7 agree. I think that we've come a long way around
8 the criteria and the voting process. I still
9 think we struggle with the fact that we're not
10 the endorsing body for the measures. But that
11 when we have measures come before us that have
12 not been endorsed by NQF, it puts us in the
13 position about whether we're endorsing or not
14 issue.

15 I think the one thing I would suggest
16 that we figure out who is, a lot of the criteria
17 that were up there, the explanation, still
18 suggest that we're in the endorsing measurement
19 business, really not asking are the measure
20 specifications or endorsed already, is it
21 appropriate for rulemaking.

22 Because I think what we're really

1 asking is we're voting is is this measure
2 appropriate for a rulemaking in a specific area.
3 So even an endorsed measure may not be
4 appropriate for rulemaking.

5 Whereas, if it's not endorsed, to me
6 that's almost like a hurdle of why are we even
7 discussing it in the first place. To me it's
8 almost a criteria, it can't, if it's not endorsed
9 it can't even get approved by us? Because we've
10 moved and Congress has moved to really ask about
11 things.

12 Now, that, just because we don't
13 approve it and say it's not ready, that doesn't
14 mean CMS we're advisory. They can go ahead and
15 use it and they're under certain time frames that
16 they have to use that. But I don't think we
17 should be pushing that.

18 And I'd like to see, I don't think
19 it's new criteria, but I think in the assessment
20 of these it's really about, I'd like to see more
21 of our discussion move. Because I still, reading
22 all these discussions, we're still talking about

1 risk adjustment, we're relitigating the
2 endorsement process. And we're relitigating it
3 not in a way of is the measure appropriate.

4 You know, I could see, you know, an
5 endorsed measure that's used for primary care
6 that CMS wants to apply to ophthalmologists
7 that's endorsed that may not be appropriate for
8 rulemaking, but there's no exchanges in it.

9 If we don't like the risk adjustment
10 for primary care, they want to use it in MIPS and
11 primary care and it's already endorsed, I don't
12 see why we, there's no reason we should be
13 arguing against that, unless we think the risk
14 adjustment is fundamentally different for MIPS.
15 But clearly when it came through it was
16 evaluated.

17 And so I think, I'd like to see us
18 move away from that, continue to relitigate the
19 endorsement process, and move more towards
20 advising CMS on using the measures in rulemaking.

21 That also means that when they come to
22 us, it's not clear always what rule they want to.

1 It tells me what the program, exactly how it's
2 going to use. It's hard for that discussion.
3 And I'd like to see the committees coming to us
4 advising us not on all the advice about whether
5 the risk adjustment, you know, I'm just bored
6 reading about risk adjustment out there.

7 That's not our role, it never was our
8 charge. And so the question is we fall into that
9 trap by continuing to sort of ask for that and
10 CMS responding to it when we don't get any
11 information about how the measure is going to be
12 used in rulemaking and what that rule is. Within
13 the constraints that CMS is during rulemaking
14 they can't reveal certain things.

15 CO-CHAIR KHAN: Well, yeah, I mean,
16 this is inherent in a system in which we get the
17 information sort of in the stream of development
18 of the regulation. And we get it early. And I
19 guess the question is if we got it later, we
20 wouldn't have as much say as we have now.

21 So, but I think listening to the
22 points you're making, you really are close to the

1 senators sitting around deciding what the crime
2 is. As well as whether or not there was a crime.

3 Other, Bruce?

4 CO-CHAIR HALL: I didn't want to cut
5 that conversation short with David though is
6 that?

7 MEMBER BAKER: I'm finished with mine.

8 CO-CHAIR HALL: Okay, question 40,
9 that second bullet up there just reads a little
10 curious. So will we ever find, maybe we just
11 have to go and see, but will we ever find
12 ourselves in that situation where it says if no
13 category achieves greater than 60 percent, we
14 default to the work group? If no category
15 receives greater than 60 percent, won't we
16 default to do not support?

17 MR. STOLPE: Thanks, Sam Stolpe. So
18 the answer to the question is yes, it is possible
19 to arrive at this. And the reason that we have
20 gone with this, or at least the rationale that the
21 committee arrived at for coming to this
22 particular rule of how we engage in the voting

1 procedure, is that we need to reach a decision
2 category on every measure.

3 Now, with that being in place, if
4 there isn't a clear consensus on any given
5 category, then it was the preference of the
6 committee that we should defer to the work group
7 decision and allow that to stand. Now, given
8 that we do need to arrive at a conclusion.

9 CO-CHAIR KHAN: But the will of the
10 coordinating committee could be to do, use the --
11 I mean, that was the recommendation assessment
12 that was involved. It's really up to us what we
13 want our default to be, isn't it? I mean, if we
14 can accept the -- or is that the rule?

15 MR. STOLPE: So the rule that we've
16 established is that this decision category
17 reached by the work group will stand in the event
18 that we can't arrive at a consensus around any
19 one category ourselves.

20 MEMBER BAKER: I scratched my head on
21 this one a little bit. And I support the default
22 to the work group, because one of the votes would

1 be do not support. And if the group votes
2 against that, then it doesn't make sense to
3 default to do not support.

4 CO-CHAIR KHAN: Right. Okay, okay,
5 any questions on, comments on the phone? Okay,
6 hearing --

7 MS. BUCHANAN: And I still have to
8 really quickly review the role of feedback. I
9 wanted to stop there because I thought it was
10 really important. But if we move on really
11 quickly, just wanted to say that even within your
12 discussion guide, the rural health work group has
13 provided feedback on every measure.

14 It has not affected the algorithm or
15 the decision category, but it does look at every
16 measure under consideration from the rural
17 perspective. That is in the discussion guide, I
18 just wanted to let people know. And that was
19 just all I wanted to say about that.

20 CO-CHAIR KHAN: So you, everything
21 finished? Okay, so we've finished the immediate
22 morning business, I think, with CMS, and with the

1 ministerial side of managing our process today.
2 We're about 15 minutes behind, we'll catch up.

3 So let me propose that we take a
4 break, we come back at ten minutes before the
5 hour. And we come back at 11:00, or 10:50, and
6 then we'll start into the hospital side. We
7 start off with public comment on that. So you've
8 got ten minutes.

9 (Whereupon, the above-entitled matter
10 went off the record at 10:40 a.m. and resumed at
11 10:51 a.m.)

12 CO-CHAIR KAHN: As we get into the
13 hospital programs for our review, we have an
14 opportunity for public comment prior to our
15 review. So, if anyone would like to make a
16 comment -- do we have a microphone? -- we have a
17 microphone over here.

18 And I would ask you, one, to limit
19 your comments to the hospital program
20 recommendations that were made by the Task Force;
21 that you limit your comments to no more than two
22 minutes -- just be brief -- and make any comments

1 on opportunities to improve the current hospital
2 measure set at this time.

3 So, we'll give a moment to see if
4 anybody comes up. We also will go over and check
5 with Kate to see whether anybody is in the chat
6 box. I don't see anybody proceeding to the
7 microphone. So, do we have anybody in the chat
8 box?

9 MS. BUCHANAN: Is there anyone that
10 would like to make a comment on the phone, you
11 can say it aloud, or in the chat box? Right now,
12 Chip, I don't see anything.

13 CO-CHAIR KAHN: Okay. Going once,
14 going twice. We now have had our allotment of
15 time for public comment.

16 And I'm now going to turn it over to
17 Sam to introduce the Hospital Workgroup Co-Chairs
18 and provide the staff's overview of the Hospital
19 Workgroup recommendations. When they finish, we
20 will go through each measure and ask the lead
21 discussants to provide input. And we have also
22 have additional lead discussants as well as main

1 lead discussants. So, we'll thoroughly review
2 each of the measures.

3 So, with that, I'm going to pass it
4 off to Sam.

5 MR. STOLPE: Excellent. Do we have
6 Dr. Sean Morrison on the line?

7 (No response.)

8 Okay. Sean, if you're on mute, then
9 we're not hearing you. If you could unmute your
10 line?

11 (No response.)

12 Okay. We're not seeing him. So,
13 we'll just proceed with just the staff overview.

14 With this portion of it, we're talking
15 about an overview of the overall recommendations
16 that were provided by the Hospital Workgroup as
17 well as moving into high-level overviews of each
18 of the measures and the deliberations that were
19 conducted by the Hospital Workgroup.

20 So, here we have the list of the
21 federal programs that were considered by the
22 Hospital Workgroup. As you can see, there were a

1 total of six measures that were considered. One
2 for ESRD QIP; two for IQR; one for the Inpatient
3 Psychiatric Facility QRP, and then, two for the
4 PPS-exempt Cancer Hospital Quality Reporting
5 Program.

6 So, the leading key themes centered
7 around a couple of things. First, patient safety
8 was a very strong focal point for the discussion.
9 And the Workgroup emphasized that patients and
10 consumers value patient safety measures
11 extensively, especially for public accountability
12 programs when making considerations between which
13 facilities to select, that these measures are
14 intuitive for patients; and that facilities,
15 moreover, can improve patient safety through
16 quality improvement programs.

17 There's also a theme around having a
18 system view of measurement across settings.
19 Measures specified for a single care setting that
20 address system-level issues with shared
21 accountability were seen to potentially pose
22 challenges in determining which entity should be

1 measured and how. So, really, it's an
2 accountability issue, especially in areas of
3 shared responsibility.

4 The MAP Workgroup also stated that,
5 while it's necessary to review measures using the
6 same specific approach, there's a need to examine
7 measures at the system-level context in which
8 they are embedded. It's just the complexity of
9 measurement interrelation and how multiple
10 programs can be applied to one measured entity.

11 So, each of the Workgroups were also
12 asked to respond in a similar manner to the
13 presentation that Dr. Schreiber gave and, also, I
14 just wanted to share two key points that the
15 Hospital Workgroup focused on.

16 First was around programs and
17 settings, including issues related to priorities
18 for workforce availability, provider burnout,
19 licensure expansions and standardization across
20 states, staffing standards, and training. And
21 they identified a series of potential measurement
22 gaps as well with their focal points being

1 specialty care, changes in functional status
2 measures, measures that improve the usability and
3 safety of EHRs, among other gaps that were
4 identified.

5 So now, we're going to move into a
6 discussion of the individual measures that were
7 voted on by the group. So, first up, there's two
8 measures considered for PTS Exam Hospital Quality
9 Reporting Program. Both of these are National
10 Healthcare Safety Network measures, one for
11 CAUTI, for catheter-associated urinary tract
12 infection and the other for central-line-
13 infection-associated bloodstream. Both of these
14 measures were support for rulemaking. They're
15 both NQF-endorsed, and public comments that were
16 received, each of them had two public comments
17 and those were both supportive of the measure for
18 each of the measures.

19 For the next program that was
20 considered, this is the Inpatient Psychiatric
21 Facility Quality Reporting Program. And there
22 was a measure considered there, followup after

1 psychiatric hospitalization. This measure was do
2 not support for rulemaking. And the rationale
3 around this particular measure was that the
4 attribution ended up being quite tricky. The
5 numerator requires patient choice.

6 The MAP also noted some consideration
7 around Stark laws, limiting the ability for
8 hospitals to be able to ensure necessary SUD
9 treatment and appropriate psychiatric followup.
10 And then lastly, particularly for rural
11 hospitals, that telehealth followup is a critical
12 tool for ensuring that the measure numerators are
13 addressed.

14 Next up is the End Stage Renal Disease
15 Quality Incentive Program, the ESRD QIP. The
16 standardized transfusion ratio for dialysis
17 facilities is a measure that is already inside of
18 the program, but had undergone two changes.
19 First, that there's a new identification
20 algorithm for transfusions and, second, the
21 exclusion of Medicare Advantage patients.

22 It received one public comment, and

1 that was supportive of the Workgroup
2 recommendation of conditional support, the
3 conditional support being that it, as this is a
4 revised measure based upon NQF-2979 that was
5 implemented, that the full measure itself be
6 considered by the Renal Standing Committee for
7 endorsement of NQF.

8 Our last program here is the Hospital
9 Inpatient Quality Reporting Program and Medicare
10 and Medicaid Promoting Interoperability Program
11 for Eligible Hospitals and Critical Access
12 Hospitals measures. The first measure is the
13 Maternal Morbidity Measure. The Workgroup did
14 not support this measure for rulemaking with
15 potential for mitigation. We received a number
16 of public comments related to this, nine in
17 total.

18 The general overview of that is that
19 there were process concerns as well as some
20 criticism that this, as a structural measure
21 without adequate testing, needs to have NQF
22 endorsement. We'll review a little bit more

1 detail as we get towards the vote, some more
2 issues related with the categorization of this as
3 do not support for rulemaking with potential for
4 mitigation. Yes, but we will get to that in just
5 a moment.

6 The last measure on our list is here
7 is around Hospital Harm - Severe Hyperglycemia.
8 And this measure also received quite a few public
9 comments, 13 in total. The comments were largely
10 supportive of the MAP recommendation, but they
11 did address a number of exclusion concerns,
12 population-specific, such as diabetic
13 ketoacidosis, for example. It's one condition
14 for which you don't want to aggressively treat
15 hyperglycemia.

16 This concept of aggressively
17 decreasing hyperglycemia was one of concern as
18 well, that it might actually result in a more
19 frequent hypoglycemia, as measured entities seek
20 to develop policies that may result in some
21 unintended consequences. Nonetheless, this
22 measure did receive conditional support for

1 rulemaking with the overall rationale that there
2 is no measure of this currently included inside
3 of IQR and this is a very important measurement
4 area to address.

5 Next slide.

6 Okay. So, let's not go to lunch.
7 We'll essentially go back and do each one of the
8 measure and go through the discussion one by one.

9 So, Chip, back up to you.

10 CO-CHAIR KAHN: Okay. So, the Chairs,
11 we didn't have Chairs?

12 MR. STOLPE: We didn't have Dr.
13 Morrison on the line.

14 CO-CHAIR KAHN: So that we'll go to
15 the discussants?

16 MR. STOLPE: Next? That's right.

17 CO-CHAIR KAHN: So, we have a list of
18 discussants for each of the measures, and we'll
19 go one measure at a time. So, if I'm correct,
20 we're going to start with MUC19-18, which is the
21 National Healthcare Safety Network Catheter-
22 Associated Urinary Tract Infection Outcome

1 measure. And we're going to start with Leah
2 Binder.

3 MEMBER PETERSON: Chip, a process
4 question for you.

5 CO-CHAIR KAHN: Yes?

6 MEMBER PETERSON: Sorry, Leah, I'm a
7 little confused. I thought we were going to vote
8 first whether or not to support the
9 recommendation, and then, if necessary, go to the
10 discussant. Did I misunderstand that? That's
11 how it was presented.

12 CO-CHAIR KAHN: Oh, am I messing up
13 the process? Taroon?

14 MEMBER PETERSON: So, if we support
15 it, there's no reason to then have an hour
16 discussion.

17 MR. AMIN: Let's go back to the
18 previous slide, if we can, just to review it,
19 just to make sure everyone is on the page.

20 CO-CHAIR KAHN: Okay. Well, we could
21 go back to the slide. A suggestion has been made
22 that the slide should say, if it didn't, that we

1 would suspend the discussion if there was support
2 for, I mean ready support, for the Subcommittee,
3 I mean the Committee's recommendation. We could
4 proceed that way, and then, assuming that we can
5 dispense with some of these measures pretty
6 quickly, is that okay?

7 Okay. So, let me go to my other notes
8 here. And so, we'll proceed that way. And I'll
9 remind everyone that, to get a decision on the
10 recommendation, we need 60 percent of a yes vote;
11 and that if we don't get 60 percent on supporting
12 their position, we'll then go down sort of the
13 algorithm of all these different options as a
14 Committee.

15 Where's my recommendation?

16 MR. STOLPE: It's on the slide.
17 Support for rulemaking.

18 CO-CHAIR KAHN: Okay. So, on
19 MUC19-18, the recommendation was support for
20 rulemaking. So, does everyone have -- we need to
21 take a recorded vote -- so, does everyone have
22 the Poll Everywhere? Do we need any instruction

1 on Poll Everywhere?

2 MS. BUCHANAN: A session was opened
3 earlier. I think we were able to get responses.
4 But if anyone is having any issues, just place
5 your --

6 CO-CHAIR KAHN: What is the password?

7 MS. BUCHANAN: You shouldn't have to
8 put in a password. It should just let you enter
9 your name and you should be able to vote.

10 The question is now open.

11 PARTICIPANT: I'm on line.

12 CO-CHAIR KAHN: Yes?

13 PARTICIPANT: I can't even see the
14 password. I'm not seeing anything to vote. All
15 it's saying is that something would show up
16 eventually.

17 MS. BUCHANAN: So, the voting link you
18 should be on is pollev.com/nqfvote130one.

19 MR. AMIN: Spell out one, though.

20 MS. BUCHANAN: Oh, 1 as in --

21 CO-CHAIR KAHN: Okay.

22 MS. BUCHANAN: This is Kate. My

1 apologies. I'm sending out the link right now.
2 There was an issue with it.

3 CO-CHAIR KAHN: Okay.

4 MS. BUCHANAN: So, one moment.

5 CO-CHAIR KAHN: So, everyone will get
6 a link, and when you get the link, you just hit
7 the link or click on the link, and you'll get
8 right to the place. And then, I guess you'll
9 bring it up?

10 PARTICIPANT: And you'll see the
11 question. The question's already up.

12 CO-CHAIR KAHN: David? David, do you
13 have a comment?

14 MEMBER GIFFORD: I just have a
15 question on the process. And I know we're trying
16 to expedite this, so we don't have to go through
17 it by section. If the lead discussant or if
18 someone really feels that the current
19 recommendation warrants something different, but
20 we're not all privy to that, how do we address
21 that?

22 So, let's say we just all unanimously

1 vote to approve this measure, but there really is
2 some concern about discussion --

3 CO-CHAIR KAHN: David, we're going to
4 go measure by measure.

5 MEMBER GIFFORD: No, I understand
6 that.

7 CO-CHAIR KAHN: On each one, we're
8 going to ask whether or not there's a consensus.
9 If anyone objects, we can start with the
10 discussants. Is that -- I don't understand
11 the --

12 MEMBER GIFFORD: What's this vote
13 right now that we're holding? So, right now, we
14 were all asked to vote on this measure.

15 CO-CHAIR KAHN: As far as I understand
16 on MUC19-18, which is the first measure, no one
17 voiced from the body that we needed to go through
18 a discussion on it.

19 MEMBER GIFFORD: No, we weren't given
20 that option. And that's not the process. The
21 process right now is we're voting without any
22 discussion.

1 CO-CHAIR KAHN: Yes. So, David, we're
2 voting right now. We're voting right now to
3 accept support. The question in front of you is,
4 do you accept the recommendation support for
5 rulemaking? Your answer is yes or no. And if we
6 don't get 60 percent, then we dive into
7 discussion and revoting. If we get 60 percent,
8 we move on.

9 CO-CHAIR HALL: Well, no, but the
10 problem is that David is raising an important
11 point, which is that, if there is any opposition
12 or concern about the recommendation, you could
13 get 60 percent and there could be a feeling in
14 the body, among the discussants, that they wanted
15 to discuss it, which could have affected the
16 vote. So, you really can't go forward with a
17 vote unless we can look around and see a
18 consensus that there's no reason to have a
19 discussion. You've got to have a discussion.

20 CO-CHAIR KAHN: So, we could do is we
21 could, you and I as the Chairs, can say we can
22 start by asking, does anyone object to an initial

1 vote on the recommendation? If there are any
2 objections, then we'll go to discussion. If
3 there are no objections, we vote and that doesn't
4 guarantee we'll hit 60 percent. Is everybody
5 okay with that?

6 CO-CHAIR HALL: That was what I --

7 MEMBER PETERSON: You should have a
8 process. Your step two you can allow for
9 clarifying questions, where you can ask your
10 question and seek clarification. And then, step
11 three is where you go to your initial vote. And
12 then, step four is the lead discussants. It's on
13 your slide 31 and slide 32.

14 CO-CHAIR KAHN: David, what we're
15 doing I thought I had articulated, but I guess I
16 failed to. But we want to try to go through, for
17 any -- we want to get rid of the non-
18 controversial measures and move to the ones that
19 we're going to need to focus time on.

20 MEMBER GIFFORD: I completely agree
21 with that. I just want to make sure that --

22 CO-CHAIR KAHN: But if anyone has

1 something to say, we need to discuss it.

2 MS. CLARK: Yes, so this is Apryl. I
3 think let's go to 531. I think we'll review what
4 the recommendation is.

5 I think, Chip, if you guys could then
6 ask if there's any clarification, like anybody
7 who wants to discuss it or has --

8 CO-CHAIR KAHN: Well, we'll do that.
9 We'll do that. We need to move forward. We've
10 got to move forward. We've only got so much
11 time. We don't want to lose people during the
12 day.

13 So, I'm going to go back to MUC19-18.
14 I'm going to ask the question of the group, is
15 there a reason to discuss it or can we go
16 straight to a vote? Does anybody want to have a
17 discussion of it? Then, we'll go through the
18 lead discussants and proceed.

19 MR. AMIN: Does Harold have a question
20 or not?

21 CO-CHAIR KAHN: I was avoiding
22 Harold's question.

1 MEMBER PINCUS: My question was the
2 order in which we're discussing these things.
3 Because I was looking at the list and everything
4 with the lead discussants and things don't seem
5 to be in any sort of particular order. So, is
6 there a list, so we can anticipate when things
7 will come up?

8 CO-CHAIR KAHN: Yes. They don't have
9 this list we have right here?

10 MR. STOLPE: Yes, it's in the slides.
11 There's no separate list, but we're going in the
12 order that they're presented inside of the
13 slides.

14 So, at this point, there's clarifying
15 questions that would like to be asked or people
16 need to say we need to move discussion. That's
17 the order of proper --

18 CO-CHAIR KAHN: Yes, I think we're
19 okay on this measure. And are we okay in terms
20 of everyone having the system up?

21 MS. BUCHANAN: So, I sent an email at
22 11:07 with the link. I apologize for the

1 confusion earlier. 11:07 is the correct link,
2 that email.

3 CO-CHAIR KAHN: Okay. So, do people
4 have the link up? I don't myself, but --

5 MEMBER MORALES: We already voted
6 because there was eight of us who already voted.
7 Is that gone? Do we vote again or not?

8 MS. CLARK: Your vote is still
9 counted. I haven't cleared them. So, you should
10 be good and it should be reflected.

11 MEMBER MORALES: Thanks.

12 CO-CHAIR KAHN: Okay. Everybody that
13 has a link please vote.

14 MEMBER QASEEM: Chip, this is Amir
15 over the phone. It's just a little bit difficult
16 on this end over the phone. Can you just give a
17 two-sentence summary what are we doing? We're
18 going to vote --

19 CO-CHAIR KAHN: Okay. Okay. I'm
20 sorry. We're voting on MUC19-18, the National
21 Healthcare Safety Network Catheter-Associated
22 Urinary Tract Infection Outcome measure. And

1 we're voting on it because there was no request
2 for a discussion on that. And we're voting on
3 the recommendation of the Workgroup which was to
4 support for rulemaking.

5 Okay. Do we have 60 percent?

6 MS. BUCHANAN: Okay. So, we will now
7 close the voting.

8 We have a vote 18 yes and 1 no to
9 recommend or for the final recommendation of
10 support. I will share that in one second.

11 CO-CHAIR KAHN: Okay. So, we now made
12 it through our first vote. And we're going to
13 see the vote on the screen.

14 MS. BUCHANAN: And again to clarify,
15 for MUC2019-18, we have 18 yes votes and 1 no
16 vote.

17 CO-CHAIR KAHN: Okay. Well, we've
18 clearly cleared the 60 percent.

19 MS. BUCHANAN: Yes.

20 CO-CHAIR KAHN: So, while we're trying
21 to get the vote up, can we -- maybe people could
22 just believe it. Why don't we go to the next

1 one? Because we've got to roll.

2 So, let's go to the next slide or the
3 slide with the next measure on it, MUC19-19,
4 which is the National Healthcare Safety Network
5 Central Line-Associated Bloodstream Infection
6 Outcome measure. And my question is, is there
7 any need for discussion by our discussants on
8 this measure? The recommendation of the
9 Workgroup is to support for rulemaking. So, on
10 the phone or here at NQF, is there anyone on the
11 Coordinating Committee that would like us to have
12 a full discussion of this measure before we would
13 take a vote on the recommendation of the
14 Workgroup? Going once, going twice. So, let's
15 go to a vote on this.

16 This is MUC19-19, and we're now
17 voting.

18 MS. BUCHANAN: Our apologies, people
19 on the phone actually can see the votes. It's
20 screen-sharing. We'll need to troubleshoot here,
21 but I did want you to know that --

22 CO-CHAIR KAHN: Okay. As long as

1 we're in this 18-to-1 range, we're okay.

2 MS. BUCHANAN: Yes.

3 CO-CHAIR KAHN: So, where are we vote-
4 wise?

5 MS. BUCHANAN: So, we have 17 yeses,
6 zero noes.

7 CO-CHAIR KAHN: Okay.

8 MS. BUCHANAN: Oh, sorry. Apologies,
9 Chip. The voting is now closed. It is 19 yeses
10 and zero noes.

11 CO-CHAIR KAHN: Great. So, we have
12 now confirmed the recommendation of the Workgroup
13 on MUC19-19.

14 So now, let's proceed to Inpatient
15 Psychiatric Facility Quality Reporting Program.
16 And we need to get on the screen the information
17 for MUC19-22, Followup After Psychiatric
18 Hospitalization. Could you get that on the
19 screen?

20 MEMBER ROBERTS: Can you maybe just
21 clarify before each one what the Workgroup
22 recommendation is?

1 CO-CHAIR KAHN: Well, no, actually, I
2 verbally described it on both the two measures.
3 I'll do it on this one, too.

4 MEMBER ROBERTS: Thank you.

5 CO-CHAIR KAHN: I just have to have it
6 up, so everyone can read it also. I mean, I'll
7 say it; you'll see it on the screen.

8 Okay. Okay. So now, we have the
9 correct one on the screen? No, that's the first
10 one.

11 Okay. So, for MUC19-22, you'll see
12 that the Workgroup recommendation was do not
13 support for followup after psychiatric
14 hospitalization. So, my question to the group
15 is, do we want to have a discussion of that or do
16 we want to accept the recommendation of the
17 Workgroup? Does anyone want to have a
18 discussion?

19 And it looks like Harold does. So, I
20 suggest that we proceed with our agenda there,
21 which is we would start with David Baker and
22 Esther Morales as our main discussants, and then,

1 we have some other additional discussants I'll
2 get to in a moment.

3 So, David, could you speak to this
4 measure and comment on it? And then, Esther,
5 would you comment on it? And then, others can
6 speak. After we go through the formal
7 discussants, any other members of the
8 Coordinating Committee who would like to speak
9 are welcome to.

10 MEMBER BAKER: I'll just say a few
11 words about the concerns of the Workgroup. The
12 followup after hospitalization depends on patient
13 choice, their ability to followup, whether there
14 are providers that can see patients within their
15 community. As I think everybody knows, there's a
16 major problem with a shortage of psychiatrists
17 and psychiatric health care workers to follow up
18 on patients. In many rural areas this is a
19 particular problem, despite the issue of
20 telehealth.

21 So, I think, conceptually, it's an
22 important measure, but, practically, it's a

1 difficult one. So, I agree with the
2 recommendation of the Workgroup do not support.

3 CO-CHAIR KAHN: Okay. Esther?

4 MEMBER MORALES: I just echo what he
5 says, and even though there is a code,
6 apparently, for telehealth for this, it's not
7 generally used by practitioners. And therefore,
8 I totally agree with the Workgroup recommendation
9 on this measure.

10 CO-CHAIR KAHN: Okay. Leah? The
11 discussants, I wanted to get the discussants in.
12 Leah?

13 MEMBER BINDER: We would actually tend
14 to support this measure actually. The issue of
15 followup after psychiatric hospitalization is a
16 major priority. It's one of the top priorities
17 for purchasers, at least that I have worked with.
18 They are very concerned with this.

19 And the fact that it is difficult for
20 patients to access care following hospitalization
21 is a fact that this measure should observe. We
22 actually need to quantify that. We need to look

1 at that. And this is a way of tracking that.
2 There are so few good measures on behavioral
3 health at all, certainly on acute care.
4 Behavioral health, there's almost nothing. And
5 this would be very helpful. We need to support
6 this measure.

7 CO-CHAIR KAHN: Okay. Is Mary Barton
8 here? Mary? Do you have comments on this?

9 MEMBER BARTON: It's built off of a
10 measure that NCQA uses to evaluate health plans.
11 And I can't really speak to this question of how
12 CMS has modified it. It's my understanding that
13 our General Counsel has actually approached CMS
14 to ask them under what authority they're
15 modifying it. And so, I think it would be
16 premature for me to speak about this being used
17 in this program.

18 CO-CHAIR KAHN: Okay. Libby Hoy?

19 MEMBER HOY: Yes.

20 CO-CHAIR KAHN: Can you address this?
21 Any comments on this measure?

22 MEMBER HOY: No comments at this time

1 pertaining to the discussion. I am concerned
2 about followup following psychiatric
3 hospitalization, but I need to learn more about
4 this specific measure. Let's hear more about it.

5 CO-CHAIR KAHN: Okay. Nancy? Nancy
6 Foster?

7 MEMBER FOSTER: Thanks, Chip.

8 First of all, I just want to clarify.
9 There is already a measure used in the Inpatient
10 Psychiatric Hospital Reporting Program that is
11 followup after psychiatric hospitalization. This
12 is an amended part of that. It would have -- I'm
13 not sure I'm going to get all of the parts of the
14 amendment right -- but it would have extended it
15 to those who are substance use disorder patients
16 and maybe somebody else, but at least substance
17 use disorder patients was the largest expansion
18 of it.

19 And insomuch as the Workgroup looked
20 at this and talked about it, my understanding,
21 because I wasn't at that Workgroup meeting, but
22 there was some concern; there were concerns

1 expressed about the fact that the same evidence
2 base does not exist for being able to do this and
3 having it have a positive impact on patient
4 outcomes in the substance use disorder. I mean,
5 intellectually, I think we'd be interested to
6 know whether that happens, but, in fact, all of
7 the evidence that was cited was about patients
8 with mental health disorders, not substance use
9 disorders. So, the measure expansion didn't hang
10 together in a way.

11 And my understanding from having
12 talked to people who were at the Workgroup was
13 that there was an interest in the current measure
14 continuing. There was no move to take it out of
15 the program. So, there would continue to be work
16 and measurement of followup after psychiatric
17 hospitalization for mental health disorder, but
18 they did not feel that this was right for the
19 extension that was being proposed. And that's
20 why they voted not to support this measure. But
21 they in no way meant take the old measure out, as
22 I understood it. And it's a shame we don't have

1 the Chair here to verify that, but perhaps staff
2 can.

3 CO-CHAIR KAHN: Okay. Harold?

4 MEMBER PINCUS: I have three points
5 about this. One is let's get some clarification
6 about that particular issue that Nancy raised.
7 If we do not support this, does the current
8 measure stay or does that eliminate this measure?

9 CO-CHAIR KAHN: I don't know why we
10 would affect the current measure.

11 MEMBER PINCUS: Well, Nancy's right,
12 this is for an expansion. It's an expansion for
13 patients hospitalized for drug and alcohol
14 disorders.

15 CO-CHAIR KAHN: Okay.

16 MEMBER PINCUS: Just need to get the
17 official word from --

18 CO-CHAIR KAHN: I was looking at CMS.

19 MEMBER PINCUS: Yes, looking at CMS.
20 What is the end here?

21 MEMBER SCHREIBER: So, you are
22 correct, this will not change what is currently

1 being reported. This is an expanded measure for
2 substance abuse disorders.

3 The conversation really that did occur
4 during the Hospital Group actually was more along
5 the lines of -- and, Maria, correct me because
6 you were there with me. And I know we have some
7 of our content experts on the phone. It really
8 was more along the lines of we don't like this
9 measure at all because of the difficulties of
10 getting followup and people didn't want to be
11 held responsible for that.

12 That being said -- and that was the
13 thrust of the conversation, correct?

14 MEMBER SCARLATOS: That's correct.

15 MEMBER SCHREIBER: Yes. But, that
16 being said, this doesn't change the fact that
17 this measure does exist already. What this does
18 change is whether or not we would propose for
19 rulemaking this expanded measure. And I will
20 just say that CMS takes this seriously in their
21 advisement recommendations.

22 Do you want to comment? Add anything?

1 CO-CHAIR KAHN: So, Harold, do you
2 have further comment?

3 MEMBER PINCUS: Yes, I have two other
4 points I wanted to make.

5 CO-CHAIR KAHN: Yes.

6 MEMBER PINCUS: So, the current
7 measure has its limitations because there are
8 questions about the ultimate validity of what it
9 is that a single visit actually means and whether
10 people are actually engaged in care. But the
11 reality is that people that wind up in, either
12 for mental health or substance abuse, that wind
13 up in this setting, it's really hard to get in.
14 You have to be really, really sick and, like I
15 said, it's been incredibly shortened. So, the
16 notion of somebody going from 24-hour care to
17 nothing just in terms of common sense is not a
18 good idea. But there needs to be more evidence
19 about it actually looking at that.

20 But I'm concerned, actually, about the
21 comments in the report that says MAP expressed
22 concern that the numerator requires patient

1 choice in pursuing followup, which almost
2 everything requires patient choice. And if that
3 is the case, we would not have any measures that
4 would really be available. So, I have some
5 concerns about that, you know, embracing that
6 larger concept.

7 And also it says, and may not reflect
8 whether followup care has been arranged by the
9 hospital being measured. I'm not sure what that
10 even means and how that plays a role in terms of
11 the rationale for not supporting this.

12 But it seems to me that the hospital
13 does have responsibility for arranging care and
14 having some kind of connection to facilitate that
15 followup.

16 MR. STOLPE: Harold, if I could just
17 clarify what the staff attempted to capture in
18 the discussion that was held by the Hospital
19 Workgroup? The concern that was expressed is
20 that, given that the onus to ensure that followup
21 care has occurred, if outreach is made by the
22 hospital and followup care is scheduled, they

1 were concerned that the patient may not elect to
2 still go through with that, and that the efforts
3 by the hospital wouldn't necessarily be
4 acknowledged, but would be for naught. But they
5 did the best that they could and it didn't
6 happen. That's what the Workgroup expressed as a
7 concern.

8 MEMBER PINCUS: But that is with
9 almost anything, any kind of treatment you
10 prescribe for a patient. Any kind of treatment
11 you prescribe for a patient is subject to those
12 same issues.

13 CO-CHAIR KAHN: Well, do they say
14 that, frankly, because of the patient population
15 that we're talking about?

16 MR. STOLPE: Yes. So, that was
17 directly factored into their considerations.
18 Moreover, there's also the Stark law issue that
19 they find it problematic to be able to provide
20 that care directly.

21 MEMBER PINCUS: How is that any
22 different from any other treatment? I get

1 concerned about treating behavioral health issues
2 from a different perspective than anything else.
3 I mean, basing it on the nature of the patient is
4 ridiculous. I mean, that's almost offensive to
5 say that somehow you could have a lower standard
6 of care because somehow these are more difficult
7 patients in following up.

8 MR. AMIN: Just in terms of the
9 conversation within the Workgroup, the question
10 of attribution for this population, this group,
11 what they disagreed with essentially, the thrust
12 of the conversation from the Hospital Workgroup,
13 but I think the question of attribution was
14 really what the group was getting at.

15 But all of these comments that we're
16 describing here, I think we could certainly
17 reframe the way the Coordinating Committee
18 rationale moves forward with the measure.

19 MEMBER BAKER: May I just add in one
20 comment? So, I agree with Harold. Oh, I'm
21 sorry.

22 CO-CHAIR KAHN: Well, go ahead, David.

1 MEMBER BAKER: So, I agree with
2 Harold. The issue about patient choice, or I'll
3 say their willingness to followup, also depends
4 on the quality of the handoff. And if you look
5 at the organizations that are doing this
6 extremely well with warm handoffs, they have
7 higher followup rates. So, this is something
8 that's within the control of organizations to
9 some degree.

10 I don't understand the Stark law
11 issue, but, to me, the issue really is there is a
12 tremendous shortage, particularly for substance
13 use disorder, of providers, particularly for
14 opioid addiction. I mean, this is a national
15 problem, and everybody has recognized this. I
16 think there are 3 million, 2 million, people with
17 opioid addiction right now. And particularly in
18 a lot of rural areas, this is just not available.

19 We've looked at this a lot as we were
20 developing our standards around this area, and we
21 heard this repeatedly from experts around the
22 country. So, that's my concern, is that this is

1 not fully within the control of the hospitals.

2 CO-CHAIR KAHN: I'm sure people want
3 to answer some of the points that were just made,
4 but let's just proceed. I guess, Mary? Misty
5 next, and then, Steve has been waiting for a long
6 time.

7 MEMBER ROBERTS: Yes, I'm just curious
8 if the Workgroup actually knew that there's
9 already an existing measure. Because it seems
10 that the rationale behind it doesn't necessarily
11 address the additional inclusion of what's added
12 to the measure. The rationale doesn't make sense
13 of why they suggested do not support. So,
14 there's nothing new coming forth that would say
15 do not support this.

16 MR. STOLPE: So, Dave, the Workgroup
17 was unequivocally aware that this was already
18 inside of the ICFQR. But we, as staff, of
19 course, we have transcripts and we have our
20 collective memories that we use to define what
21 the course of the conversation was. And so, when
22 they voted for do not support, we just assumed

1 that those reasons align with the thrust of the
2 conversation.

3 CO-CHAIR KAHN: Okay. Steve?

4 MEMBER WOJCIK: Yes, thank you.

5 I appreciate all the comments. I
6 think we're in line with Leah's comment that it
7 seems do not support is kind of a drastic move,
8 especially considering that the requirements from
9 the mental health community was that they have
10 increased the requirements for plans to cover
11 substance abuse treatment, including inpatient,
12 on an equal basis or greater than for other
13 conditions.

14 We're seeing a lot of increased use
15 for substance abuse treatment, a lot of questions
16 about that treatment. So, I would echo Leah.
17 I'm glad Nancy made the clarification, because
18 that was the question that I had, not being part
19 of the Workgroup and not reading all of the
20 materials, and knowing that this is an expansion.
21 That's a critical area.

22 I think in terms of equity I didn't

1 make any comments earlier, but I'm hoping that
2 equity is going to be broadly defined to include
3 things like the access to whatever the treatment
4 is in rural areas. In my view, that's part of
5 the equity discussion, not just other factors,
6 because we're really talking about your ability
7 to access and get the appropriate care,
8 regardless of what the factor is.

9 And I agree with Harold's comments
10 because I think most of the objections can apply
11 to everything else. If you're a hospital, an
12 acute inpatient hospital, you're increasingly
13 being responsible for the followup care. You
14 have to deal with the Stark, the kickback. You
15 have patient choice. You have to cooperate with
16 the other providers in the community in order to
17 make sure that that person has appropriate
18 followup care.

19 So, I'm wondering if there is some
20 alternative to the drastic do not support,
21 because I think that sends the wrong signal.

22 Thank you.

1 CO-CHAIR KAHN: Okay. Let me go to
2 Nancy next. Nancy?

3 MEMBER FOSTER: Thanks.

4 All right. So, as I say, I wasn't at
5 the Workgroup. From comments I've heard from our
6 members, there's an additional concern about this
7 particular expansion vis-a-vis the Stark and,
8 then, kickback laws, for one of the very reasons
9 that David mentioned, right? There are very few
10 providers available in many communities for
11 people with substance use disorder, too few in
12 many communities. To put pressure on the
13 hospital to get someone lined to go to a next
14 visit, just so they can get a good score on that
15 measure, may mean they're sending people
16 extraordinary distances or just not able to
17 conform because there's no available provider
18 within a short amount of time to send these
19 people to.

20 And that became a concern vis-a-vis
21 the Stark law, because if you knew that such-and-
22 such a provider had a slot or usually had slots

1 available within seven days, you would want to be
2 pushing the patient there because it's more
3 likely they're going to get that followup
4 treatment, which, arguably, might be good. But
5 you would be in violation of the Stark law by
6 pushing the patient to a particular provider
7 rather than allowing patient choice of that. So,
8 it really gets a little too complicated around
9 the particulars of the substance use disorder
10 treatment, given the current situation in which
11 we're working.

12 None of that is to say that hospitals
13 are trying to get out of responsibility for these
14 patients. Quite the contrary, they're looking to
15 find resources or build resources in their
16 communities to appropriately provide care.
17 Particularly for people with opioid use disorder,
18 they just don't exist right now. So, maybe it's
19 the timing of the measure. Maybe it's something
20 else. But this is much more complicated than,
21 gee, I'd like to get a followup appointment for
22 my patient who has just had their hip replaced or

1 just had a coronary stent placed. This is very
2 challenging.

3 CO-CHAIR KAHN: I know we have some
4 signs up, but is there anyone on the phone, Jeff,
5 who wanted to comment on this?

6 MEMBER SCHIFF: I just wanted to
7 support the -- you've got the echo. If you could
8 take care of that for me?

9 I wanted to support the group's
10 recommendation and say that, at least for opioid
11 use disorder, there are better recommendations or
12 better measures. There's a 180-day retention in
13 medication-assisted treatment measures that I
14 think gets more to this overarching sort of
15 higher-level measure retention.

16 And I also think that I agree with a
17 lot of the presenters that putting the onus on
18 the facilities is not a good way to move forward
19 in this key area.

20 CO-CHAIR KAHN: Okay. Let me start
21 with David, and then I'll come back over here.

22 MEMBER GIFFORD: So, I guess I have

1 two questions to ask, one for CMS and the staff.
2 One is it sounds like the existing measure may
3 just change the denominator by adding in opioid
4 use disorder and others. And I've not heard
5 anyone complain about reliability and validity of
6 changing the measure. Is that correct?

7 MR. STOLPE: Yes, there would be
8 concern about this.

9 MEMBER GIFFORD: The second one, I
10 think we, as a body, have all applauded Michelle
11 early on when talking about transitions in care,
12 the importance of transitions in care. I think
13 David nicely summarized the literature on how you
14 could influence that.

15 We're not striving for 100 percent on
16 each of these measures. We know not everybody is
17 going to follow up. I would completely endorse
18 Harold's point of it's about choice. We're
19 trying to break down the silos, and this is a
20 measure that's moving in that direction.

21 I guess, to me, the question hinges
22 on, are you trying to measure, hold accountable

1 providers for care that's impossible to deliver?
2 So, if you're asking someone to do followup with
3 a psychiatrist, but CMS will not pay for
4 psychiatric followup, that seems like that would
5 be wrong. If it's just hard to find these
6 individuals and hard to do followup, and it may
7 be that you have limited choice, that, to me,
8 seems different. Then, I would support Leah and
9 everything else, that I don't see why we would
10 turn this down, given the direction of it. But
11 it hinges on that.

12 But it seems like most of the comments
13 are this is just too hard for us and we don't
14 want to be held accountable, rather than care
15 outside just doesn't exist. And so, I think the
16 question is, how much does care just not exist?
17 And you can't hold someone accountable for
18 something that's not possible versus holding
19 someone accountable that's just hard.

20 And so, the question, I guess, for CMS
21 and the staff, is this asking us to do care that
22 just doesn't exist?

1 MEMBER SCHREIBER: No, I mean,
2 clearly, CMS is trying to encourage and
3 incentivize providers making sure that behavioral
4 health patients with substance disorders, as well
5 as other behavioral health issues, get
6 appropriate followup care.

7 MEMBER GIFFORD: You pay for that care
8 to follow through?

9 MEMBER SCHREIBER: We pay for that
10 care. We're encouraging that care. We think
11 it's important that patients actually get that
12 care, not just that they have an appointment,
13 that some miss, but that they actually get that
14 care.

15 The care is available. I completely
16 understand and agree that it is limited in some
17 places, and many organizations are building that
18 capacity now as we speak, some within primary
19 care, some within psychiatry or psychology. But
20 it does exist, and this actually, I think or
21 hope, incentivizes organizations to continue to
22 build that capability, so that patients can get

1 care.

2 I mean, you can see we brought this
3 measure forward because we support it and we
4 think it's important that these patients receive
5 followup care. We understand the points and we
6 took it back under consideration, but I have to
7 tell you, we still think it's important that
8 these patients get this followup care.

9 CO-CHAIR KAHN: I hope that the body
10 will bear with me here. I'd like to ask -- I
11 think we've had a very full discussion -- does
12 anyone else have something to add that's
13 different or a different angle with what they're
14 going to say? And I'm happy to entertain it, but
15 I just want to make sure -- I mean, because I
16 think we've got a lot on the table. And what
17 Michelle just laid out I think really describes
18 the motivation of CMS very well. I think we have
19 the concerns of the provider side heard. But I'm
20 happy to have everybody talk, but we do need to
21 move on, unless there's something else. And I'll
22 start with Misty.

1 MEMBER ROBERTS: Okay. I just want to
2 say two things. No. 1, inpatient hospital
3 admissions for mental health and hospital
4 admissions on other things that put people in
5 substance abuse, those are currently two NCQA
6 measures that health claims do measure. And we
7 do measure those every year and they are
8 administrative measures that are kind of easy to
9 track and everything. And the rates are
10 horrible, but they're getting better as we
11 measure them every year. And it would be great
12 to have partners from the facilities that would
13 work with us to get those measures up.

14 What I don't see, what I don't
15 actually understand is why combine, because, for
16 the health plan, it's two different measures.
17 There's one measure for mental health and there's
18 one measure for substance abuse. Why put them in
19 one measure when you need to see different types
20 of providers? A lot of the providers that you
21 see after substance abuse are your PCP-type
22 providers who manage you, and not necessarily a

1 mental health professional. So, why not have
2 those as two different measures for the facility,
3 just like they are for the health plan?

4 And those are my comments. I don't
5 necessarily think that this should not go to
6 rulemaking, but I do think that that's a
7 consideration that we should take. And I would
8 now, based on this discussion, support moving
9 forward in that manner.

10 CO-CHAIR KAHN: On the particular
11 question, does CMS have an answer?

12 MEMBER SCHREIBER: Frankly, it was
13 just for ease of having a single measure.

14 CO-CHAIR KAHN: Okay. Emma?

15 MEMBER HOO: I would just add that,
16 given the new modalities around telemedicine, and
17 we recognize that access is a challenge, but
18 there are a lot of solutions that are available
19 and we're seeing huge expansion in the commercial
20 markets as well.

21 And secondly, we see a massive growth
22 in non-network, non-contracted mental health

1 facilities that do not engage in transitions,
2 management, or coordination. And there needs to
3 be some accountability in that arena as well.

4 CO-CHAIR KAHN: Okay. Leah? Leah?

5 MEMBER BINDER: There is a shift that
6 I think most of us in this room have all
7 contributed to, which is a shift toward
8 population health, toward hospitals really
9 thinking of their obligations to the patients as
10 extending beyond the walls of the actual
11 facility. And this is an example of where that's
12 important, where it isn't enough to discharge
13 someone into the community without actually
14 knowing that they're getting appropriate care.
15 So that their ultimate outcome is what we want to
16 achieve.

17 That is extremely hard. It's hard on
18 every category of admissions, but it is certainly
19 particularly hard for substance abuse.
20 Nonetheless, that also makes it more important in
21 particularly the opioid crisis.

22 I want to encourage hospitals to

1 continue their leadership and really pushing the
2 boundaries of their own traditional thinking
3 about what their responsibilities are. And I
4 think that this measure helps us to get there.

5 CO-CHAIR KAHN: David?

6 MEMBER BAKER: So, I think this issue
7 that Michelle raised about the ability of
8 hospitals to develop their own programs is really
9 important. We have seen some good examples of
10 this. It's a little bit different with
11 buprenorphine clinics and others.

12 So, my question for Michelle is, when
13 would this actually go into effect? Because if
14 this was adopted in the programs, and
15 organizations knew that this was going to be in
16 place and effective, let's say, in two years,
17 then they would have had the time to develop that
18 capacity.

19 MEMBER DUSEJA: So, the answer really
20 is how we phrase it, propose it in the rule. So,
21 if we decide to propose it this year, we could
22 delay implementation for a couple of years in

1 that proposal based on the concerns that we're
2 hearing here.

3 MEMBER BAKER: Yes, we've done that
4 with some of our standards, like the maternal
5 standards where we gave a longer runway because
6 we knew it was going to be a while for
7 organizations to ramp up.

8 MEMBER DUSEJA: That's right.

9 CO-CHAIR KAHN: Okay. David? And I
10 hope this is the end.

11 MEMBER GIFFORD: If we accept the
12 recommendation not for rulemaking, what needs to
13 be done to get us to a point to make it for
14 rulemaking? I have not heard anything out there.
15 It's like we have to wait for the health care
16 community to build this huge, integrated system
17 and everything else. That's never going to
18 happen without driving incentives. So, I don't
19 see -- it's not like the measure spec needs to be
20 changed. It's not like the patients have to
21 change. So, I'm not sure why we would vote not
22 for rulemaking. What are the things that would

1 make us get to the point to be there?

2 CO-CHAIR KAHN: Okay. Harold can
3 close.

4 MEMBER PINCUS: So, I'm not sure this
5 is -- it would probably take a motion. But I
6 would make a motion that this be conditionally
7 supported with the condition being that it be
8 split into two measures, one for mental health
9 and one for substance abuse, and that there be a
10 delay in the substance use measure.

11 CO-CHAIR KAHN: Let me make this
12 suggestion because we have a process. One, we're
13 going to vote on the recommendation first. I
14 assume from what I hear that we will not get 60
15 percent for the recommendation. That being the
16 case, we'll then go to the four options, and in a
17 sense we act as the Workgroup at that point,
18 making our own recommendations. And we would
19 have the ability there, when we get to whatever
20 the conditional, to have our conditions. So, I
21 don't think we need an amendment because we'll go
22 through the process.

1 MEMBER PINCUS: Okay. So, I can bring
2 up that motion there?

3 CO-CHAIR KAHN: Yes, there will be an
4 opportunity to do that.

5 MEMBER PINCUS: Okay.

6 MEMBER GOODMAN: Chip, I just want to
7 clarify what we're voting on is do not support.
8 So, a positive would be do not support.

9 CO-CHAIR KAHN: Right. I hadn't
10 gotten to the vote yet.

11 MEMBER GOODMAN: Okay.

12 CO-CHAIR KAHN: I was just describing
13 for Harold the process. I will get that with the
14 vote.

15 So, I guess, Jeff, could you be quick
16 on the phone?

17 MEMBER SCHIFF: Oh, I already made my
18 comments earlier. Thanks.

19 CO-CHAIR KAHN: Okay. Great.

20 Okay. Without any further comments,
21 I think we've had a full discussion here. So,
22 this is how we will proceed. The Workgroup made

1 a recommendation do not support for rulemaking.
2 We will now vote whether or not to accept that
3 recommendation. So, a yes vote is a vote in
4 favor of the Workgroup recommendation. A no vote
5 is opposed to the Workgroup recommendation.

6 If the recommendation, if this vote,
7 if there's 60 percent yes, then we will move on
8 to the next measure. If there's 60 percent no,
9 then we'll move on to the procedural voting to
10 see whether or not we would accept the measure,
11 accept the measure with condition, and the
12 others. We'll go through the four options.

13 Are there any questions?

14 MEMBER PINCUS: Just to clarify, not
15 60 percent no. If there's not --

16 CO-CHAIR KAHN: Oh, I'm sorry.

17 MEMBER PINCUS: I mean, if it's not 60
18 percent yes.

19 CO-CHAIR KAHN: If it's not 60 percent
20 yes, we would move on. I think there's going to
21 be 60 percent no.

22 Okay. So, let's vote.

1 MS. BUCHANAN: So, voting is now open
2 for MUC19-22, and it's do you vote to support the
3 Workgroup recommendation which was do not support
4 for rulemaking.

5 We will be closing the measure voting
6 in just one moment. And we can close it.

7 So, the results are 2 for yes, 17 for
8 no. The Coordinating Committee does not vote to
9 support the Workgroup recommendation or the Task
10 Force recommendation.

11 CO-CHAIR KAHN: Okay. So now, we will
12 proceed down the voting to see when we will get
13 60 percent. And so, the first would be for
14 support unconditionally. The second one would be
15 for conditional. We'll get to the others -- do
16 not support, mitigate -- we'll get to the others
17 to see whether we need to go there.

18 So, the first vote -- well, actually,
19 I should say this: is there any need for further
20 discussion at all or can we proceed to the vote?

21 Hearing none, we're going to proceed
22 to the vote. And the first vote is to accept, to

1 recommend for MUC19-22 followup after psychiatric
2 hospitalization which regards opioids and such,
3 and it being added to the current mental health
4 hospitalization measure. Do we want to accept
5 this measure? And I guess we can --

6 MR. STOLPE: Support for rulemaking,
7 no conditions attached.

8 CO-CHAIR KAHN: Right, no conditions
9 attached.

10 But everybody vote.

11 MR. STOLPE: Now just a quick reminder
12 on this one, this measure is not NQF-endorsed
13 under the new specifications, just to be clear.

14 MS. BUCHANAN: So, voting is now open
15 for MUC2019-22, voting to support. Voting is
16 open and we will close it momentarily.

17 It's open for just a little bit
18 longer.

19 And voting we will now close.

20 So, the voting results for 22,
21 MUC19-22, for support is 4 for yes, 17 for no.
22 It does not receive a support recommendation.

1 CO-CHAIR KAHN: Okay. So now, we go
2 to the next question, which is, would we support
3 it conditionally and what would those conditions
4 be?

5 And Harold?

6 MEMBER PINCUS: So, just to reiterate
7 maybe, Chip, the third one, initially, it would
8 be separating the two measures, one for mental
9 health and the other for substance abuse. Delay
10 implementation of the substance abuse measure.
11 Actually, we wouldn't need to separate it because
12 it already is, the mental health one. So, to
13 make it a separate measure for substance abuse,
14 have a delay in it, and also to achieve the
15 endorsement.

16 CO-CHAIR KAHN: Okay. So, we want
17 separation and endorsement.

18 MEMBER PINCUS: Right.

19 CO-CHAIR KAHN: Okay. Those are two
20 conditions that have been offered. Oh, I'm
21 sorry, three conditions. It would be separation,
22 delay, and then, seek endorsement.

1 CO-CHAIR HALL: Can we get some
2 clarification around what is meant by delay,
3 please?

4 MEMBER PINCUS: I guess delay would
5 be, to some extent, to the discretion of CMS.
6 And I understand that they have an ability to do
7 that.

8 CO-CHAIR HALL: But would you mind,
9 Harold, reiterating the concept of the delay? In
10 your mind, the delay is to accomplish what?

11 MEMBER PINCUS: Is to accomplish,
12 allow the accountable entities to prepare for its
13 implementation.

14 CO-CHAIR HALL: So, a delay in the
15 implementation of the measure?

16 MEMBER PINCUS: Yes.

17 MR. STOLPE: Thank you.

18 CO-CHAIR KAHN: Mary?

19 MEMBER BARTON: Can you provide
20 rationale on why the separation of the measures?

21 MEMBER PINCUS: So, I mean, from my
22 point of view, I would say that it involves

1 really two different processes. I mean, from the
2 point of view of you're talking about two
3 different groups of entities that you would be
4 referring people to. Substance abuse agencies
5 tend to be separated, not always, but often tend
6 to be separate from mental health groups. The
7 populations can be considerably different,
8 although there's a lot of comorbidity. But if
9 you're talking about building internal capacity,
10 also, it's a different sort of process as well.

11 And from the point of view of
12 improvement, you would probably want to have a
13 more separated population to understand what
14 different actions you have to do to improve.

15 MEMBER BAKER: Can I just add to that,
16 that I think at the national policy level, to
17 understand the workforce issues, it would be
18 helpful to have that separation.

19 CO-CHAIR KAHN: Okay. Leah?

20 MEMBER BINDER: I would just urge us
21 not to use the word delay. I just find that
22 exactly the wrong message in considering both the

1 opioid epidemic that we're in right now -- it's
2 the leading cause of death. We really have to do
3 better than admission of delay.

4 CO-CHAIR KAHN: Harold, so there's a
5 suggestion that we not use the word --

6 MEMBER PINCUS: I'm happy to accept
7 that amendment to my motion.

8 CO-CHAIR KAHN: Okay. So, then, we
9 would have separation and seeking endorsement as
10 the two conditions for our conditional support
11 for this measure.

12 Nancy?

13 MEMBER FOSTER: So, just a question
14 here. I don't disagree with your rationale at
15 all, Harold, but by separating the two
16 conditions, we are, in essence, constructing a
17 different measure than the one that was proposed
18 and was reviewed by the Workgroup. And so, if
19 that's the language we're going to use, my
20 suggestion is that that is, at the very least, a
21 do not support, but with potential for
22 mitigation, and mitigation being fundamentally

1 altering the construct of the measure, which,
2 arguably, might be a new measure, which would
3 then put it in a do not support because it wasn't
4 the measure brought forward.

5 So, I'm trying to get --

6 CO-CHAIR KAHN: This is the easier of
7 the two this afternoon where we're going to be
8 re-adjudicating the issue because there's
9 something that is different before us than was
10 before the Workgroup. So, I think you've
11 outlined the possibility, if people want to vote
12 that way. I mean, I guess I would suggest, if
13 that's the way you want to go, then you should
14 vote against conditional. And then we would get
15 to the next stage, which would be do not support
16 with potential for mitigation.

17 MEMBER FOSTER: Well, I guess I'm
18 basically also asking the question -- and maybe
19 it isn't answerable until we've had the longer
20 discussion -- but was it NQF's intention, was it
21 the Committee's intention that a condition would
22 be fundamentally altering a measure? Or is a

1 condition more like we have to tweak this or we
2 have to get more evidence? Or are we going to
3 have to get NQF endorsement? Because conditional
4 to me seems like a relatively easy bar to jump
5 over. Getting NQF endorsement, I don't mean to
6 imply it's easy; it's an important process. But
7 it's a known quantity, and it's after you've
8 developed the measure and it's a good measure
9 that conceptually is aligned, is a relatively
10 easy --

11 CO-CHAIR KAHN: Well, let's let NQF --

12 MEMBER FOSTER: All right.

13 CO-CHAIR KAHN: Hear from the horse's
14 mouth here.

15 MR. STOLPE: The staff perspective on
16 it -- oh, sorry, Chairman -- the staff
17 perspective is that substantive changes that
18 constitute redefining a measure would fall under
19 the mitigation category, as was stated.

20 MR. AGRAWAL: Yes, that's in line. I
21 agree with you, Nancy. I think the condition
22 should be a tweak, a small change, a process

1 requirement. But if you do feel passionately
2 about creating two different measures, then those
3 are two different measures.

4 MEMBER FOSTER: And just to clarify,
5 that doesn't add any time in this case because
6 it's a relatively simple change in the way you
7 construct the measure, I think.

8 CO-CHAIR KAHN: Okay. Rebecca?

9 MEMBER KIRCH: The notations from the
10 Workgroup indicate that there could be unintended
11 consequences for patients. And I'm not able to
12 tease out what those unintended consequence
13 concerns are. Do you recall, folks who were in
14 the Workgroup?

15 CO-CHAIR KAHN: And the staff?

16 MR. AMIN: I think part of the
17 concern -- sorry, I don't know if you're going to
18 into it -- but it was around the patient choice
19 question, about making sure that there's
20 appropriate patient choice. And it was sort of
21 related to the Stark law conversation that Nancy
22 brought up, to make sure that there's still

1 patient choice.

2 MEMBER KIRCH: Patient choice about
3 getting followup or where they get the followup?

4 MR. AMIN: Where they get the
5 followup.

6 MEMBER KIRCH: Thank you.

7 CO-CHAIR KAHN: So, where I think we
8 are right now is -- and I'd like to say this, so
9 that we have clarity as to what we're voting
10 for -- it's been suggested that from the NQF
11 standpoint, if you split the measure, as was part
12 of the amendment here, that that would mean
13 you've got a new measure; and that in terms of
14 support, that wouldn't be the way that NQF
15 usually would operate on this kind of matter.

16 That being said, though, I guess my
17 question to NQF, before we go ahead and I outline
18 the vote, is that that is what has been proposed
19 as support, conditional support. And so, the
20 Committee needs to vote on it. I don't know
21 whether the Committee can get to 60 percent. If
22 the Committee gets to 60 percent, then that's the

1 decision the Committee has made, correct? Then,
2 that would be our recommendation.

3 MR. AGRAWAL: Could I ask a clarifying
4 question, though? I got the impression, Harold,
5 from your comments that you were proposing
6 splitting the measure because of an existing
7 measure already in use? I might have
8 misinterpreted that. But if you take that issue
9 off the table -- I mean, do you really feel that
10 the measure needs to be split or is it only
11 because of the one consideration of the measure
12 that CMS already utilized?

13 MEMBER PINCUS: I mean, my assumption
14 is that, under any of the votes that we make,
15 except for fully supported, that the existing
16 measure for mental health would continue in the
17 program. That's my assumption.

18 CO-CHAIR KAHN: That is a fact. It
19 will continue no matter what happens here.

20 MEMBER PINCUS: Would it continue if,
21 in fact, this measure was fully supported?

22 CO-CHAIR KAHN: Well, it would be that

1 they would combine them into one measure. So,
2 yes, it continues, though, because you still
3 are --

4 MEMBER PINCUS: What I'm saying, but
5 that is a separate measure?

6 CO-CHAIR KAHN: You're arguing it
7 creates a new measure? Yes.

8 MEMBER PINCUS: Yes.

9 CO-CHAIR KAHN: Okay.

10 MEMBER PINCUS: Yes, so it does create
11 a new measure. But, anyway, my assumption is
12 that the existing measure would continue, and
13 that it would be more beneficial to have a
14 separate measure, for the reasons I said before.

15 So, I think part of the problem, the
16 difference between conditional and support,
17 conditional versus do not support and mitigation,
18 is kind of a fuzzy -- you know, we discussed it
19 as being sort of a fuzzy difference.

20 I think the idea I had is that the
21 intent is to support the notion of this measure
22 in terms of having a measure for substance abuse.

1 CO-CHAIR KAHN: But the dilemma you
2 have, I think -- and I'm looking at CMS -- is
3 let's say, if we did recommend that they split,
4 then they have to go back to square one in a
5 sense. And I don't know if it would take as long
6 as other measures because it is relatively clear-
7 cut, but it's still --

8 MEMBER PINCUS: Yes.

9 CO-CHAIR KAHN: What I would advise is
10 the following: from what we hear from NQF, if we
11 wanted to proceed there, it actually does fit
12 much better into do not support with potential
13 for mitigation, with "mitigation" defined as
14 split the measures and endorse them.

15 Now I'm happy to do the vote on
16 conditional support, but it sounds like, at least
17 in terms of how we proceed on such things, that
18 would be a stretch here because we're asking such
19 a big question in terms of this measure.

20 MR. AGRAWAL: So, I would feel more
21 comfortable, if we are literally trying to define
22 a new measure, to go that route because I do

1 think it's a substantive change, to the point
2 that Nancy made earlier.

3 But I actually wonder if we have to.
4 So, if your concern is primarily that this
5 measure, if actually utilized by CMS, would be
6 duplicative with another CMS measure already in
7 use --

8 CO-CHAIR KAHN: No, not duplicative.
9 He's saying a different --

10 MR. AGRAWAL: Or heavily overlapping,
11 right? If you don't split it out, then it's
12 overlapping with the measure that they already
13 have.

14 CO-CHAIR KAHN: No, he's saying
15 they're different kinds of providers. It's in a
16 sense you're going to be sending some people for
17 mental health to psychiatrists; whereas, with
18 this, you've got all kinds of other providers.
19 So, it's really a different thing you're testing.
20 That's what he is saying.

21 MR. STOLPE: So, there's one other
22 component that we need to consider as well. The

1 first vote that we took here was around support,
2 right, if we actually want to support it. The
3 consensus, of course, was that we were not doing
4 that.

5 MEMBER PINCUS: The first vote was not
6 to support vote.

7 MR. STOLPE: Correct. Okay.
8 Supporting the Workgroup recommendation. And
9 then, once we moved away from that, we went to
10 support for recommendation, but we did clarify
11 that that meant not -- that this would be moving
12 forward a non-NQF-endorsed measure. So, there
13 may be those in the room that would just like the
14 latter condition, that we keep the measure
15 together, not separate it out, but the
16 conditional support be NQF endorsement. I want
17 to make sure we don't move past --

18 CO-CHAIR KAHN: So, let me offer an
19 amendment to Harold's. If we could next vote on
20 support, conditional support, and base that
21 conditional support on NQF endorsement? And
22 then, if that doesn't get 60 percent, we would

1 then go to do not support with potential for
2 mitigation. And the two criteria for mitigation
3 would be, one, splitting the measure and, two,
4 endorsement. So, if everyone would accept that,
5 let's --

6 MEMBER PINCUS: Yes, I would accept
7 that, if that makes the process --

8 CO-CHAIR KAHN: Okay. And if Harold
9 accepts that, then I propose we go forward with
10 the vote; and that we're now voting on
11 conditional support with the condition being
12 endorsement by NQF.

13 MS. BUCHANAN: Voting is now open for
14 MUC2019-22. And this is a vote on conditional
15 support.

16 We will keep it open for just a couple
17 more seconds. We are still waiting for some
18 votes to come in. So, we're keeping it open
19 for -- okay, we have 19 votes -- we have 21
20 votes. Okay. So, we are closing voting, and
21 could we quickly look at the percentages?

22 Okay. Great.

1 CO-CHAIR KAHN: Okay.

2 MS. BUCHANAN: So, the Coordinating
3 Committee votes in favor of MUC2019-22 for
4 conditional support; 14 yes votes, 7 no votes.

5 Thank you.

6 CO-CHAIR KAHN: So, I thought that
7 measure was going to become our life's work.

8 (Laughter.)

9 So now, we're moving -- oh, I'm sorry.

10 MEMBER FERGUSON: I thought in the
11 beginning we said you had to have 15 votes. Am I
12 just incorrect?

13 CO-CHAIR KAHN: You gave a percentage.

14 MS. BUCHANAN: So, we have to have 15
15 voting members present for a quorum to establish
16 voting, and then, of the members of the quorum
17 that we have attending, we have --

18 CO-CHAIR KAHN: Right, we have a
19 quorum.

20 MS. BUCHANAN: Yes.

21 MEMBER FERGUSON: Okay. I got the
22 wrong number.

1 MEMBER FOSTER: Yes, so on this one,
2 we had 21 votes. Previously, we've had 19. Did
3 more voting members come to the table that were
4 -- or come to the airwaves? I'm just curious as
5 to what the difference is.

6 CO-CHAIR HALL: We fixed Chip's phone
7 and we gave him two votes.

8 (Laughter.)

9 No.

10 CO-CHAIR KAHN: The votes are the
11 votes.

12 MS. BUCHANAN: Yes. So, several of
13 our members who have been participating via phone
14 had to step in and out, particularly for out.
15 Yes, that's the difference.

16 CO-CHAIR KAHN: Okay. Any other
17 questions?

18 (No response.)

19 Okay. We're going to now proceed to
20 -- let's see, that was the inpatient. So now,
21 we're going to the MUC19-64? Is that correct?
22 And this is the End Stage Renal Disease Quality

1 Incentive Program, standardization for
2 transmission ratio for dialysis facilities.

3 And the Workgroup, as you can see from
4 the slide, recommended conditional support for
5 rulemaking. And do you want to describe that,
6 Sam?

7 MR. STOLPE: Yes. The conditional
8 support was achieving NQF endorsement.

9 CO-CHAIR KAHN: And conditional
10 support on achieving NQF endorsement.

11 So, is there interest in having
12 discussion? Or can we go ahead and consider the
13 Workgroup's recommendation and vote on it? Do I
14 hear anything from the phone or anyone here
15 wanting to discuss this measure?

16 (No response.)

17 Going once, going twice.

18 Then, I propose that we vote now on
19 the Workgroup's recommendation for conditional
20 support for rulemaking for MUC19-64, the
21 condition being that endorsement should be
22 sought.

1 MS. BUCHANAN: Thank you so much.

2 And voting is now open.

3 So, we'll give it just a couple more
4 seconds. We only have 15 votes in.

5 And so, we are going to close voting.

6 And the voting results for MUC2019-64
7 to support the Workgroup recommendation for
8 conditional support for rulemaking is 19 yes,
9 zero no. So, that goes forward.

10 CO-CHAIR KAHN: Okay. So, let's go to
11 Hospital Inpatient Quality Reporting Program and
12 Medicare/Medicaid Promoting Interoperability
13 Program for Eligible Hospitals and Critical
14 Access Hospitals. And this is on MUC19-114,
15 Maternal Morbidity. And the recommendation of
16 the Committee, of the Task Force, was do not
17 support for rulemaking with potential for
18 mitigation.

19 Now something exceptional happened
20 here, which is mitigation since the Task Force.
21 And so, I would suggest the following: since CMS
22 undertook mitigation, that we now go to a

1 discussion of this that will, one, allow staff to
2 explain why the Task Force did what they did, and
3 then, what CMS did to mitigate.

4 And I would ask the indulgence of the
5 Coordinating Committee, that under those
6 circumstances, since this is a measure where
7 mitigation took place, we will be considering a
8 different proposal in a sense than MUC19-114 for
9 Maternal Morbidity under the Task Force. And
10 that, in a sense, we start with the four
11 alternatives when we do our voting and listen to
12 the mitigation that was considered.

13 So, I'm going to take the privilege of
14 the Chair and just move to that. Because I
15 think, otherwise, we could get into a long
16 discussion of governance with the Task Force, and
17 it's just we've moved on from there. And I think
18 we should give CMS, we should respect CMS
19 attempting here to do mitigation in midstream and
20 see how the Coordinating Committee feels about it
21 in terms of what we would want to recommend back
22 to CMS.

1 So, that being the case, I'm going to
2 recognize Sam to describe the circumstances
3 specifically. And then, I assume we will want to
4 hear from CMS in terms of what action they've
5 taken.

6 MR. STOLPE: Thanks very much, Chip.

7 And before I do that, just one note on
8 the previous measure. It was stated that it was
9 seeking NQF endorsement, but the condition is
10 actually achieving NQF endorsement. So, I just
11 wanted to make sure that that portion was clear.

12 CO-CHAIR HALL: Can I ask if there are
13 any objections to that?

14 (No response.)

15 Not hearing any, okay.

16 (Laughter.)

17 MR. STOLPE: Thanks, Bruce.

18 Okay. So, for this measure, when the
19 language around the measure was discussed by the
20 Hospital Workgroup, there were concerns that two
21 components of the way the phraseology of the
22 attestation was put forward were not sufficiently

1 clear.

2 So, the first expectation is that this
3 hospital participate inside of a quality
4 improvement initiative related to maternal
5 morbidity. But it was also expected that they
6 attest to implementing quality improvement
7 initiatives, not just like having a lip service
8 to participation, but actually implementing a
9 quality improvement initiative that addressed
10 maternal morbidity as well. So, there was some
11 wordsmithing that was done inside of the Hospital
12 Workgroup and there were some suggestions
13 proffered to CMS on how they could amend the
14 language to clarify it. With that being said,
15 there was one other condition, and that was NQF
16 endorsement.

17 And CMS has since gone through and
18 made amendments to the measure. If you would
19 like, our CMS colleagues can speak to that to
20 some extent.

21 But, given that those mitigating
22 factors have been addressed, and the traditional

1 category, voting category, that this would fall
2 under, if it were only to achieve NQF
3 endorsement, would be conditional support, what
4 Harold has proffered as a starting point for
5 voting would be, if there's no objections from
6 the Committee, removing the mitigation component
7 and starting, instead, from the conditional
8 support, if you agree that those mitigation
9 factors have been met.

10 Question from Cheryl?

11 MEMBER PETERSON: Can we just get the
12 slide that's behind this one here, so we can just
13 read it?

14 MR. STOLPE: We're attempting to do
15 that. So, apologies. It is very much our
16 intention.

17 CO-CHAIR KAHN: Nancy? Nancy?

18 MEMBER FOSTER: So, I don't know how
19 to think about this. I'm concerned with the
20 process here. I'm concerned that the open public
21 comment that's supposed to be part of this and
22 inform this discussion, and inform the Workgroup

1 discussion, could not take place because none of
2 us had seen this ahead of time. I think this is
3 not in spirit with the way the legislation calls
4 for this process to work. So, I'm deeply
5 concerned about the process here.

6 I'm also under the belief, from having
7 the read the comments, that the language here
8 around what it meant to participate in a maternal
9 mortality or morbidity -- I'm sorry -- maternal
10 morbidity collaborative was not the only concern
11 of the Hospital Workgroup and not the only reason
12 they voted do not support, but with a potential
13 for mitigation. So, maybe I'm wrong in that, but
14 help me out here because this is really
15 troubling.

16 MR. STOLPE: So, Nancy, let me address
17 two points that I think you raised here. The
18 first is stepping outside of the process. So, if
19 any of the Committee objects to us moving forward
20 with the suggestion, then we will go directly to
21 the vote for upholding the Workgroup
22 recommendation as the proposed process.

1 To your second point, we discussed
2 with the Workgroup what exactly the mitigating
3 factors were. And those two that we have listed
4 were the ones that were identified and vocalized
5 by the Committee -- excuse me -- the Workgroup
6 during the course of our discussions. So, they
7 did have other concerns that were raised in the
8 overall discussion, but in terms of actual
9 mitigating factors that CMS could address, those
10 were the two that were identified by the
11 Workgroup.

12 CO-CHAIR KAHN: Okay. I will go to
13 the Davids, but I guess I wonder, from a
14 procedural standpoint, it seems to me that, as a
15 member of the Coordinating Committee has raised
16 the issue with us breaking out of regular order,
17 which I outlined, it seems to me that we only
18 really needed one objection, and that we should
19 go back to regular order; and that the first vote
20 should be on the Task Force recommendation, and
21 that that would be only proper.

22 Now, once we get past the Task Force

1 recommendation, if it's not accepted, then I
2 think we would get into discussions about whether
3 or not -- it could be full support for the
4 changes or conditional or not support with
5 mitigation, but it seems to me that we have to go
6 back to regular order.

7 So, I would propose, unless anybody
8 objects, that we now have a vote on the Workgroup
9 recommendation and see whether or not that, then,
10 we can make a decision there or whether or not
11 we, then, get into a discussion of our own. And
12 then, we can entertain the change.

13 MR. STOLPE: If it's all right with
14 the Co-Chairs, can we first have CMS clarify
15 exactly what they did in the process of
16 mitigation?

17 CO-CHAIR KAHN: I guess my question,
18 this was really a procedural question. I mean, I
19 am happy to have CMS describe it, but I think we
20 should do that once we get beyond the vote on the
21 original recommendation. Because I have a
22 feeling that we're going to get into this other

1 part. How does the --

2 MR. AGRAWAL: I just want to endorse
3 that or support that. I'll try not to use the
4 wrong term. Sorry. I think we had tried to
5 prepare for this, realizing that we were stepping
6 out of the usual order, but for the reason that
7 there was this question about whether the
8 mitigation had occurred. I think now that
9 there's been an objection, which, again, was
10 something that we discussed, I think we've got to
11 take that objection into account. It's an
12 important, legitimate process objection. So, we
13 go to the vote on whether or not to uphold the
14 Workgroup recommendation. And only after that,
15 then, would I think we have a deeper discussion,
16 if merited, if the process would dictate it.

17 CO-CHAIR KAHN: So, let's put the
18 recommendation back up. What is this we have up
19 there now?

20 So, the recommendation of the
21 Workgroup is to not support for rulemaking with
22 potential for mitigation. And I suggest we have

1 a vote on that right now and see where we stand.

2 So, would the staff put up the --

3 MS. BUCHANAN: Absolutely. So, voting
4 is open for MUC2019-114, do you support the
5 Workgroup recommendation? And the Workgroup
6 recommendation was do not support for rulemaking,
7 potential for mitigation. Voting is open and we
8 are getting votes.

9 So, we have 19 votes, which is -- we
10 have 20. So, we are closing the voting.

11 We have received 11 votes for yes, 9
12 for no. That does not achieve a greater than or
13 equal to 60 percent approval.

14 CO-CHAIR KAHN: Okay. So, we now will
15 proceed to consideration by the body to see what
16 alternative recommendation we would want to make.
17 And I would suggest that I'm going to go down for
18 the discussants. But, before I do that, I'm
19 going to ask if there's any objection to allowing
20 CMS to proceed to give us comment on what their
21 mitigation was. So that when we get into the
22 discussion with the discussants, we have that on

1 the table. If there's any objection, then I
2 won't proceed. But do we want to let CMS put on
3 the table the mitigation? It's a question to the
4 body, on the phone.

5 MEMBER FOSTER: So, okay, I'll be the
6 stick in the mud here.

7 CO-CHAIR KAHN: Okay.

8 MEMBER FOSTER: I think in the
9 comments that were articulated prior to our
10 meeting there were a number of questions raised
11 about the process here. And the questions were
12 not about this discussion, where we start our
13 voting. The questions were, essentially, is it
14 the intent of the legislation that created this
15 body to allow essentially changes in measures on
16 the fly? So that we get to a place where we're
17 voting for something different than what was put
18 in front, was put out for public comment and
19 turned over to the NQF before the December 1st
20 deadline.

21 And I have a great deal of anxiety
22 about the thought that we would try to re-

1 adjudicate a measure on the fly, even if we came
2 up with, gee, conditional support, but it has to
3 go through NQF endorsement, because I think we
4 don't know what we're voting for. And I think it
5 doesn't honor the public and their ability to
6 comment on the measures that are before this body
7 for their recommendation if we're moving forward
8 without putting that information out for public
9 comment. And just the whole process is upended
10 when you don't have that which we are now being
11 asked to consider from the beginning. That makes
12 me a little bit crazy.

13 CO-CHAIR KAHN: Let me make this
14 suggestion, and I will erase the word
15 "mitigation". I hear what you're saying, on the
16 one hand. However, on the other hand, if we go
17 back to our discussion we just had on the
18 previous measure, there was a proposal made on
19 conditional that, frankly, redid the measure. So
20 I would argue that, if we hear from CMS and if a
21 member of the Coordinating Committee chose to
22 accept the CMS change and make a proposal for

1 conditional or mitigation, or whatever, along the
2 lines of what CMS offered, that's the same as
3 what Harold did in the last go-round. So, I hear
4 you, but from a procedural standpoint there's
5 nothing stopping this body from either putting a
6 condition or defining a mitigation, and basing it
7 on suggestions from outside, and CMS is going to
8 make a suggestion.

9 So, my proposal would be to go ahead
10 and hear CMS, to have the comments made, and if a
11 Coordinating Committee member decides to make a
12 conditional acceptance amendment, then we would
13 vote on it. I don't see that as any different,
14 frankly.

15 MEMBER FOSTER: So, I think the fact
16 that you suggested we would start with the four
17 voting categories is not consistent with what you
18 just said, Chip. So, if we allowed this group to
19 support this new, mitigated, as yet unknown
20 measure that's being brought forward to us, that
21 would be very different.

22 If what you are saying -- what I heard

1 you just say was it would be okay if this group
2 said, okay, we now agree the mitigating thing
3 should be done to the measure. And if that's
4 what CMS has already done, then they can check
5 the box and say, "Great. We've done what the MAP
6 asked us to do and life is wonderful."

7 CO-CHAIR KAHN: You're misinterpreting
8 what I said and what I did. So, what did we do?
9 We tried a procedure that was outside the regular
10 order. You objected to that. We, then, said,
11 okay, we'll go back to regular order. We then
12 had a vote on whether or not we accepted the
13 proposal of the recommendation of the Workgroup.
14 We did not get to 60 percent. So, that, then,
15 sets us into regular order, into us going down
16 the algorithm of the four.

17 In that case, if a member of the
18 Coordinating Committee chooses to offer a
19 proposal as a condition or as a mitigation, the
20 second or third alternative, and specifies what
21 it is, then that's regular order. We just did
22 that in that other measure. And then, we have to

1 get to 60 percent to actually have it take place.

2 So, it's not a question of what CMS
3 has done. It's a question that we already
4 recognize that we can set conditions if we get to
5 60. So, actually, I don't see it the same way
6 you do. And frankly, if nobody makes an
7 amendment along the lines of what CMS is going to
8 suggest, then we don't do anything.

9 So, bear with me, and we will one have
10 this suggestion, and then, we'll go down the
11 comments.

12 MEMBER BAKER: May I just make one
13 comment on that?

14 CO-CHAIR KAHN: Sure.

15 MEMBER BAKER: Because I think what
16 Nancy is saying is, if we're going to follow the
17 regular order, the first vote to support would
18 have to be on the original unmitigated measure.

19 MEMBER FOSTER: Yes.

20 MEMBER BAKER: So, then, the next one
21 would be a conditional support, and a conditional
22 support could be all of these things that we've

1 talked --

2 CO-CHAIR KAHN: Right. That's what I
3 said.

4 MEMBER BAKER: Yes.

5 CO-CHAIR KAHN: We're going to go down
6 the four votes. I'm not going down to four
7 votes. If you listen to what I said, obviously,
8 if a CMS suggestion is going to be accepted
9 because it's offered by a Coordinating Committee
10 member, it's got to be under the conditional
11 vote, or if a conditional vote fails, it's got to
12 be under the mitigation vote. It's not under the
13 first because we haven't rewritten the proposal.

14 MEMBER BAKER: Right.

15 CO-CHAIR KAHN: I'm not suggesting
16 that we accept their proposal as the first vote.
17 It would be the second or third vote. And then,
18 it would be based on someone from the Committee
19 offering what CMS has put on the table as a
20 condition or as a mitigation. I don't think
21 that's out of regular order. Am I missing
22 something?

1 MEMBER FOSTER: I did not understand
2 your proposal.

3 CO-CHAIR KAHN: Yes.

4 MEMBER FOSTER: And now I do.

5 CO-CHAIR KAHN: Okay. So, that being
6 the case, maybe to make it completely clear, I
7 propose, if it's accepted by the Committee, that
8 before we hear from CMS, we have the first vote.
9 Since we don't really need to hear from CMS, all
10 we need to have is the first vote on whether or
11 not we accept what's on the table, which is the
12 Workgroup recommendation. So, we'll in a sense
13 repeat the vote we already had, but it's the
14 first of the new four.

15 So, with that, let's have a vote.

16 (Laughter.)

17 The yes vote here would be to support
18 the Workgroup's --

19 MR. AGRAWAL: The original measure.

20 CO-CHAIR KAHN: -- the original
21 Workgroup recommendation.

22 MR. AGRAWAL: No, no, the Committee --

1 CO-CHAIR KAHN: Oh, I'm sorry. I'm
2 sorry. I'm sorry. Yes, whether you support the
3 original measure, yes. Yes.

4 MR. AGRAWAL: So, for clarity, is it
5 possible to just zoom-in on the top half of that
6 slide? That is the original measure. If it's
7 possible. If not, please only direct your eyes
8 to the top half of the slide. Okay. All right.

9 CO-CHAIR KAHN: Okay. So, to clarify
10 then, we are voting -- and I apologize for
11 misspeaking -- we are voting whether or not we
12 accept the original measure. So, we're going
13 back to square one. I apologize.

14 Is everyone clear? The Workgroup
15 recommendation has been voted. It did not get
16 the 60 percent. So, we're not going back to
17 square one and we're voting on whether or not we
18 accept the recommendation, I mean original
19 measure that was proposed by CMS.

20 MEMBER GIFFORD: Accept it for what?
21 For a rulemaking?

22 CO-CHAIR KAHN: Yes, for a rulemaking.

1 Yes, do we support for rulemaking?

2 So, with that, is that clear with
3 everyone? Let's vote.

4 MS. BUCHANAN: So, voting is open for
5 MUC2019-114 in its original text. The vote is,
6 do people support for rulemaking?

7 We are waiting on just a couple of
8 other votes. We have 20 votes. Or, no, we have
9 21 votes. Okay. So, we're going to close
10 voting.

11 And the voting results are 4 for yes,
12 17 for no. The Coordinating Committee does not
13 vote to support 2019-114.

14 CO-CHAIR KAHN: Now we go to support
15 with conditions. If anyone wants to make a
16 motion along the lines of the CMS action, then I
17 would propose, if that person did want to do
18 that, that they would probably want to have CMS
19 describe to us what they did. But I'll look at
20 the Coordinating Committee and ask, is there
21 anyone that wants to do that?

22 David?

1 MEMBER BAKER: I make a motion that
2 CMS describe what they did.

3 (Laughter.)

4 CO-CHAIR KAHN: So now, would CMS
5 describe to us the mitigation that they
6 undertook?

7 MEMBER SCHREIBER: So, if I may, let
8 me back up a little bit for even the rationale.
9 CMS recognizes this is a structural measure and
10 lots of people don't like structural measures,
11 frankly, including us most of the time, and that
12 some of the comments that you have heard from the
13 public were around a structural measure, whether
14 or not this actually proves to be efficacious.
15 Sorry, I can't pronounce this word. And that is
16 part of the conversation.

17 So, part of, I think, what you have to
18 think in your own minds is whether or not a
19 structural measure like this would have impact
20 and effect. I think that's a separate thought.

21 So, why did CMS propose a structural
22 measure when we usually don't? And that's

1 because of the importance of maternal morbidity
2 and mortality. There is a tremendous initiative
3 ongoing at HHS looking at the multiple levers
4 that HHS can affect to address the issue of
5 maternal morbidity and mortality. Because,
6 frankly, it's embarrassing that, as the richest
7 country in the world, that we have the worst
8 statistics for this. And so, consequently, this
9 has risen to the top of importance that people
10 want to affect.

11 We are in the process of developing an
12 outcomes measure. Actually, David, part of this
13 is in conjunction with what the Joint Commission
14 has been doing. So, we actually have a joint
15 effort underway to do that, but that measure
16 probably won't be ready for us to bring to you
17 for a couple of years.

18 And because we really didn't want to
19 wait a couple of years before putting something
20 in front of people to be a signal of how
21 important HHS -- and I specifically mean HHS on
22 top of CMS -- how HHS feels that this is so

1 important to flag for organizations, that they
2 should be working on this now. That is the
3 genesis of this measure.

4 When we first brought it to the
5 Hospital Committee, the biggest objection besides
6 the structure measure -- and there were lots of
7 circular conversations about whether or not
8 there's proof that being in quality improvement
9 actually improves quality, which I found a little
10 disturbing from a Committee like this, because in
11 that case what are we all doing?

12 But, beyond that, the biggest issue
13 was they didn't think it had enough teeth to just
14 say that it's an attestation that says, yeah, I'm
15 participating in some kind of quality improvement
16 that includes these bundles. What they were
17 looking for was something that had more teeth
18 that included, yes, I participate in other a
19 state or national recognized bundle and it
20 includes that I am implementing a bundle or a
21 program that actually addresses some of the key
22 concerns that lead to maternal morbidity and

1 mortality, such as hemorrhage, severe
2 hypertension, preeclampsia, and sepsis.

3 So, because of that feedback, and
4 because that really was the mitigating factor,
5 recognizing there's still an issue of structural
6 measure that you have to decide on for
7 yourselves, but the real mitigating factor -- and
8 frankly, we hashed out the language with the
9 Hospital Committee -- was to include the "and"
10 statement, "and has implemented patient safety
11 practices or bundles to address complications".
12 And you can read, "including, but not limited
13 to".

14 And I'll actually say that there is
15 something missing from this slide. The "NA"
16 would be for hospitals that do not provide
17 elective inpatient labor and delivery. That's
18 not on there, but that's how it is supposed to
19 read because we can't tell hospitals, we can't
20 penalize hospitals that are just doing the
21 occasional delivery that's an emergent delivery.

22 So, that's how this measure came

1 about. That's the genesis of it. That's how it
2 got changed.

3 Now I recognize that under normal
4 process what would happen is that we would have
5 to take concerns and mitigating factors back and
6 revise the measure, and that would require us to
7 bring this back to you next year. Frankly, there
8 wasn't a desire to wait another year, and that's
9 why we did it in the current -- what you're
10 calling "on the fly," which is true -- mitigation
11 of the language. But it was done with the
12 Hospital Committee, quite honestly, and we bring
13 that to you in its changed form.

14 Did I miss anything?

15 (No response.)

16 Are there questions on CMS's intent
17 perhaps?

18 CO-CHAIR HALL: Michelle, thank you
19 very much.

20 And can I just re-emphasize, it
21 remains a simple attestation, though. There's
22 not some intended submission of some other

1 evidence of those --

2 MEMBER SCHREIBER: Nope, there's no
3 submission of other evidence. There's actually
4 not even a score. It's a yes/no attestation.

5 CO-CHAIR KAHN: Okay. So, we know
6 what's on the table from David. That would be
7 acceptance with the condition that these changes
8 be made. Is that what you've got? Is that the
9 proposition, David?

10 MEMBER BAKER: No, I had not made any
11 proposition --

12 CO-CHAIR KAHN: Okay.

13 MEMBER BAKER: -- for what the
14 conditions should be. And I would think that the
15 list might be more extensive. Nancy brought up
16 the issue about public comment on this. So, I'll
17 let others make a proposal for what the condition
18 should be.

19 CO-CHAIR KAHN: Okay.

20 MEMBER BINDER: Could I make the
21 motion that we approve with the condition --

22 CO-CHAIR KAHN: Sure.

1 MEMBER BINDER: -- of this wording
2 that's changed?

3 And I want to add just a reminder. I
4 really appreciate, Nancy, your attention to the
5 process. I think that is actually really
6 important. I'm glad you brought it up.

7 But I do think it's important for us
8 to recognize this is an advisory -- we serve as
9 an advisory committee. What we vote doesn't just
10 happen. I think we should err on the side of
11 giving CMS the most robust possible advice and
12 guidance on the perspective of our various
13 stakeholders on how this would play out. But I
14 do think that it is a positive thing for us to be
15 able to weigh-in on something that CMS sees some
16 urgency for, and I would agree there is urgency.

17 CO-CHAIR KAHN: Okay. Bruce?

18 MEMBER QASEEM: This is Amir on the
19 phone. Can I just chime-in over here?

20 CO-CHAIR KAHN: Sure, sure.

21 MEMBER QASEEM: So, I think we're
22 doing wonderful discussion and I totally agree

1 with what Michelle is saying. Conceptually, it's
2 an important measure. It's a priority area.

3 But I'm struggling over here now, when
4 I put my MAP hat on, because I don't think we are
5 here to vote on national priority areas. What I
6 am supposed to do today is that I need to have a
7 performance measure in front of me, and I need to
8 see whether it meets certain criteria or not,
9 because, otherwise, we're not going to be able to
10 compare it. We won't have any inter-rater
11 reliability because all measures are coming in
12 with different sort of information.

13 So, are we today voting on a measure
14 concept? MAP has done that traditionally. We
15 have been looking at a performance measure, but
16 it is presented to us, and then, we review it and
17 we decide whether it's a good enough performance
18 measure or not.

19 CO-CHAIR KAHN: Well, I'm going to
20 recognize Jeff in a moment on the phone.

21 But let me say that we have gotten
22 measures in all forms, I think, over the

1 experience. And some have been in very early,
2 early stages, and often they were not endorsed.
3 So, I don't think it's unusual. I think we need
4 to do the analysis and use the criteria you
5 described, but this isn't completely new. We've
6 faced this kind of problem in different ways
7 before.

8 Before I go to Jeff, we do now have a
9 proposal that we would endorse -- I mean, not
10 endorse -- we would recommend for the measure
11 with a condition that the language and the
12 approach of the measure be changed along the
13 lines of what Michelle described. So, that's on
14 the table as our next proposition, unless someone
15 wants to suggest a further amendment to it.

16 And Bruce is raising his hand, before
17 I go to Jeff.

18 CO-CHAIR HALL: And I know you're
19 going to go to Jeff, but I just wanted to clarify
20 with Leah, Leah, you made the motion. The
21 Workgroup's two concerns also included NQF
22 endorsement. So, do you want to preserve that or

1 were you specifically saying you did not want to
2 continue with that condition? I mean, your
3 suggestion was to adopt the language, but does
4 your suggestion still include NQF endorsement?

5 MEMBER BINDER: Yes. Yes.

6 CO-CHAIR HALL: Okay, it does.

7 CO-CHAIR KAHN: Okay. Just to clarify
8 then, the proposition on the table would be to
9 recommend this measure as amended by what CMS has
10 proposed, and they would -- I used the word
11 "seek" earlier, but it's "receive"? -- and
12 receive endorsement.

13 Okay. Jeff?

14 MEMBER SCHIFF: I just wanted to speak
15 in favor of this, kind of echoing Michelle's
16 remarks and just pointing out that this is really
17 the work of the California Quality Forum, and
18 they have had significant success in decreasing
19 maternal mortality based on having these bundles.
20 And when we think about having cascading measures
21 which is part of a CMS vision, this is a perfect
22 example of how an infrastructure measure can move

1 to an important health outcome. So, I'm just
2 speaking in support as mitigated.

3 CO-CHAIR KAHN: Okay. Is there anyone
4 else that wants to comment? Nancy?

5 MEMBER FOSTER: Actually, I'd like to
6 -- I don't know if this will be considered
7 friendly -- I'd like to offer a friendly
8 amendment to the language to see if Leah would
9 accept.

10 I am aware of some systems that are
11 large enough to essentially run their own
12 collaborative internally to work on this very
13 important issue. The signal has been sent, and
14 very well received, that we need to improve
15 behavior here.

16 But if it said, instead of "statewide
17 and/or national perinatal quality improvement
18 initiative," which implies a certain structure,
19 instead, could it be rewritten as "multi-hospital
20 perinatal collaborative" and let the extent of it
21 be left up to the choice of the hospitals
22 involved?

1 CO-CHAIR KAHN: Leah?

2 MEMBER BINDER: I'm comfortable about
3 it. I guess I would ask Michelle as well.

4 CO-CHAIR KAHN: Michelle?

5 MEMBER SCHREIBER: I understand what
6 you're driving at. The problem is, once you say
7 "multi-hospital," that means two hospitals
8 really. I mean, it's two community hospitals
9 banding together and actually doing some work.

10 Most of the systems that I believe
11 you're referring to we felt would qualify as
12 either statewide or national. Ascension,
13 Dignity, they are multi-state sort of national
14 programs and, yes, they absolutely have some
15 wonderful work that's ongoing. And we sort of
16 consider those to be national.

17 CO-CHAIR KAHN: Okay, Leah, I think
18 it's up to you.

19 MEMBER QASEEM: And then, one more
20 question, if I might. And it's a pretty general
21 measure.

22 CO-CHAIR KAHN: Yes.

1 MEMBER QASEEM: I'm not too worried
2 about it. I'm looking at the measure specs over
3 here. There is nothing about it. It's all
4 empty. What are we voting today?

5 CO-CHAIR KAHN: It's an attestation of
6 a program.

7 MEMBER QASEEM: Is it a measure or
8 not?

9 CO-CHAIR KAHN: It's a process
10 measure. It's an attestation of a program.

11 MR. STOLPE: And this is Sam Stolpe
12 with NQF.

13 So, just for point of clarification,
14 attestation measures are not particularly
15 prominent inside of NQF's portfolio, but there is
16 a precedent for their existence. We do have
17 measures that have gone through and received NQF
18 endorsement that follow a very comparable pattern
19 to what is laid out in front of us, when there's
20 just a numerator statement that's very terse and
21 says what the attestation is, and the denominator
22 statement just says yes or no. So, we've have

1 endorsed those in the past.

2 MEMBER QASEEM: But have you gotten
3 any comments from the folks who live and breathe
4 this arena? Have they said that this is a good
5 measure? They haven't said it's a good measure?
6 I'm a general internist. This is not my topic
7 area. So, I'm just trying to understand what
8 feedback have we gotten. I don't have enough
9 information today, guys.

10 CO-CHAIR KAHN: Amir, I think you're
11 raising the issue in the sense that Nancy was
12 raising. And my answer to you is you're a member
13 of the Coordinating Committee. You're going to
14 have an opportunity to vote in a few minutes.
15 And I have a sense where your vote would be,
16 considering if you don't feel comfortable with
17 going forward, don't vote to go forward.

18 MEMBER BINDER: I would amend my
19 motion to include multi-hospital systems. I
20 think that the flexibility of that is okay, given
21 that the strength of the wording now also
22 requires a certain level of information that goes

1 along with it. And I do know there are some
2 excellent multi-hospital initiatives that are out
3 there. So, I would support that.

4 CO-CHAIR KAHN: Okay. Let's come to
5 David. David? First, David, and then, the next
6 David.

7 MEMBER GIFFORD: I think Michelle did
8 a great job explaining why it's important to have
9 a structural measure, which we certainly don't
10 do. I don't know whether -- I don't think it's
11 worthy of a condition. They are talking about it
12 moving towards an outcome measure down the road.
13 But having seen how the baby-friendly
14 designation, which is a structural measure,
15 changed hospital pediatric care, and changed
16 outcomes, and I think given the huge importance
17 of maternal mortality in this country, and it's
18 slipping, having this moving the hospitals in the
19 right direction makes a huge amount of sense.

20 So, I don't want to throw an extra
21 condition on it, but I think it would behoove us
22 as an organization not to give some advice to CMS

1 that this measure be sunset in the future, when
2 there's more of an outcome or whenever everyone's
3 attesting it. And it's clear it's not going to
4 create reliability and validity, but it will move
5 us down the field.

6 And so, I think Michelle's
7 presentation was very compelling. It sort of
8 switched my vote, and I recommend it.

9 CO-CHAIR KAHN: Okay. Thanks, David.
10 David?

11 MEMBER BAKER: So, this is really sort
12 of a clarifying question. Just so everybody
13 knows, the Joint Commission, we've been working
14 with American College of Obstetricians and
15 Gynecologists for about a year and a half now.
16 And we released standards that every Joint
17 Commission hospital will need to pass, starting
18 July 1st for maternal hemorrhage and maternal
19 hypertension. These will be assessed on survey.

20 So, my question is, would those
21 organizations that have been ahead of the curve,
22 would they still need to participate in a

1 collaborative? Because many of them have been
2 participating in collaboratives for two years.
3 They've been directly working with the AIM
4 program. And if they have a surveyor onsite who
5 goes through, and they've got hemorrhage cards
6 and they've got policies and they've gone through
7 the team training programs, and they met all of
8 these very rigorous standards, I would hope that
9 they wouldn't need to participate in a
10 collaborative.

11 MEMBER SCHREIBER: David, then the
12 answer to their question on the attestation is
13 yes.

14 MEMBER BAKER: But they might not
15 still be doing this. They might have done this
16 two years ago. I mean, the ACOG has been running
17 these AIM collaboratives now for at least three
18 years, if not four years.

19 MEMBER SCHREIBER: So, correct me if
20 I'm wrong, but I thought those were ongoing
21 initiatives that organizations continue to update
22 and track the data, which I guess to us is still

1 participating.

2 MEMBER BAKER: Yes. I guess, going
3 forward, though, organizations, they may not be
4 participating in a formal statewide
5 collaborative. They have achieved this. They've
6 implemented these things. Their past
7 implementation. I think that we'll see that more
8 and more.

9 Right now, there's probably not all
10 that many, based on what we've seen from ACOG,
11 particularly for hemorrhage and hypertension.
12 But I think, going forward, there are going to be
13 organizations that will have this fully
14 implemented. It will be business as usual. And
15 I think the measure that we've talked about will
16 be much more important for those organizations to
17 know whether they are successful.

18 MEMBER SCHREIBER: I guess my only
19 counsel would be that I believe those
20 organizations who have done this work and have
21 implemented these should just answer "yes" to the
22 attestation. And then, you're correct, over time

1 the goal is to replace this with the outcomes
2 measure that's in development. They're a couple
3 of years off.

4 MEMBER BAKER: Okay. So, with your
5 permission, we'll communicate that to --

6 CO-CHAIR KAHN: Okay. Liz?

7 MEMBER GOODMAN: So, I had two
8 comments. One is going back to before we changed
9 it to include the multi-hospital collaboratives,
10 whether or not CMS would consider some kind of a
11 dropdown menu to say what is a "yes" and what
12 isn't a "yes". Because it sounds like it's
13 formal participation in a collaborative or
14 something that closely looks like that, right?
15 And if I were the attester, I'm not sure I would
16 know how to answer it.

17 The other issue that the Rule
18 Committee pointed out -- and there are at least
19 five pieces of pending federal legislation
20 creating more of these collaboratives -- is not
21 every geography has a collaborative.

22 So, I think to the extent that you are

1 able to say this also would qualify, because (a)
2 you don't have a collaborative or (b) you're past
3 it, that that would be useful to those people who
4 are responsible for the attesting.

5 CO-CHAIR KAHN: Okay. Leah?

6 MEMBER BINDER: I totally agree with
7 that point. I think it's important to offer
8 enough flexibility, so that hospitals can get
9 going; they have a mechanism to move along in
10 this process.

11 I appreciate your point about
12 hospitals that are already achieving higher
13 standards in terms of their efforts around
14 maternal mortality. That's important. But I
15 would also add that, especially at this stage as
16 we're addressing this problem, we want the higher
17 performers to be involved. We don't want them to
18 walk away. They have the lessons learned that
19 all the rest of the hospitals can implement. So,
20 I think the encouragement of the team effort and
21 involvement and focus on this issue is part of
22 what's important about this.

1 CO-CHAIR KAHN: Okay. Can we go to a
2 vote on this? Just to repeat --

3 MR. STOLPE: Yes, I think we need to
4 restate.

5 CO-CHAIR KAHN: So, this would be to
6 endorse the measure with conditions. And I'm
7 going to ask Leah, because I want to make sure
8 that we follow her language. The conditions
9 being that the language in this attestation would
10 be changed to -- and can we actually read the
11 language? I don't know if it's better if you do
12 it or CMS does it. Maybe if CMS would. Could
13 you actually, Michelle, or one of you, actually
14 read the language, so that everyone could
15 understand?

16 MEMBER SCHREIBER: We can, and don't
17 get me wrong, we're happy to.

18 CO-CHAIR KAHN: Right.

19 MEMBER SCHREIBER: But it sounds like
20 there may be other language that people are
21 looking to change.

22 CO-CHAIR KAHN: The only language that

1 I thought changed was the addition of the multi-
2 hospital.

3 MEMBER SCHREIBER: The multi-hospital.

4 CO-CHAIR KAHN: The multi-hospital.

5 MEMBER SCHREIBER: And as implemented
6 and possibly a checkbox, a dropdown checkbox.

7 CO-CHAIR KAHN: Okay. So, if you
8 could add that, if you could read it, just so
9 that --

10 MEMBER SCHREIBER: So, the updated
11 wording is, "Does your hospital or hospital
12 system participate in the statewide national
13 perinatal improvement collaborative program aimed
14 at improving maternal outcomes during inpatient
15 labor/delivery and postpartum care, and has
16 implemented patient safety practices and bundles
17 to address complications, including, but not
18 limited to, hemorrhage, severe hypertension,
19 preeclampsia, and sepsis?"

20 CO-CHAIR KAHN: Right.

21 MEMBER SCHREIBER: So, forgive me, but
22 what I heard was the conditions are (a) accepting

1 the revised language; (b) inserting multi-state,
2 and (c) considering having a dropdown list that
3 is more specific to allow for organizations to
4 answer this better. Did I capture everything?

5 CO-CHAIR KAHN: Yes, and the other
6 being endorsement, I think.

7 MEMBER SCHREIBER: But it's multi-
8 hospital. Multi-hospital.

9 CO-CHAIR KAHN: And then, the other
10 being endorsement. Okay.

11 So, I hope everyone understands the
12 proposition.

13 Bruce?

14 CO-CHAIR HALL: Well, could I clarify?
15 So, there was one comment about just two
16 hospitals. So, do we want to say national,
17 state, or regional collaborative of three or more
18 hospitals is one question? And then, going back
19 to David's comment, the other possibility, we
20 could say, does your hospital currently or have
21 you within the last 18 months participated in AIM
22 and implemented practices? So, those would be

1 two possibilities.

2 CO-CHAIR KAHN: I would ask on the
3 first one that you have so many different
4 circumstances out there. But, yes, the problem
5 is you could have two small hospitals get
6 together, but, frankly, you could have two
7 hospitals get together that are much bigger than
8 a lot of systems. So, I think to get into -- I
9 mean, it's just an attestation anyway. I mean
10 it's really an aspirational kind of thing. So, I
11 think to get into that kind of level of
12 definition, at least from my perspective, would
13 be -- then, you're going to get into CMS having
14 to determine how many hospitals they actually
15 have. I guess I would argue against it.

16 MEMBER GIFFORD: I feel like we're
17 drifting into what Nancy said.

18 CO-CHAIR KAHN: Yes.

19 MEMBER GIFFORD: And we're getting
20 into endorsement process, which we've already
21 said this has to go back through endorsement. In
22 that endorsement process, that's where the

1 Committee can work out those details. I think
2 the conversation can be captured to CMS as they
3 go back through the endorsement process. But, to
4 me, I feel like we're going beyond our role as
5 the Coordinating Committee at this point.

6 CO-CHAIR KAHN: And if people feel
7 that way, that will be reflected in their vote.
8 And I think we're at the stage now where we
9 really need to proceed.

10 So, I think it's clear what the
11 proposition is on the table. Unless, Leah, I
12 mean Leah would --

13 MEMBER BINDER: I just want to stay
14 with multi-hospital.

15 CO-CHAIR KAHN: Okay. So, that being
16 the case, then if you vote yes, you're going to
17 be voting for a recommendation that the measure
18 go forward with the conditions that were outlined
19 by Michelle. And the proposition was put on the
20 table by Leah. If everyone accepts that -- that
21 was one of the things I mentioned. I mean yes.
22 So, let's go forward then and have a vote.

1 MS. BUCHANAN: Great. So, voting is
2 now open for MUC2019-114, conditional support.

3 We're still waiting on some votes.

4 Seventeen -- I know that some members
5 on the phone had to step off, but we have 19, 20.
6 Okay. So, we are at 20 votes. We're going to
7 close it.

8 Voting results are 17 vote yes, 3 vote
9 no. So, MUC2019-114 goes forward.

10 CO-CHAIR KAHN: Okay. So, that's it.
11 One more for hospital, though. Okay. One more,
12 and I'm sure everybody wants to get to lunch now.

13 (Laughter.)

14 MUC19-26 is Hospital Harm, and we'll
15 look at the measure. And the recommendation was
16 conditional support for rulemaking. And I'll
17 look at Sam.

18 MR. STOLPE: Yes, pending NQF
19 endorsement.

20 CO-CHAIR KAHN: Okay. And I'll look
21 at the list of discussants. Do we want to go
22 ahead and have a discussion or should we go ahead

1 and have the first vote, the first vote being on
2 the recommendation of the Task Force?

3 MS. CLARK: I apologize, Jeff. Libby
4 Hoy, who was lead discussant, did send a couple
5 of comments. Is it okay if I read them or would
6 you prefer me not?

7 CO-CHAIR KAHN: Well, Libby is on the
8 phone.

9 MS. CLARK: She had to step off.

10 CO-CHAIR KAHN: Oh, okay. If she sent
11 comments, then we should do it.

12 MS. BUCHANAN: We need the first vote.

13 CO-CHAIR KAHN: Oh, I'm sorry. What?

14 MS. BUCHANAN: We may not have
15 comments.

16 CO-CHAIR KAHN: Well, the awkward
17 thing here is that she actually gave comments.
18 So, I guess I'm protecting her. I mean, I guess
19 the definition is she wanted to comment.

20 MEMBER KIRCH: Is the nature of the
21 comment such that it would suggest that she would
22 have objected to us proceeding?

1 CO-CHAIR KAHN: Okay. So, can you
2 make a judgment as to the nature of the comments?

3 PARTICIPANT: How about I just do
4 this. Before we vote, let's just talk about it.
5 But I'll raise one concern over here. Is that --

6 CO-CHAIR KAHN: Okay. So, let's go
7 ahead, then, with Libby's comments.

8 MS. BUCHANAN: So, I'm just going to
9 read them verbatim.

10 "May control an early response to
11 hypoglycemic state and has the strong potential
12 to improve patient safety, which would avoid
13 catastrophic impacts to patients when missed.
14 The Workgroup raises concerns about the ability
15 of EHRs to capture data at the point of care, but
16 also acknowledges that there will be minimal
17 reporting requirement. Conditions for acceptance
18 might include NQF endorsement and a coordination
19 of existing measures."

20 CO-CHAIR KAHN: Okay. Nancy, I think
21 you were the next discussant.

22 MEMBER FOSTER: I agree with Libby's

1 comments and the comments of the Workgroup. This
2 is a measure that the Workgroup had suggested
3 definitely had to go forward as a paired measure,
4 and I believe that's the intent of CMS in using
5 it. But I think a question to put on the table
6 there is this theory that, if you have paired
7 measures, you essentially create a balance of not
8 over incentivizing people to swing in one
9 direction or another. In other words, we don't
10 want to create hypoglycemia by having a climate
11 of hyperglycemia, nor do we want to create
12 hyperglycemia by having just the hypoglycemia
13 measure.

14 So, the pairing is thought to lead to
15 better outcome. That's a theory that I have not
16 seen proof of anywhere. And I worry that, by
17 having these two measures perhaps independently
18 acting, that we will, in fact, create more harm.

19 So, I think one of the conditions here
20 would be close monitoring of how this gets rolled
21 out and whether there is, in fact, greater harm
22 caused by having two measures. My concern being,

1 not my theory, but my concern being that if a
2 patient comes in hyperglycemic or is
3 hyperglycemic when they are in the hospital,
4 you're going to push them and it may lead to
5 hypoglycemia, and vice versa. And so, you may
6 end up getting more harm than help.

7 CO-CHAIR KAHN: If I can ask, this
8 would be electronic?

9 MEMBER FOSTER: Yes.

10 CO-CHAIR KAHN: Do we know that all of
11 the information that will support the measure is
12 comparable across records? Or is that going to
13 be a problem?

14 MEMBER BAKER: I believe that was
15 something that was addressed during the measure
16 development, that they looked at that. That was
17 one of the things in general. There were a
18 number of measures that were developed under an
19 initiative to look at safety measures for
20 electronic health records and they did look
21 across different electronic health records, but I
22 can't give you any specifics. I don't recall.

1 CO-CHAIR KAHN: And that was a problem
2 or that was something they thought was not a
3 problem?

4 MEMBER BAKER: Yes, it was a problem.
5 It was a problem. I don't believe it was for
6 this. Otherwise, it probably would not have
7 passed out of that group. But I'm just saying
8 simply that they did look at that.

9 CO-CHAIR KAHN: Okay. Thanks.
10 Thanks, Dave.

11 Yes, I would like the measure expert
12 to comment on this because I know from
13 experience, not on this, but in comparable areas,
14 that there are a lot of assumptions made about
15 what's in the electronic health record. And you
16 go from hospital to hospital and there are
17 incremental differences in how things are
18 recorded.

19 MEMBER BAKER: I think that's much
20 less likely for this because they have pretty
21 much the raw data.

22 MEMBER SCHREIBER: I'm sorry. I think

1 we have Gale (phonetic) and Joe on the phone as
2 our content experts, if you guys would like to
3 weigh-in to answer that, please.

4 PARTICIPANT: We have our entire
5 international support contractor on the phone.
6 They can answer the question.

7 But can you briefly -- what was the
8 question?

9 CO-CHAIR KAHN: I just want to make
10 sure that the data is going to be comparable
11 across from the electronic records.

12 PARTICIPANT: Yes, we have tested it
13 from multiple EHR vendors -- Cerner, Epic,
14 Meditech -- from urban, rural, urban in teaching,
15 and urban non-teaching. So, a variety of
16 hospitals.

17 CO-CHAIR KAHN: Okay.

18 PARTICIPANT: Did that answer the
19 question or?

20 CO-CHAIR KAHN: Yes, that's fine.

21 PARTICIPANT: Okay.

22 CO-CHAIR KAHN: So, was Amir on the

1 phone?

2 MEMBER QASEEM: Yes, yes, I'm still
3 here.

4 Frankly, this is a bad measure.
5 Looking at the specifics, looking at the CMS
6 data, from 1999, according to CMS, from 1999 to
7 2013 -- that's the latest data; I just pulled it
8 up -- the hyperglycemic events have been going
9 down. And they've been going down, as they
10 report, which is good, right? But the
11 hypoglycemic event -- I'm looking at the scope
12 over here -- it's been tremendously -- it's like
13 hitting 35 or something percent.

14 And then, we are heading towards the
15 direction in this measure, we are pushing for
16 addressing the hyperglycemic events versus what
17 the CMS data is showing is that the much bigger
18 problem we have in the hospital is the
19 hypoglycemic event.

20 And it's, frankly, a bad measure.
21 There's no need for this measure. We need to
22 start working towards controlling the

1 hypoglycemia which leads to death, which is a
2 bigger problem.

3 I'll shut up.

4 (Laughter.)

5 CO-CHAIR KAHN: Okay. Nancy?

6 MEMBER FOSTER: So, this is Nancy.

7 Just for clarification, there is a
8 hypoglycemic measure which -- I mean, I can't
9 remember whether it's implemented or not. So, it
10 might be great to have some clarification around
11 how CMS is intending to implement this as a
12 paired set, if not, or what is the intent?

13 CO-CHAIR KAHN: Okay. Could CMS
14 respond?

15 MEMBER DUSEJA: Yes.

16 PARTICIPANT: This is Joe.

17 MEMBER DUSEJA: Go ahead, Joe.

18 PARTICIPANT: So, I mean, we can't
19 exactly say what is happening in rulemaking right
20 now, but what we can say is the idea is to move
21 these eCQM hospital harm measures to the eCQM
22 list for hospitals to pick from and eventually

1 have an eCQM harm composite of all of these
2 harms. But, as they're developed individually,
3 our aim is to propose them through rulemaking and
4 have them available until we have the harm
5 composite complete.

6 CO-CHAIR KAHN: Okay. So, I propose
7 we proceed with all the information that's on the
8 table. And on this measure, there was a
9 recommendation that it be conditionally
10 supported. What's the pleasure? Let's have a
11 vote.

12 MEMBER BAKER: Can you just specify
13 what the conditions were?

14 CO-CHAIR KAHN: No, the condition was
15 endorsement.

16 MEMBER BAKER: Oh, I'm sorry. It said
17 this is --

18 CO-CHAIR KAHN: No, it's said
19 conditional support for the rulemaking. The only
20 condition was endorsement.

21 MEMBER BAKER: Just NQF endorsement?

22 CO-CHAIR KAHN: Yes, that's what I

1 said.

2 MEMBER BAKER: Thank you. That's all
3 I was asking.

4 CO-CHAIR KAHN: Okay. So, if we could
5 now vote on the recommendation of the Committee,
6 of the Task Force? This would be a "yes" would
7 be to support the recommendation of the Task
8 Force. A "no" would be to oppose the
9 recommendation of the Task Force.

10 PARTICIPANT: This is Joe.

11 Something that you just said, did you
12 say that it was not endorsed?

13 MR. STOLPE: No, we haven't voted yet,
14 Joe.

15 CO-CHAIR KAHN: The question was
16 whether, as a condition, it would be endorsed.
17 That was the condition, right?

18 PARTICIPANT: It is endorsed now.

19 MR. STOLPE: Oh, it's gone through.

20 CO-CHAIR KAHN: Oh, it is endorsed
21 now? Oh.

22 PARTICIPANT: Yes, and it's 3533.

1 CO-CHAIR KAHN: Oh.

2 MR. STOLPE: So, it was newly endorsed
3 after -- correct, yes. So, it finalized the
4 endorsement process, yes.

5 CO-CHAIR KAHN: Well, let's vote as
6 standing, and then, it would have met the
7 condition.

8 MS. BUCHANAN: So, voting for 2019-26,
9 Hospital Harm, to accept the offered
10 recommendation of conditional support is now
11 open.

12 We are still waiting on some votes.

13 We have 18 votes. We have 19 votes.
14 We have 20, which is as many as we have.

15 So, the recommendation is 16 yes, 4
16 no. The Coordinating Committee votes to move
17 2019-26.

18 CO-CHAIR KAHN: So, that would be the
19 vote on that measure. And the fact that they
20 have met the condition, it has been done.

21 So, that finishes the hospital
22 measures. We have half an hour for lunch. Let

1 me suggest that we try to do lunch in 20 minutes
2 and get back here at 1:30. Is that okay?

3 MR. STOLPE: It's appropriate to
4 continue eating your lunch as we resume
5 discussions as well.

6 CO-CHAIR KAHN: Yes, don't worry about
7 that, but I think we need to get back.

8 MR. STOLPE: We don't want any choking
9 hazards.

10 CO-CHAIR KAHN: But we'll be back at
11 1:30, which would put us half an hour behind.
12 But Bruce is going to do a better job than me.
13 So, he'll catch up, I'm sure.

14 (Whereupon, the proceedings went off
15 the record for lunch at 1:09 p.m. and went back
16 on the record at 1:33 p.m.)

17 CO-CHAIR HALL: All right. At this
18 point, we'd like to resume work. We're about 30
19 minutes behind the printed schedule; the agenda
20 for the day. So at this point, I would like to
21 ask if there's anyone that would like to make
22 public comment on clinician programs, either in

1 person or on the line.

2 We'll give folks a few seconds to
3 settle back in here. Is there anyone present or
4 on the line who would like to make public comment
5 on clinician programs? You guys got anything?

6 MEMBER MORALES: I thought we were
7 going through them one measure at a time to make
8 comments.

9 CO-CHAIR HALL: No, just public
10 comment in general right now.

11 MEMBER MORALES: Okay.

12 CO-CHAIR HALL: Okay. Not hearing
13 any, I will turn over the stand for the pre-
14 rulemaking commentary.

15 MR. STOLPE: Very good. Thank you
16 very much. Now we're going to be visiting the
17 Clinician Workgroup Program, so we're very
18 excited this year to not only have MIPS and SSP
19 be included, but for the first time, Medicare
20 Part C and Part D Star ratings program for
21 consideration by the Clinician Workgroup and this
22 committee.

1 We had a total of ten measures, but I
2 want to emphasize, this is not ten unique
3 measures. There's one measure that was
4 considered for MIPS as well as for SSP.

5 I'd like to visit the overarching
6 themes of the Clinical Workgroup. First, the
7 Clinician Workgroup emphasized the importance of
8 shared accountability for performance measures,
9 especially when they are -- have broad
10 implications across a population.

11 The concern that was raised is that
12 when there is shared accountability for an
13 outcome, and that gets attributed, especially to
14 a single physician, that it might not entirely be
15 within that physician's control, or clinician's
16 control, to perform well on that measure.

17 We also recognized that addressing
18 social determinates of health is a major priority
19 for the health system broadly speaking, but also
20 noted the challenges with addressing that through
21 quality measurement.

22 We also spent some time talking to

1 appropriate opioid measurement, as you'll likely
2 have noted, there are three opioid measures that
3 are being considered for Medicare Part C and D.

4 The workgroup acknowledged a very
5 important shared responsibility for individual
6 providers, health systems, and plans to address
7 issues of pain management as well as opioid use
8 disorder, and emphasized the proper measures need
9 to be applied across the healthcare system, such
10 that opioid overdose deaths continue to decline
11 in a manner that's verifiable.

12 Continuing the themes, they also
13 wanted to share a couple of their key
14 considerations related to meaningful measures
15 initiative. They encouraged CMS to continue the
16 effort to optimize simple predicative analytics
17 and AI, to understand the opportunities for
18 quality improvement, and those efforts should
19 prioritize increased feedback to providers
20 through actionable quality measurement and
21 clinical decision support.

22 They also encouraged CMS to focus on

1 patient safety in public reporting, noting again,
2 comparable to what the Hospital Workgroup
3 emphasized, that the consumers do find these
4 types of measures more intuitive and useful than
5 other measure types.

6 And they also supported CMS' efforts
7 -- excuse me, to encourage local communities,
8 health systems, specialty societies, and others
9 to develop new measures -- or new types of
10 performance measures using emerging data sources.

11 Okay. So let's move forward into a
12 discussion of the measures themselves. We're
13 going to start with MUC19-27, hospital-wide 30-
14 day all-cause, unplanned, readmission rate for
15 the merit-based incentive payment program
16 eligible clinical group.

17 So just want to emphasize that this is
18 for clinical groups, not for individual
19 clinicians. This measure received conditional
20 support for rulemaking and those were two
21 conditions now when it's usually just the NQF
22 endorsement, but this is pending removal and

1 replacement of NQF 1789 in the MIPS program
2 measure set, and the CDP standing committee
3 review of the reliability performance at the
4 physician group level, which is slated to occur
5 in the spring 2020 measure evaluation cycle.

6 This measure garnered quite a few
7 public comments, and I just want to review the
8 overarching themes for the 17 comments that were
9 received.

10 Some were supportive of the measure,
11 others expressed opposition to population health
12 measures attributed at the physician level in
13 general, which again, was a theme related to the
14 workgroup discussion as well.

15 There were attribution concerns,
16 concerns about how risk adjustment would be
17 implemented in this, and also, some concerns that
18 -- related to evidence that providers can easily
19 influence this measure.

20 Wanted to pivot to our workgroup co-
21 chairs. I see that Rob is on the line, do we
22 have Bruce on the line as well?

1 DR. BAGLEY: Yes, Bruce is on.

2 MR. STOLPE: All right. Very good.

3 Would either of you like to supplement any of my
4 remarks related to this measure with any
5 highlights from the workgroup?

6 DR. BAGLEY: Not from me.

7 DR. FIELDS: I don't think I have any
8 additional comments. This is Rob.

9 MR. STOLPE: All right. Very good.
10 Thanks, gentlemen. Turn it over to Bruce Hall.

11 CO-CHAIR HALL: So what we're going to
12 do is just a slight tweak on the morning. So
13 we're going to have Sam introduce each measure
14 and we're going to take it up as soon as Sam
15 gives the brief introduction.

16 So having had the brief introduction
17 for 19-27, hospital-wide 30-day all-cause,
18 unplanned readmission for MIPS-eligible clinician
19 groups. Does anyone want to put forward any
20 clarifying questions before we vote on the
21 recommendation from the workgroup?

22 So if you want a full discussion, you

1 would vote down the recommendation of the
2 workgroup. If you have any minor clarifying
3 questions, we'll take those now. David? David?

4 MEMBER GIFFORD: I guess I don't have
5 a minor clarifying, I'm one of the lead
6 discussants, and this and the site measure were
7 the two that cause me most discussion. I'm
8 really torn between supporting this and not and
9 felt it needed a full discussion.

10 So I don't have any re-clarifying, I
11 have broader issues that stand.

12 CO-CHAIR HALL: Okay. So as one of
13 the leads, David's expressing a desire for full
14 discussion. So do you want us to vote down the
15 workgroup recommendation first or just proceed
16 with full discussion?

17 Let's go with the recommendation vote
18 first. Okay. So in the context of David's
19 comment, we will still vote right now to yes or
20 no on conditional support. And you heard
21 comments about the conditions from Sam.

22 MS. BUCHANAN: Voting is now open on

1 2019-27 to move forward with the workgroup
2 recommendation of conditional support for
3 rulemaking. Voting is open.

4 MEMBER ROBERTS: I'm sorry, can you
5 clarify the conditions?

6 CO-CHAIR HALL: The conditions are,
7 one, seeking NQF endorsement, and two, removal of
8 the current measure that was comparable expense
9 from the MIPS catalog of measures. Okay. Voting
10 is open.

11 MS. BUCHANAN: Voting is open. We are
12 still waiting for some votes. We have 15 so far.
13 We have 16, which -- okay. So we can stop
14 voting. 19. Okay. So we received 10 votes for
15 yes, 9 votes for no, that does not achieve a
16 greater than 76 percent consensus, so the
17 coordinating committee does not recommend
18 conditional support for rulemaking for 2019-27.

19 CO-CHAIR HALL: So we're not accepting
20 that off the bat. Now we'll open for full
21 discussion. So, David, would you like to open
22 that discussion?

1 MEMBER GIFFORD: So I think this is a
2 question of whether the measure is -- needs
3 mitigation for rulemaking besides just NQF
4 endorsement. And that's where I move for
5 discussion.

6 This measure is a modification of an
7 existing measure on the hospital side that is
8 applied to individual physicians and is modifying
9 the sample size to capture more physicians in the
10 measure, physician groups in the measure.

11 There were, as pointed out, robust
12 public comments on this. There were 17 public
13 comments, 16 were opposing this, and one was in
14 favor. The one in favor is a primary care
15 physician group. I don't know how you count AMA,
16 as whether they're a primary care physician or
17 not, they oppose.

18 And all the opposition was around the
19 attribution issue and use in rulemaking. There's
20 some questions about risk adjustment and
21 everything else, but I am not going to raise them
22 because that's really for the endorsement piece

1 of it.

2 The concern was that this measure
3 developed a new attribution method that
4 attributes each discharge from the hospital to
5 see if they got great follow-up from the three
6 different physicians.

7 And many of the specialty physicians
8 felt that they're being attributed to this was
9 not necessarily accurate and they shouldn't be
10 held accountable for it.

11 So there were complaints about
12 ophthalmology, there were complaints with cancer,
13 in line with some of the more subspecialty
14 groups.

15 And I'm not sure how best to interpret
16 that information because if it's in a payment
17 issue and how they do attribution, I think we
18 clearly want their coordination, we clearly want
19 issue, but did not appear, and I went back and
20 looked at the measure specs, this is almost a
21 different than measure spec issue, because I
22 think it's going to get NQF endorsement.

1 It's, is the attribution method
2 appropriate for MIPS for a specialist, and I
3 think I would like to want to see some
4 information around that as a mitigating factor
5 before I would say this is ready for rulemaking,
6 and so that was the concern.

7 But I'm torn on the fence with it. I
8 could be sort of swayed back on the other angle
9 with this. Generally, I would say the complaints
10 from physicians not wanting to be attributable to
11 them and everything else that's not perfect, I
12 tend to overlook that because there's no perfect
13 measure and everything else, but this, I had a
14 lot of questions in the public comments and
15 reading it.

16 Also, it was not clear -- it looked
17 like this had gone through NQF endorsement and
18 was getting close to it, but it wasn't, and then
19 -- so I actually asked, and I don't know if the
20 staff won't allow me, it turned out they asked
21 for additional information, the information they
22 got led them to say they were going to probably

1 lead to endorsement, but then it turned out that
2 information was inaccurate, and so now it's going
3 back to begin the endorsement, is that correct?

4 That's correct?

5 MR. AMIN: Bruce knows this while
6 being on the standing committee, but basically,
7 just so that everyone's on the same page, the
8 measure was submitted for endorsement, the
9 committee reviewed it, if you're looking at any
10 of the draft reports and looking at the original
11 voting, there was some during the post-comment
12 call, there was a number of comments provided by
13 various stakeholders related to the reliability
14 test.

15 During the post-comment call, the
16 committee reviewed the post-comment -- reviewed
17 the reliability statistics provided by the
18 developer. There was some confusion about what
19 was actually submitted and in order -- rather
20 than re-adjudicating the conversation, the
21 committee decided to re-look at the entire
22 measure during the next cycle.

1 So it was, basically, to spend more
2 time thoughtfully looking at the reliability
3 statistics.

4 MEMBER GIFFORD: So I think we have on
5 the floor from the recommendation floor, the
6 endorsement is still going through that process.

7 MR. AMIN: Yes.

8 MEMBER GIFFORD: I guess my question
9 is, is there a mitigating factor, and I think,
10 you know, we are trying to push for care
11 coordination between doctors and everything else,
12 it's not clear that this measure is ready for
13 that rulemaking on that piece.

14 I think it's moving in the right
15 direction, I think it's very supporting, and I
16 wanted to make sure we had that discussion,
17 because to me, it wasn't a slam dunk, just
18 getting NQF endorsement and go forward with it,
19 like many of the other measures that we have.

20 CO-CHAIR HALL: Great. Thank you.
21 Well stated. Cheryl, do you have more to add.

22 MEMBER PETERSON: So David and I had

1 a conversation, so I would actually agree with
2 his remarks. I had looked at the reliability
3 question that had been raised and actually, with
4 the American Heart Association and the comments
5 that they made, regarding whether or not this is
6 more appropriate be solely a systems level as
7 opposed to a physician and business group level.

8 So I think my comments would track
9 with what David has already said. Thank you.

10 CO-CHAIR HALL: Thank you. Scott,
11 would you like to add?

12 MEMBER FERGUSON: Yes. The AMA does
13 not support the current recommendation due to
14 lack of support during the public comment, the
15 lack of sufficient evidence to support the
16 broader attribution and reliability, and
17 validity, of the results.

18 We think that the reliability factor
19 should at least be between 0.7 and 0.8, and we
20 don't see that in the numbers that we've got.

21 CO-CHAIR HALL: Thank you. Emma, do
22 you have additional comments?

1 MEMBER GIFFORD: Just one thing, the
2 reliability is not the reliability in the
3 measure, it's the reliability of the attribution
4 component of that. I just want to make sure
5 that's clear.

6 CO-CHAIR HALL: Is that correct,
7 Scott?

8 MEMBER FERGUSON: Yes, sir.

9 CO-CHAIR HALL: Thank you. Emma?

10 MEMBER GIFFORD: The measure appears
11 to be a reliable, valid measure, and it's going
12 through NQF endorsement, and this idea of a
13 system is clear it's good. To me, that's why
14 it's a discussion about rulemaking.

15 CO-CHAIR HALL: Thanks. Thank you,
16 David. Emma?

17 MEMBER HOO: We have had experience
18 with physician-level measurement and physician
19 group level as well as practice level, and there
20 are mechanisms to bring that data together in an
21 effective way that does reflect performance, and,
22 you know, without having gone deep into the full

1 detail of this measure, I'd hate to kind of throw
2 the baby out with the bath water around, you
3 know, the opportunity here to improve on these
4 processes and getting to more granular
5 information.

6 CO-CHAIR HALL: Thank you. And then
7 the last discussant, Amir, on the phone? Amir,
8 do you have any additional concerns or comments?

9 Not hearing anything, I would propose
10 we will proceed with the vote for full support
11 and if that passes, we're done, if it doesn't
12 pass, we'll ask for motions.

13 MEMBER HOO: I'm sorry, can we clarify
14 a couple of things about attribution?

15 CO-CHAIR HALL: Yes.

16 MEMBER HOO: Thank you.

17 MEMBER DUSEJA: So, hi, this is Reena.
18 I just wanted to let you know that, currently, we
19 do have a version of this measure within the next
20 present. And what we have made in terms of
21 determinations on how it will be applicable for
22 our clinicians that participate within this, is

1 that it would be at the group level for greater
2 than, you know, 16 providers or more, if the
3 measure would be calculated.

4 What you have -- what you are looking
5 at right now is actually a measure that's pre-
6 specified to now include just certain groups of
7 specialized, and I'll just repeat this so that
8 you guys are aware, but it's for medicine, for
9 surgery and gynecology, cardiorespiratory and
10 cardiovascular conditions and neurology.

11 So that's what the measure is looking
12 at. As far as policy making and how we'll apply
13 that to this measure, to the program, we do have
14 precedents of applying it at the group level.

15 CO-CHAIR HALL: Thank you.

16 MEMBER GIFFORD: Bruce, can I just
17 suggest maybe a spear on. I raise the question
18 of whether -- I don't think we should up to the
19 higher level, the question is, I think we should
20 revisit the current MAP recommendation now that
21 people have heard the objection, and vote on
22 that, and then I would go down to the next one,

1 because I think people who voted no could hear my
2 comments, and may not be compelling enough to
3 switch their vote.

4 As I said, I'm not sure whether I'd
5 switch it.

6 CO-CHAIR HALL: I understand and
7 support that. I think it's a matter of,
8 technically, do you want us to march from the
9 top, down, I think it only takes a couple seconds
10 to do each.

11 MR. STOLPE: Let's go ahead and do it,
12 just to follow a process.

13 CO-CHAIR HALL: So first vote is just
14 full support and then if we don't succeed there,
15 we'll proceed with David's suggestion. Full
16 support?

17 MR. STOLPE: And just a reminder, if
18 we do not reach consensus, we default to the
19 workgroup's suggestion.

20 So even if we continually vote no, we
21 will revert back to the workgroup conditional
22 support.

1 MS. BUCHANAN: So voting is now open
2 for MUC2019-27, do you support the measure. And
3 give it just a couple more seconds. Okay. We
4 are at 20. So voting is now closed. Six people
5 have voted in support, yes, fourteen have voted
6 no. The measure will not move forward with
7 support.

8 CO-CHAIR HALL: So I would, again, now
9 invite the discussants to propose a motion.

10 MEMBER GIFFORD: I think my motion
11 would be to mitigating factors, to look more data
12 on the attribution for specialists for
13 rulemaking.

14 CO-CHAIR HALL: And are you saying you
15 want to move to do not support with mitigation,
16 and we're just going to skip conditional?

17 MEMBER GIFFORD: Yes.

18 CO-CHAIR HALL: Okay.

19 MEMBER GIFFORD: And that would be my
20 recommendation, but if you're following the
21 process of, we have to go to conditions with
22 endorsement, then --

1 CO-CHAIR HALL: Okay. Yes. Does
2 anyone want to propose a version that would be
3 conditional support with particular conditions?
4 I'm not hearing any support for that. So do you
5 want us to vote on that without having specified
6 any conditions?

7 MR. STOLPE: It seems that we've
8 already done that.

9 CO-CHAIR HALL: Yes, so we'll -- yes.
10 Yes, Cheryl.

11 MEMBER PETERSON: So we've already
12 voted on -- we voted on the workgroup's
13 recommendation.

14 CO-CHAIR HALL: Right.

15 MEMBER PETERSON: So we could do
16 conditional support again with a different one of
17 the conditions.

18 CO-CHAIR HALL: Right. And I have to
19 -- my interpretation is that, any time we've had
20 discussion, people are allowed to change their
21 opinion, and so it's not out of the question that
22 you would re-vote the category, but we don't --

1 but right now, we don't have a particular motion
2 to attach conditions, so you want us to vote on
3 conditional without conditions or move on?

4 MR. STOLPE: It seems to me that we
5 could vote on the conditions if -- but I'll --

6 CO-CHAIR HALL: What would the
7 conditions be?

8 MR. STOLPE: So the conditions that
9 were proffered by the workgroup, just a reminder,
10 is that we -- that one, the measure that's
11 currently in MIPS be removed, and that's 1789,
12 NQF-1789, and then this measure receive NQF
13 endorsement.

14 CO-CHAIR HALL: So we have not had any
15 motion to modify that. Let's just re-vote that
16 in the context of having had CMS' input and
17 having had the discussion that we just had. So
18 we will re-vote conditional support with the same
19 conditions.

20 MEMBER QASEEM: So may I interject
21 support for David's recommendation about
22 mitigation, because this condition that we keep

1 on putting in about NQF endorsement, having been
2 on MAP for a very long time, I don't think that
3 really carries much of a weight. Maybe I missed
4 something.

5 I mean, we keep on saying we need to
6 get NQF endorsement, that doesn't happen, so at
7 the last MAP meeting even, we decided that we
8 need to keep that in mind when we are reviewing
9 any of these measures.

10 So frankly, I was actually more
11 strongly leaning towards do not support, but I
12 can live with what David had as the mitigation.
13 I mean, the attribution issue is a fundamental
14 issue. It needs to be resolved. That's not even
15 conditional.

16 You have an inherent problem with the
17 performance measure. That needs to be fixed.

18 CO-CHAIR HALL: Thank you. Thank you.
19 Nancy?

20 MEMBER FOSTER: I just wanted to ask
21 a clarifying question of Reena. And forgive me,
22 as I don't understand all of the groups in the

1 MIPS, you said it would be applied to internal
2 medicine, certain general surgery, general
3 surgery, and is it just general internal medicine
4 or is it anybody who's an internist?

5 MEMBER DUSEJA: So it's based on the
6 condition. So what I described are the
7 conditions that the RF score is passing this on,
8 so it would be the conditions that would lead to
9 a readmission, so it's around medicine, surgery,
10 cardiorespiratory, cardiovascular, and neurology.

11 Traditionally, this measure has been
12 applied to those that are taking care of them
13 within the hospital, right, that are making those
14 decisions, so that would be, like, for example,
15 the hospitalists on the record.

16 So that's the work that's being done
17 with our score, with our looking at the measure,
18 and attribution.

19 MEMBER FOSTER: Thank you. That
20 helps a lot.

21 CO-CHAIR HALL: So I understand the
22 motion is, we'll just re-vote conditional

1 support. We have not had any motion to change
2 the conditions that's applied to the workgroup,
3 but we're re-voting in light of the discussion we
4 just had. Yes, Reena.

5 MEMBER DUSEJA: We just heard from our
6 contractor. So they also wanted just for the
7 committee to know that if we're not moving
8 forward with this measure, then the single
9 attribution measure that we currently have within
10 the program, it'll be attributed to an outpatient
11 clinician-only, and that the outpatient clinician
12 may not have seen the patient prior to
13 readmission, will continue to be in the program.

14 And I'm not sure if Lisa Sutter is the
15 one who emailed us that, so, Lisa, I don't know
16 if you want to say anything else based on what
17 you just sent us. May she? Go ahead, Lisa.

18 MEMBER HINES: Thank you. I just
19 wanted to clarify that the current measure that
20 is in MIPS right now, as said, a single
21 outpatient clinician. That clinician is defined
22 the greatest number of encounters in a 12-month

1 measurement period, but may or may not reflect a
2 clinician that has seen the patient prior to
3 readmission.

4 And the attribution of the measure,
5 multiple clinicians, was initiated by our
6 technical expert panel, felt that care
7 coordination and shared accountability were the
8 most important things for this measure, and
9 therefore, we pivoted away from an attribution
10 approach for an inpatient clinician to a broader
11 shared attribution approach as is currently
12 specified. Thank you.

13 CO-CHAIR HALL: Thank you. David, do
14 you have another concern?

15 MEMBER GIFFORD: No, I'm just -- I'm
16 personally confused. I mean, I'm torn, and I'm
17 afraid the way we're following this process, if
18 we go down the current recommendation and then we
19 vote down the mitigation, the question is, how do
20 we toy between the two, and personally --

21 CO-CHAIR HALL: Well, to be clear, my
22 intent is to ask if anybody wants to propose an

1 alternate set of conditions, we would vote that
2 instead, if not, we will vote what was originally
3 attached.

4 If that fails, we'll do a final ask
5 for alternate conditions, so there'd be an
6 opportunity there to change the conditional
7 attachments, and if that were to fail, we would
8 go, as you said, to do not support with
9 mitigation. Yes, David.

10 MEMBER GIFFORD: So just rewording the
11 dilemma that I think we're in is, people -- the
12 experts are really dissatisfied with the current
13 measure and we're at risk for saying, well, this
14 measure that is under consideration today has its
15 imperfections, so we'll stick with a worse
16 measure.

17 So that's just what the dilemma is.

18 CO-CHAIR HALL: Although I agree with
19 that sentiment, although, in fairness, it's a
20 little weird for us to accept something because
21 what else is out there is not what we want.
22 That's a different criteria than we normally

1 apply. Harold?

2 MEMBER PINCUS: So a way to kind of
3 skirt the issue by -- and I don't know whether it
4 would be to not support with mitigation, but
5 there are three elements of the mitigation. One
6 is that the existing measure be removed, the
7 second is that, the attribution issue gets
8 resolved for this measure, and number three is
9 that it get into endorsement.

10 CO-CHAIR HALL: Harold, are you
11 willing to put that forward as a conditional
12 approval request or do you want to wait and hold
13 that as a do not support mitigation request?

14 MEMBER PINCUS: I guess my sense is
15 that I'm not -- it might be better to -- if we
16 short circuit it to a do not support kind of
17 thing, that would be the quickest way to resolve
18 it.

19 CO-CHAIR HALL: Yes, I will ask for a
20 conditional vote on something before we land
21 there, but I'm willing to certainly take your
22 suggestions and make that --

1 MEMBER PINCUS: I mean, we do the same
2 thing, only conditionally, we do the same thing -
3 -

4 CO-CHAIR HALL: Right. Exactly. Yes,
5 Executive Secretary.

6 MR. AGRAWAL: Can I just clarify.
7 Weren't two out of the three conditions that you
8 just laid out already conditions in the
9 workgroup's recommendations?

10 MEMBER PINCUS: Yes.

11 MR. AGRAWAL: And just to be clear for
12 the coordinating committee, you could, if you so
13 elected, add a third condition and then take a
14 vote.

15 CO-CHAIR HALL: As conditional.

16 MR. AGRAWAL: Yes, as conditional.

17 CO-CHAIR HALL: Before moving to --

18 MEMBER PINCUS: At this point, I'm not
19 sure what the difference would be, whether it was
20 conditional support versus do not support.

21 MEMBER GIFFORD: Well, I think it
22 comes down to, our job is to give advice to CMS

1 as to whether the measure is ready for
2 rulemaking, and just because it doesn't have NQF
3 endorsement doesn't mean -- I think we could say,
4 yes, well, it's still ready for rulemaking, but
5 go ahead and get the endorsement.

6 MEMBER PINCUS: Yes, that's where we
7 need three conditions.

8 MEMBER GIFFORD: To me, the question
9 is, no, it's not ready for rulemaking until you
10 go to these other steps. So even though the
11 conditions are roughly the same, it's whether we
12 are saying it's ready for rulemaking, to proceed
13 with that, or not, because as has been pointed
14 out, the recommendation of condition for
15 endorsement has not ever stopped CMS from putting
16 it out there.

17 They have, some of them, brought back
18 for endorsement, some they've not. So it really
19 depends on that. I mean, I think we should track
20 that, because how often the conditions are
21 brought back here, and I know we've asked for
22 that in the past, and I reiterate that we try to

1 do that as a committee --

2 CO-CHAIR HALL: So that's a point --

3 MEMBER GIFFORD: To me, that's the
4 difference in -- the reason I'm concerned is, if
5 it doesn't pass the condition, and it doesn't
6 pass the next one, I would go back and pass the
7 condition. I would then change my vote to pass
8 the condition and I don't want to get us into a
9 catch-22 where we can't get back to it.

10 And I just want to know how we
11 procedurally handle that, because that's my
12 concern with that.

13 CO-CHAIR HALL: Sure. So --

14 MEMBER GIFFORD: Because I mean, I
15 personally probably would be not to recommend for
16 rulemaking, but if the rest of the group doesn't
17 agree with that, I will switch my vote to support
18 for condition.

19 CO-CHAIR HALL: Okay. All right. So,
20 which is the working group's recommendation was
21 conditional support with the two conditions we
22 originally heard, right? So right now, I would

1 ask this committee to either propose a new set of
2 conditions or to endorse that we re-vote the
3 original two conditions. Thoughts from anyone?
4 Leah?

5 MEMBER BINDER: I would just say that
6 it's probably a good practice for us to try and
7 err on the side of workgroup recommendations when
8 we can, and sort of, you know, turning them
9 upside down and litigating things. I mean, there
10 is a purpose for the workgroup, so I think I
11 would prefer to just, maybe, add something to the
12 condition, but keep it where the -- you know,
13 unless we have -- it's just the workgroup has
14 totally disagreed, I think that we should try and
15 favor the workgroup recommendations.

16 CO-CHAIR HALL: Great. Thank you.
17 Scott?

18 MEMBER FERGUSON: I don't think it's
19 ready for rulemaking. I think that the
20 attribution needs to be based on evidence and
21 proven to be valid before we move it to
22 rulemaking.

1 CO-CHAIR HALL: All right. Having
2 heard all the cards that are up, I will propose
3 that we re-vote the two conditions as the
4 workgroup had originally passed them to us, in
5 line with Leah's suggestion. Now, conditional
6 support with the two conditions of NQF approval
7 and removal of the existing metric.

8 MEMBER PINCUS: What about the third
9 condition?

10 CO-CHAIR HALL: Well, I'm proposing we
11 stick with the original workgroup, but if someone
12 wants to move otherwise, Harold, I had
13 interpreted you as landing on, do not support
14 mitigating.

15 MEMBER PINCUS: Right. But I'm just
16 clarifying, I thought we already voted on the --

17 CO-CHAIR HALL: We voted before
18 discussion, people are allowed to change their
19 opinion during a discussion --

20 MEMBER PINCUS: We're voting again.

21 CO-CHAIR HALL: -- so we're voting
22 again at this level. We're voting conditional

1 support with the workgroup's original conditions.
2 Is that clear to everybody? Okay. That's the
3 vote. So everyone vote, please.

4 MS. BUCHANAN: Thank you very much.
5 Voting for 2019-27, conditional support, which is
6 based on the workgroup recommendation, is now
7 open. We have -- we're waiting on just a couple
8 more votes and then we will close, so giving
9 people just one more moment.

10 We have 18 votes and I don't think
11 that we have anymore, so we're good to go. I'm
12 closing the voting. The results are 13 yes, 5
13 no, so the coordinating committee recommends
14 moving forward with 2019-27 with the workgroup
15 recommendation of conditional support for
16 rulemaking.

17 CO-CHAIR HALL: Great. Thank you.
18 Next up, I'll throw back to Sam real quick for
19 28.

20 MR. STOLPE: Very good. Moving on to
21 our next measure. We are now looking at MUC2019-
22 28. And this is the risk standardized

1 complication rate following elective primary
2 total hip arthroplasty and/or total knee
3 arthroplasty for MIPS-eligible clinicians and
4 clinician groups.

5 Now, the recommendation for this is
6 support for rulemaking. This measure is NQF
7 endorsed as NQF-3493, which is based on a
8 comparable measure, NQF-1550, which also is
9 utilized, but this if for hospitals.

10 So the primary focus of the workgroup
11 around this one was that they agreed with many of
12 the comments that came in related to patient-
13 reported outcomes, performance measures, such as
14 functional status, et cetera, related to TKA and
15 THA are both desirable, but they emphasized that
16 they would be complementary to this measure.

17 And the overall comments that were
18 received tended to focus on the fact that the
19 commenters considered patient-reported outcomes
20 to be better, and then expressing a common theme
21 that we saw around concerns for both attribution
22 and reliability of the measure as applied.

1 I'll pivot to our co-chairs to add any
2 supplementary comments. Rob or Bruce?

3 DR. BAGLEY: Nothing additional for
4 me.

5 DR. FIELDS: Nothing from me.

6 CO-CHAIR HALL: Thank you, both. Does
7 anyone want to ask clarifying questions at this
8 point before our initial vote of the workgroup
9 recommendation? Again, if you would like full
10 discussion, then either speak now and/or you
11 would vote down that recommendation. Misty?

12 MEMBER ROBERTS: Yes, so clarification
13 is that this is an existing measure at the
14 facility level and now there's an attribution for
15 clinician level? Is that --

16 MR. STOLPE: That's correct.

17 MEMBER ROBERTS: Okay.

18 MR. STOLPE: So there is an NQF
19 measure, 1550, around which NQF -- excuse me,
20 3493, which is this measure, has been based. And
21 3493 has gone through the endorsement process.

22 CO-CHAIR HALL: Anyone else with

1 questions before we take our first vote? Not
2 seeing or hearing anything, we'll vote first to
3 accept support for rulemaking.

4 MS. BUCHANAN: Voting is open for
5 MUC2019-26 to move forward on the workgroup
6 recommendation of support for rulemaking.

7 CO-CHAIR HALL: Sorry, Kate, 28.

8 MS. BUCHANAN: Thank you. Measure
9 2019-28, moving forward with the workgroup
10 recommendation of support. Let's see. Give it
11 just one more second, see if we have any other
12 lingering votes. I know that some people had to
13 leave.

14 And we have 16 votes, which is enough.
15 Oh, we have one more. Great. So we are going to
16 close voting and the vote results are 16 in
17 support and 1 against, so MUC2019-28 will move
18 forward with the workgroup recommendation support
19 for rulemaking.

20 CO-CHAIR HALL: Thank you. We'll turn
21 to 19-66, hemodialysis vascular access.

22 MR. STOLPE: All right. Very good.

1 So this measure received conditional -- excuse
2 me, this measure received conditional support for
3 rulemaking. The condition being receipt of NQF
4 endorsement.

5 The committee, overall, liked this
6 measure and expressed fairly strong support for
7 it. The comments mainly focused on having
8 additional conditions being added to the
9 recommendation, that additional testing be
10 completed to improve reliability and validity of
11 the measure.

12 Anything from our co-chairs to
13 supplement?

14 DR. BAGLEY: This is Bruce. I think
15 that you're right about the overall consensus of
16 our group. We felt this was a good measure and
17 should go forward.

18 CO-CHAIR HALL: Thank you, both. Do
19 any of our lead discussants or anyone else in the
20 room have clarifying questions before the first
21 vote? Oh, Scott, I'm sorry. Didn't see your
22 flag.

1 MEMBER WALTERS: That's okay. You
2 mentioned the additional testing for the
3 reliability and validity of results. Is that
4 something that will be incorporated in that or
5 does that need to be a separate item?

6 CO-CHAIR HALL: Well, were this to go
7 forward under the workgroup's recommendation, it
8 would require submission of that reliability and
9 validity testing for endorsement by NQF.

10 MEMBER WALTERS: Okay.

11 CO-CHAIR HALL: Any other comments
12 prior to first vote? Not seeing any. So our
13 first vote here is conditional support, the
14 conditions that need to be heard from Sam.

15 MS. BUCHANAN: All right. Thank you
16 very much. Voting is open now for MUC19-66 to
17 move forward with the workgroup recommendation of
18 conditional support for rulemaking. And we need
19 just a couple more votes.

20 So we will close voting. We have 16
21 votes. And the voting results are 16 in support
22 of moving forward with the workgroup

1 recommendation. 0 do not support, so the
2 workgroup recommendation moves forward.

3 CO-CHAIR HALL: Thank you. We'll move
4 on to 19-37, Sam.

5 MR. STOLPE: All right. Thank you
6 very much. So this is for MUC2019-37, clinician
7 and clinician group risk standardized hospital
8 admission rates for patients with multiple
9 chronic conditions.

10 Just to note that in the Medicare
11 Shared Savings Program, the score would be at the
12 ACO level. Clearly, this is at the MIPS provider
13 or provider group level. So this measure
14 received a do not support with potential for
15 mitigation.

16 And I'm sorry, I'm having trouble
17 identifying where the mitigating factors are.

18 MEMBER SCHREIBER: Higher reliability.

19 MR. STOLPE: What's that?

20 MEMBER SCHREIBER: Higher reliability.

21 MR. STOLPE: Oh, achieving a higher
22 reliability score. Thanks, Dr. Schreiber. So

1 this particular measure had a very robust
2 discussion with our MAP clinician workgroup,
3 where a number of concerns were expressed around
4 the reliability of the measure and the validity
5 of the measure overall.

6 Its applicability to MIPS providers
7 was called into question. Also inside of the
8 public comments, it tracked fairly closely
9 without the workgroup discussion as well. I'll
10 turn it over to our co-chairs to supplement with
11 any comments.

12 DR. BAGLEY: This is Bruce, I think
13 you fairly outlined our discussion.

14 MR. STOLPE: Thank you. Can --

15 DR. FIELDS: This is Rob. Nothing to
16 add.

17 MR. STOLPE: Thank you, both. Can we
18 clarify what's on the screen there, which reads
19 differently than what you said?

20 Yes, that text there reads differently
21 than this text. Oh, right, so the name of the
22 measure, the score would be at the -- so just to

1 clarify, this measure is being considered for two
2 separate programs. One, the Shared Savings
3 Program, so we'll discuss this measure again
4 immediately following this vote, and its
5 applicability for shared savings.

6 Here, we're considering it
7 specifically for MIPS at the provider -- the
8 individual provider or the provider group level.
9 At the MIPS consideration, the clinician
10 workgroup did not feel that this would be
11 appropriate for rulemaking under the current
12 reliability testing.

13 And as specified, that in order for it
14 to move forward, the mitigating factor would be
15 to achieve a reliability standard higher than
16 what they received.

17 CO-CHAIR HALL: Great. Thank you.
18 David?

19 MEMBER GIFFORD: I'd be curious to
20 hear from the co-chairs why the recommendation
21 from the MAP was not recommended here, but on the
22 previous one we talked about, it was, and the

1 issue is the same thing about reliability of
2 attribution. Is it roughly the same measure and
3 it's the same issue, so what swayed them one way
4 versus the other? I'm just curious about that.

5 CO-CHAIR HALL: Okay. So we'll
6 consider this still clarification prior to our
7 first vote and, Scott, in the mirror, do you want
8 to -- can you shed insight on David's question?

9 MEMBER PINCUS: Can I also add one
10 other item for clarification?

11 CO-CHAIR HALL: Yes, Harold.

12 MEMBER PINCUS: Which is, it's not
13 clear to me what the expected mitigation is. It
14 looks like, just from reading the text here, it
15 looks like the mitigation is to not apply it to
16 the individual, which would then really be, do
17 not support.

18 CO-CHAIR HALL: Okay. So, Scott
19 and/or Amir, could you comment on those concerns?
20 Amir? I'll let Scott go first.

21 MEMBER FERGUSON: It's the same as
22 we've had with several of these, the reliability

1 and the validity of the data. We did not support
2 the previous one and don't support this one. I
3 think that answers his question.

4 PARTICIPANT: Can the developers
5 respond to the questions?

6 MEMBER PINCUS: I guess my question
7 is, when it says, do not support with mitigation,
8 so --

9 CO-CHAIR HALL: So let me invite the
10 developer to comment on the couple of concerns
11 that have been expressed.

12 MEMBER DUSEJA: Let me just start in
13 terms of what we heard from the workgroup. One
14 was the issue around reliability. They wanted a
15 minimum reliability of 0.7, was what was
16 discussed during the discussion last month.

17 The other thing had to do with
18 assurances that we would be applying it, not to
19 the individual clinician level, but applying it
20 to the group level, similar to how we've been
21 applying the HWR, Richard. So those were the two
22 things beyond having it endorsed.

1 And then we probably -- we do have a
2 measure developer, so I just wanted to pause and
3 see if they wanted to add anything.

4 DR. DRYE: Yes, hi, it's Elizabeth
5 Drye from Yale. The reliability, to clarify,
6 those two things, in some ways, go together
7 because the more patients and clinicians are
8 together, the higher the reliability score.

9 And so one of the things that we
10 clarified in the, I think really, rich discussion
11 of the workgroup, that both things were of
12 concern, and so what we'll be doing when, I
13 think, the committee is asking, how do we
14 mitigate, we'll be coming back to CMS with
15 empiric testing that shows how different group
16 sizes affect reliability scores, and the number
17 of providers that would be eligible to report the
18 measure, and the number of patients included in
19 that, and then CMS can make a decision about how
20 to move forward, given the committee's input, and
21 the testing developed.

22 CO-CHAIR HALL: So, Liz, this is Bruce

1 Hall. Thank you very much and my understanding,
2 though, that what you may come back with is, you
3 may come back with a group level threshold that
4 you think meets some reliability number.

5 The challenge in front of us is to
6 either approve or not approve without knowing
7 what that would be. I'll turn to the room,
8 David?

9 MEMBER GIFFORD: Is there a minimum
10 reliability number? Because in reading the
11 public comments, some people are advocating 0.8,
12 some are advocating 0.7, is there something -- is
13 this sort of a new science that we don't have a
14 number yet, and that's why everyone's arguing
15 about it?

16 CO-CHAIR HALL: The NQF has a white
17 paper on this topic from the recent past, a year
18 or two ago, and the reality is just that, most
19 people think about reliability in terms of, sort
20 of, typical agreement statistics, where something
21 greater than 0.4 might be okay, but greater than
22 0.7 and 0.8 really becomes good and strong, and

1 particularly for high stakes purposes, you
2 probably want to argue for something up in the
3 area of 0.7 or 0.8, but there's not an industry
4 standard.

5 MEMBER GIFFORD: This is reliability
6 around attribution. This is not -- like, we test
7 reliability and the rate of reliability, right?
8 Yes.

9 CO-CHAIR HALL: No, so when we're --

10 MEMBER GIFFORD: There's not a
11 standard number that's, once you get it, everyone
12 sort of says, okay, there's debate between 0.7
13 and 0.8.

14 MEMBER BAKER: Can someone explain, I
15 don't even know what reliability in terms of
16 attribution means. I'm sorry.

17 MR. STOLPE: So the way that we
18 usually describe it at NQF is that at the score
19 level reliability testing, what we mean is, the
20 confidence that you have that you have
21 appropriately forced ranked, by a performance, a
22 group of providers.

1 So if we're taking all of their
2 performance scores, some of the performance score
3 will be attributable to actual signal, or real
4 quality differences, and parts it will be
5 stochastic, just statistical in nature, and we
6 call that noise.

7 So when a signal-to-noise analysis is
8 looking at that, kind of, confidence that we
9 have, that if we say, this provider performed at
10 a 0.85, and this provider performed at a 0.87,
11 that there truly is a difference between those
12 and not that they are actually switching the
13 order for some reason.

14 MEMBER BAKER: So I'll take a look at
15 the white paper, but I don't know how you do
16 that, comparing two individuals. Are you looking
17 at the performance of two different points in
18 time and seeing the agreement?

19 MR. STOLPE: You're looking at their
20 performance relative to one another over the same
21 performance period. So the way that you do it is
22 a little bit sophisticated, but the methodology

1 that's typically used is called the beta-binomial
2 methodology that was outlined in a white paper by
3 Adams in 2009, and this is the, probably, most
4 common way that reliability at the score level is
5 demonstrated in submissions for endorsement at
6 NQF.

7 MEMBER BAKER: Okay. Thanks. I'll
8 take a look.

9 CO-CHAIR HALL: And I think Liz was
10 just trying to add to her comments. Liz?

11 DR. DRYE: Sure. Thanks. Just to
12 clarify, this isn't the reliability of the
13 attribution algorithm, it's about some aggregate
14 score results, so they're separate things.

15 The attribution algorithm is focusing
16 on how we assign patients to providers, or
17 provider groups, and get a group of patients,
18 then, whose outcome we'll use to give them an
19 aggregate score, so it's about once we assign
20 them, what's the reliability of that score?

21 CO-CHAIR HALL: Thanks, Liz. So we
22 still haven't taken a first vote. What's the

1 temperature in the room? Do people feel
2 comfortable enough to take a first vote? The
3 first vote would be -- where are we? The first
4 vote would be, do not support with mitigation.
5 Do people have any other questions before first
6 vote?

7 Not seeing any --

8 DR. DRYE: Sorry, Bruce.

9 CO-CHAIR HALL: Yes.

10 DR. DRYE: I'm just going to --

11 CO-CHAIR HALL: Yes, go ahead.

12 DR. DRYE: I just want to jump in with
13 one more piece of background with this. Someone
14 mentioned that you don't have the numbers in
15 front of you that relate to the group size or
16 number of patients to the reliability results
17 we're getting.

18 We did present those to the workgroup,
19 so they saw those numbers when they considered
20 this. Usually don't get into that depth in this
21 discussion, but those were considered and I think
22 -- so they could see the size of the groups, they

1 know that 0.7's reliability.

2 That was on older data, so we're
3 updating everything, but again, we gave them data
4 for that.

5 CO-CHAIR HALL: Thank you. So it
6 seems the context here is that the workgroup has
7 seen those and was -- had concerns about
8 reliability down at the individual level, as
9 stated there, this measure is provider or
10 provider group.

11 The workgroup was concerned about the
12 individual level reliability, and suggested
13 mitigation, which I'll have Sam restate.

14 MR. STOLPE: Sure. Thank you. Now,
15 what we have written up in the discussion guide
16 related to this is that, the measure should apply
17 to clinician groups with an appropriate
18 reliability threshold, e.g., 0.7.

19 That was outlined as the primary
20 mitigating factor, but the workgroup did have a
21 couple of other things that they outlined as
22 potential mitigating factors. First, they noted

1 that the measure developer should also consider
2 NQF guidance on attribution and consider the
3 patient preference and selection as an
4 attribution method as those data become
5 available.

6 So currently, they are not available.
7 Just wanted to stress that point. MAP also
8 suggested that rather than moving directly to
9 this outcome measure, that CMS could consider
10 process measures that would get to the desired
11 outcome through a stepwise approach to increasing
12 accountability.

13 CO-CHAIR HALL: Thank you, Sam. So
14 with that said, let's take first vote on do not
15 support with the mitigation that Sam just
16 described. Sorry, we'll hold that. Yes, Esta.

17 MEMBER MORALES: I just want to ask,
18 is it only the first one that we're considering
19 or all that list of issues that you brought up?

20 CO-CHAIR HALL: Those were the
21 conditions described by the clinician workgroup.
22 However, I do want to stress that the first

1 condition was the most concrete. The others were
2 put forward as considerations.

3 MEMBER MORALES: So we want to
4 consider only the first one?

5 CO-CHAIR HALL: We want to consider
6 exactly what they said. We're now either
7 accepting or rejecting exactly what they said and
8 then we can modify if necessary.

9 MEMBER MORALES: Okay. Thank you.

10 CO-CHAIR HALL: Yes. Thank you.
11 Okay. So we're going to vote on exactly what the
12 workgroup put forward right now.

13 MS. BUCHANAN: Thank you very much.
14 Voting is now open for MUC2019-37. This is for
15 MIPS and it is to move forward with the workgroup
16 recommendation of do not support for rulemaking
17 with potential for mitigation.

18 Waiting on -- oh, we have 17? Okay.
19 So we will close voting. Oh, wait. We have 18.
20 Okay. Now we're going to close voting. So we
21 had 15 people vote yes, 3 vote no, so MUC2019-37
22 for MIPS puts forward the workgroup

1 recommendation of do not support for rulemaking,
2 potential for mitigation.

3 CO-CHAIR HALL: Thank you. I'll ask
4 Sam to make any additional comments necessary for
5 this different category, the same measure,
6 different category.

7 MR. STOLPE: Right. So this should be
8 fairly straightforward. We're talking about the
9 same measure, but applied to the ACO level. So
10 the workgroup recommendation for this was
11 conditional support for rulemaking. The
12 condition being that it achieves NQF endorsement.

13 Now, the public comments did align
14 very closely with the workgroup discussion on
15 this measure. And generally speaking, the
16 workgroup felt that this measure could much more
17 comfortably be applied to a shared savings type
18 structure.

19 Whereas, ACOs tend to have a pretty
20 robust series of service offerings that offset
21 the risk, and also have a much larger sample size
22 to consider, that this would make it more

1 reliable and much more suitable for those
2 reasons.

3 I'll pivot to the workgroup co-chairs
4 for any additional comments.

5 DR. BAGLEY: That sounds right.

6 DR. FIELDS: Yes, nothing from me.

7 MR. STOLPE: Okay. Thank you, both.
8 Everyone in the room, on the line, having heard
9 what we've heard, does anybody need further
10 conversation before the first vote? Oh, yes.

11 MEMBER ROBERTS: Yes, sorry. I'm
12 looking at my screen here and it seems to be the
13 workgroup recommendation under the MSSP seems to
14 be different than what's on the screen. It says,
15 conditional support for rulemaking on the screen,
16 and it says, do not support for rulemaking with
17 potential for mitigation, unless I'm looking at
18 this wrong.

19 MR. STOLPE: So that's for the MIPS
20 measure that's --

21 MEMBER ROBERTS: Okay. Well, it's
22 actually different. It says it in the shared

1 savings one. The MIPS one actually says,
2 conditional support for rulemaking. So are they
3 backwards in the document?

4 MR. STOLPE: We must have got them
5 backwards in the document.

6 CO-CHAIR HALL: I know mine reads
7 shared savings conditional. I don't know if
8 there's --

9 MEMBER ROBERTS: Okay. I just want to
10 make sure.

11 MR. STOLPE: It looks like it's
12 correct inside of the discussion guide.

13 CO-CHAIR HALL: Sam, can you just
14 please state exactly what the truth is?

15 MR. STOLPE: Let me pull up the report
16 and actually confirm this, so my apologies for
17 any confusion. I'm looking at the measure here
18 and inside of the report it's listed as MAP
19 conditionally supported MUC2019-37 pending NQF
20 endorsement, so what you see on the screen is
21 correct.

22 MEMBER ROBERTS: Okay.

1 CO-CHAIR HALL: You all right with
2 that, Misty?

3 MEMBER ROBERTS: Yes.

4 CO-CHAIR HALL: Okay. Anyone else
5 with concerns or questions before the first vote?
6 Okay. First vote is conditional support,
7 condition being, NQF endorsement.

8 MS. BUCHANAN: Thank you very much.
9 Voting is now open for MUC2019-37. This is for
10 MSSP to move forward the workgroup recommendation
11 of conditional support for rulemaking. And we'll
12 be closing soon, so just -- there are a couple
13 more votes that could come in. Okay. So we are
14 closing voting.

15 We received 18 votes yes, 0 votes no,
16 MUC2019-37 for SSP moves forward with the
17 conditional support for rulemaking.

18 CO-CHAIR HALL: Thank you. We'll turn
19 to Part C and Part D STAR category now and we'll
20 start with 19-14.

21 MR. STOLPE: All right. Very good.
22 And so now we're going to review MUC2019-14,

1 follow-up after emergency department visit for
2 people with multiple high-risk chronic
3 conditions. This measure was conditionally
4 supported by the MAP Clinician Workgroup for
5 rulemaking, pending NQF endorsement.

6 Overall, the workgroup was fairly
7 supportive of this measure, noted the importance
8 of care coordination as a CMS priority, and that
9 this measure encourages health plans to think
10 broadly about their beneficiaries and how they
11 are -- how their care is coordinated after they
12 leave the emergency room.

13 The comments related to this measure
14 followed around, again, fairly comparable to
15 workgroup discussions around concerns, namely
16 that follow-up be better defined.

17 Then there were some concerns,
18 especially related to special needs plans,
19 related to timeframe, the data source, and the
20 nature of the notifications that go to patients.

21 Any other comments related to this
22 that came from the workgroup that our clinician

1 co-chairs can provide?

2 DR. BAGLEY: This is Bruce. I think
3 that's fair. This looks like a good measure to
4 help get at the care coordination issue.

5 DR. FIELDS: Nothing in addition to
6 add.

7 MR. STOLPE: Now we just go to
8 gathering questions.

9 CO-CHAIR KAHN: Well, do we have any
10 questions or can we go to a vote on the
11 recommendation? Oh, comments?

12 MEMBER MORALES: Okay. So I have a
13 couple of comments. Number one, a lot of times
14 care coordinators are not in the know -- don't
15 even know when somebody goes into the emergency
16 room, and so we need a lot of interoperability
17 about people who go to the emergency room and
18 then are discharged that have care coordination
19 follow-up with them.

20 So that's number one concern, and then
21 I totally agree with the comment for special
22 needs plans, and I have a big Medicare/Medicaid

1 plan and MMP plan, where if this is going to be
2 considered for a STAR rating, then at least those
3 particular Medicare contracts with a large number
4 of SNP members need to be accounted for in some
5 way, because it's going to be more difficult for
6 those members who are discharged from the ER that
7 are Medicare and Medicaid combined and special
8 needs members, to get the follow-up.

9 And that just needs to be accounted in
10 the STAR measure process.

11 MR. STOLPE: Okay. Other questions or
12 concerns in this -- at this stage? Yes, Liz.

13 MEMBER GOODMAN: I would just say that
14 that's consistent with what we heard from the
15 rest of our plans.

16 MR. STOLPE: Other questions or
17 concerns? Anyone on the phone? Okay.

18 PARTICIPANT: Is there an open comment
19 on this?

20 CO-CHAIR HALL: No, not yet. Thank
21 you very much. Mary?

22 MEMBER BARTON: Thank you. As

1 mentioned, I'll recuse myself from this vote, but
2 I just want to point out that the population who
3 are these high-risk medical conditions, multiple
4 chronic conditions, is somewhere between, I
5 think, 8 and 14 percent of the population in the
6 Medicare -- in Medicare group, so it's really the
7 sicker end of the spectrum.

8 And NCQA said it's -- even though it
9 might be hard for patients who have challenges,
10 such as being dually eligible, that that doesn't
11 mean that they're not really even more important
12 to find.

13 And so that's our support.

14 CO-CHAIR HALL: Thank you. Okay. I'm
15 not seeing any other flags, so we'll move to
16 first vote, conditional support, and the
17 condition being NQF endorsement.

18 MS. BUCHANAN: Thank you. Voting is
19 now open for MUC2019-14, for the workgroup
20 recommendation of conditional support for
21 rulemaking.

22 And we'll give it just one more

1 second. Okay. We are closing the voting. We
2 received 16 votes yes, 2 votes no. The
3 coordinating committee has voted to move forward
4 with 2019-14 for recommendation for conditional
5 support.

6 CO-CHAIR HALL: Thank you. 19-21.

7 MR. STOLPE: Excellent. Transitions
8 of care between the inpatient and outpatient
9 settings, including notifications of admissions
10 and discharges, patient engagement, and
11 medication reconciliation post discharge.

12 So this measure also received
13 conditional support for rulemaking, with the same
14 condition, pending NQF endorsement of the
15 measure. Now, this was noted that this is
16 designated as a first year measure for HEDIS
17 2018, and MAP observed that Medicare
18 beneficiaries are at particular risk during
19 transitions of care because of higher
20 comorbidities, declining cognitive function, and
21 increased medication use.

22 Comments were largely supportive, but

1 again, comparable to the other measure. Special
2 needs plans were particularly concerned around
3 timing, the data source, and the method of
4 notification related to these measures.

5 I'll turn it over to our workgroup co-
6 chairs for supplementary comments.

7 DR. BAGLEY: This is Bruce. This is
8 really the essence of what they're supposed to be
9 doing and it's a great way to measure it. We
10 have pretty good consensus around this.

11 DR. FIELDS: And no additional
12 comments from me.

13 MR. STOLPE: Great. Thank you.

14 CO-CHAIR HALL: Thank you. So in the
15 room, we'll ask for some comments or questions
16 before going to a vote to see where we are.
17 Mary? I'm sorry, Misty?

18 MEMBER ROBERTS: Thanks. I think some
19 of the same concerns that Esther brought up apply
20 to this measure as well, but probably even more
21 so. I think this is probably the most concerning
22 measure for me as I was reading through.

1 I just think with the feasibility from
2 a health plan perspective, I think the concern
3 with one of the commenters actually presented it
4 well in terms of, well, who is actually supposed
5 to notify whom of what and by, and how are they
6 supposed to?

7 So I think there's still some
8 questions around that. The timeliness of the
9 notification is a concern. Right now, it's, for
10 us, a very manual process. We're not going to
11 get claims within 24 hours. The fact that it is
12 claims as well as, basically, a record review.

13 It's very concerning, really, around
14 the feasibility and the complexity of this, not
15 to mention that there's four measures involved.
16 It's a composite measure.

17 And then we have to think about the
18 med rec post discharge already in a measure in
19 the program and how we would address that.

20 CO-CHAIR HALL: Thank you, Misty.
21 Elizabeth.

22 MEMBER GOODMAN: I would just second

1 what Misty just said. I would also say that our
2 plans are very concerned about the cost of
3 administering the measure as well as the fact
4 that often rural patients are being seen outside
5 of their communities and the communication
6 patterns are not terrific, and there is no
7 electronic data standard for the transmission of
8 this data at this time.

9 CO-CHAIR HALL: Thank you. Esther.

10 DR. FIELDS: I'm sorry. This is Rob
11 Fields. One of the co-chairs of the coordination
12 workgroup, so if it's appropriate, may I respond,
13 based on the context of the conversation, to some
14 of that?

15 CO-CHAIR HALL: Sure, Rob. Go ahead.

16 DR. FIELDS: I would just like to
17 point out, just to make sure everyone's aware,
18 and it may be obvious, but we do have
19 representation from the rural workgroup in the
20 clinician workgroup, so we did hear from them as
21 well, and as part of the deliberation, so took
22 that into account, and to the overall -- into the

1 vote, and to the feelings of the group.

2 I would also say there was -- with
3 this and other measures, there was general
4 discussion within the clinician workgroup about
5 while there are certainly challenges and
6 interoperability in communication between all
7 sorts of facets of the health system, I don't
8 think anyone can argue with the fact that that
9 is, in fact, our charge, is to coordinate care.

10 And it does become a little bit of a
11 chicken or the egg thing where if no one plants a
12 flag to define what it is that we're supposed to
13 be doing to achieve coordination of care, then
14 what is the incentive to do it?

15 And while there were certainly similar
16 concerns that were expressed, I think the overall
17 feeling of the workgroup, as expressed, I think,
18 by the recommendations, is that at some point,
19 you have to plant that flag and move in a
20 direction that leads to better coordination of
21 care in what is otherwise a super broken system.

22 And many of us that have moved into

1 value-based care have already tried to solve
2 these problems, and have solved these problems,
3 and to some degree, this is a -- we believe that
4 there needs to be a push to continue to do that
5 across the board.

6 And I know Bruce and others have felt
7 that we had a different experience, but that's
8 sort of my general take and summary about some of
9 these last couple of measures.

10 DR. BAGLEY: This is Bruce, I totally
11 agree.

12 CO-CHAIR HALL: Okay. Thank you,
13 both. We'll continue in the room. Esther.

14 MEMBER MORALES: I want to speak as an
15 end user of this measure, because I had about
16 2500 medical records that I had to get for this
17 measure, because two of the subsections of this
18 measure, the notification of admission and the
19 notification of discharge, are done entirely by
20 medical record.

21 And unless you're an integrated
22 delivery system with a hospitalist, you're

1 probably never going to be able to make sure that
2 it's in the -- all the requirements for the
3 medical record are in the medical record when you
4 go look for it.

5 So it is expensive for us to go and
6 it's very annoying for the physician for us to
7 try to find the medical records where you can't
8 find evidence of this happening.

9 So these two components, the admission
10 that -- the notification of admission and the
11 notification of discharge are very difficult to
12 do. There's no administrative way to do it
13 except for getting a medical record.

14 And so our position is until that is
15 available, somehow, to do it administratively,
16 that this is a lot of work for very little
17 outcome.

18 CO-CHAIR HALL: Thank you, Esther.
19 Misty?

20 MEMBER ROBERTS: Yes, I just wanted to
21 respond to the comment on the phone. I think
22 that we all agree that the intent of the measure

1 is appropriate, and it does need to be addressed,
2 but I think we're talking about including this in
3 the Star Rating Programs, and I think that's the
4 concern that, where the notification is to come
5 from the hospital to the health plan, so
6 therefore, the health plan is being held
7 accountable for something that the hospital is
8 supposed to do.

9 So if the hospital doesn't provide the
10 health plan with the information, therefore, the
11 health plan is then penalized, so I think that's
12 important to take into consideration.

13 CO-CHAIR HALL: Thank you. Other
14 concerns prior to a vote?

15 MEMBER QASEEM: So this is Amir. I
16 was looking at this measure. I absolutely hear
17 what everyone is saying, that it's going to be
18 burden, but the others who said we need to move
19 in this direction to address it, a broken system,
20 it's about time.

21 I mean, from medication
22 reconciliation, I'm not really sure if we're

1 going to be able to get good data and all, but
2 the people waiting for that side of the system to
3 fix itself versus we push it, sort of reminds me
4 of the maternal mortality sort of measure this
5 morning we discussed.

6 So I hear the concerns, but I think
7 it's time to move it.

8 CO-CHAIR HALL: Thank you, Amir.
9 Mary?

10 MEMBER ROBERTS: And again, this is an
11 NCQA measure, which I will recuse myself from the
12 voting lines, but I think that what has -- you
13 know, what Amir said was well put, that it's time
14 to set up those data systems to get the
15 information to flow more easily.

16 And I'm just trying to find out from
17 my team when, certainly, NCQA's intention to
18 retire the medication reconciliation measure as
19 the transitions of care measure becomes more
20 widely used, and the idea is that there's only
21 one chart review that's required.

22 I'm not downplaying how difficult that

1 chart review is today, but it should not always
2 be that difficult. And I don't know of any other
3 way other than starting to get the ball moving in
4 the right direction.

5 CO-CHAIR HALL: Elizabeth?

6 MEMBER GOODMAN: I think to Mary's
7 point, right, these -- that I can't emphasize
8 enough how important it is to the plan that we
9 not be doing the measure that just changed last
10 year on med recon, it's a D measure right now,
11 and this measure, that they have to sort of one
12 way or the other, and that it be a display
13 measure for some period of time while the system
14 fixes itself.

15 So I don't think anybody's
16 disagreeing, I know no one is disagreeing, that
17 this is a laudable goal, but we need some time to
18 implement this.

19 CO-CHAIR HALL: So, Elizabeth, what I
20 heard from you almost sounded like new conditions
21 that we would consider, so if everyone's okay,
22 we'll move to vote for the group -- the exact

1 workgroup recommendation in front of us first,
2 the exact recommendation is, conditional support
3 with NQF endorsement only, the only condition,
4 right?

5 And if anyone would like to have
6 deeper discussion or propose alternate
7 conditional support, or any other part, then you
8 would just vote down this measure now, so we'll
9 vote this first.

10 Mary, did I catch you already or not?
11 Yes? Okay. So right now, we're voting on the
12 exact workgroup recommendation.

13 MS. BUCHANAN: Voting is now open for
14 2019-21. It's to vote to accept the workgroup
15 recommendation as conditional support for
16 rulemaking. And we need just one or two more
17 votes. Okay. So we are closing voting. We
18 received 8 votes yes, 10 votes no.

19 The coordinating committee does not
20 vote to move forward 2019-21 of the workgroup
21 recommendation for conditional support.

22 CO-CHAIR HALL: I'd like to propose

1 that we go right away and vote full support.
2 We've had some conversation anticipating that
3 we'll come back to some other version of
4 conditions to be discussed, so can we -- anyone
5 object to voting full support first? Starting at
6 the top. Okay.

7 So we'll vote full support.

8 MS. BUCHANAN: Voting is now open for
9 2019-21, support for rulemaking. And we need
10 several more votes. Okay. We're going to close
11 the voting in just a minute. Anyone else who
12 hasn't voted, please do so. Okay. We are
13 closing voting. Closing voting now.

14 For MUC2019-21 vote of support, we
15 received 6 yes, 13 no, the committee does not
16 move forward with support for 2019-21.

17 CO-CHAIR HALL: That brings us back to
18 the conditional category. Would anyone like to
19 have further discussion or would anyone like to
20 propose a different set of conditions for
21 consideration? Yes. Elizabeth.

22 MEMBER GOODMAN: I'm happy to go back

1 to where we were with the proposed condition,
2 that this only be implemented after the D measure
3 is removed and that it be placed -- if it is to
4 be placed in Stars methodology, that it be a
5 display measure for some period until the system
6 can catchup with the information.

7 The whole one is or the D measure is?

8 DR. GOLDSTEIN: This is Liz Goldstein
9 from CMS. This is display measure right now and
10 we are required to -- any measure added to Stars
11 rulemaking, we're required to have it displayed
12 for at least two years, or more, before it moves
13 to Stars. None of them move directly to Stars.

14 MEMBER GOODMAN: Yes. Thank you. I'm
15 sorry, I should have said that at the beginning,
16 the issue is that it not become a Star measure
17 before the D measure is removed.

18 CO-CHAIR HALL: Elizabeth, could I
19 impose on you to restate what you want to propose
20 the conditions to be?

21 MEMBER GOODMAN: Sure. Or maybe Misty
22 can state it more clearly.

1 CO-CHAIR HALL: Okay. Sure, sure.

2 MEMBER ROBERTS: Well, I actually had
3 a clarifying question, but I think what you're
4 saying is that it does not move to Stars.
5 Apparently, it's on display, which, how long has
6 it been on display?

7 MEMBER GOODMAN: One year.

8 MEMBER ROBERTS: One year.

9 DR. GOLDSTEIN: This is Garcia right
10 now that's on display?

11 MEMBER ROBERTS: So it would at least
12 have another year, it sounds like, but --

13 DR. GOLDSTEIN: At least one more
14 year, and often, it's more than two years,
15 depending on, you know, feedback that we get.

16 MEMBER ROBERTS: And then not be moved
17 to a Stars measure until the current med rec post
18 discharge is removed from Stars. And then my
19 clarifying question is, is it NQF endorsed? Do
20 we know?

21 CO-CHAIR HALL: It is not.

22 DR. GOLDSTEIN: It is not NQF

1 endorsed, and we wouldn't have the existing
2 medication reconciliation measure in this
3 measure, it would be, you know, having it twice,
4 so that one would automatically be removed before
5 this is implemented in Stars.

6 MEMBER ROBERTS: So I would also
7 suggest that we have NQF endorsement also as a
8 condition.

9 CO-CHAIR HALL: Great. So you heard
10 three conditions from Misty and Elizabeth.
11 Anyone else with other concerns, questions, or
12 other thoughts?

13 I'm no seeing or hearing any, so I
14 will support the proposal that we're going to
15 vote now on conditional. Conditions being the
16 existing measure has to go away, the display
17 period has to be completed, and NQF endorsement.

18 MS. BUCHANAN: Thank you very much.
19 Voting is now open for 2019-21 with conditional
20 support. And we're just going to close it in one
21 moment. Give an opportunity for any additional
22 votes. Okay. We can close the vote. We

1 received 15 yes, 3 no, MUC2019-21 will move
2 forward as conditional support.

3 CO-CHAIR HALL: Thanks, everyone.
4 That was good conversation. 19-57, Sam.

5 MR. STOLPE: Very good. Thank you.
6 Before we get too far down the road in the
7 discussion of this measure, the NQF staff need to
8 make a series of clarifying comments about MUC19-
9 57, use of opioids at high dosage in persons
10 without cancer.

11 And I'm going to preface these
12 comments with an apology, so there's been some
13 confusion about this measure, some of it was --
14 is our fault, and we want to own that, so our
15 apologies, sincerely, for any lack of clarity and
16 confusion that we've generated as a staff.

17 So when CMS submitted these measures
18 for consideration, they stated in their
19 submission that only one of these three opioid
20 measures would be advancing into the Star
21 ratings.

22 With this in mind, NQF staff had the

1 impression that the clinician workgroup would be
2 tasked with selecting which of the three measures
3 to move forward.

4 So NQF staff reviewed the three
5 measures together and provided a preliminary
6 analysis of the measures. The workgroup, for
7 this measure, NQF staff assigned a preliminaries
8 category of conditional support for rulemaking,
9 which you're seeing in front of you.

10 The condition being that this measure
11 would be supported in the event that the other
12 two measures did not move forward into the Stars.
13 So if, for example, the workgroup would have
14 said, do not support for the other two, the
15 condition would be fulfilled that the other two
16 would not be advancing in the Stars, this would
17 be the preferred measure.

18 So in a conversation with CMS just
19 before the workgroup meeting, and this was after
20 the preliminary analyses had been sent to the
21 workgroup, it was clarified that CMS would prefer
22 that the workgroup not suggest which of the

1 measures to move forward, but rather, to consider
2 the three measures on their own merits for
3 inclusion in the program.

4 Now, in an effort to reduce the
5 confusion for the meeting, rather than update the
6 preliminary analysis and discussion guides and
7 try to explain it over email, we thought that
8 would generate more confusion, so instead, we
9 elected to explain this in person.

10 During the meeting, staff clarified to
11 the workgroup that each of the measures should be
12 considered individually and the conditional
13 support was based on the other two measures not
14 moving forward.

15 Now, we've reviewed the transcript of
16 the in-person meeting and the nature of the staff
17 recommendation on the conditions was emphasized
18 several times over by both the co-chairs during
19 the discussion, as well as by staff, and
20 including just before the vote on the measure.

21 So it appears that it was well
22 understood by the workgroup that they were voting

1 on the measures irrespective of whether the
2 measures should advance into the Stars.

3 So you can see how these are two
4 conflicting things. We conditioned it upon
5 moving forward in the Stars and simultaneously
6 told the workgroup not to consider them, whether
7 or not the others were moving into the Stars.

8 So, in subsequent conversations with
9 the workgroup co-chairs and with CMS confirmed
10 this; however, NQF did not make this change
11 during the vote.

12 So the workgroup voted to support the
13 preliminary analysis of conditional support
14 instead of voting to support for rulemaking.
15 Now, since NQF staff has subsequently met with
16 the coordinating committee co-chairs, and the MAP
17 clinician co-chairs, we would like to suggest
18 that the MAP coordinating committee for the
19 conditions do not reflect the intention of the
20 workgroup and should therefore be removed.

21 So NQF suggests moving forward with an
22 initial starting vote of support for rulemaking

1 for the sake of clarity and to ensure that the
2 wishes of the workgroup are best represented for
3 the MAP coordinating committee.

4 All three of these measures do carry
5 an NQF endorsement and would be considered as
6 suitable for inclusion in the program for the
7 first two measures, the last one was do not
8 support for rulemaking.

9 I want to pause here for any
10 clarifying questions that you might have for the
11 staff related to the proposition we're putting on
12 the table.

13 CO-CHAIR HALL: So let's try to keep
14 it to clarifying questions for the staff. Yes.

15 MEMBER SCHREIBER: Can I ask a
16 question of Sam?

17 CO-CHAIR HALL: Michelle.

18 MEMBER SCHREIBER: Thank you. If I
19 recall, though, the do not support for rulemaking
20 was because people thought that that was
21 basically like a combination of the two above.
22 If we're supposed to vote on these only as they

1 stand, are we supposed to look at that measure
2 differently than what the group did?

3 MR. STOLPE: No, so we're just talking
4 about Measure 57 for now.

5 MEMBER SCHREIBER: Okay.

6 MR. STOLPE: The other two measures,
7 the workgroup feels comfortable with where
8 they've landed on the recommendation.

9 MEMBER SCHREIBER: Okay. Thank you.

10 MR. STOLPE: It's only this first one
11 where the conditional support, the workgroup did
12 not feel that accurately represented the
13 discussion and what they wanted to proffer as
14 their recommendation, which would be support for
15 rulemaking.

16 MEMBER SCHREIBER: Thank you for the
17 clarification.

18 CO-CHAIR HALL: Harold.

19 MEMBER PINCUS: That's actually what
20 I wanted to know, what was their intention, was
21 to support it?

22 MR. STOLPE: Correct. So our review

1 of the transcript, our conversation with the
2 workgroup co-chairs, put it firmly in the camp of
3 support for rulemaking as the intended purpose of
4 the workgroup.

5 MEMBER PINCUS: So not conditional
6 support.

7 MR. STOLPE: Correct. Given that the
8 conditions truly don't make sense in light of the
9 discussion.

10 CO-CHAIR HALL: Any other initial
11 queries?

12 MEMBER PINCUS: So we should apply our
13 same consideration as the workgroup applied.

14 MR. STOLPE: I'm sorry, could you
15 clarify what you mean by that?

16 MEMBER PINCUS: So in terms of not
17 taking each one on their own standing rather than
18 looking across all three.

19 CO-CHAIR HALL: We should take each on
20 its own standing, yes.

21 MEMBER PINCUS: Okay.

22 CO-CHAIR HALL: So just technically,

1 do you want us to vote down the conditional
2 support first or you don't care about that?

3 MR. STOLPE: So what we would like to
4 do is proffer that as the starting point, unless
5 there is an objection from the coordinating
6 committee.

7 CO-CHAIR HALL: Conditional support or
8 full support?

9 MR. STOLPE: Full support as the
10 starting point, unless there is an objection on
11 the part of the committee, in which case, we will
12 begin voting on conditional support.

13 (Off-microphone comment.)

14 CO-CHAIR HALL: That's an option.
15 That's an option for us to just start with
16 conditional support, we've heard what we just
17 heard, and we can start with conditional support
18 and change course.

19 Misty, did you have a question or
20 Elizabeth?

21 MEMBER GOODMAN: I think we have the
22 same question, which is, that we don't -- our

1 plans fundamentally have a problem, we're fine
2 with the measure, the issue is that the PQA
3 measure and the NCQA measures don't -- that's in
4 HEDIS, are not identical, creates an enormous
5 burden, in terms of measurement burden, on the
6 plans where they're subject to both HEDIS and the
7 Stars methodology, and so we would like to see
8 them aligned.

9 I'm just trying to understand, from a
10 technical standpoint, if we're -- the conditioned
11 support, I mean, I'm just not sure which option
12 gets that part of the issue in the discussion.

13 CO-CHAIR HALL: I think, probably, it
14 sounds like that would be something you would
15 want to offer as a conditional consideration, so
16 what we can do is, we can begin with what's in
17 front of us, conditional support, we've heard
18 from Sam, the staff, that that does not -- did
19 not end up representing all the proper thought
20 that was put into this, so it's on us to sort of
21 accept or reject it.

22 Our staff has emphasized to us it does

1 not seem to represent what it was intended to
2 represent, so it's on us now to accept or reject
3 conditional support as offered by the workgroup.
4 Is that okay?

5 DR. BAGLEY: Bruce. My hand's up.

6 CO-CHAIR HALL: Yes, I'm sorry. Is
7 that Bruce or Rob? Oh, Jeff, sorry.

8 DR. BAGLEY: It's Bruce Bagley. Yes,
9 I think that if you're going to debate this,
10 you're going to debate whether we came to a
11 conclusion of support versus that we came to a
12 conclusion of support with the conditional
13 support.

14 So I don't know how you can debate
15 that unless you're in the meeting. So what we're
16 saying is that we really are trying to have
17 support for rulemaking.

18 CO-CHAIR KAHN: This is Chip. I would
19 hope that we would vote this down and then get
20 into the regular order, but I think for us, we
21 had a long discussion earlier about, you know,
22 following the regular order regarding what this

1 was, and even if there was an error here, we can
2 correct the error, assuming that we all swim
3 together, and just vote this down, and then move
4 to the issue of full support, support with
5 conditions, turn it down with mitigation, we have
6 all those choices.

7 So I think we should not spend a lot
8 of time talking about this, we should just get it
9 off the table and move to the next step.

10 CO-CHAIR HALL: So let's go ahead and
11 vote the -- I know there's a couple flags up, but
12 I think what we're saying is, we'll have an
13 opportunity for further discussion in just a
14 second, most likely. Let's vote the workgroup
15 conditional support.

16 We've heard that the -- comments about
17 it.

18 MS. BUCHANAN: Great. So we are
19 opening voting for MUC2019-57 of the workgroup
20 recommendation, conditional support for
21 rulemaking. And going to give it just another
22 couple seconds to get a couple more votes in.

1 Okay. We are going to close the vote.
2 We received 0 votes yes, 18 votes no to move
3 forward with the workgroup recommendation.

4 CO-CHAIR HALL: Okay. So thank you,
5 all. That's off the table and now we will start
6 back on a full support, but first, we'll invite
7 conversation. Harold.

8 MEMBER PINCUS: So I think I have,
9 sort of, three issues. One is, it's not clear
10 what the issue is, you know, about these. Is it
11 that we're considering only one of them or
12 considering each of them independently, I think
13 that's clear that we're supposed to be
14 considering each one independently.

15 Number two is, what was brought up by
16 my colleagues from the health plans is that,
17 there seems to be some differences between
18 different ways in which these are
19 operationalized, and I actually didn't see that
20 in the discussion here, and I don't know how that
21 gets brought into the discussion, but I think
22 that needs to be in the discussion in some way.

1 And I don't know the way to bring it
2 in in terms of just a support, not support kind
3 of thing. Number three is, I do think, and this
4 is for, like, a separate topic, is, I think we
5 need to change the process a bit, because this
6 sort of going through everything in a stepwise
7 fashion rather than dealing with the issues for
8 the measure, you know, across the board, is
9 probably -- would be a lot more efficient in some
10 ways and less confusing.

11 But anyways, so it's clear that we
12 should deal with each of these separately. Where
13 do we deal with the issue about the differential
14 operationalization of the measure?

15 CO-CHAIR HALL: And the burden that
16 that creates.

17 MEMBER PINCUS: Yes.

18 CO-CHAIR HALL: So the developer would
19 like to make a comment. Mary, I'll invite you to
20 put your comments on the table first and then
21 we'll allow the developer to respond.

22 MEMBER BARTON: Great. So the --

1 CO-CHAIR HALL: Mic, please.

2 MEMBER BARTON: Thank you. So I was
3 not recusing myself, since this is a PQA version
4 of the measure, but the difference between the
5 NCQA measure that's used in health plan reporting
6 for reporting to NQA and the PQA measure, which
7 is used in Part D plans and then is now proposed
8 for the Part C and D Stars, is that the PQA
9 measure requires the patient, for the high-dose
10 measure, the patient has to be at that high dose
11 for 90 or more days, whereas, the NCQA measure
12 looks for people who have been at a high dose for
13 15 or more days.

14 So it's a very different bar, and then
15 for the multiple providers measure, which NCQA
16 also has an analog, they look within a six-month
17 period for four or more providers to write
18 prescriptions, or four or more pharmacies to fill
19 prescriptions, and we look over a year for four
20 different entities to either write or fill
21 prescriptions.

22 So again, it's a more stringent

1 approach, and I say that without value.

2 CO-CHAIR HALL: Great. Thank you,
3 Mary. We'll invite the developer. There's a
4 measure developer right there next to Harold.

5 MEMBER HINES: Thank you. I'm Lisa
6 Hines with the Pharmacy Quality Alliance. PQA's
7 high-dose measure, I'm going to talk about these
8 two together because they are analogous measures
9 by NCQA, where PQA endorsed in 2015, and NQF
10 endorsed in 2017, and have been reported in
11 Medicare Part D patient safety reports at that
12 time.

13 And are currently display measures in
14 Part D. The high-dose measure is in the Medicaid
15 adult core set. NCQA adapted PQA's measures and
16 as the first measure on the market, the NQF-
17 endorsed measure, we do believe that our measures
18 align most closely with the evidence and have had
19 a great deal of vetting.

20 We do welcome harmonization and
21 alignment with our colleagues at NCQA, to the
22 extent that they are willing to harmonize with

1 the PQA measures.

2 CO-CHAIR HALL: What are we, if this
3 is already as widely established, as noted, and
4 already approved, what specific questions are in
5 front of us? You said it's already on display
6 for Stars.

7 MEMBER HINES: Yes, sir.

8 CO-CHAIR HALL: So what's the question
9 in front of us?

10 MR. STOLPE: So the question is, the
11 display ratings are, of course, quite a bit
12 different than the Star ratings in terms of their
13 application and accountability implications.

14 So these measures are being considered
15 for migration from the display into the Star
16 ratings directly. So we're to consider each one
17 of these measures, one by one, for their
18 suitability to do so.

19 So the question in front of you is,
20 essentially, is MUC19-57, use of opioids at high
21 dosage, suitable for movement from the display
22 into the Star ratings.

1 CO-CHAIR HALL: Thank you for that
2 clarity. I'll go over to David first.

3 MEMBER GIFFORD: I got a question for,
4 I guess, Michelle, is the creation of the Star
5 rating done through regulation?

6 MEMBER SCHREIBER: This is the MA's
7 Star rating or no?

8 CO-CHAIR HALL: Microphone, please.

9 MEMBER GIFFORD: So do it through the
10 MA Star rating, is an item moved into the scoring
11 through regulation?

12 MEMBER SCHREIBER: Yes, so do we have
13 Medicare on the phone? Can you answer that? I
14 believe the answer is yes, but I want Medicare to
15 answer it because it's their statutes.

16 (Telephonic interference)

17 MEMBER GIFFORD: The answer's yes?

18 PARTICIPANT: Yes. It would have to
19 be through regulation and on display for at least
20 two years prior to moving to Stars.

21 MEMBER GIFFORD: And just a separate
22 broad policy question of CMS, and we may want to

1 think about it, you don't use rulemaking for a
2 lot of the other Star ratings, and compare, is
3 that the only rulemaking.

4 MEMBER SCHREIBER: But we're starting
5 to change. Remember, hospital Stars ratings go
6 into the rulemaking this year too, so all of
7 these programs will be --

8 MEMBER GIFFORD: So are you switching
9 all the settings in the rulemaking?

10 MEMBER SCHREIBER: Yes.

11 MEMBER GIFFORD: Okay. But I think we
12 may want to think about, though, because adding
13 measures and how they score on the Star rating is
14 a very different methodology, the payment, and
15 the assigning this rule for rulemaking, I mean,
16 as we decide what's for rulemaking, we need to
17 understand how that is because just saying, yes,
18 it's a measure to add on to public reporting is
19 very different, so I would think that that's
20 something we need to tackle and understand.

21 I've done a lot with CMS and a lot
22 with public reporting and the Star ratings, and

1 it's not nearly as simple as just saying, yes,
2 rulemaking, so I think we should be educated as a
3 committee to think about that process.

4 That doesn't affect, I think, our vote
5 today, but I was just curious as to why we were
6 voting on the rulemaking because I'm familiar
7 with provider Star ratings, not the MA plan as
8 well, a little bit, I didn't realize it was in
9 the rule.

10 MEMBER SCHREIBER: But that's why I
11 had to ask, because it's outside of, actually,
12 our department. This belongs to the Center for
13 Medicare, so that's why the clarification.

14 CO-CHAIR HALL: Nancy?

15 MEMBER FOSTER: So I just wanted to
16 ask for clarification on another issue that was
17 raised in the comments, which is that there are
18 patients who do not have cancer, but who have
19 other chronic diseases that require pain
20 management, who have begun to emerge as groups,
21 complaining that they are having challenges
22 getting the pain management that they need in

1 order to lead their best lives.

2 And yet, I don't see that incorporated
3 in here, I'm worried about the unintended
4 consequences of this, several of the commenters
5 said as much, several of the commenters with a
6 lot more clinical expertise than I have, which is
7 zero, have said -- commented on that, so
8 aggressively moving forward with this, but put it
9 in Star ratings, without addressing those
10 concerns, seems a challenge to me, and I wonder
11 about the perspective.

12 CO-CHAIR HALL: Misty?

13 MEMBER ROBERTS: Thanks. I have a
14 comment and a few questions, so bear with me.
15 First, I think David made a really good point
16 that it doesn't seem like, maybe, everybody in
17 the group understands the implications of some of
18 these programs.

19 We're voting on measures, but it's not
20 just the measures, there are also implications to
21 these measures being included in certain
22 programs, so I think it's very important that the

1 group understands that, so if there hasn't been
2 that baseline knowledge, I suggest that, somehow,
3 that gets incorporated into the process.

4 The other thing is, a couple
5 questions, just to clarify, Lisa, I think you
6 mentioned that the measures are endorsed, all
7 three measures are endorsed, and then, what about
8 the NCQA measures, are they endorsed, Mary? No?
9 Okay.

10 And then, Lisa, your point I think you
11 made was that they are -- you feel that yours are
12 most closely aligned with the evidence, can you
13 provide any clarification on why you think that's
14 true?

15 MEMBER HINES: So the average of 90
16 days is to represent long-term opioid use, so to
17 more reflect chronic opioid therapy, what we call
18 chronic opioid therapy, or long-term therapy for
19 patients with non-cancer common pain, so that's
20 the 90-day duration. So I'm highlighting the
21 differences.

22 The measure aligns with the CDC

1 guidelines and the underlying primary evidence,
2 the high-dose measure. The multiple provider
3 measure aligns with evidence indicating an
4 increased risk of overdose.

5 The six-month time period is
6 reflective of the underlying studies that
7 evaluated multiple prescribers, and the threshold
8 reflects, and of that doctor and pharmacy
9 shopping behavior that most closely correlated
10 with increased risk of drug overdose.

11 So it's based in the evidence and
12 subject matter expert input.

13 CO-CHAIR HALL: Lisa, thank you. Were
14 there any other comments that you wanted to give
15 a brief response to that you heard in the last
16 couple minutes?

17 MEMBER HINES: Just acknowledge the
18 importance of the implications of the program and
19 the Star ratings, and PQA acknowledges that that
20 is a true concern, and it is also a concern of
21 ours, and anything that we can do to ensure that
22 our measures are not misapplied and, you know, we

1 are open to.

2 CO-CHAIR HALL: Thank you. Elizabeth?

3 MEMBER GOODMAN: I just wanted to
4 clarify, Liz, if she's still on the phone, that
5 should this measure be -- come off of the display
6 page and go into the Stars methodology, the HEDIS
7 measure will come off, right?

8 Because if that's not the case, then
9 we are -- we have two completely different
10 measures in the same measure set.

11 CO-CHAIR HALL: Do we know that?

12 MR. STOLPE: That's not the case. So
13 just a quick correction on that. So the HEDIS
14 measure is not currently in the Star ratings.
15 It's just in the HEDIS measure set, to which many
16 health plans are held accountable, both to HEDIS
17 and the Stars.

18 MEMBER GOODMAN: All right. I
19 misunderstood what you said before. Thank you.

20 CO-CHAIR HALL: David?

21 MEMBER BAKER: So I just wanted to
22 comment on the issue that Nancy Foster raised.

1 So I have voted down measures in the past because
2 of concerns of adverse consequences, and I
3 thought about that a fair amount for this, and
4 I'm less concerned about this, because the way
5 the measure is designed.

6 90 MMEs is a really high dose. And if
7 somebody is above that, the chance that they
8 would just be kicked off, which is a concern for
9 individual physicians, right, I think that's very
10 unlikely. Most people, they try to taper them
11 down, and so if somebody's at 120, they just have
12 to get down to 85.

13 So that concern that we're seeing
14 nationally of people just being cutoff, I'm less
15 worried about for this measure. Also, the fact
16 that it's applied at the group level, these large
17 groups will be able to set up taper clinics with
18 people who actually have the expertise to do this
19 safely, so I agree this is a concern, but I'm
20 less concerned about it for this group.

21 CO-CHAIR HALL: On the phone we have
22 Libby.

1 MEMBER HOY: Hi. I really do think
2 that the last comment didn't -- definitely
3 hearing from our patients and we believe that
4 they're being set up, they're being discharged
5 from provider groups, and so that is definitely
6 happening.

7 And I think your comment is, you're
8 saying, that the upper limit is high enough that
9 -- and I think I understand it up there, it's a
10 tapering piece to this measure?

11 CO-CHAIR HALL: Lisa, why -- I'll have
12 Lisa Hines address that.

13 MEMBER HINES: Hi. Thank you for your
14 question. There's not a tapering component to
15 this measure. That is a measurement gap. And do
16 want to, again, point out that this is a
17 retrospective, claims-based, population-level
18 measure and wouldn't necessarily be appropriate
19 at a provider level.

20 CO-CHAIR HALL: Rebecca?

21 MEMBER HOY: Thank you.

22 MEMBER KIRCH: Thank you. Rebecca

1 Kirch, National Patient Advocate Foundation, and
2 I, like Nancy, am actually -- I'm still stuck.
3 I'm not allayed, because I know that patients who
4 need higher dose opioids, even if they don't have
5 cancer, are being cut off, not tapered off.

6 And so the implications, as Misty
7 mentions here, could be quite significant. So
8 I'm not sure that I'm enough reassured that a
9 Star rating support, that's just kind of
10 bulldozing, especially when we know CDC is re-
11 looking at the guidelines because they've been
12 misapplied, and there isn't sufficient evidence
13 behind it.

14 CO-CHAIR HALL: Great. We've heard a
15 lot of very deep concerns, a lot of very rational
16 enthusiasm to move forward, so any other -- yes.

17 MEMBER QASEEM: This is Amir. Can I
18 chime in?

19 CO-CHAIR HALL: Yes, Amir.

20 MEMBER QASEEM: Yes, I think I will
21 say this discussion has been a good discussion.
22 My thing is like, there is a lot already that's

1 happening at the state level anyways to get some
2 of this -- to address the whole epidemic. That's
3 really where the target has gone.

4 And I'm wondering, do we need to move
5 in the direction of mitigating the damage that's
6 already occurred in the opioid prescribing route
7 and addressing what we're talking about.

8 And I heard what David is saying,
9 David Baker, I hear the 90 MME is pretty high,
10 but then when I'm looking at the list of the
11 opioid medication, there's some medications that
12 are listed in there that are being used to treat
13 addiction to narcotic pain relievers, David, and
14 I'm a little worried about that that will lead to
15 -- there's some proven intervention, which
16 physicians have stopped using, which will lead to
17 some other problems, right?

18 Because we already know that some of
19 these medications are not getting prescribed,
20 people are then heading towards getting even
21 stronger narcotics, like heroin and other
22 illicitly obtained opioids. That's an issue.

1 So I'm struggling still. I mean, I
2 hear some of the discussions. Again, the need
3 for this measure. But then there's some harm
4 that I'm still a little bit worried about.

5 CO-CHAIR HALL: Amir, thank you. I'm
6 going to have Lisa Hines clarify an issue for
7 you.

8 MEMBER HINES: So this measure, both
9 of these measures, exclude products that are
10 indicated for medication-assisted treatment, and
11 in fact, all buprenorphine products are excluded
12 from these measures.

13 MEMBER QASEEM: Oh, because I saw them
14 listed in the list of opioid medications, so
15 maybe I missed that.

16 CO-CHAIR HALL: Okay. Well, we have
17 the word of the developer, that that's the case.
18 Rebecca, are you okay? Yes. Okay. All right.
19 Amir, did you have any other follow-up question
20 or are you okay?

21 MEMBER QASEEM: No, and again, you
22 guys know this topic a little bit better, if

1 someone can tell me, how is this measure going to
2 help above and beyond what the state-run
3 prescription drug monitoring programs are already
4 doing and what are we adding here that's of
5 value?

6 MEMBER BAKER: So I'll comment on
7 that, Amir.

8 CO-CHAIR HALL: David.

9 MEMBER BAKER: I mean, when you get up
10 to these very high doses, there are substantial
11 risks to patients, particularly somebody who's
12 obese, may have sleep apnea, patients with sleep
13 apnea, patients with chronic obstructive
14 pulmonary disease, so it's not like there's no
15 risk if somebody's on 120 MMEs.

16 If you think about what's happening
17 with the prescription drug monitoring programs in
18 the state, those are really valuable, but there's
19 no sharp edge to those, right?

20 So this is something that allows --
21 this allows groups to be able to look at their
22 performance on this measure, and hopefully they

1 would respond and set up some of these programs.

2 I think the biggest risk and the
3 biggest danger is for individual physicians to be
4 handling these patients who are seeing multiple
5 providers, or on these very high doses. A lot of
6 these patients have opioid use disorder, they
7 need to be tapered, and they need to be treated
8 for their chronic pain, and they need to deal
9 with their opioid addiction.

10 So, you know, that just is not really
11 addressed by the state programs of these
12 policies, so it's a very tricky issue. And
13 again, if this was for individual clinician
14 measures, I would vote against it, because they
15 will do the easy thing and they will just say
16 that they won't see the patient anymore. That's
17 what we're seeing nationally.

18 CO-CHAIR HALL: Thank you, everyone.
19 Great comments all around. We will, just in a
20 second, move to vote for full support. Any other
21 concerns that people haven't had a chance to get
22 out? Not seeing any, we'll go to vote for full

1 support.

2 MS. BUCHANAN: Thank you very much.
3 Voting for MUC2019-57, vote for full support is
4 now open. And we are still waiting for some
5 votes. We need a couple more. Okay. We are at
6 17 votes, so we will close the voting. We
7 received -- oh, we'll close it now, we received
8 13 yes, 5 no. MUC2019-57 moves forward with
9 support.

10 CO-CHAIR HALL: Thank you. Thank you,
11 everybody. Good discussion. We'll move to -60.

12 MR. STOLPE: Excellent. Okay. So
13 MUC19-60, use of opioids from multiple providers
14 in persons without cancer, again, same measure
15 developer. This was very well supported by the
16 workgroup overall and seemed to be that if they
17 were put into the position for which one to move
18 forward, they tend to lean towards this one,
19 because of the unintended consequences that were
20 discussed, associated with the first measure.

21 But again, largely supportive. Public
22 comments seemed to be largely supportive as well.

1 I'll pivot to our co-chairs for any other
2 comments related to the workgroup discussion.

3 DR. BAGLEY: No additional comment.

4 CO-CHAIR HALL: Great. Thank you very
5 much. Does anyone in the room have -- or online,
6 have any clarifications to request before our
7 first vote? Not seeing any, our first vote will
8 be to accept the recommendation of full support.

9 MS. BUCHANAN: Voting is now open for
10 2019-60, moving forward with the workgroup
11 recommendation of support for rulemaking. Okay.
12 We are closing voting. We received 17 votes yes,
13 2 votes no, MUC2019-60 will move forward with the
14 workgroup recommendation of support for
15 rulemaking.

16 CO-CHAIR HALL: Thanks, Kate. Thanks,
17 everyone. -61, Sam.

18 MR. STOLPE: All right. Very good.
19 Thank you. This last measure, when it came under
20 consideration by the workgroup, they followed
21 along comparable lines to what they did when they
22 considered these three measures for inclusion in

1 SSP last year.

2 The workgroup saw this particular
3 measure to be largely duplicative of the other
4 two, with not added benefit associated with
5 having both things captured.

6 Now, each of the preceding two
7 measures is, essentially, captures the entire
8 population because persons to be captured in the
9 numerator of this measure -- excuse me, in the
10 denominator of this measure, need to have both
11 multiple providers and high dosage.

12 So either of the two measures will
13 capture the full patient population represented
14 by this measure, so the workgroup saw this as
15 essentially duplicative.

16 Public comments were reflected in the
17 same, but we did receive some supportive
18 comments. Any supplementary information that our
19 two workgroup co-chairs would like to add?

20 DR. BAGLEY: No additional comment.

21 CO-CHAIR HALL: Thank you. So it's a
22 little bit of a grey zone to say we're

1 considering this by itself, and yet, we're
2 calling it duplicative with two others. Does
3 anyone have any clarifying questions or issues
4 they'd like to raise? Yes, Mary?

5 MEMBER BARTON: It just becomes a very
6 small number, because you have to have both high
7 dose and the multiple providers, and it's just --
8 it's not always a very clear quality signal to
9 use something that is such a low number.

10 CO-CHAIR HALL: And so that's a
11 concern that's different than saying it's
12 duplicative. That's a concern around the sample
13 size. Yes. Nancy?

14 MEMBER FOSTER: Well, I'm a bit
15 confused about how to express this, but I would
16 be remiss to not say at some point, I don't think
17 all three of these should be adopted in the Star
18 program and I -- so if we were to vote each of
19 these independently, then we're going to end up
20 suggesting all three move forward, unless we
21 explicitly say, no, and I don't know how to do
22 that in the context of what we're discussing now.

1 CO-CHAIR HALL: Yes, the issue might
2 be that we find objections to this that are not
3 related to the other two, so for instance, an
4 objection around sample size, if that's true,
5 would be unrelated to the other two. That's one
6 possible thought, but I'll let, Harold, you put
7 your thought on the table, and then I'll, again,
8 have Lisa respond.

9 Please use your microphone, Harold.
10 Thank you.

11 MEMBER PINCUS: How come nobody ever
12 suggested that it be an or rather than an and?

13 CO-CHAIR HALL: Dave, would you like
14 to throw a thought out first or after Lisa?
15 Okay. Didn't know if you had something maybe
16 Lisa could respond to. Lisa, do you want to
17 respond?

18 MEMBER HINES: Perhaps hindsight is
19 20/20, but when these were developed, this was
20 thought to be the most, kind of, egregious, or,
21 you know, highest risk population. As time has
22 gone on, the measure rates are very low, and

1 we're becoming concerned about the measure
2 reliability.

3 And in fact, each of these, kind of,
4 numerator areas of focus are separate risk
5 factors for opioid overdose, and so merit
6 measurement in and of themselves, or, you know,
7 multiple rate measure might make sense in the
8 future.

9 CO-CHAIR HALL: David?

10 MEMBER GIFFORD: I go back to my
11 original point, I don't know how to vote for this
12 on rulemaking because I don't know how CMS is
13 going to use it in the Star rating. There's Star
14 ratings where they have multiple domains, they
15 have multiple measures, they're weighted
16 differently, if you add this into one of those
17 with multiple measures with low ratings, it
18 really doesn't matter.

19 If you make this a single measure in
20 a single domain, with lots of weighting, that
21 drives a Star rating, I'm going to pay a lot more
22 attention and worry about what the potential

1 impact will be on it.

2 And so understanding that, really is
3 important to the rulemaking decision that we
4 have, otherwise we're just voting -- me, I'm just
5 voting on whether it's a reliable measure or not,
6 and there's a ton of reliable valid measures that
7 CMS, TEPs, and everyone has written, should not
8 be used in Star ratings.

9 CO-CHAIR HALL: Well, as you know, and
10 as many of us in the room know, who have worked
11 in conjunction with the NQF for years, we've
12 always traditionally been asked to think about
13 measures without worrying about their
14 implementation, and that feels particularly
15 challenging for the role of this committee, as
16 you point out.

17 MEMBER GIFFORD: But that's not the
18 role of this committee.

19 CO-CHAIR HALL: Yes, exactly.

20 MEMBER GIFFORD: I think that's what
21 we struggle with historically is, we try to adopt
22 that philosophy, and that's why we re-litigated

1 the endorsement process so often over the years
2 in this group, and I think if you look at our
3 statutory authority and what we're doing, it is
4 not to re-litigate that.

5 And it's why, I think, we moved to the
6 condition where we've just sort of taken it off
7 the table that it has to get endorsed.

8 CO-CHAIR HALL: And yet, it doesn't
9 seem, and I'll invite Michelle to comment in a
10 minute, but it doesn't seem like we are also in a
11 position of judging a proposed implementation,
12 right? That also feels like it might out of our
13 scope. Just a thought.

14 Elizabeth, I'll invite your comment
15 and then I'll ask Michelle if she has any
16 comments.

17 MEMBER GOODMAN: Thank you. I support
18 wholeheartedly what David just said. I think the
19 -- I would offer for consideration, that we think
20 about offering conditions on these measures, that
21 they explicitly not -- that the area of
22 measurement not be duplicative for the purposes

1 of payment.

2 I think that it's really -- these are
3 very burdensome for our plans, they're hard to
4 do, we absolutely understand the intent and the
5 goal here, and we absolutely support it, but, you
6 know, adding three separate measurements of
7 opioid addiction to the Stars methodology is
8 really a very high burden.

9 CO-CHAIR HALL: Thank you. Michelle,
10 are there any parts you would like to comment on?

11 MEMBER SCHREIBER: Yes, actually,
12 perspective, because I've been thinking about
13 your question, and it's a really very good
14 question, only I don't think I will ever be able
15 to answer it, sadly, because you're absolutely
16 right, your point is absolutely correct, there is
17 a big difference if you're going to put this in,
18 and use hospital Star for using -- a hospital
19 Stars program, and you're going to give it this
20 tremendous weight and it's going to have its own
21 category, because that's going to, really, weight
22 what your Stars distribution is and what

1 hospitals do well and what don't.

2 And yet, at the same time, we're kind
3 of in this quandary, because number one, because
4 of law, actual law, around rule writing. We
5 couldn't tell that to you even if we knew it,
6 because that places you at a special advantage
7 that, obviously, we can't do, and that is against
8 the law when it comes to rule writing.

9 And the second is, okay, we don't
10 always know when these are -- you know, this is
11 something that gets discussed in the program, and
12 we actually don't even know to bring that to you
13 here.

14 So I'm struggling a bit because I
15 understand, frankly, we'd like to be transparent
16 as much as we can, but I don't know that we'll
17 ever solve that problem, unfortunately, which
18 leaves us, then, with kind of the question of,
19 what's the merit of using this in a payment
20 program?

21 CO-CHAIR HALL: Great. Thank you.
22 That's very helpful. David, comments?

1 MEMBER GIFFORD: No, I really
2 appreciate that quandary, but I do think it
3 probably behooves us to be educated and just
4 about how the different Star ratings are done,
5 because they're so different, because then we
6 have some sense about what it is.

7 And I think most of us have some
8 familiarity with the payment issues, because
9 we're all providers in some way, and we
10 understand the payment issues, most people, I've
11 found, don't understand the Star ratings at all,
12 unless you really delve into it.

13 So I think if you're moving to
14 rulemaking, I don't think that's a good policy
15 move, but if you guys are moving --

16 MEMBER SCHREIBER: We don't have any
17 choice. Quite honestly. We don't love it
18 either.

19 CO-CHAIR HALL: All right. Thank you.

20 MEMBER GIFFORD: But I think we need
21 to do a little bit more on that, because it's not
22 an all or nothing denominator. I think that goes

1 exactly within the way that we're going to do it.
2 So with that, realize where it's going to be.

3 CO-CHAIR HALL: But that's more of a
4 comment that, maybe, this group could be educated
5 next year in preparation for other deliberations.

6 MEMBER SCHREIBER: So, Bruce, that's
7 what I was thinking, maybe sort of an
8 orientation, even a WebEx, prior to these
9 meetings, we could take on education about the
10 Stars ratings.

11 MEMBER GIFFORD: And I think we need
12 the MAP workgroups too, because if we're going to
13 -- I completely agree with Leah, we should be
14 giving deference to them, but if they're just
15 reviewing -- and I think we need to give them an
16 instruction, they're just reviewing them to re-
17 litigate the risk adjustment and social
18 determinants of health, then the issue about
19 whether NQF endorsed or not, then we're not --
20 then I don't believe we should defer to them.

21 I think that's our responsibility to
22 make sure they've done that due diligence.

1 CO-CHAIR HALL: Yes, great points.
2 Okay. What's in front of us is the
3 recommendation of do not support. Does anyone
4 else want further discussion before we vote on
5 that first recommendation?

6 Not seeing any request for other
7 conversation, so we will vote on do not support.

8 MS. BUCHANAN: Voting for MUC2019-61,
9 the workgroup recommendation of do not support
10 for rulemaking, is now open. We'll give it just
11 a couple more seconds. Okay. We are closing the
12 voting now. We received 19 votes yes, 0 votes
13 no, MUC2019-61 will move forward with the
14 workgroup recommendation, do not support for
15 rulemaking.

16 CO-CHAIR HALL: Thanks, everyone. I'm
17 going to turn the mic over to Chip.

18 CO-CHAIR KAHN: Okay. And I'm really
19 going to be strict about this. We take a five-
20 minute break, but we really need to get back,
21 because we're behind, and we need to finish in a
22 timely way. Nancy, do you need speak before the

1 break?

2 MEMBER FOSTER: It's a very quick
3 comment relative to this discussion.

4 CO-CHAIR KAHN: Yes.

5 MEMBER FOSTER: I know NQF staff tried
6 to collect all the comments, that was a very rich
7 discussion with a lot of concerns, and I think
8 that needs to be reflected, including our
9 concerns about overemphasis of this, depending on
10 how CMS incorporates it into rulemaking, that we
11 would encourage them not to over-emphasize it, as
12 I think what I was hearing.

13 CO-CHAIR HALL: Thank you, Nancy.

14 CO-CHAIR KAHN: Okay.

15 CO-CHAIR HALL: We will reflect that,
16 correct?

17 MEMBER FOSTER: Thank you.

18 CO-CHAIR KAHN: Okay. Thank you,
19 Nancy. It's 3:35, so we will -- 3:40, we're
20 going to start, because we know people have
21 schedules and have to leave, and we want to keep
22 our quorum, so please be back at 3:40.

1 (Whereupon, the foregoing matter went
2 off the record at 3:35 p.m. and went back on the
3 record at 3:40 p.m.)

4 CO-CHAIR KAHN: And make any comments
5 on MUCs or opportunities to improve the current
6 PAC LTC measure set at this time, if you have
7 suggestions to make, and I think the microphone
8 is over here.

9 So at least in terms of the
10 microphone, we'll get -- I guess people could
11 send comments to the chat box, but first
12 opportunity is up here on the microphone. Do we
13 have anybody who is not a member of the
14 coordinating committee, or otherwise in the room,
15 who wants to make public comment on long-term
16 care, post acute care?

17 Okay. I'm not seeing a crowd rushing
18 to the microphone, I'm not seeing anyone rushing
19 to the microphone, so we'll move on and I'll look
20 at Kate and ask, is there anybody in the chat
21 box?

22 MS. BUCHANAN: No one in the chat box.

1 CO-CHAIR KAHN: Okay. So we're going
2 to proceed to the measures that we have for
3 consideration and I believe we have --

4 CO-CHAIR HALL: Amy Moyer is the
5 staffer.

6 CO-CHAIR KAHN: Oh, where's Amy?

7 CO-CHAIR HALL: She is telephonic.

8 CO-CHAIR KAHN: Oh, okay. Amy, can
9 you hear?

10 MS. MOYER: Hi, this is Amy. Yes, I'm
11 in Wisconsin, but I'm here by phone.

12 CO-CHAIR KAHN: Okay. Great. So
13 could you -- I'm going to turn it over to you to
14 introduce the chairs of the workgroup and the
15 recommendations.

16 MS. MOYER: Hello, everyone. I'm Amy
17 Moyer. I'm a director here at NQF. This is my
18 first time doing the MAP process, so hopefully
19 this will go smoothly.

20 My co-chairs, I believe, are on the
21 line. I know Gerri Lamb was able to join us.
22 I'm not sure if Kurt Merkelz is on the line as

1 well, but we had some really robust discussion as
2 part of the MAP PAC/LTC workgroup that's here.

3 We had two measures under
4 consideration, one in the home health quality
5 reporting program, and one in the hospice quality
6 reporting program.

7 We also filled the rest of the day
8 with some terrific strategic discussions that get
9 into the overarching theme of the meeting.

10 So we were supportive of CMS'
11 inclusion of patient-reported outcomes in its
12 Meaningful Measures update. Patient-reported
13 outcomes has long been an area identified by
14 PAC/LTC as being an important priority for
15 measurement.

16 There's a lot of care that takes place
17 in this setting that is important to be aligned
18 with the patient's goals and preferences, and we
19 would solicit that through the voice of the
20 patient.

21 The discussion we had around measure
22 gaps this year was cross-program and some was

1 program and setting agnostic, looking at the
2 patient population as a whole, we discussed what
3 were the areas that would be most meaningful and
4 have the highest impact for measurement.

5 In that area, we identified care
6 coordination as the highest priority measure gap
7 for the program. Patients who received care from
8 post-acute care and long-term care providers have
9 frequently transitioned from multiple sites of
10 care.

11 And that's really important that we
12 have measures of how well those transitions are
13 coordinated and that the information moves with
14 the patients as well.

15 In addition, we emphasized the need
16 for alignment of measurement across the full
17 continuum of care, and developed an overarching
18 look at concepts and priorities for performance
19 measurement.

20 So moving to the first measure under
21 consideration, this is for the -- I think we have
22 these locked. Nope, sorry. So the home health

1 quality reporting program, we looked at a measure
2 of home health towards end stay, potentially for
3 medical hospitalization measure.

4 This measure is a measure of any
5 hospital admission occurring across the whole of
6 the home health encounter, which takes a holistic
7 view of the patient's home health stay.

8 It is only looking at hospital
9 admissions that were considered to be
10 preventable. There was an expert panel that went
11 through a process of looking at admission reasons
12 and refining that.

13 Public comments were generally
14 supportive of the measure and the workgroup
15 conditionally supported the measure for
16 rulemaking. They would like to see the measure
17 obtain NQF endorsement and in addition, CMS
18 indicated there are two existing program measures
19 that they would be retiring upon an
20 implementation of this measure.

21 So I'm going to pause there and see if
22 Gerri and Kurt have anything they'd like to add.

1 DR. LAMB: Good afternoon. This is
2 Gerri Lamb. I'm glad to be with you. I think
3 Amy summarized things well. It was an excellent
4 meeting. Lots of rich discussion with CMS and
5 the two reasons that Amy identified for
6 conditional were the ones that the committee felt
7 needed to be there.

8 CO-CHAIR KAHN: Good. So any other
9 comments or -- Amy?

10 MS. MOYER: Nothing more from me.

11 CO-CHAIR KAHN: Okay. Well, I'll go
12 to the committee now. Do we need a discussion
13 leading into the vote, initial vote, on the
14 MUC19-34, the coordinating committee on the home
15 health quality reporting program measure? Misty.

16 MEMBER ROBERTS: Yes, quick question.
17 How is preventable defined?

18 CO-CHAIR KAHN: Amy?

19 MS. MOYER: Sure. There was a fairly
20 robust presentation around this that CMS
21 provided. I think throughout the workgroup, we
22 were extremely impressed with the level of data

1 analysis that had gone into the development of
2 these measures.

3 I know that they had a technical
4 expert panel that looked at it and I can't
5 remember if they had any specific data around
6 what was considered preventable or not, but it
7 was a broad technical expert panel that looked
8 specifically at meaning and this measure.

9 DR. LAMB: Amy, I believe -- this is
10 Gerri, I'm hearing echoing, by the way, I hope
11 you all aren't.

12 CO-CHAIR KAHN: We hear you fine.

13 DR. LAMB: I believe that what they
14 had put forward was preventable by diagnostic
15 category based on many years of research on what
16 are the subsets of diagnoses that are high
17 likelihood preventable.

18 I don't have the list in front of me,
19 but CMS went through a lengthy discussion of how
20 they selected those conditions.

21 PARTICIPANT: Yeah, this is Alan
22 Lerner (phonetic) from CMS. I'm not sure if you

1 can hear me.

2 CO-CHAIR KAHN: Yes, we can hear you.

3 PARTICIPANT: But they were based
4 initially on the ARHQ conditions that were setup,
5 but eventually it was a mix of inadequate
6 management of chronic conditions, inadequate
7 management of infections, inadequate management
8 of other unplanned events, and also, inadequate
9 injury prevention.

10 And so it was the diagnostic
11 categories within all those four major domains.

12 MEMBER ROBERTS: So just to clarify,
13 essentially, a modified version of the ARHQ PQI
14 avoidable hospitalizations measure?

15 PARTICIPANT: Right. Based on that,
16 but then expanded out --

17 MEMBER ROBERTS: Okay.

18 PARTICIPANT: -- to include other
19 conditions that were more appropriate for post-
20 acute care patients.

21 MEMBER ROBERTS: Thanks.

22 CO-CHAIR KAHN: Okay. Other

1 questions? Okay. Hearing none, none of the
2 phone, then I think we can go to a vote on MUC19-
3 34, and on that one, it was a conditional support
4 for rulemaking.

5 MS. BUCHANAN: And voting for MUC2019-
6 34 is now open. And give it just one more
7 second. Okay.

8 CO-CHAIR KAHN: Great. It looks like
9 --

10 MS. BUCHANAN: Yes, so we received 19
11 yeses, 0 nos, so MUC2019-34 was following the
12 workgroup recommendation of conditional support.

13 CO-CHAIR KAHN: Very good. And I
14 think this is the last one. So we're on the last
15 metric at this point. This is a -- this is the
16 hospice MUC19-33, hospice visits in the last days
17 of life, and, Amy, would you take it away to
18 explain?

19 MS. MOYER: Absolutely. So this is --
20 there were a couple versions of this measure that
21 CMS did some really impressive data analysis on
22 to determine which sort of hospice visits

1 correlated with a positive experience for
2 patients, and particular, the caregivers in this
3 case.

4 Hospice kind of represents the best in
5 class of the measure, and would be replacing two
6 existing measures in the program. The measure
7 would add hospital visits in the final three days
8 of a patient's life, at least two good ways, it
9 is, they are looking for visits from a registered
10 nurse or a medical social worker, and those are
11 in-person visits, not telephone.

12 The committee also expressed support
13 for this measure and with conditional support,
14 pending NQF review and endorsement, and removal
15 of the existing hospice visit measures from the
16 program.

17 We did receive several public comments
18 on this. Some of the public comments were
19 questions about this measure versus the existing
20 measures in the program, and some had questions
21 on the, sort of, data that were then answered by
22 CMS for the in-person meeting.

1 I will, with that, turn it over to
2 Gerri for any additional comments.

3 DR. LAMB: Sure. I would just like to
4 call this measure out. It was one of the most
5 robust discussions that I recall us having. This
6 was an important measure in a variety of ways, in
7 that, there were public comments and lots of
8 discussion about teamwork, who contributes to
9 patient outcomes, whether it's appropriate to
10 call out specific team members in a
11 interprofessional team.

12 This is a case of the data that was
13 done being just so comprehensive and so
14 convincing, as well as having a committee that
15 really looked at the implications of this measure
16 for quality in hospice and also using teams
17 effectively.

18 It was just a great discussion and I
19 think the, as Amy said, vote could have gone
20 either way and I do believe it was the discussion
21 and the data report from CMS that really was
22 tremendously convincing, that this is an

1 important measure and one that we should move
2 forward.

3 CO-CHAIR KAHN: Great. So let's bring
4 it here as a discussion. I see Harold.

5 MEMBER PINCUS: So I had a couple of
6 questions that I have some concerns about. I
7 have a couple questions and concerns about this
8 measure. When you said that the measure could
9 have gone either way, could you say a little bit
10 more about what was the -- what were the two ways
11 and the arguments calling out both ways?

12 DR. LAMB: I think the critical
13 question that came from both the public comments
14 and the discussion is, how do you identify the
15 last 30 days of life as well as how do you make
16 decisions about which team members are deemed
17 essential in that time period.

18 We talked about those issues, we
19 talked about the public comments. The data that
20 were presented showed a correlation between
21 symptoms and last days of life that gave credence
22 to the ability to identify that as well as data

1 that supports which team members are highly
2 correlated to patient satisfaction.

3 I'll let Alan jump in on that if he's
4 available, but those were really critical pieces
5 of information in supporting this measure.

6 PARTICIPANT: And this is Alan. First
7 of all, thank you for an excellent summary of the
8 measure, and certainly, I'm here to answer any
9 other questions, but again, as Gerri said, I
10 think the questions that came up primarily were
11 ability to identify patients in that last window,
12 and why we are proceeding from going from the
13 measures that are already adopted in the program,
14 which are based on the assessment, to going to a
15 claims-based, no-burden version of this measure
16 that actually includes the services that tested
17 most importantly for being needed in the last
18 couple days of life.

19 And the discussion -- and the emphasis
20 from our standpoint was really, we weren't
21 discounting the need for the entire hospice team
22 during the entire hospice stay, but that during

1 this critical, what I'd almost call the hospice
2 ICU, the last few days of life, that we wanted to
3 ensure that the right services were being
4 provided, and those services are from an RN,
5 primarily, and then also from a social worker.

6 And our reasons for choosing them were
7 based on the compelling correlations that we
8 found before -- between those hospices that
9 provided those types of services and the family
10 recommendation satisfaction that we're seeing in
11 the CAP survey.

12 MEMBER PINCUS: So I just had three
13 concerns, one is, if you're looking at this --
14 looking at, sort of, you know, a patient or
15 family-reported outcome measures in relation to
16 this, when you're already collecting the outcome
17 measure, what's the marginal benefit of adding
18 this process measure over and above, you know,
19 the data you're already collecting in the
20 satisfaction?

21 PARTICIPANT: Right. And again, we
22 are using the satisfaction measure almost as a

1 way to validate the importance of this measure.

2 MEMBER PINCUS: But I guess the
3 question is, why do need it if you already have
4 the data about satisfaction?

5 PARTICIPANT: Well, again, it's a
6 matter of having a more robust set that just
7 because the outcome is improved satisfaction, how
8 do hospices get there to improve satisfaction?
9 And so it's through different sorts of processes
10 or what they should be providing during that
11 stay.

12 MEMBER PINCUS: But having had some
13 personal experience recently with hospice, you
14 know, there were -- I've observed that there was
15 a number of visits that were, really, purely
16 perfunctory, in a number of ways, and it seems to
17 me that that wouldn't necessarily be what you
18 want to encourage, is having just visits, it's
19 really the quality of the visits.

20 Number two is, you know, that whether
21 you're adding some degree of unreliability,
22 because of the difficulty in making predictions

1 about when the last 30 days of life are, so you
2 have a -- you know, it seems to be a fairly low
3 bar of just saying there has to be a visit.

4 And also adding some degree of
5 unreliability. And, you know, I'm not sure why
6 you wouldn't go with and strengthen, in some
7 ways, the, you know, family reported outcomes
8 component of this.

9 PARTICIPANT: We're not discounting
10 the family reported outcomes of it. We are just
11 attempting to make sure that the right services
12 are coming to patients in those last few days of
13 life.

14 I wouldn't consider those last few
15 days of life if it's as perfunctory. I would
16 consider them important.

17 MEMBER PINCUS: Well, I can tell you
18 that the ones that we experienced were
19 perfunctory.

20 DR. LAMB: Yes, I appreciate your
21 personal experience and it's interesting that
22 many of the people on the committee also had

1 experiences, and we had quite a discussion of the
2 -- I think what you're raising is the quality
3 versus quantity of visits, and why we thought
4 this measure was particularly important is,
5 number one, that what contributes to the patient
6 and family experience is multi-component, and
7 there were compelling data to support these
8 particular providers being significantly related
9 to that satisfaction.

10 Are there many others? Probably so,
11 but we have data to support that these particular
12 providers, the nurses and the social workers, do
13 make a difference to families.

14 CO-CHAIR KAHN: Well, why don't I --
15 Harold, anything else?

16 MEMBER PINCUS: No, that was it.

17 CO-CHAIR KAHN: Okay.

18 MEMBER PINCUS: And I still have a
19 question about the marginal value in this over
20 and above the catch itself.

21 CO-CHAIR KAHN: Do we have any other
22 comments? Nancy, I'm sorry.

1 MEMBER FOSTER: I just want to
2 clarify, and I think I understood your point,
3 Harold, the, really, that last sentence you made,
4 you said, if we already know what the value is of
5 the patient's reported experience, or the
6 family's report of the patient's experience, and
7 we have other mechanisms for telling people how
8 they can score better on that, what's the value
9 of having this, a measure, when what you really
10 care about, what you want to report to the public
11 is, how is this hospice versus that hospice
12 doing, and really delivering care that satisfies
13 the needs of the patient.

14 CO-CHAIR KAHN: Chairs, do we have any
15 other comments from -- I think we've heard about
16 the discussion at the group. I guess if there's
17 no other discussion, do we want to at least call
18 the question on the recommendation and I'm sorry,
19 the recommendation of the conditional support was
20 because of the endorsement, is that correct?

21 MEMBER QASEEM: So can I just ask,
22 like, a question over here? I'm just curious

1 about when April discusses the group, what was
2 the final vote? Was it 60/40 or was it 90/10? I
3 mean, it does have an impact on, at least, my
4 judgement to that. Is it something possible? Do
5 we have that information?

6 CO-CHAIR KAHN: Amy, do you know that
7 or does any of the staff here know that? The
8 staff is going to pull the numbers.

9 MEMBER QASEEM: Thanks so much.

10 CO-CHAIR KAHN: While they're doing
11 that, Rebecca, do you have a comment?

12 MEMBER KIRCH: I can't decide, because
13 I'm supposed to be a discussant, and I was
14 waiting to follow the process.

15 CO-CHAIR KAHN: Well, while we're
16 waiting, why don't you --

17 MEMBER KIRCH: I can stretch it out a
18 little longer. I'm torn, like Harold has
19 described, because there are some patients and
20 families who find it intrusive and they don't
21 need that support, and I would have rather seen
22 the patient caregiver reported outcomes measures

1 move us towards the quality of those visits.

2 If it's a nurse showing up to pickup
3 the leftover opioids, which we've seen reported,
4 that's not a quality visit, but that would check
5 this box. And so I have some deep-seated
6 concerns, both professionally and personally,
7 having experienced good hospice, bad hospice, and
8 no hospice with different loved ones, as well as
9 what I know just from the patient population we
10 serve.

11 So this feels a little too easy as
12 it's written to capture what we really want, and
13 I feel like it's moving away from quality instead
14 of quantity, and I feel like it's moving away
15 from patient and caregiver reported outcomes in a
16 way that just gives me some pause.

17 CO-CHAIR KAHN: While we're looking
18 for the --

19 PARTICIPANT: This is Alan again, can
20 I just mention again that there is the hospice
21 visits measure that is already adopted in the
22 hospice quality reporting program, that's already

1 being publicly reported, or on hospice care, one
2 of the pair of these -- of that measure, and this
3 would be a replacement for that measure that's
4 already being reported.

5 And it would be a claims-based version
6 that would be a overt burden version, and would
7 be, the existing measure that's being reported is
8 being reported on professional visits, which
9 essentially are RN and physician visits that are
10 being done also in the last three days of life,
11 and that this would be replacing with RN and
12 social work visits.

13 So that would be which, again, tests
14 better.

15 CO-CHAIR KAHN: Michelle, does CMS
16 have a comment?

17 MEMBER SCHREIBER: We do. The vote,
18 since Amir asked, was close, it was 9 in favor, 6
19 opposed.

20 CO-CHAIR KAHN: Okay. Why don't we,
21 I guess --

22 MEMBER MORALES: Having that kind of

1 context is really important and there's a couple
2 of times that this has come up today, so if
3 there's a rule, or there's a MUC that we're
4 talking about that's replacing other ones, that
5 should be at the beginning of the discussion, so
6 we know that there was, maybe, a worse measure
7 before, and now this is a better one, so that we
8 know what the context is.

9 Because this is now the second or
10 third time today that this has come up and I'm
11 sorry, I thought I read through everything, and I
12 didn't know any of that, so that's just a
13 recommendation for the future, that if it's
14 something replacing other things, that somebody
15 should let us know right away that that's the
16 context for which we're evaluating something.

17 CO-CHAIR KAHN: Okay. And that was
18 one of the conditions that was placed by the
19 workgroup, so why don't we go ahead and let's
20 vote on it and see where that gets us in terms of
21 the process.

22 And if we don't approve the

1 recommendation, then obviously, we'll have a lot
2 more time to talk about the various possibilities
3 of the next step.

4 So the workgroup recommended
5 conditional support based on the endorsement and
6 based on the removal of other -- of the other
7 measure. So can we have a vote on this.

8 CO-CHAIR HALL: And that's removal of
9 two hospice measures; two existing hospice
10 measures.

11 MS. BUCHANAN: And voting for 2019-33,
12 the workgroup recommendation conditional support
13 for rulemaking is open. We'll give it just a
14 couple of seconds. Okay. We are closing the
15 voting. We received 15 votes yes, 4 no, the
16 coordinating committee recommends MUC2019-33 for
17 conditional support in rulemaking.

18 CO-CHAIR KAHN: Great. So that's an
19 acceptance and that's the final measure for
20 review. I think the point about having, you
21 know, full information is really important and I
22 wonder whether on these brief slides here, next

1 year, whether we should have, when we have
2 conditional, there should be a bullet that
3 describes what the conditional is.

4 CO-CHAIR HALL: I agree. Certainly
5 for that, and as well as for the mitigating for
6 the do not supports.

7 CO-CHAIR KAHN: Right. That way I
8 think we have it all in one place. And I guess
9 the other issue I'll ask the staff about is, we
10 don't have the votes on these items and should
11 we? The vote was asked from the workgroup.
12 Would that be useful?

13 CO-CHAIR HALL: If this committee
14 thinks it was useful, it's certainly something
15 we could migrate into the --

16 CO-CHAIR KAHN: Personally, looking
17 around the room, think it would be, because then
18 it gives us some perspective, and we really go
19 into the discussion with context, both in terms
20 of what they meant by conditional, and two, you
21 know, this, you know, 9/6 is important.

22 CO-CHAIR HALL: I feel just a little

1 differently, because I think that we -- you know,
2 there's a structure to this process and that
3 group is supposed to land on a decision, and
4 otherwise, it becomes that continuous variable
5 that we're re-evaluating, so obviously, different
6 people are going to feel different ways.

7 CO-CHAIR KAHN: Well, I mean, frankly,
8 we are re-evaluating, one, and two, but we're not
9 really re-evaluating most of it.

10 CO-CHAIR HALL: Then we might as well
11 ask, what percentage of that group was in favor
12 and not even ask if they reach a decision.

13 CO-CHAIR KAHN: I think it's another
14 variable. I think it's a variable that informs
15 us how strongly they felt about it. This is just
16 recommendations.

17 MEMBER QASEEM: Yes, I see this as
18 just one additional variable. It's just giving
19 us information when we're going to be making our
20 judgement call. It is something that's close and
21 we are all struggling with it, I think then it
22 becomes reasonable and important enough variable

1 versus if the other one -- the condition
2 recommendation came with 90 percent of the vote.

3 I have to think twice before we
4 overturn a decision.

5 CO-CHAIR KAHN: Okay. With that,
6 those recommendations, I'll pass it back to Bruce
7 to go to the next stage.

8 CO-CHAIR HALL: And I'll pass it to
9 Sam.

10 MR. STOLPE: I like the buck passing
11 here. This is beautiful. So what we're actually
12 going to do next is have a future direction of
13 the pre-rulemaking process discussion, and this
14 is slated to be a discussion led by Bruce, but
15 basically, what we're looking to capture in the
16 next few moments as we're winding down in this
17 meeting, is what went right and what you see as
18 things that we could potentially do better.

19 It's really just two simple questions
20 that were proffered for the committee to
21 consider. Now, we do this every year and I'll
22 turn it over to Bruce to facilitate, but those

1 are the questions that we'd like you to think
2 about.

3 CO-CHAIR HALL: And there have been a
4 couple of minor suggestions like that just
5 mentioned that I'm sure you guys have already
6 captured and we have those. David.

7 MEMBER GIFFORD: You know, there is no
8 perfect measure and measure of it is messy, and I
9 think it's gotten better every year, and I've
10 been involved with NQF since the beginning, the
11 whole endorsement process, it just gets better
12 and better every year.

13 I think this committee gets better and
14 better every year with, you know, refining it
15 down and really, what our charge is, and I think
16 this meeting is better than the previous years as
17 well.

18 So that's something that's good and I
19 think we, you know, really adopt the philosophy
20 of how to do it better.

21 I would suggest that we've invested a
22 lot of time in the last couple years refining

1 these voting categories of conditions and
2 everything else, yet, we have no idea of what's
3 happening with that follow-up.

4 And I would think it would be very
5 helpful before next year's meeting to get some
6 sense for, like, the last two years, we have made
7 recommendations for conditions. At least, you
8 know, as moderately as efficient, how many
9 actually came back for endorsement?

10 Because I know in some of my areas, a
11 lot of them have never come back for endorsement.
12 Some of them, we have approved and CMS has never
13 put in the rules, so they're still hanging out
14 there with our support, without any rulemaking,
15 and so maybe, you know, whether we think about
16 whether our endorsement has a time limiting thing
17 before they bring it back.

18 Because I know there's one, or a
19 couple measures in our area that, I mean, I'm
20 happy they're endorsed and I think they're going
21 to eventually use them in the rulemaking, but
22 it's been four years and they haven't put it in

1 the rules.

2 And I know they're working on it, and
3 it takes time, but I think we -- things have
4 changed, and so answer the question, should we
5 come back for this.

6 So one would be getting some feedback
7 on that technician issue. And it is a little bit
8 more robust going forward. I think the other one
9 is guidance to the MAP committees, less comment
10 about the specifications of measures about, you
11 know, endorsement, if we're going to get
12 endorsement, we know that that's going to go
13 through that.

14 The question is, are the specification
15 in the measures going to impact how they're going
16 to use them in the rule? And that, I think, we
17 better be robust in deciding what it is, within
18 the context of knowing how it's going to be used
19 in the rule.

20 And then it's clear, over the years,
21 one of the public comments that we get over and
22 over again in comments putting on the table, is

1 this understanding of attribution from the
2 physician side, but also, accountability for care
3 after some patient has left that person.

4 And if we had stated, as a NQF, and
5 CMS, and healthcare in general, that we want
6 better care coordination. We want to move away
7 from siloing. We continually see those comments.

8 I think it would be helpful going
9 forward, and some, whether it's this group tackle
10 it, but does NQF or CMS tackle with, sort of, a
11 white paper. We're moving in that direction, but
12 how do we -- when it is that it's gone too far
13 that it shouldn't be rulemaking.

14 Just because we like it, it's not --
15 and I think the comments would be more robust and
16 our discussion more robust if we were talking
17 about that.

18 I thought the discussion we had at the
19 psychiatric issue really reflected that today.
20 And I think somehow putting that into a white
21 paper or guide would be helpful for referring to
22 as a status going forward.

1 And so it's mostly attribution of
2 individual physicians, but attributable across
3 providers, we get at. I guess those are my major
4 comments with it, but, you know, I applaud you
5 guys at the NQF staff.

6 And what's interesting is, looking at
7 the NQF staff, it's like every year it's a new
8 set of staff, so one thing for the NQF staff is,
9 how do we give institutional memory, because it's
10 clear that some of the institutional memory is by
11 committee members and not by staff on this.

12 And I think some has slipped through
13 the cracks because of that.

14 CO-CHAIR HALL: And you already made
15 an earlier suggestion for some education around
16 rulemaking as well.

17 MEMBER GIFFORD: Oh, yes,
18 understanding if the shift is going to be more
19 measures are coming to us for use in public
20 reporting programs, you know, we all have gone
21 through training, and I don't whether new members
22 get training in all the payment models, but we

1 did a lot of time educating ourselves about MIPS,
2 when that came to us, because we kind of
3 understood the others.

4 I think we need the same with this
5 group, as part of the orientation of new
6 committee members coming onboard as well.

7 CO-CHAIR KAHN: Yes, I think that the
8 group appreciates Michelle offering at the
9 beginning to give us this feedback, and I think
10 it's really, really important, and I don't know
11 whether we -- I don't know -- well, I guess the
12 money may not be there, I don't know, but I don't
13 know if we have to necessarily wait until next
14 year, at some point, when you all will be ready,
15 I mean, we could have a conference call to at
16 least go over the materials.

17 But I think this issue of the feedback
18 loop is really, really important, and it is one
19 thing that we're really missing, and it's a body
20 of knowledge that you have now as to what
21 happened with all these recommendations and if
22 there is a big matrix in the sky, it'd be nice to

1 see it.

2 CO-CHAIR HALL: Harold?

3 MEMBER PINCUS: I agree with David in
4 terms of this process has sort of continued to
5 move and improve, and especially the interaction
6 back and forth with CMS has really been terrific.

7 And I think also I would agree with
8 David in terms of also the focus on, sort of, fit
9 for purpose of the measures, you know, is an
10 important way of thinking about it.

11 I would add to this point, and I
12 especially agree about the follow-up, I would add
13 to his point about follow-up, not just in terms
14 of what happens with the measures, but what
15 happens with the data about the measures that are
16 collected and how that actually has been useful
17 and influenced this, you know, so it's not just,
18 you know, does the measure actually get endorsed,
19 but do the measures, once utilized, provide the
20 useful data, and information, and influencing how
21 the health system operates.

22 So that's kind of what, you know,

1 would be good to get back. The other thing is,
2 it might be useful, because, you know, the whole
3 voting, you know, process has gotten, I think, a
4 little bit clumsy in terms of -- and I'm thinking
5 about, you know, when you do an NIH grant review,
6 a lot of times what they do is, at the beginning,
7 you know, they say, like, let's get just the
8 sounding from the two primary reviewers, let's
9 get a, you know, couple of sentences from the two
10 primary reviewers, sort of, up front that helps
11 to orient people to what the issues are.

12 And I think that might be a good idea,
13 because it could make some, sort of, more use,
14 because we do have assignments of people to be
15 primary reviewers, and it might be good to just
16 get a couple of sentences from them up front to
17 be able to orient people to what it's all about.

18 CO-CHAIR HALL: Great thoughts.

19 David?

20 MEMBER BAKER: I'll just give a little
21 countervailing point to what Harold just said. I
22 actually really like the idea of first voting on

1 whether or not to accept the workgroup
2 recommendation, because some of these measures,
3 they were, you know, re-specification of existing
4 measures and it's just, we shouldn't be spending
5 a lot of time on those.

6 So it's tricky, because some of the
7 times I think you're right to have that framing
8 would be really helpful, but at the same time,
9 for some of these, it's like, to use the NIH
10 study section, it's triage, right?

11 MEMBER PINCUS: Yes. Well, that's
12 what I'm saying, I'm just talking about a few
13 sentences, not a, you know, long diatribe.

14 CO-CHAIR HALL: Other thoughts or
15 suggestions? Cheryl?

16 MEMBER PETERSON: Just one piece to
17 that, not a long diatribe, but also not overly
18 biased. So we're not here to hear your opinion
19 about it, but to hear the overall issue.

20 CO-CHAIR KAHN: Well, remember, we did
21 at one point, a few years ago, sort of, have
22 everything clustered together, and then I think

1 there was concern about the clustering of the
2 measures that were more routine, and then we
3 separate it all out.

4 I think we -- I mean, if we have two
5 days -- I think we do have to be -- this year we
6 were fortunate that there were a limited number
7 of measures. If we had more measures, we
8 couldn't handle without --

9 CO-CHAIR HALL: We used to just pull
10 off the consent calendar, right, only talk about
11 things that got pulled. And so I think the
12 current process is a little better. It's a
13 little more uniform, consistent, but we can
14 definitely improve on just trying to make sure we
15 stay efficient and not waste time on discussion
16 where we don't need it, so that's great feedback.
17 Nancy?

18 MEMBER FOSTER: A couple of comments,
19 one, to sort of reiterate something that I said
20 to you in the hallway, you and Chip did an
21 extraordinary job getting us through a lot of
22 material and thank you and I think maybe you

1 should give lessons to other chairs.

2 CO-CHAIR HALL: Thank you. I've had
3 the privilege of learning from Chip for a couple
4 years, and certainly, I don't want to prematurely
5 cut the conversation short, but certainly, Chip
6 and I thank each and every one of you for your
7 expertise, your time or effort, and this
8 incredible staff.

9 I mean, you think about the amount of
10 background and context that you guys prepared and
11 delivered on the spot, truly fantastic, but also,
12 Michelle, thank you so much for being here and
13 giving us your insights.

14 And those couple of developers who
15 chimed in too, I know Yale Core, and PQA, but
16 there were others as well, so I wanted to -- did
17 I miss anybody?

18 CO-CHAIR KAHN: No, this is great.
19 Thank you so much. And I think we had great
20 support from the staff, and great suggestions, so
21 that next year should be even better.

22 CO-CHAIR HALL: Public comment.

1 That's yours.

2 CO-CHAIR KAHN: Oh, do we have any
3 public comment on procedural or otherwise?

4 CO-CHAIR HALL: Let's check in the
5 room for anyone. On the phones? We did have
6 some in the chat, so --

7 CO-CHAIR KAHN: The chat box?

8 MS. BUCHANAN: Yes.

9 CO-CHAIR KAHN: Okay. Could you give
10 us the chat box report?

11 MS. BUCHANAN: Absolutely. So this is
12 a comment on MAP MUC19-14 and MUC19-21 measures.
13 Special needs and Medicare and Medicaid plans
14 serve primarily dually eligible complex
15 individuals who have high levels of social risk
16 factors and multiple chronic conditions.

17 Plans in the SNP Alliance non-profit
18 voluntary leadership organization have
19 approximately 2.2 million beneficiaries they
20 serve. There are two proposed measures under
21 consideration where SNP and MMP measures
22 expressed some concern several years ago when the

1 measures were under development.

2 We see that our concerns remain, but
3 based on the minor specifications, the measures
4 are 19-14, follow-up after emergency department
5 visit, people with multiple high-risk chronic
6 conditions, MUC19-21, transitions of care between
7 the inpatient and outpatient settings, including
8 notifications of admissions and discharges,
9 patient engagement, and medication reconciliation
10 post discharge.

11 While these health plans fully support
12 timely and robust follow-up after ED and poor
13 transitions in care, the key issues of the
14 special needs and Medicare and Medicaid plans,
15 health plans that are expressed about these
16 measures concern the timeframe data source of the
17 notification to whom by whom, and how when and
18 whether these measures are being appropriately
19 applied.

20 Plans are concerned about the aspects
21 of these processes described within the measure
22 which are outside their control. It seems likely

1 that the measure assumes an integrated and
2 seamless health information exchange with
3 hospitals or other providers, settings, notifying
4 health plans with a very short timeframe of ED or
5 transition event.

6 This is not the case, unfortunately.
7 Therefore, it will likely be served. Only
8 certain health plans will be able to meet these
9 tight timeframes, such as health plans that are
10 the insurance portion of a large enterprise or
11 integrated health delivery system, where the
12 plans have access to 24/7 health information
13 exchange on shared electronic health record via
14 electronic platforms.

15 All other health plans that operate
16 independently and are not part of the integrated
17 provider delivery system will likely show poor
18 rates. They do not have access to the electronic
19 record systems, providers discharged to the ER,
20 or making the transitions between care or
21 settings.

22 Furthermore, the transitions of care

1 measure actually requires plans to request charts
2 from providers and context --

3 PARTICIPANT: Can you slow down just
4 a little bit?

5 MS. BUCHANAN: Sure. And conduct
6 chart review in order to ascertain performance by
7 the provider, which we are all aware of is a very
8 laborious process.

9 Because of the higher proportion of
10 complex care members and the SNPs and MMPs have
11 enrolled a much higher proportion of complex
12 chronically compromised members. These plans are
13 expected to be impacted by the challenge of these
14 measures at a higher rate.

15 That is, these plans have more
16 individuals in the denominator for those measures
17 and thus will be more affected. This will place
18 heavy burden on plans that treat the most
19 vulnerable populations, diverting resources that
20 offer information that is actionable by the
21 health plan in terms of their control to direct
22 faster information exchanged by providers in

1 their community, or allow the plan to access
2 their electronic health record platforms.

3 We're wrapping up. In reviewing the
4 MAP criteria, we do not believe these two
5 measures contribute to efficient use of
6 measurement resources, can be feasibly reported,
7 nor are they applicable nor appropriately
8 specified for the program's intended settings of
9 care, level of analysis, and population.

10 Therefore, we would recommend the
11 measures would not support rulemaking for Part C
12 and D measure set. We see the need for
13 measurement to be retooled and suggest that
14 revised measure testing be done to determine its
15 applicability for provider organizations.

16 The settings that will be keeper of
17 the information needed for the measure to be
18 calculated rather than applied to health grants.

19 CO-CHAIR HALL: Thank you.

20 CO-CHAIR KAHN: Any other messages?

21 MS. BUCHANAN: That was it.

22 CO-CHAIR KAHN: Okay. So even though

1 we --

2 MEMBER QASEEM: Chip, this is Amir
3 again. Can I just make a comment?

4 CO-CHAIR KAHN: Sure.

5 MEMBER QASEEM: So I think the meeting
6 went really well. I totally enjoyed it. I wish
7 I was there in person. One thing I do want to
8 bring up -- oh, one more thing, Bruce's comment,
9 I wholeheartedly agree and hopeful we can adopt
10 those.

11 One general comment is that when
12 initially MAP was convened, our charge is -- and
13 it still is, that we are supposed to review
14 performance measures. During the process for the
15 past few years, we have a little bit moved away
16 and we started mixing performance measures review
17 with the review of measurement concepts, or you
18 can call them quality, whatever you want to call
19 them.

20 And I do think it's important for us
21 to differentiate those because if you're
22 reviewing measurement concepts, it has a whole

1 different standard that we need to keep in mind
2 rather than you give a thumbs up or down versus
3 reviewing the specific performance measures.

4 Even in today's conversation, a lot of
5 issues were brought up, like for example, the
6 reliability and validity, which many times is not
7 going to apply to the measurement concept, so
8 that you don't even have the information.

9 I'm looking at some of the measures
10 that we went through today. We don't even have a
11 numerator or denominator listed over there. So
12 somehow I think for my sake, or my understanding,
13 and maybe I am -- you know, you guys know my
14 background, we need to have some sort of a
15 standard methodology.

16 If you're going to review measurement
17 concepts, then we all need to be on the same page
18 that that has a whole different set of variables
19 we need to keep in mind when we're reviewing it
20 and giving it a thumbs up and down, otherwise
21 we're mixing apples and oranges.

22 Whether it's NQF that gives us

1 guidance on this, or whether we come up with it
2 within the committee, I'm fine with it, but we
3 can't say that the measurement concept is okay on
4 one hand, and on the other hand, we are holding
5 some of the measures that were higher level of
6 reliability and validity, and are asking for
7 data, or show me the proof that there is evidence
8 that this works or this doesn't work.

9 So that's one comment. Second one is,
10 I do think that it is important, Michelle, I
11 don't know if you're in the room or not, that we
12 need to start aligning or harmonizing some of
13 these measures alongside with what CQMT is doing,
14 because I sit on CQMT as well.

15 Those of you who don't know, it's a
16 core quality measure collaborative for
17 public/private payers, and I know what MAP is
18 doing is for rulemaking and all that, but
19 ultimately, I'm looking at the bottom-line is
20 it's performance measures we are all reviewing,
21 and I'm seeing lack of harmonization of what I'm
22 reviewing and what is getting a thumbs up through

1 CQMT committee versus what's happening at the MAP
2 committee.

3 And somehow, now both of them are
4 under the umbrella and so our mission is to
5 harmonize these two as well.

6 CO-CHAIR KAHN: Thanks, Amir. I think
7 on the first comment, it's something David
8 constantly brings up, is that we have this
9 balancing, because unfortunately, because of the
10 process, we do have a lot of measures coming -- a
11 number of measures coming here that have not been
12 endorsed, that have not gone through that -- the
13 endorsement process, which looks specifically at
14 the issues, it's an omission that you're talking
15 about.

16 So we sort of have this balancing.
17 I'm not sure, considering what we have to work
18 with, that we can avoid that, but I think it just
19 sort of is what it is.

20 I think in terms of the harmonization,
21 years and years ago, Gerry Shea and I chaired a
22 strategy committee that looked at the future of

1 MAP. I don't know, how many years ago was that?
2 Anybody know?

3 It was probably eight years ago at
4 least, and actually, harmonization was one of our
5 primary goals that we never either had time for
6 or never could fit into our agenda, but I think
7 that's really critical and we spent a lot of time
8 talking about burden, or potential burden, and
9 there, there's not just burden, there's also
10 potential for tremendous confusion or mixed
11 signal, so we really -- I mean, from my view, if
12 we can figure out how to work more towards a
13 single platform where we're -- all the measures
14 are harmonious between the different payers, that
15 could be really critical.

16 MEMBER QASEEM: And so just to answer
17 to your first one, I absolutely agree it's a
18 balancing act, and I'm not opposed to reviewing
19 measurement concepts, but I do think that as a
20 committee member, all of us need to be on the
21 same page as to what rules apply or what needs to
22 be met -- what criteria needs to be met, for

1 someone -- for something to become a measurement
2 concept that we give it a thumbs up or thumbs
3 down.

4 If we are not all on the same page or
5 using the same playbook, I think we're going to
6 end up -- well, I don't even know what rules
7 we're applying when it comes to a measurement
8 concept, is it a national priority area, or do we
9 use what Michelle presented today, that there
10 might be data showing that care is not being
11 provided at a level where it needs to be.

12 And many times, I don't even have that
13 information, so I'm not opposed to doing the
14 measurement concept, but my ask is that we need
15 to have a rule of engagement when we're going to
16 be looking at the measurement concept.

17 Otherwise, I worry that we maybe just
18 giving thumbs up to measurement concepts, which
19 may lead to, eventually, developing performance
20 measures in that arena, and lead to proliferation
21 of measures, which may necessarily -- may not
22 improve care.

1 We believe it will improve care, but
2 we don't even have a feedback loop about what MAP
3 recommendations are being met or not met. We
4 don't have any feedback loop around performance
5 of these performance measures that we have been
6 recommending over the past five years.

7 We went in with many of these measures
8 and said, we believe this is going to improve
9 quality of care. Five years later, can someone
10 show me data to prove that this measure has been
11 out there, look, we have moved the quality
12 needle.

13 OPERATOR: I'm sorry, there's been an
14 internal error. You will be disconnected now.

15 (Laughter.)

16 CO-CHAIR KAHN: I think the Russians
17 had it in for you. Anyway, I think these are --
18 I guess he is. Did we lose him?

19 CO-CHAIR HALL: Sounds like it to me.

20 CO-CHAIR KAHN: And that was really --
21 I think he made a very important point, and it is
22 something we have to contend with, because even

1 if we get a feedback from CMS on what the status
2 of the measures are in the program, that is not
3 necessarily going to give us a good feel for how
4 successful the measures are.

5 I mean, that's an important question
6 too, but I'm sure that's something CMS worries a
7 lot about as well.

8 So with that, are there any other
9 comments, thoughts?

10 MEMBER SCHREIBER: Can I make just one
11 --

12 CO-CHAIR KAHN: Sure.

13 MEMBER SCHREIBER: Everybody got a
14 chance to say thank you, so I just want to take
15 an opportunity on behalf of CMS to say thank you
16 to all of you, to NQF, to our co-chairs
17 certainly, but to all of you for spending a
18 tremendous amount of time and providing
19 thoughtful feedback to us.

20 So that was just my opportunity to say
21 thank you, also, specifically to you.

22 CO-CHAIR KAHN: Thank you. We

1 appreciate it. Any other thoughts? Last chance.
2 I think we're ending about 15 minutes early. So
3 we'll adjourn.

4 MR. STOLPE: Well, we still have some
5 next steps that we're going to review.

6 CO-CHAIR KAHN: Oh, what next steps?

7 MR. STOLPE: Before we jump to -- jump
8 for the door, let's go ahead and take a look at
9 that. Kate was going to cover these, but let me
10 just pull them up so I actually can see them in
11 the slides.

12 So let me just pivot to Kate as soon
13 as she comes back into the room. She's checking
14 on the connection, but -- now, the next steps are
15 fairly limited.

16 What's going to happen is, NQF will be
17 updating our reports based on the comments and
18 the discussion today. Those will all reflect the
19 new voting categories that we arrived at, as the
20 coordinating committee, as well as the rationale.
21 Those will be provided to CMS and will be in
22 short order.

1 The only thing that I wanted to say on
2 behalf of the NQF staff is again, to thank our
3 two terrific co-chairs for leading us through the
4 day, to each of you around the table for your
5 thoughtful comments and participation, and would
6 be remiss if we did not thank NQF, or sorry,
7 excuse me, CMS for the --

8 (Telephonic interference.)

9 MR. STOLPE: All right. Apologies for
10 the technical glitch there. I'm just offering
11 some closing remarks actually, and it's simply
12 this, it remains to us to say thank you.

13 Thank you to all of you for
14 participation, to our co-chairs, to the
15 committee, for the public, for our measure
16 developers, the NQF staff, and of course, CMS for
17 your engagement in this.

18 Very much appreciate the tone that
19 you're bringing to the committee. It means a
20 lot. So thanks to everyone and safe travels home.

21 (Whereupon, the meeting in the above-
22 entitled matter was concluded at 4:35 p.m.)

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This is to certify that the foregoing transcript

In the matter of: MAP Coordinating Committee

Before: NQF

Date: 01-15-20

Place: Washington, DC

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1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com