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**

C-O-N-T-E-N-T-S

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

9:02 a.m.

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

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

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

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

this point, it's called Poll Everywhere.

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

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

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

Couple of more items. One, please

mute your cellphones if you have not already. And a couple of items to note related to quality measures that were on the MUC list that have been removed, MUC-110 and 112, emergency department utilization and acute hospital utilization. Both have been removed for consideration but will remain on the list, so to speak.

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

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

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

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

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

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

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

CO-CHAIR KHAN: Some meeting objectives

and DOIs.

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

PARTICIPANT: Let's do the DOIs.

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

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

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

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

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

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

PARTICIPANT: Please use your microphones. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. GIBLIN: Great, thank you.

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

PARTICIPANT: They're working on it.

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

we'll move to the rest of the organizations.

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

MS. GIBLIN: Right, as a subject member.

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

MS. GIBLIN: Great.

CO-CHAIR KHAN: Other than my day job.

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

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

MS. GIBLIN: Okay, and Rebecca.

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

MS. GIBLIN: Yes, sorry.

PARTICIPANT: I have the pleasure but not everyone does.

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

MS. GIBLIN: And Rebecca.

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

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

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

MS. GIBLIN: Yes.

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

And it's always a little difficult for

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

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

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

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

MS. GIBLIN: Yes, thank you.

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

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

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

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

care standards.

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

But QMVIG houses the vast majority of this in terms of measures development and in terms of the value-based programs.

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

From that, we narrow down a list of

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

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

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

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

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

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

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

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

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

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

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

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

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

The other thing that we've been

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

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

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

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

American, the College of Thoracic Surgeons.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTICIPANT: Neurology.

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

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

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

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

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

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

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

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

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

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

going in the right direction.

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

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

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

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

to overall quality and outcomes of care.

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

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

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

So that's what we're really looking

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

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

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

And you can think of the key

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions or comments?

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

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

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

PARTICIPANT: Hello.

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

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

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

CO-CHAIR KHAN: Others?

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

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

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

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

CO-CHAIR KHAN: Great.

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

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

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

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

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

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

CO-CHAIR KHAN: Great, any others?

(Simultaneous speaking.)

PARTICIPANT: CMS.

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

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

(CMS telephonic introductions.)

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

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

PARTICIPANT: Rebecca introduced herself.

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

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

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

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

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

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

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

CO-CHAIR KHAN: Okay.

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

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

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

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

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

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

MR. AMIN: Taroon Amin, NQF consultant.

MR. STOLPE: Sam Stolpe, Senior Director.

MS. CLARK: Apryl Clark, Chief of Staff.

MS. BUCHANAN: Kate Buchanan, Senior Project Manager.

MS. CHOGAN: Ameera Chogan, Project Analyst.

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

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

PARTICIPANT: We are set.

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

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

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

(Laughter.)

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

So let's --

MEMBER GOODMAN: I'm Liz Goodman with AHIP.

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

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

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

experience.

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

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

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

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

of the core of everything we should be doing.

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

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

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

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

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

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

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

CO-CHAIR KHAN: Great. Okay, David.

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

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

The other thing I'll just bring up

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

CO-CHAIR KHAN: David.

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

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

helpful to figure out how to align that better.

CO-CHAIR KHAN: Harold.

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

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

MEMBER QASEEM: People who want to have coaching.

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

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

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

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

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

CO-CHAIR KHAN: Leah.

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

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

administration for this.

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

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

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

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

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

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

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

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

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

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

MEMBER SCHREIBER: Is there somebody else?

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

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

CO-CHAIR KHAN: Okay, great. Misty.

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

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

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

MEMBER SCHREIBER: Any time.

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

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

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

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

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

CO-CHAIR KHAN: Okay, Esther.

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

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

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

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

CO-CHAIR KHAN: Let me go to Scott.

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

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

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

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

appreciate the thoughts going forward on digital collection as well.

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

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

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

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

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

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

CO-CHAIR KHAN: We can hear you fine.

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

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

And those people are not individually

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

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

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

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

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

MEMBER SCHREIBER: Thank you.

CO-CHAIR KHAN: Thanks. So Amir. Going once. Amir, are you on mute?

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

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

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

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

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

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

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

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

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

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

CO-CHAIR KHAN: Yes, please.

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

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

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

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

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

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

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

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

MEMBER SCHREIBER: Right.

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

MEMBER SCHREIBER: Happy to do that.

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

MEMBER GIFFORD: It's on this very point.

CO-CHAIR KHAN: Okay, David.

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

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

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

CO-CHAIR KHAN: Yes, perfectly.

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

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

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

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

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

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

CO-CHAIR KHAN: Thanks a lot. Michelle, any other comments, or?

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

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

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

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

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

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

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

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

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

Two, the measure is evidence-based and

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

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

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

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

that were used last year.

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

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

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

prior to implementation.

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

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

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

(Music plays.)

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

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

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

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

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

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

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

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

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

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

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

PARTICIPANT: Which has led at least --

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

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

as a work group recommendation.

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

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

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

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

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

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

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

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

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

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

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

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

Harold, do you have a question or comment?

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

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

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

impeachment, where each one is really deciding --

(Laughter.)

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

(Laughter.)

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

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

Because I think what we're really

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other, Bruce?

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

MEMBER BAKER: I'm finished with mine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(No response.)

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

(No response.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It received one public comment, and

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

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

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

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

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

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

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

Next slide.

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

So, Chip, back up to you.

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

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

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

MR. STOLPE: Next? That's right.

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

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

MEMBER PETERSON: Chip, a process question for you.

CO-CHAIR KAHN: Yes?

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

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

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

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

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

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

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

Where's my recommendation?

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

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

on Poll Everywhere?

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

CO-CHAIR KAHN: What is the password?

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

The question is now open.

PARTICIPANT: I'm on line.

CO-CHAIR KAHN: Yes?

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

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

MR. AMIN: Spell out one, though.

MS. BUCHANAN: Oh, 1 as in --

CO-CHAIR KAHN: Okay.

MS. BUCHANAN: This is Kate. My

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

CO-CHAIR KAHN: Okay.

MS. BUCHANAN: So, one moment.

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

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

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

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

So, let's say we just all unanimously

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

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

MEMBER GIFFORD: No, I understand that.

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

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

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

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

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

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

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

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

CO-CHAIR HALL: That was what I --

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

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

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

CO-CHAIR KAHN: But if anyone has

something to say, we need to discuss it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER MORALES: Thanks.

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

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

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

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

Okay. Do we have 60 percent?

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

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

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

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

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

MS. BUCHANAN: Yes.

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

one? Because we've got to roll.

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

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

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

CO-CHAIR KAHN: Okay. As long as

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

MS. BUCHANAN: Yes.

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

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

CO-CHAIR KAHN: Okay.

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

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

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

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

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

MEMBER ROBERTS: Thank you.

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

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Okay. Esther?

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

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

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

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

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

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

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

CO-CHAIR KAHN: Okay. Libby Hoy?

MEMBER HOY: Yes.

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

MEMBER HOY: No comments at this time

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

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

MEMBER FOSTER: Thanks, Chip.

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

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

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

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

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

CO-CHAIR KAHN: Okay. Harold?

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

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

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

CO-CHAIR KAHN: Okay.

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

CO-CHAIR KAHN: I was looking at CMS.

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

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

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

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

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

MEMBER SCARLATOS: That's correct.

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

Do you want to comment? Add anything?

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

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

CO-CHAIR KAHN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

not fully within the control of the hospitals.

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

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

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

that those reasons align with the thrust of the conversation.

CO-CHAIR KAHN: Okay. Steve?

MEMBER WOJCIK: Yes, thank you.

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

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

I think in terms of equity I didn't

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

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

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

Thank you.

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

MEMBER FOSTER: Thanks.

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

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

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

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

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

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

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

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

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

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

MEMBER GIFFORD: So, I guess I have

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

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

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

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

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

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

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

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

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

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

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

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

care.

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Okay. Emma?

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

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

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

CO-CHAIR KAHN: Okay. Leah? Leah?

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

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

I want to encourage hospitals to

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

CO-CHAIR KAHN: David?

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

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

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

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

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

MEMBER DUSEJA: That's right.

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

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

make us get to the point to be there?

CO-CHAIR KAHN: Okay. Harold can close.

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

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

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

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

MEMBER PINCUS: Okay.

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

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

MEMBER GOODMAN: Okay.

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

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

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

CO-CHAIR KAHN: Okay. Great.

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

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

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

Are there any questions?

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

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

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

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

Okay. So, let's vote.

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Right, no conditions attached.

But everybody vote.

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

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

It's open for just a little bit longer.

And voting we will now close.

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

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

And Harold?

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

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

MEMBER PINCUS: Right.

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

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

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

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

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

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

MEMBER PINCUS: Yes.

MR. STOLPE: Thank you.

CO-CHAIR KAHN: Mary?

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

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

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

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

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

CO-CHAIR KAHN: Okay. Leah?

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

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

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

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

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

Nancy?

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

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

So, I'm trying to get --

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

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

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

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

MEMBER FOSTER: All right.

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

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

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

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

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

CO-CHAIR KAHN: Okay. Rebecca?

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

CO-CHAIR KAHN: And the staff?

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

patient choice.

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

MR. AMIN: Where they get the followup.

MEMBER KIRCH: Thank you.

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

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

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

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

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

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

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

CO-CHAIR KAHN: Well, it would be that

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

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

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

MEMBER PINCUS: Yes.

CO-CHAIR KAHN: Okay.

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

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

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

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

MEMBER PINCUS: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Great.

CO-CHAIR KAHN: Okay.

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

Thank you.

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

(Laughter.)

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

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

CO-CHAIR KAHN: You gave a percentage.

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

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

MS. BUCHANAN: Yes.

MEMBER FERGUSON: Okay. I got the wrong number.

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

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

(Laughter.)

No.

CO-CHAIR KAHN: The votes are the votes.

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

CO-CHAIR KAHN: Okay. Any other questions?

(No response.)

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

Incentive Program, standardization for transmission ratio for dialysis facilities.

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

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

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

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

(No response.)

Going once, going twice.

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

MS. BUCHANAN: Thank you so much.

And voting is now open.

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

And so, we are going to close voting.

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

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

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

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

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

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

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

MR. STOLPE: Thanks very much, Chip.

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

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

(No response.)

Not hearing any, okay.

(Laughter.)

MR. STOLPE: Thanks, Bruce.

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

clear.

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

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

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

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

Question from Cheryl?

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

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

CO-CHAIR KAHN: Nancy? Nancy?

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

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

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

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

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

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

Now, once we get past the Task Force

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

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

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

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

part. How does the --

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

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

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

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

So, would the staff put up the --

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

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

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

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

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

MEMBER FOSTER: So, okay, I'll be the stick in the mud here.

CO-CHAIR KAHN: Okay.

MEMBER FOSTER: I think in the comments that were articulated prior to our meeting there were a number of questions raised about the process here. And the questions were not about this discussion, where we start our voting. The questions were, essentially, is it the intent of the legislation that created this body to allow essentially changes in measures on the fly? So that we get to a place where we're voting for something different than what was put in front, was put out for public comment and turned over to the NQF before the December 1st deadline.

And I have a great deal of anxiety about the thought that we would try to re-

adjudicate a measure on the fly, even if we came up with, gee, conditional support, but it has to go through NQF endorsement, because I think we don't know what we're voting for. And I think it doesn't honor the public and their ability to comment on the measures that are before this body for their recommendation if we're moving forward without putting that information out for public comment. And just the whole process is upended when you don't have that which we are now being asked to consider from the beginning. That makes me a little bit crazy.

CO-CHAIR KAHN: Let me make this suggestion, and I will erase the word "mitigation". I hear what you're saying, on the one hand. However, on the other hand, if we go back to our discussion we just had on the previous measure, there was a proposal made on conditional that, frankly, redid the measure. So I would argue that, if we hear from CMS and if a member of the Coordinating Committee chose to accept the CMS change and make a proposal for

conditional or mitigation, or whatever, along the lines of what CMS offered, that's the same as what Harold did in the last go-round. So, I hear you, but from a procedural standpoint there's nothing stopping this body from either putting a condition or defining a mitigation, and basing it on suggestions from outside, and CMS is going to make a suggestion.

So, my proposal would be to go ahead and hear CMS, to have the comments made, and if a Coordinating Committee member decides to make a conditional acceptance amendment, then we would vote on it. I don't see that as any different, frankly.

MEMBER FOSTER: So, I think the fact that you suggested we would start with the four voting categories is not consistent with what you just said, Chip. So, if we allowed this group to support this new, mitigated, as yet unknown measure that's being brought forward to us, that would be very different.

If what you are saying -- what I heard

you just say was it would be okay if this group said, okay, we now agree the mitigating thing should be done to the measure. And if that's what CMS has already done, then they can check the box and say, "Great. We've done what the MAP asked us to do and life is wonderful."

CO-CHAIR KAHN: You're misinterpreting what I said and what I did. So, what did we do? We tried a procedure that was outside the regular order. You objected to that. We, then, said, okay, we'll go back to regular order. We then had a vote on whether or not we accepted the proposal of the recommendation of the Workgroup. We did not get to 60 percent. So, that, then, sets us into regular order, into us going down the algorithm of the four.

In that case, if a member of the Coordinating Committee chooses to offer a proposal as a condition or as a mitigation, the second or third alternative, and specifies what it is, then that's regular order. We just did that in that other measure. And then, we have to

get to 60 percent to actually have it take place.

So, it's not a question of what CMS has done. It's a question that we already recognize that we can set conditions if we get to 60. So, actually, I don't see it the same way you do. And frankly, if nobody makes an amendment along the lines of what CMS is going to suggest, then we don't do anything.

So, bear with me, and we will one have this suggestion, and then, we'll go down the comments.

MEMBER BAKER: May I just make one comment on that?

CO-CHAIR KAHN: Sure.

MEMBER BAKER: Because I think what Nancy is saying is, if we're going to follow the regular order, the first vote to support would have to be on the original unmitigated measure.

MEMBER FOSTER: Yes.

MEMBER BAKER: So, then, the next one would be a conditional support, and a conditional support could be all of these things that we've

talked --

CO-CHAIR KAHN: Right. That's what I said.

MEMBER BAKER: Yes.

CO-CHAIR KAHN: We're going to go down the four votes. I'm not going down to four votes. If you listen to what I said, obviously, if a CMS suggestion is going to be accepted because it's offered by a Coordinating Committee member, it's got to be under the conditional vote, or if a conditional vote fails, it's got to be under the mitigation vote. It's not under the first because we haven't rewritten the proposal.

MEMBER BAKER: Right.

CO-CHAIR KAHN: I'm not suggesting that we accept their proposal as the first vote. It would be the second or third vote. And then, it would be based on someone from the Committee offering what CMS has put on the table as a condition or as a mitigation. I don't think that's out of regular order. Am I missing something?

MEMBER FOSTER: I did not understand your proposal.

CO-CHAIR KAHN: Yes.

MEMBER FOSTER: And now I do.

CO-CHAIR KAHN: Okay. So, that being the case, maybe to make it completely clear, I propose, if it's accepted by the Committee, that before we hear from CMS, we have the first vote. Since we don't really need to hear from CMS, all we need to have is the first vote on whether or not we accept what's on the table, which is the Workgroup recommendation. So, we'll in a sense repeat the vote we already had, but it's the first of the new four.

So, with that, let's have a vote.

(Laughter.)

The yes vote here would be to support the Workgroup's --

MR. AGRAWAL: The original measure.

CO-CHAIR KAHN: -- the original Workgroup recommendation.

MR. AGRAWAL: No, no, the Committee --

CO-CHAIR KAHN: Oh, I'm sorry. I'm sorry. I'm sorry. Yes, whether you support the original measure, yes. Yes.

MR. AGRAWAL: So, for clarity, is it possible to just zoom-in on the top half of that slide? That is the original measure. If it's possible. If not, please only direct your eyes to the top half of the slide. Okay. All right.

CO-CHAIR KAHN: Okay. So, to clarify then, we are voting -- and I apologize for misspeaking -- we are voting whether or not we accept the original measure. So, we're going back to square one. I apologize.

Is everyone clear? The Workgroup recommendation has been voted. It did not get the 60 percent. So, we're not going back to square one and we're voting on whether or not we accept the recommendation, I mean original measure that was proposed by CMS.

MEMBER GIFFORD: Accept it for what? For a rulemaking?

CO-CHAIR KAHN: Yes, for a rulemaking.

Yes, do we support for rulemaking?

So, with that, is that clear with everyone? Let's vote.

MS. BUCHANAN: So, voting is open for MUC2019-114 in its original text. The vote is, do people support for rulemaking?

We are waiting on just a couple of other votes. We have 20 votes. Or, no, we have 21 votes. Okay. So, we're going to close voting.

And the voting results are 4 for yes, 17 for no. The Coordinating Committee does not vote to support 2019-114.

CO-CHAIR KAHN: Now we go to support with conditions. If anyone wants to make a motion along the lines of the CMS action, then I would propose, if that person did want to do that, that they would probably want to have CMS describe to us what they did. But I'll look at the Coordinating Committee and ask, is there anyone that wants to do that?

David?

MEMBER BAKER: I make a motion that CMS describe what they did.

(Laughter.)

CO-CHAIR KAHN: So now, would CMS describe to us the mitigation that they undertook?

MEMBER SCHREIBER: So, if I may, let me back up a little bit for even the rationale. CMS recognizes this is a structural measure and lots of people don't like structural measures, frankly, including us most of the time, and that some of the comments that you have heard from the public were around a structural measure, whether or not this actually proves to be efficacious. Sorry, I can't pronounce this word. And that is part of the conversation.

So, part of, I think, what you have to think in your own minds is whether or not a structural measure like this would have impact and effect. I think that's a separate thought.

So, why did CMS propose a structural measure when we usually don't? And that's

because of the importance of maternal morbidity and mortality. There is a tremendous initiative ongoing at HHS looking at the multiple levers that HHS can affect to address the issue of maternal morbidity and mortality. Because, frankly, it's embarrassing that, as the richest country in the world, that we have the worst statistics for this. And so, consequently, this has risen to the top of importance that people want to affect.

We are in the process of developing an outcomes measure. Actually, David, part of this is in conjunction with what the Joint Commission has been doing. So, we actually have a joint effort underway to do that, but that measure probably won't be ready for us to bring to you for a couple of years.

And because we really didn't want to wait a couple of years before putting something in front of people to be a signal of how important HHS -- and I specifically mean HHS on top of CMS -- how HHS feels that this is so

important to flag for organizations, that they should be working on this now. That is the genesis of this measure.

When we first brought it to the Hospital Committee, the biggest objection besides the structure measure -- and there were lots of circular conversations about whether or not there's proof that being in quality improvement actually improves quality, which I found a little disturbing from a Committee like this, because in that case what are we all doing?

But, beyond that, the biggest issue was they didn't think it had enough teeth to just say that it's an attestation that says, yeah, I'm participating in some kind of quality improvement that includes these bundles. What they were looking for was something that had more teeth that included, yes, I participate in other a state or national recognized bundle and it includes that I am implementing a bundle or a program that actually addresses some of the key concerns that lead to maternal morbidity and

mortality, such as hemorrhage, severe hypertension, preeclampsia, and sepsis.

So, because of that feedback, and because that really was the mitigating factor, recognizing there's still an issue of structural measure that you have to decide on for yourselves, but the real mitigating factor -- and frankly, we hashed out the language with the Hospital Committee -- was to include the "and" statement, "and has implemented patient safety practices or bundles to address complications". And you can read, "including, but not limited to".

And I'll actually say that there is something missing from this slide. The "NA" would be for hospitals that do not provide elective inpatient labor and delivery. That's not on there, but that's how it is supposed to read because we can't tell hospitals, we can't penalize hospitals that are just doing the occasional delivery that's an emergent delivery.

So, that's how this measure came

about. That's the genesis of it. That's how it got changed.

Now I recognize that under normal process what would happen is that we would have to take concerns and mitigating factors back and revise the measure, and that would require us to bring this back to you next year. Frankly, there wasn't a desire to wait another year, and that's why we did it in the current -- what you're calling "on the fly," which is true -- mitigation of the language. But it was done with the Hospital Committee, quite honestly, and we bring that to you in its changed form.

Did I miss anything?

(No response.)

Are there questions on CMS's intent perhaps?

CO-CHAIR HALL: Michelle, thank you very much.

And can I just re-emphasize, it remains a simple attestation, though. There's not some intended submission of some other

evidence of those --

MEMBER SCHREIBER: Nope, there's no submission of other evidence. There's actually not even a score. It's a yes/no attestation.

CO-CHAIR KAHN: Okay. So, we know what's on the table from David. That would be acceptance with the condition that these changes be made. Is that what you've got? Is that the proposition, David?

MEMBER BAKER: No, I had not made any proposition --

CO-CHAIR KAHN: Okay.

MEMBER BAKER: -- for what the conditions should be. And I would think that the list might be more extensive. Nancy brought up the issue about public comment on this. So, I'll let others make a proposal for what the condition should be.

CO-CHAIR KAHN: Okay.

MEMBER BINDER: Could I make the motion that we approve with the condition --

CO-CHAIR KAHN: Sure.

MEMBER BINDER: -- of this wording that's changed?

And I want to add just a reminder. I really appreciate, Nancy, your attention to the process. I think that is actually really important. I'm glad you brought it up.

But I do think it's important for us to recognize this is an advisory -- we serve as an advisory committee. What we vote doesn't just happen. I think we should err on the side of giving CMS the most robust possible advice and guidance on the perspective of our various stakeholders on how this would play out. But I do think that it is a positive thing for us to be able to weigh-in on something that CMS sees some urgency for, and I would agree there is urgency.

CO-CHAIR KAHN: Okay. Bruce?

MEMBER QASEEM: This is Amir on the phone. Can I just chime-in over here?

CO-CHAIR KAHN: Sure, sure.

MEMBER QASEEM: So, I think we're doing wonderful discussion and I totally agree

with what Michelle is saying. Conceptually, it's an important measure. It's a priority area.

But I'm struggling over here now, when I put my MAP hat on, because I don't think we are here to vote on national priority areas. What I am supposed to do today is that I need to have a performance measure in front of me, and I need to see whether it meets certain criteria or not, because, otherwise, we're not going to be able to compare it. We won't have any inter-rater reliability because all measures are coming in with different sort of information.

So, are we today voting on a measure concept? MAP has done that traditionally. We have been looking at a performance measure, but it is presented to us, and then, we review it and we decide whether it's a good enough performance measure or not.

CO-CHAIR KAHN: Well, I'm going to recognize Jeff in a moment on the phone.

But let me say that we have gotten measures in all forms, I think, over the

experience. And some have been in very early, early stages, and often they were not endorsed. So, I don't think it's unusual. I think we need to do the analysis and use the criteria you described, but this isn't completely new. We've faced this kind of problem in different ways before.

Before I go to Jeff, we do now have a proposal that we would endorse -- I mean, not endorse -- we would recommend for the measure with a condition that the language and the approach of the measure be changed along the lines of what Michelle described. So, that's on the table as our next proposition, unless someone wants to suggest a further amendment to it.

And Bruce is raising his hand, before I go to Jeff.

CO-CHAIR HALL: And I know you're going to go to Jeff, but I just wanted to clarify with Leah, Leah, you made the motion. The Workgroup's two concerns also included NQF endorsement. So, do you want to preserve that or

were you specifically saying you did not want to continue with that condition? I mean, your suggestion was to adopt the language, but does your suggestion still include NQF endorsement?

MEMBER BINDER: Yes. Yes.

CO-CHAIR HALL: Okay, it does.

CO-CHAIR KAHN: Okay. Just to clarify then, the proposition on the table would be to recommend this measure as amended by what CMS has proposed, and they would -- I used the word "seek" earlier, but it's "receive"? -- and receive endorsement.

Okay. Jeff?

MEMBER SCHIFF: I just wanted to speak in favor of this, kind of echoing Michelle's remarks and just pointing out that this is really the work of the California Quality Forum, and they have had significant success in decreasing maternal mortality based on having these bundles. And when we think about having cascading measures which is part of a CMS vision, this is a perfect example of how an infrastructure measure can move

to an important health outcome. So, I'm just speaking in support as mitigated.

CO-CHAIR KAHN: Okay. Is there anyone else that wants to comment? Nancy?

MEMBER FOSTER: Actually, I'd like to -- I don't know if this will be considered friendly -- I'd like to offer a friendly amendment to the language to see if Leah would accept.

I am aware of some systems that are large enough to essentially run their own collaborative internally to work on this very important issue. The signal has been sent, and very well received, that we need to improve behavior here.

But if it said, instead of "statewide and/or national perinatal quality improvement initiative," which implies a certain structure, instead, could it be rewritten as "multi-hospital perinatal collaborative" and let the extent of it be left up to the choice of the hospitals involved?

CO-CHAIR KAHN: Leah?

MEMBER BINDER: I'm comfortable about it. I guess I would ask Michelle as well.

CO-CHAIR KAHN: Michelle?

MEMBER SCHREIBER: I understand what you're driving at. The problem is, once you say "multi-hospital," that means two hospitals really. I mean, it's two community hospitals banding together and actually doing some work.

Most of the systems that I believe you're referring to we felt would qualify as either statewide or national. Ascension, Dignity, they are multi-state sort of national programs and, yes, they absolutely have some wonderful work that's ongoing. And we sort of consider those to be national.

CO-CHAIR KAHN: Okay, Leah, I think it's up to you.

MEMBER QASEEM: And then, one more question, if I might. And it's a pretty general measure.

CO-CHAIR KAHN: Yes.

MEMBER QASEEM: I'm not too worried about it. I'm looking at the measure specs over here. There is nothing about it. It's all empty. What are we voting today?

CO-CHAIR KAHN: It's an attestation of a program.

MEMBER QASEEM: Is it a measure or not?

CO-CHAIR KAHN: It's a process measure. It's an attestation of a program.

MR. STOLPE: And this is Sam Stolpe with NQF.

So, just for point of clarification, attestation measures are not particularly prominent inside of NQF's portfolio, but there is a precedent for their existence. We do have measures that have gone through and received NQF endorsement that follow a very comparable pattern to what is laid out in front of us, when there's just a numerator statement that's very terse and says what the attestation is, and the denominator statement just says yes or no. So, we've have

endorsed those in the past.

MEMBER QASEEM: But have you gotten any comments from the folks who live and breathe this arena? Have they said that this is a good measure? They haven't said it's a good measure? I'm a general internist. This is not my topic area. So, I'm just trying to understand what feedback have we gotten. I don't have enough information today, guys.

CO-CHAIR KAHN: Amir, I think you're raising the issue in the sense that Nancy was raising. And my answer to you is you're a member of the Coordinating Committee. You're going to have an opportunity to vote in a few minutes. And I have a sense where your vote would be, considering if you don't feel comfortable with going forward, don't vote to go forward.

MEMBER BINDER: I would amend my motion to include multi-hospital systems. I think that the flexibility of that is okay, given that the strength of the wording now also requires a certain level of information that goes

along with it. And I do know there are some excellent multi-hospital initiatives that are out there. So, I would support that.

CO-CHAIR KAHN: Okay. Let's come to David. David? First, David, and then, the next David.

MEMBER GIFFORD: I think Michelle did a great job explaining why it's important to have a structural measure, which we certainly don't do. I don't know whether -- I don't think it's worthy of a condition. They are talking about it moving towards an outcome measure down the road. But having seen how the baby-friendly designation, which is a structural measure, changed hospital pediatric care, and changed outcomes, and I think given the huge importance of maternal mortality in this country, and it's slipping, having this moving the hospitals in the right direction makes a huge amount of sense.

So, I don't want to throw an extra condition on it, but I think it would behoove us as an organization not to give some advice to CMS

that this measure be sunset in the future, when there's more of an outcome or whenever everyone's attesting it. And it's clear it's not going to create reliability and validity, but it will move us down the field.

And so, I think Michelle's presentation was very compelling. It sort of switched my vote, and I recommend it.

CO-CHAIR KAHN: Okay. Thanks, David. David?

MEMBER BAKER: So, this is really sort of a clarifying question. Just so everybody knows, the Joint Commission, we've been working with American College of Obstetricians and Gynecologists for about a year and a half now. And we released standards that every Joint Commission hospital will need to pass, starting July 1st for maternal hemorrhage and maternal hypertension. These will be assessed on survey.

So, my question is, would those organizations that have been ahead of the curve, would they still need to participate in a

collaborative? Because many of them have been participating in collaboratives for two years. They've been directly working with the AIM program. And if they have a surveyor onsite who goes through, and they've got hemorrhage cards and they've got policies and they've gone through the team training programs, and they met all of these very rigorous standards, I would hope that they wouldn't need to participate in a collaborative.

MEMBER SCHREIBER: David, then the answer to their question on the attestation is yes.

MEMBER BAKER: But they might not still be doing this. They might have done this two years ago. I mean, the ACOG has been running these AIM collaboratives now for at least three years, if not four years.

MEMBER SCHREIBER: So, correct me if I'm wrong, but I thought those were ongoing initiatives that organizations continue to update and track the data, which I guess to us is still

participating.

MEMBER BAKER: Yes. I guess, going forward, though, organizations, they may not be participating in a formal statewide collaborative. They have achieved this. They've implemented these things. Their past implementation. I think that we'll see that more and more.

Right now, there's probably not all that many, based on what we've seen from ACOG, particularly for hemorrhage and hypertension. But I think, going forward, there are going to be organizations that will have this fully implemented. It will be business as usual. And I think the measure that we've talked about will be much more important for those organizations to know whether they are successful.

MEMBER SCHREIBER: I guess my only counsel would be that I believe those organizations who have done this work and have implemented these should just answer "yes" to the attestation. And then, you're correct, over time

the goal is to replace this with the outcomes measure that's in development. They're a couple of years off.

MEMBER BAKER: Okay. So, with your permission, we'll communicate that to --

CO-CHAIR KAHN: Okay. Liz?

MEMBER GOODMAN: So, I had two comments. One is going back to before we changed it to include the multi-hospital collaboratives, whether or not CMS would consider some kind of a dropdown menu to say what is a "yes" and what isn't a "yes". Because it sounds like it's formal participation in a collaborative or something that closely looks like that, right? And if I were the attester, I'm not sure I would know how to answer it.

The other issue that the Rule Committee pointed out -- and there are at least five pieces of pending federal legislation creating more of these collaboratives -- is not every geography has a collaborative.

So, I think to the extent that you are

able to say this also would qualify, because (a) you don't have a collaborative or (b) you're past it, that that would be useful to those people who are responsible for the attesting.

CO-CHAIR KAHN: Okay. Leah?

MEMBER BINDER: I totally agree with that point. I think it's important to offer enough flexibility, so that hospitals can get going; they have a mechanism to move along in this process.

I appreciate your point about hospitals that are already achieving higher standards in terms of their efforts around maternal mortality. That's important. But I would also add that, especially at this stage as we're addressing this problem, we want the higher performers to be involved. We don't want them to walk away. They have the lessons learned that all the rest of the hospitals can implement. So, I think the encouragement of the team effort and involvement and focus on this issue is part of what's important about this.

CO-CHAIR KAHN: Okay. Can we go to a vote on this? Just to repeat --

MR. STOLPE: Yes, I think we need to restate.

CO-CHAIR KAHN: So, this would be to endorse the measure with conditions. And I'm going to ask Leah, because I want to make sure that we follow her language. The conditions being that the language in this attestation would be changed to -- and can we actually read the language? I don't know if it's better if you do it or CMS does it. Maybe if CMS would. Could you actually, Michelle, or one of you, actually read the language, so that everyone could understand?

MEMBER SCHREIBER: We can, and don't get me wrong, we're happy to.

CO-CHAIR KAHN: Right.

MEMBER SCHREIBER: But it sounds like there may be other language that people are looking to change.

CO-CHAIR KAHN: The only language that

I thought changed was the addition of the multi-hospital.

MEMBER SCHREIBER: The multi-hospital.

CO-CHAIR KAHN: The multi-hospital.

MEMBER SCHREIBER: And as implemented and possibly a checkbox, a dropdown checkbox.

CO-CHAIR KAHN: Okay. So, if you could add that, if you could read it, just so that --

MEMBER SCHREIBER: So, the updated wording is, "Does your hospital or hospital system participate in the statewide national perinatal improvement collaborative program aimed at improving maternal outcomes during inpatient labor/delivery and postpartum care, and has implemented patient safety practices and bundles to address complications, including, but not limited to, hemorrhage, severe hypertension, preeclampsia, and sepsis?"

CO-CHAIR KAHN: Right.

MEMBER SCHREIBER: So, forgive me, but what I heard was the conditions are (a) accepting

the revised language; (b) inserting multi-state, and (c) considering having a dropdown list that is more specific to allow for organizations to answer this better. Did I capture everything?

CO-CHAIR KAHN: Yes, and the other being endorsement, I think.

MEMBER SCHREIBER: But it's multi-hospital. Multi-hospital.

CO-CHAIR KAHN: And then, the other being endorsement. Okay.

So, I hope everyone understands the proposition.

Bruce?

CO-CHAIR HALL: Well, could I clarify? So, there was one comment about just two hospitals. So, do we want to say national, state, or regional collaborative of three or more hospitals is one question? And then, going back to David's comment, the other possibility, we could say, does your hospital currently or have you within the last 18 months participated in AIM and implemented practices? So, those would be

two possibilities.

CO-CHAIR KAHN: I would ask on the first one that you have so many different circumstances out there. But, yes, the problem is you could have two small hospitals get together, but, frankly, you could have two hospitals get together that are much bigger than a lot of systems. So, I think to get into -- I mean, it's just an attestation anyway. I mean it's really an aspirational kind of thing. So, I think to get into that kind of level of definition, at least from my perspective, would be -- then, you're going to get into CMS having to determine how many hospitals they actually have. I guess I would argue against it.

MEMBER GIFFORD: I feel like we're drifting into what Nancy said.

CO-CHAIR KAHN: Yes.

MEMBER GIFFORD: And we're getting into endorsement process, which we've already said this has to go back through endorsement. In that endorsement process, that's where the

Committee can work out those details. I think the conversation can be captured to CMS as they go back through the endorsement process. But, to me, I feel like we're going beyond our role as the Coordinating Committee at this point.

CO-CHAIR KAHN: And if people feel that way, that will be reflected in their vote. And I think we're at the stage now where we really need to proceed.

So, I think it's clear what the proposition is on the table. Unless, Leah, I mean Leah would --

MEMBER BINDER: I just want to stay with multi-hospital.

CO-CHAIR KAHN: Okay. So, that being the case, then if you vote yes, you're going to be voting for a recommendation that the measure go forward with the conditions that were outlined by Michelle. And the proposition was put on the table by Leah. If everyone accepts that -- that was one of the things I mentioned. I mean yes. So, let's go forward then and have a vote.

MS. BUCHANAN: Great. So, voting is now open for MUC2019-114, conditional support.

We're still waiting on some votes.

Seventeen -- I know that some members on the phone had to step off, but we have 19, 20. Okay. So, we are at 20 votes. We're going to close it.

Voting results are 17 vote yes, 3 vote no. So, MUC2019-114 goes forward.

CO-CHAIR KAHN: Okay. So, that's it. One more for hospital, though. Okay. One more, and I'm sure everybody wants to get to lunch now.

(Laughter.)

MUC19-26 is Hospital Harm, and we'll look at the measure. And the recommendation was conditional support for rulemaking. And I'll look at Sam.

MR. STOLPE: Yes, pending NQF endorsement.

CO-CHAIR KAHN: Okay. And I'll look at the list of discussants. Do we want to go ahead and have a discussion or should we go ahead

and have the first vote, the first vote being on the recommendation of the Task Force?

MS. CLARK: I apologize, Jeff. Libby Hoy, who was lead discussant, did send a couple of comments. Is it okay if I read them or would you prefer me not?

CO-CHAIR KAHN: Well, Libby is on the phone.

MS. CLARK: She had to step off.

CO-CHAIR KAHN: Oh, okay. If she sent comments, then we should do it.

MS. BUCHANAN: We need the first vote.

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

MS. BUCHANAN: We may not have comments.

CO-CHAIR KAHN: Well, the awkward thing here is that she actually gave comments. So, I guess I'm protecting her. I mean, I guess the definition is she wanted to comment.

MEMBER KIRCH: Is the nature of the comment such that it would suggest that she would have objected to us proceeding?

CO-CHAIR KAHN: Okay. So, can you make a judgment as to the nature of the comments?

PARTICIPANT: How about I just do this. Before we vote, let's just talk about it. But I'll raise one concern over here. Is that --

CO-CHAIR KAHN: Okay. So, let's go ahead, then, with Libby's comments.

MS. BUCHANAN: So, I'm just going to read them verbatim.

"May control an early response to hypoglycemic state and has the strong potential to improve patient safety, which would avoid catastrophic impacts to patients when missed. The Workgroup raises concerns about the ability of EHRs to capture data at the point of care, but also acknowledges that there will be minimal reporting requirement. Conditions for acceptance might include NQF endorsement and a coordination of existing measures."

CO-CHAIR KAHN: Okay. Nancy, I think you were the next discussant.

MEMBER FOSTER: I agree with Libby's

comments and the comments of the Workgroup. This is a measure that the Workgroup had suggested definitely had to go forward as a paired measure, and I believe that's the intent of CMS in using it. But I think a question to put on the table there is this theory that, if you have paired measures, you essentially create a balance of not over incentivizing people to swing in one direction or another. In other words, we don't want to create hypoglycemia by having a climate of hyperglycemia, nor do we want to create hyperglycemia by having just the hypoglycemia measure.

So, the pairing is thought to lead to better outcome. That's a theory that I have not seen proof of anywhere. And I worry that, by having these two measures perhaps independently acting, that we will, in fact, create more harm.

So, I think one of the conditions here would be close monitoring of how this gets rolled out and whether there is, in fact, greater harm caused by having two measures. My concern being,

not my theory, but my concern being that if a patient comes in hyperglycemic or is hyperglycemic when they are in the hospital, you're going to push them and it may lead to hypoglycemia, and vice versa. And so, you may end up getting more harm than help.

CO-CHAIR KAHN: If I can ask, this would be electronic?

MEMBER FOSTER: Yes.

CO-CHAIR KAHN: Do we know that all of the information that will support the measure is comparable across records? Or is that going to be a problem?

MEMBER BAKER: I believe that was something that was addressed during the measure development, that they looked at that. That was one of the things in general. There were a number of measures that were developed under an initiative to look at safety measures for electronic health records and they did look across different electronic health records, but I can't give you any specifics. I don't recall.

CO-CHAIR KAHN: And that was a problem or that was something they thought was not a problem?

MEMBER BAKER: Yes, it was a problem. It was a problem. I don't believe it was for this. Otherwise, it probably would not have passed out of that group. But I'm just saying simply that they did look at that.

CO-CHAIR KAHN: Okay. Thanks. Thanks, Dave.

Yes, I would like the measure expert to comment on this because I know from experience, not on this, but in comparable areas, that there are a lot of assumptions made about what's in the electronic health record. And you go from hospital to hospital and there are incremental differences in how things are recorded.

MEMBER BAKER: I think that's much less likely for this because they have pretty much the raw data.

MEMBER SCHREIBER: I'm sorry. I think

we have Gale (phonetic) and Joe on the phone as our content experts, if you guys would like to weigh-in to answer that, please.

PARTICIPANT: We have our entire international support contractor on the phone. They can answer the question.

But can you briefly -- what was the question?

CO-CHAIR KAHN: I just want to make sure that the data is going to be comparable across from the electronic records.

PARTICIPANT: Yes, we have tested it from multiple EHR vendors -- Cerner, Epic, Meditech -- from urban, rural, urban in teaching, and urban non-teaching. So, a variety of hospitals.

CO-CHAIR KAHN: Okay.

PARTICIPANT: Did that answer the question or?

CO-CHAIR KAHN: Yes, that's fine.

PARTICIPANT: Okay.

CO-CHAIR KAHN: So, was Amir on the

phone?

MEMBER QASEEM: Yes, yes, I'm still here.

Frankly, this is a bad measure. Looking at the specifics, looking at the CMS data, from 1999, according to CMS, from 1999 to 2013 -- that's the latest data; I just pulled it up -- the hyperglycemic events have been going down. And they've been going down, as they report, which is good, right? But the hypoglycemic event -- I'm looking at the scope over here -- it's been tremendously -- it's like hitting 35 or something percent.

And then, we are heading towards the direction in this measure, we are pushing for addressing the hyperglycemic events versus what the CMS data is showing is that the much bigger problem we have in the hospital is the hypoglycemic event.

And it's, frankly, a bad measure. There's no need for this measure. We need to start working towards controlling the

hypoglycemia which leads to death, which is a bigger problem.

I'll shut up.

(Laughter.)

CO-CHAIR KAHN: Okay. Nancy?

MEMBER FOSTER: So, this is Nancy.

Just for clarification, there is a hypoglycemic measure which -- I mean, I can't remember whether it's implemented or not. So, it might be great to have some clarification around how CMS is intending to implement this as a paired set, if not, or what is the intent?

CO-CHAIR KAHN: Okay. Could CMS respond?

MEMBER DUSEJA: Yes.

PARTICIPANT: This is Joe.

MEMBER DUSEJA: Go ahead, Joe.

PARTICIPANT: So, I mean, we can't exactly say what is happening in rulemaking right now, but what we can say is the idea is to move these eCQM hospital harm measures to the eCQM list for hospitals to pick from and eventually

have an eCQM harm composite of all of these harms. But, as they're developed individually, our aim is to propose them through rulemaking and have them available until we have the harm composite complete.

CO-CHAIR KAHN: Okay. So, I propose we proceed with all the information that's on the table. And on this measure, there was a recommendation that it be conditionally supported. What's the pleasure? Let's have a vote.

MEMBER BAKER: Can you just specify what the conditions were?

CO-CHAIR KAHN: No, the condition was endorsement.

MEMBER BAKER: Oh, I'm sorry. It said this is --

CO-CHAIR KAHN: No, it's said conditional support for the rulemaking. The only condition was endorsement.

MEMBER BAKER: Just NQF endorsement?

CO-CHAIR KAHN: Yes, that's what I

said.

MEMBER BAKER: Thank you. That's all I was asking.

CO-CHAIR KAHN: Okay. So, if we could now vote on the recommendation of the Committee, of the Task Force? This would be a "yes" would be to support the recommendation of the Task Force. A "no" would be to oppose the recommendation of the Task Force.

PARTICIPANT: This is Joe.

Something that you just said, did you say that it was not endorsed?

MR. STOLPE: No, we haven't voted yet, Joe.

CO-CHAIR KAHN: The question was whether, as a condition, it would be endorsed. That was the condition, right?

PARTICIPANT: It is endorsed now.

MR. STOLPE: Oh, it's gone through.

CO-CHAIR KAHN: Oh, it is endorsed now? Oh.

PARTICIPANT: Yes, and it's 3533.

CO-CHAIR KAHN: Oh.

MR. STOLPE: So, it was newly endorsed after -- correct, yes. So, it finalized the endorsement process, yes.

CO-CHAIR KAHN: Well, let's vote as standing, and then, it would have met the condition.

MS. BUCHANAN: So, voting for 2019-26, Hospital Harm, to accept the offered recommendation of conditional support is now open.

We are still waiting on some votes.

We have 18 votes. We have 19 votes. We have 20, which is as many as we have.

So, the recommendation is 16 yes, 4 no. The Coordinating Committee votes to move 2019-26.

CO-CHAIR KAHN: So, that would be the vote on that measure. And the fact that they have met the condition, it has been done.

So, that finishes the hospital measures. We have half an hour for lunch. Let

me suggest that we try to do lunch in 20 minutes and get back here at 1:30. Is that okay?

MR. STOLPE: It's appropriate to continue eating your lunch as we resume discussions as well.

CO-CHAIR KAHN: Yes, don't worry about that, but I think we need to get back.

MR. STOLPE: We don't want any choking hazards.

CO-CHAIR KAHN: But we'll be back at 1:30, which would put us half an hour behind. But Bruce is going to do a better job than me. So, he'll catch up, I'm sure.

(Whereupon, the proceedings went off the record for lunch at 1:09 p.m. and went back on the record at 1:33 p.m.)

CO-CHAIR HALL: All right. At this point, we'd like to resume work. We're about 30 minutes behind the printed schedule; the agenda for the day. So at this point, I would like to ask if there's anyone that would like to make public comment on clinician programs, either in

person or on the line.

We'll give folks a few seconds to settle back in here. Is there anyone present or on the line who would like to make public comment on clinician programs? You guys got anything?

MEMBER MORALES: I thought we were going through them one measure at a time to make comments.

CO-CHAIR HALL: No, just public comment in general right now.

MEMBER MORALES: Okay.

CO-CHAIR HALL: Okay. Not hearing any, I will turn over the stand for the pre-rulemaking commentary.

MR. STOLPE: Very good. Thank you very much. Now we're going to be visiting the Clinician Workgroup Program, so we're very excited this year to not only have MIPS and SSP be included, but for the first time, Medicare Part C and Part D Star ratings program for consideration by the Clinician Workgroup and this committee.

We had a total of ten measures, but I want to emphasize, this is not ten unique measures. There's one measure that was considered for MIPS as well as for SSP.

I'd like to visit the overarching themes of the Clinical Workgroup. First, the Clinician Workgroup emphasized the importance of shared accountability for performance measures, especially when they are -- have broad implications across a population.

The concern that was raised is that when there is shared accountability for an outcome, and that gets attributed, especially to a single physician, that it might not entirely be within that physician's control, or clinician's control, to perform well on that measure.

We also recognized that addressing social determinates of health is a major priority for the health system broadly speaking, but also noted the challenges with addressing that through quality measurement.

We also spent some time talking to

appropriate opioid measurement, as you'll likely have noted, there are three opioid measures that are being considered for Medicare Part C and D.

The workgroup acknowledged a very important shared responsibility for individual providers, health systems, and plans to address issues of pain management as well as opioid use disorder, and emphasized the proper measures need to be applied across the healthcare system, such that opioid overdose deaths continue to decline in a manner that's verifiable.

Continuing the themes, they also wanted to share a couple of their key considerations related to meaningful measures initiative. They encouraged CMS to continue the effort to optimize simple predicative analytics and AI, to understand the opportunities for quality improvement, and those efforts should prioritize increased feedback to providers through actionable quality measurement and clinical decision support.

They also encouraged CMS to focus on

patient safety in public reporting, noting again, comparable to what the Hospital Workgroup emphasized, that the consumers do find these types of measures more intuitive and useful than other measure types.

And they also supported CMS' efforts -- excuse me, to encourage local communities, health systems, specialty societies, and others to develop new measures -- or new types of performance measures using emerging data sources.

Okay. So let's move forward into a discussion of the measures themselves. We're going to start with MUC19-27, hospital-wide 30-day all-cause, unplanned, readmission rate for the merit-based incentive payment program eligible clinical group.

So just want to emphasize that this is for clinical groups, not for individual clinicians. This measure received conditional support for rulemaking and those were two conditions now when it's usually just the NQF endorsement, but this is pending removal and

replacement of NQF 1789 in the MIPS program measure set, and the CDP standing committee review of the reliability performance at the physician group level, which is slated to occur in the spring 2020 measure evaluation cycle.

This measure garnered quite a few public comments, and I just want to review the overarching themes for the 17 comments that were received.

Some were supportive of the measure, others expressed opposition to population health measures attributed at the physician level in general, which again, was a theme related to the workgroup discussion as well.

There were attribution concerns, concerns about how risk adjustment would be implemented in this, and also, some concerns that -- related to evidence that providers can easily influence this measure.

Wanted to pivot to our workgroup co-chairs. I see that Rob is on the line, do we have Bruce on the line as well?

DR. BAGLEY: Yes, Bruce is on.

MR. STOLPE: All right. Very good. Would either of you like to supplement any of my remarks related to this measure with any highlights from the workgroup?

DR. BAGLEY: Not from me.

DR. FIELDS: I don't think I have any additional comments. This is Rob.

MR. STOLPE: All right. Very good. Thanks, gentlemen. Turn it over to Bruce Hall.

CO-CHAIR HALL: So what we're going to do is just a slight tweak on the morning. So we're going to have Sam introduce each measure and we're going to take it up as soon as Sam gives the brief introduction.

So having had the brief introduction for 19-27, hospital-wide 30-day all-cause, unplanned readmission for MIPS-eligible clinician groups. Does anyone want to put forward any clarifying questions before we vote on the recommendation from the workgroup?

So if you want a full discussion, you

would vote down the recommendation of the workgroup. If you have any minor clarifying questions, we'll take those now. David? David?

MEMBER GIFFORD: I guess I don't have a minor clarifying, I'm one of the lead discussants, and this and the site measure were the two that cause me most discussion. I'm really torn between supporting this and not and felt it needed a full discussion.

So I don't have any re-clarifying, I have broader issues that stand.

CO-CHAIR HALL: Okay. So as one of the leads, David's expressing a desire for full discussion. So do you want us to vote down the workgroup recommendation first or just proceed with full discussion?

Let's go with the recommendation vote first. Okay. So in the context of David's comment, we will still vote right now to yes or no on conditional support. And you heard comments about the conditions from Sam.

MS. BUCHANAN: Voting is now open on

2019-27 to move forward with the workgroup recommendation of conditional support for rulemaking. Voting is open.

MEMBER ROBERTS: I'm sorry, can you clarify the conditions?

CO-CHAIR HALL: The conditions are, one, seeking NQF endorsement, and two, removal of the current measure that was comparable expense from the MIPS catalog of measures. Okay. Voting is open.

MS. BUCHANAN: Voting is open. We are still waiting for some votes. We have 15 so far. We have 16, which -- okay. So we can stop voting. 19. Okay. So we received 10 votes for yes, 9 votes for no, that does not achieve a greater than 76 percent consensus, so the coordinating committee does not recommend conditional support for rulemaking for 2019-27.

CO-CHAIR HALL: So we're not accepting that off the bat. Now we'll open for full discussion. So, David, would you like to open that discussion?

MEMBER GIFFORD: So I think this is a question of whether the measure is -- needs mitigation for rulemaking besides just NQF endorsement. And that's where I move for discussion.

This measure is a modification of an existing measure on the hospital side that is applied to individual physicians and is modifying the sample size to capture more physicians in the measure, physician groups in the measure.

There were, as pointed out, robust public comments on this. There were 17 public comments, 16 were opposing this, and one was in favor. The one in favor is a primary care physician group. I don't know how you count AMA, as whether they're a primary care physician or not, they oppose.

And all the opposition was around the attribution issue and use in rulemaking. There's some questions about risk adjustment and everything else, but I am not going to raise them because that's really for the endorsement piece

of it.

The concern was that this measure developed a new attribution method that attributes each discharge from the hospital to see if they got great follow-up from the three different physicians.

And many of the specialty physicians felt that they're being attributed to this was not necessarily accurate and they shouldn't be held accountable for it.

So there were complaints about ophthalmology, there were complaints with cancer, in line with some of the more subspecialty groups.

And I'm not sure how best to interpret that information because if it's in a payment issue and how they do attribution, I think we clearly want their coordination, we clearly want issue, but did not appear, and I went back and looked at the measure specs, this is almost a different than measure spec issue, because I think it's going to get NQF endorsement.

It's, is the attribution method appropriate for MIPS for a specialist, and I think I would like to want to see some information around that as a mitigating factor before I would say this is ready for rulemaking, and so that was the concern.

But I'm torn on the fence with it. I could be sort of swayed back on the other angle with this. Generally, I would say the complaints from physicians not wanting to be attributable to them and everything else that's not perfect, I tend to overlook that because there's no perfect measure and everything else, but this, I had a lot of questions in the public comments and reading it.

Also, it was not clear -- it looked like this had gone through NQF endorsement and was getting close to it, but it wasn't, and then -- so I actually asked, and I don't know if the staff won't allow me, it turned out they asked for additional information, the information they got led them to say they were going to probably

lead to endorsement, but then it turned out that information was inaccurate, and so now it's going back to begin the endorsement, is that correct?

That's correct?

MR. AMIN: Bruce knows this while being on the standing committee, but basically, just so that everyone's on the same page, the measure was submitted for endorsement, the committee reviewed it, if you're looking at any of the draft reports and looking at the original voting, there was some during the post-comment call, there was a number of comments provided by various stakeholders related to the reliability test.

During the post-comment call, the committee reviewed the post-comment -- reviewed the reliability statistics provided by the developer. There was some confusion about what was actually submitted and in order -- rather than re-adjudicating the conversation, the committee decided to re-look at the entire measure during the next cycle.

So it was, basically, to spend more time thoughtfully looking at the reliability statistics.

MEMBER GIFFORD: So I think we have on the floor from the recommendation floor, the endorsement is still going through that process.

MR. AMIN: Yes.

MEMBER GIFFORD: I guess my question is, is there a mitigating factor, and I think, you know, we are trying to push for care coordination between doctors and everything else, it's not clear that this measure is ready for that rulemaking on that piece.

I think it's moving in the right direction, I think it's very supporting, and I wanted to make sure we had that discussion, because to me, it wasn't a slam dunk, just getting NQF endorsement and go forward with it, like many of the other measures that we have.

CO-CHAIR HALL: Great. Thank you. Well stated. Cheryl, do you have more to add.

MEMBER PETERSON: So David and I had

a conversation, so I would actually agree with his remarks. I had looked at the reliability question that had been raised and actually, with the American Heart Association and the comments that they made, regarding whether or not this is more appropriate be solely a systems level as opposed to a physician and business group level.

So I think my comments would track with what David has already said. Thank you.

CO-CHAIR HALL: Thank you. Scott, would you like to add?

MEMBER FERGUSON: Yes. The AMA does not support the current recommendation due to lack of support during the public comment, the lack of sufficient evidence to support the broader attribution and reliability, and validity, of the results.

We think that the reliability factor should at least be between 0.7 and 0.8, and we don't see that in the numbers that we've got.

CO-CHAIR HALL: Thank you. Emma, do you have additional comments?

MEMBER GIFFORD: Just one thing, the reliability is not the reliability in the measure, it's the reliability of the attribution component of that. I just want to make sure that's clear.

CO-CHAIR HALL: Is that correct, Scott?

MEMBER FERGUSON: Yes, sir.

CO-CHAIR HALL: Thank you. Emma?

MEMBER GIFFORD: The measure appears to be a reliable, valid measure, and it's going through NQF endorsement, and this idea of a system is clear it's good. To me, that's why it's a discussion about rulemaking.

CO-CHAIR HALL: Thanks. Thank you, David. Emma?

MEMBER HOO: We have had experience with physician-level measurement and physician group level as well as practice level, and there are mechanisms to bring that data together in an effective way that does reflect performance, and, you know, without having gone deep into the full

detail of this measure, I'd hate to kind of throw the baby out with the bath water around, you know, the opportunity here to improve on these processes and getting to more granular information.

CO-CHAIR HALL: Thank you. And then the last discussant, Amir, on the phone? Amir, do you have any additional concerns or comments?

Not hearing anything, I would propose we will proceed with the vote for full support and if that passes, we're done, if it doesn't pass, we'll ask for motions.

MEMBER HOO: I'm sorry, can we clarify a couple of things about attribution?

CO-CHAIR HALL: Yes.

MEMBER HOO: Thank you.

MEMBER DUSEJA: So, hi, this is Reena. I just wanted to let you know that, currently, we do have a version of this measure within the next present. And what we have made in terms of determinations on how it will be applicable for our clinicians that participate within this, is

that it would be at the group level for greater than, you know, 16 providers or more, if the measure would be calculated.

What you have -- what you are looking at right now is actually a measure that's pre-specified to now include just certain groups of specialized, and I'll just repeat this so that you guys are aware, but it's for medicine, for surgery and gynecology, cardiorespiratory and cardiovascular conditions and neurology.

So that's what the measure is looking at. As far as policy making and how we'll apply that to this measure, to the program, we do have precedents of applying it at the group level.

CO-CHAIR HALL: Thank you.

MEMBER GIFFORD: Bruce, can I just suggest maybe a spear on. I raise the question of whether -- I don't think we should up to the higher level, the question is, I think we should revisit the current MAP recommendation now that people have heard the objection, and vote on that, and then I would go down to the next one,

because I think people who voted no could hear my comments, and may not be compelling enough to switch their vote.

As I said, I'm not sure whether I'd switch it.

CO-CHAIR HALL: I understand and support that. I think it's a matter of, technically, do you want us to march from the top, down, I think it only takes a couple seconds to do each.

MR. STOLPE: Let's go ahead and do it, just to follow a process.

CO-CHAIR HALL: So first vote is just full support and then if we don't succeed there, we'll proceed with David's suggestion. Full support?

MR. STOLPE: And just a reminder, if we do not reach consensus, we default to the workgroup's suggestion.

So even if we continually vote no, we will revert back to the workgroup conditional support.

MS. BUCHANAN: So voting is now open for MUC2019-27, do you support the measure. And give it just a couple more seconds. Okay. We are at 20. So voting is now closed. Six people have voted in support, yes, fourteen have voted no. The measure will not move forward with support.

CO-CHAIR HALL: So I would, again, now invite the discussants to propose a motion.

MEMBER GIFFORD: I think my motion would be to mitigating factors, to look more data on the attribution for specialists for rulemaking.

CO-CHAIR HALL: And are you saying you want to move to do not support with mitigation, and we're just going to skip conditional?

MEMBER GIFFORD: Yes.

CO-CHAIR HALL: Okay.

MEMBER GIFFORD: And that would be my recommendation, but if you're following the process of, we have to go to conditions with endorsement, then --

CO-CHAIR HALL: Okay. Yes. Does anyone want to propose a version that would be conditional support with particular conditions? I'm not hearing any support for that. So do you want us to vote on that without having specified any conditions?

MR. STOLPE: It seems that we've already done that.

CO-CHAIR HALL: Yes, so we'll -- yes. Yes, Cheryl.

MEMBER PETERSON: So we've already voted on -- we voted on the workgroup's recommendation.

CO-CHAIR HALL: Right.

MEMBER PETERSON: So we could do conditional support again with a different one of the conditions.

CO-CHAIR HALL: Right. And I have to -- my interpretation is that, any time we've had discussion, people are allowed to change their opinion, and so it's not out of the question that you would re-vote the category, but we don't --

but right now, we don't have a particular motion to attach conditions, so you want us to vote on conditional without conditions or move on?

MR. STOLPE: It seems to me that we could vote on the conditions if -- but I'll --

CO-CHAIR HALL: What would the conditions be?

MR. STOLPE: So the conditions that were proffered by the workgroup, just a reminder, is that we -- that one, the measure that's currently in MIPS be removed, and that's 1789, NQF-1789, and then this measure receive NQF endorsement.

CO-CHAIR HALL: So we have not had any motion to modify that. Let's just re-vote that in the context of having had CMS' input and having had the discussion that we just had. So we will re-vote conditional support with the same conditions.

MEMBER QASEEM: So may I interject support for David's recommendation about mitigation, because this condition that we keep

on putting in about NQF endorsement, having been on MAP for a very long time, I don't think that really carries much of a weight. Maybe I missed something.

I mean, we keep on saying we need to get NQF endorsement, that doesn't happen, so at the last MAP meeting even, we decided that we need to keep that in mind when we are reviewing any of these measures.

So frankly, I was actually more strongly leaning towards do not support, but I can live with what David had as the mitigation. I mean, the attribution issue is a fundamental issue. It needs to be resolved. That's not even conditional.

You have an inherent problem with the performance measure. That needs to be fixed.

CO-CHAIR HALL: Thank you. Thank you. Nancy?

MEMBER FOSTER: I just wanted to ask a clarifying question of Reena. And forgive me, as I don't understand all of the groups in the

MIPS, you said it would be applied to internal medicine, certain general surgery, general surgery, and is it just general internal medicine or is it anybody who's an internist?

MEMBER DUSEJA: So it's based on the condition. So what I described are the conditions that the RF score is passing this on, so it would be the conditions that would lead to a readmission, so it's around medicine, surgery, cardiorespiratory, cardiovascular, and neurology.

Traditionally, this measure has been applied to those that are taking care of them within the hospital, right, that are making those decisions, so that would be, like, for example, the hospitalists on the record.

So that's the work that's being done with our score, with our looking at the measure, and attribution.

MEMBER FOSTER: Thank you. That helps a lot.

CO-CHAIR HALL: So I understand the motion is, we'll just re-vote conditional

support. We have not had any motion to change the conditions that's applied to the workgroup, but we're re-voting in light of the discussion we just had. Yes, Reena.

MEMBER DUSEJA: We just heard from our contractor. So they also wanted just for the committee to know that if we're not moving forward with this measure, then the single attribution measure that we currently have within the program, it'll be attributed to an outpatient clinician-only, and that the outpatient clinician may not have seen the patient prior to readmission, will continue to be in the program.

And I'm not sure if Lisa Sutter is the one who emailed us that, so, Lisa, I don't know if you want to say anything else based on what you just sent us. May she? Go ahead, Lisa.

MEMBER HINES: Thank you. I just wanted to clarify that the current measure that is in MIPS right now, as said, a single outpatient clinician. That clinician is defined the greatest number of encounters in a 12-month

measurement period, but may or may not reflect a clinician that has seen the patient prior to readmission.

And the attribution of the measure, multiple clinicians, was initiated by our technical expert panel, felt that care coordination and shared accountability were the most important things for this measure, and therefore, we pivoted away from an attribution approach for an inpatient clinician to a broader shared attribution approach as is currently specified. Thank you.

CO-CHAIR HALL: Thank you. David, do you have another concern?

MEMBER GIFFORD: No, I'm just -- I'm personally confused. I mean, I'm torn, and I'm afraid the way we're following this process, if we go down the current recommendation and then we vote down the mitigation, the question is, how do we toy between the two, and personally --

CO-CHAIR HALL: Well, to be clear, my intent is to ask if anybody wants to propose an

alternate set of conditions, we would vote that instead, if not, we will vote what was originally attached.

If that fails, we'll do a final ask for alternate conditions, so there'd be an opportunity there to change the conditional attachments, and if that were to fail, we would go, as you said, to do not support with mitigation. Yes, David.

MEMBER GIFFORD: So just rewording the dilemma that I think we're in is, people -- the experts are really dissatisfied with the current measure and we're at risk for saying, well, this measure that is under consideration today has its imperfections, so we'll stick with a worse measure.

So that's just what the dilemma is.

CO-CHAIR HALL: Although I agree with that sentiment, although, in fairness, it's a little weird for us to accept something because what else is out there is not what we want. That's a different criteria than we normally

apply. Harold?

MEMBER PINCUS: So a way to kind of skirt the issue by -- and I don't know whether it would be to not support with mitigation, but there are three elements of the mitigation. One is that the existing measure be removed, the second is that, the attribution issue gets resolved for this measure, and number three is that it get into endorsement.

CO-CHAIR HALL: Harold, are you willing to put that forward as a conditional approval request or do you want to wait and hold that as a do not support mitigation request?

MEMBER PINCUS: I guess my sense is that I'm not -- it might be better to -- if we short circuit it to a do not support kind of thing, that would be the quickest way to resolve it.

CO-CHAIR HALL: Yes, I will ask for a conditional vote on something before we land there, but I'm willing to certainly take your suggestions and make that --

MEMBER PINCUS: I mean, we do the same thing, only conditionally, we do the same thing --

CO-CHAIR HALL: Right. Exactly. Yes, Executive Secretary.

MR. AGRAWAL: Can I just clarify. Weren't two out of the three conditions that you just laid out already conditions in the workgroup's recommendations?

MEMBER PINCUS: Yes.

MR. AGRAWAL: And just to be clear for the coordinating committee, you could, if you so elected, add a third condition and then take a vote.

CO-CHAIR HALL: As conditional.

MR. AGRAWAL: Yes, as conditional.

CO-CHAIR HALL: Before moving to --

MEMBER PINCUS: At this point, I'm not sure what the difference would be, whether it was conditional support versus do not support.

MEMBER GIFFORD: Well, I think it comes down to, our job is to give advice to CMS

as to whether the measure is ready for rulemaking, and just because it doesn't have NQF endorsement doesn't mean -- I think we could say, yes, well, it's still ready for rulemaking, but go ahead and get the endorsement.

MEMBER PINCUS: Yes, that's where we need three conditions.

MEMBER GIFFORD: To me, the question is, no, it's not ready for rulemaking until you go to these other steps. So even though the conditions are roughly the same, it's whether we are saying it's ready for rulemaking, to proceed with that, or not, because as has been pointed out, the recommendation of condition for endorsement has not ever stopped CMS from putting it out there.

They have, some of them, brought back for endorsement, some they've not. So it really depends on that. I mean, I think we should track that, because how often the conditions are brought back here, and I know we've asked for that in the past, and I reiterate that we try to

do that as a committee --

CO-CHAIR HALL: So that's a point --

MEMBER GIFFORD: To me, that's the difference in -- the reason I'm concerned is, if it doesn't pass the condition, and it doesn't pass the next one, I would go back and pass the condition. I would then change my vote to pass the condition and I don't want to get us into a catch-22 where we can't get back to it.

And I just want to know how we procedurally handle that, because that's my concern with that.

CO-CHAIR HALL: Sure. So --

MEMBER GIFFORD: Because I mean, I personally probably would be not to recommend for rulemaking, but if the rest of the group doesn't agree with that, I will switch my vote to support for condition.

CO-CHAIR HALL: Okay. All right. So, which is the working group's recommendation was conditional support with the two conditions we originally heard, right? So right now, I would

ask this committee to either propose a new set of conditions or to endorse that we re-vote the original two conditions. Thoughts from anyone? Leah?

MEMBER BINDER: I would just say that it's probably a good practice for us to try and err on the side of workgroup recommendations when we can, and sort of, you know, turning them upside down and litigating things. I mean, there is a purpose for the workgroup, so I think I would prefer to just, maybe, add something to the condition, but keep it where the -- you know, unless we have -- it's just the workgroup has totally disagreed, I think that we should try and favor the workgroup recommendations.

CO-CHAIR HALL: Great. Thank you. Scott?

MEMBER FERGUSON: I don't think it's ready for rulemaking. I think that the attribution needs to be based on evidence and proven to be valid before we move it to rulemaking.

CO-CHAIR HALL: All right. Having heard all the cards that are up, I will propose that we re-vote the two conditions as the workgroup had originally passed them to us, in line with Leah's suggestion. Now, conditional support with the two conditions of NQF approval and removal of the existing metric.

MEMBER PINCUS: What about the third condition?

CO-CHAIR HALL: Well, I'm proposing we stick with the original workgroup, but if someone wants to move otherwise, Harold, I had interpreted you as landing on, do not support mitigating.

MEMBER PINCUS: Right. But I'm just clarifying, I thought we already voted on the --

CO-CHAIR HALL: We voted before discussion, people are allowed to change their opinion during a discussion --

MEMBER PINCUS: We're voting again.

CO-CHAIR HALL: -- so we're voting again at this level. We're voting conditional

support with the workgroup's original conditions. Is that clear to everybody? Okay. That's the vote. So everyone vote, please.

MS. BUCHANAN: Thank you very much. Voting for 2019-27, conditional support, which is based on the workgroup recommendation, is now open. We have -- we're waiting on just a couple more votes and then we will close, so giving people just one more moment.

We have 18 votes and I don't think that we have anymore, so we're good to go. I'm closing the voting. The results are 13 yes, 5 no, so the coordinating committee recommends moving forward with 2019-27 with the workgroup recommendation of conditional support for rulemaking.

CO-CHAIR HALL: Great. Thank you. Next up, I'll throw back to Sam real quick for 28.

MR. STOLPE: Very good. Moving on to our next measure. We are now looking at MUC2019-28. And this is the risk standardized

complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty for MIPS-eligible clinicians and clinician groups.

Now, the recommendation for this is support for rulemaking. This measure is NQF endorsed as NQF-3493, which is based on a comparable measure, NQF-1550, which also is utilized, but this if for hospitals.

So the primary focus of the workgroup around this one was that they agreed with many of the comments that came in related to patient-reported outcomes, performance measures, such as functional status, et cetera, related to TKA and THA are both desirable, but they emphasized that they would be complementary to this measure.

And the overall comments that were received tended to focus on the fact that the commenters considered patient-reported outcomes to be better, and then expressing a common theme that we saw around concerns for both attribution and reliability of the measure as applied.

I'll pivot to our co-chairs to add any supplementary comments. Rob or Bruce?

DR. BAGLEY: Nothing additional for me.

DR. FIELDS: Nothing from me.

CO-CHAIR HALL: Thank you, both. Does anyone want to ask clarifying questions at this point before our initial vote of the workgroup recommendation? Again, if you would like full discussion, then either speak now and/or you would vote down that recommendation. Misty?

MEMBER ROBERTS: Yes, so clarification is that this is an existing measure at the facility level and now there's an attribution for clinician level? Is that --

MR. STOLPE: That's correct.

MEMBER ROBERTS: Okay.

MR. STOLPE: So there is an NQF measure, 1550, around which NQF -- excuse me, 3493, which is this measure, has been based. And 3493 has gone through the endorsement process.

CO-CHAIR HALL: Anyone else with

questions before we take our first vote? Not seeing or hearing anything, we'll vote first to accept support for rulemaking.

MS. BUCHANAN: Voting is open for MUC2019-26 to move forward on the workgroup recommendation of support for rulemaking.

CO-CHAIR HALL: Sorry, Kate, 28.

MS. BUCHANAN: Thank you. Measure 2019-28, moving forward with the workgroup recommendation of support. Let's see. Give it just one more second, see if we have any other lingering votes. I know that some people had to leave.

And we have 16 votes, which is enough. Oh, we have one more. Great. So we are going to close voting and the vote results are 16 in support and 1 against, so MUC2019-28 will move forward with the workgroup recommendation support for rulemaking.

CO-CHAIR HALL: Thank you. We'll turn to 19-66, hemodialysis vascular access.

MR. STOLPE: All right. Very good.

So this measure received conditional -- excuse me, this measure received conditional support for rulemaking. The condition being receipt of NQF endorsement.

The committee, overall, liked this measure and expressed fairly strong support for it. The comments mainly focused on having additional conditions being added to the recommendation, that additional testing be completed to improve reliability and validity of the measure.

Anything from our co-chairs to supplement?

DR. BAGLEY: This is Bruce. I think that you're right about the overall consensus of our group. We felt this was a good measure and should go forward.

CO-CHAIR HALL: Thank you, both. Do any of our lead discussants or anyone else in the room have clarifying questions before the first vote? Oh, Scott, I'm sorry. Didn't see your flag.

MEMBER WALTERS: That's okay. You mentioned the additional testing for the reliability and validity of results. Is that something that will be incorporated in that or does that need to be a separate item?

CO-CHAIR HALL: Well, were this to go forward under the workgroup's recommendation, it would require submission of that reliability and validity testing for endorsement by NQF.

MEMBER WALTERS: Okay.

CO-CHAIR HALL: Any other comments prior to first vote? Not seeing any. So our first vote here is conditional support, the conditions that need to be heard from Sam.

MS. BUCHANAN: All right. Thank you very much. Voting is open now for MUC19-66 to move forward with the workgroup recommendation of conditional support for rulemaking. And we need just a couple more votes.

So we will close voting. We have 16 votes. And the voting results are 16 in support of moving forward with the workgroup

recommendation. 0 do not support, so the workgroup recommendation moves forward.

CO-CHAIR HALL: Thank you. We'll move on to 19-37, Sam.

MR. STOLPE: All right. Thank you very much. So this is for MUC2019-37, clinician and clinician group risk standardized hospital admission rates for patients with multiple chronic conditions.

Just to note that in the Medicare Shared Savings Program, the score would be at the ACO level. Clearly, this is at the MIPS provider or provider group level. So this measure received a do not support with potential for mitigation.

And I'm sorry, I'm having trouble identifying where the mitigating factors are.

MEMBER SCHREIBER: Higher reliability.

MR. STOLPE: What's that?

MEMBER SCHREIBER: Higher reliability.

MR. STOLPE: Oh, achieving a higher reliability score. Thanks, Dr. Schreiber. So

this particular measure had a very robust discussion with our MAP clinician workgroup, where a number of concerns were expressed around the reliability of the measure and the validity of the measure overall.

Its applicability to MIPS providers was called into question. Also inside of the public comments, it tracked fairly closely without the workgroup discussion as well. I'll turn it over to our co-chairs to supplement with any comments.

DR. BAGLEY: This is Bruce, I think you fairly outlined our discussion.

MR. STOLPE: Thank you. Can --

DR. FIELDS: This is Rob. Nothing to add.

MR. STOLPE: Thank you, both. Can we clarify what's on the screen there, which reads differently than what you said?

Yes, that text there reads differently than this text. Oh, right, so the name of the measure, the score would be at the -- so just to

clarify, this measure is being considered for two separate programs. One, the Shared Savings Program, so we'll discuss this measure again immediately following this vote, and its applicability for shared savings.

Here, we're considering it specifically for MIPS at the provider -- the individual provider or the provider group level. At the MIPS consideration, the clinician workgroup did not feel that this would be appropriate for rulemaking under the current reliability testing.

And as specified, that in order for it to move forward, the mitigating factor would be to achieve a reliability standard higher than what they received.

CO-CHAIR HALL: Great. Thank you. David?

MEMBER GIFFORD: I'd be curious to hear from the co-chairs why the recommendation from the MAP was not recommended here, but on the previous one we talked about, it was, and the

issue is the same thing about reliability of attribution. Is it roughly the same measure and it's the same issue, so what swayed them one way versus the other? I'm just curious about that.

CO-CHAIR HALL: Okay. So we'll consider this still clarification prior to our first vote and, Scott, in the mirror, do you want to -- can you shed insight on David's question?

MEMBER PINCUS: Can I also add one other item for clarification?

CO-CHAIR HALL: Yes, Harold.

MEMBER PINCUS: Which is, it's not clear to me what the expected mitigation is. It looks like, just from reading the text here, it looks like the mitigation is to not apply it to the individual, which would then really be, do not support.

CO-CHAIR HALL: Okay. So, Scott and/or Amir, could you comment on those concerns? Amir? I'll let Scott go first.

MEMBER FERGUSON: It's the same as we've had with several of these, the reliability

and the validity of the data. We did not support the previous one and don't support this one. I think that answers his question.

PARTICIPANT: Can the developers respond to the questions?

MEMBER PINCUS: I guess my question is, when it says, do not support with mitigation, so --

CO-CHAIR HALL: So let me invite the developer to comment on the couple of concerns that have been expressed.

MEMBER DUSEJA: Let me just start in terms of what we heard from the workgroup. One was the issue around reliability. They wanted a minimum reliability of 0.7, was what was discussed during the discussion last month.

The other thing had to do with assurances that we would be applying it, not to the individual clinician level, but applying it to the group level, similar to how we've been applying the HWR, Richard. So those were the two things beyond having it endorsed.

And then we probably -- we do have a measure developer, so I just wanted to pause and see if they wanted to add anything.

DR. DRYE: Yes, hi, it's Elizabeth Drye from Yale. The reliability, to clarify, those two things, in some ways, go together because the more patients and clinicians are together, the higher the reliability score.

And so one of the things that we clarified in the, I think really, rich discussion of the workgroup, that both things were of concern, and so what we'll be doing when, I think, the committee is asking, how do we mitigate, we'll be coming back to CMS with empiric testing that shows how different group sizes affect reliability scores, and the number of providers that would be eligible to report the measure, and the number of patients included in that, and then CMS can make a decision about how to move forward, given the committee's input, and the testing developed.

CO-CHAIR HALL: So, Liz, this is Bruce

Hall. Thank you very much and my understanding, though, that what you may come back with is, you may come back with a group level threshold that you think meets some reliability number.

The challenge in front of us is to either approve or not approve without knowing what that would be. I'll turn to the room, David?

MEMBER GIFFORD: Is there a minimum reliability number? Because in reading the public comments, some people are advocating 0.8, some are advocating 0.7, is there something -- is this sort of a new science that we don't have a number yet, and that's why everyone's arguing about it?

CO-CHAIR HALL: The NQF has a white paper on this topic from the recent past, a year or two ago, and the reality is just that, most people think about reliability in terms of, sort of, typical agreement statistics, where something greater than 0.4 might be okay, but greater than 0.7 and 0.8 really becomes good and strong, and

particularly for high stakes purposes, you probably want to argue for something up in the area of 0.7 or 0.8, but there's not an industry standard.

MEMBER GIFFORD: This is reliability around attribution. This is not -- like, we test reliability and the rate of reliability, right? Yes.

CO-CHAIR HALL: No, so when we're --

MEMBER GIFFORD: There's not a standard number that's, once you get it, everyone sort of says, okay, there's debate between 0.7 and 0.8.

MEMBER BAKER: Can someone explain, I don't even know what reliability in terms of attribution means. I'm sorry.

MR. STOLPE: So the way that we usually describe it at NQF is that at the score level reliability testing, what we mean is, the confidence that you have that you have appropriately forced ranked, by a performance, a group of providers.

So if we're taking all of their performance scores, some of the performance score will be attributable to actual signal, or real quality differences, and parts it will be stochastic, just statistical in nature, and we call that noise.

So when a signal-to-noise analysis is looking at that, kind of, confidence that we have, that if we say, this provider performed at a 0.85, and this provider performed at a 0.87, that there truly is a difference between those and not that they are actually switching the order for some reason.

MEMBER BAKER: So I'll take a look at the white paper, but I don't know how you do that, comparing two individuals. Are you looking at the performance of two different points in time and seeing the agreement?

MR. STOLPE: You're looking at their performance relative to one another over the same performance period. So the way that you do it is a little bit sophisticated, but the methodology

that's typically used is called the beta-binomial methodology that was outlined in a white paper by Adams in 2009, and this is the, probably, most common way that reliability at the score level is demonstrated in submissions for endorsement at NQF.

MEMBER BAKER: Okay. Thanks. I'll take a look.

CO-CHAIR HALL: And I think Liz was just trying to add to her comments. Liz?

DR. DRYE: Sure. Thanks. Just to clarify, this isn't the reliability of the attribution algorithm, it's about some aggregate score results, so they're separate things.

The attribution algorithm is focusing on how we assign patients to providers, or provider groups, and get a group of patients, then, whose outcome we'll use to give them an aggregate score, so it's about once we assign them, what's the reliability of that score?

CO-CHAIR HALL: Thanks, Liz. So we still haven't taken a first vote. What's the

temperature in the room? Do people feel comfortable enough to take a first vote? The first vote would be -- where are we? The first vote would be, do not support with mitigation. Do people have any other questions before first vote?

Not seeing any --

DR. DRYE: Sorry, Bruce.

CO-CHAIR HALL: Yes.

DR. DRYE: I'm just going to --

CO-CHAIR HALL: Yes, go ahead.

DR. DRYE: I just want to jump in with one more piece of background with this. Someone mentioned that you don't have the numbers in front of you that relate to the group size or number of patients to the reliability results we're getting.

We did present those to the workgroup, so they saw those numbers when they considered this. Usually don't get into that depth in this discussion, but those were considered and I think -- so they could see the size of the groups, they

know that 0.7's reliability.

That was on older data, so we're updating everything, but again, we gave them data for that.

CO-CHAIR HALL: Thank you. So it seems the context here is that the workgroup has seen those and was -- had concerns about reliability down at the individual level, as stated there, this measure is provider or provider group.

The workgroup was concerned about the individual level reliability, and suggested mitigation, which I'll have Sam restate.

MR. STOLPE: Sure. Thank you. Now, what we have written up in the discussion guide related to this is that, the measure should apply to clinician groups with an appropriate reliability threshold, e.g., 0.7.

That was outlined as the primary mitigating factor, but the workgroup did have a couple of other things that they outlined as potential mitigating factors. First, they noted

that the measure developer should also consider NQF guidance on attribution and consider the patient preference and selection as an attribution method as those data become available.

So currently, they are not available. Just wanted to stress that point. MAP also suggested that rather than moving directly to this outcome measure, that CMS could consider process measures that would get to the desired outcome through a stepwise approach to increasing accountability.

CO-CHAIR HALL: Thank you, Sam. So with that said, let's take first vote on do not support with the mitigation that Sam just described. Sorry, we'll hold that. Yes, Esta.

MEMBER MORALES: I just want to ask, is it only the first one that we're considering or all that list of issues that you brought up?

CO-CHAIR HALL: Those were the conditions described by the clinician workgroup. However, I do want to stress that the first

condition was the most concrete. The others were put forward as considerations.

MEMBER MORALES: So we want to consider only the first one?

CO-CHAIR HALL: We want to consider exactly what they said. We're now either accepting or rejecting exactly what they said and then we can modify if necessary.

MEMBER MORALES: Okay. Thank you.

CO-CHAIR HALL: Yes. Thank you. Okay. So we're going to vote on exactly what the workgroup put forward right now.

MS. BUCHANAN: Thank you very much. Voting is now open for MUC2019-37. This is for MIPS and it is to move forward with the workgroup recommendation of do not support for rulemaking with potential for mitigation.

Waiting on -- oh, we have 17? Okay. So we will close voting. Oh, wait. We have 18. Okay. Now we're going to close voting. So we had 15 people vote yes, 3 vote no, so MUC2019-37 for MIPS puts forward the workgroup

recommendation of do not support for rulemaking, potential for mitigation.

CO-CHAIR HALL: Thank you. I'll ask Sam to make any additional comments necessary for this different category, the same measure, different category.

MR. STOLPE: Right. So this should be fairly straightforward. We're talking about the same measure, but applied to the ACO level. So the workgroup recommendation for this was conditional support for rulemaking. The condition being that it achieves NQF endorsement.

Now, the public comments did align very closely with the workgroup discussion on this measure. And generally speaking, the workgroup felt that this measure could much more comfortably be applied to a shared savings type structure.

Whereas, ACOs tend to have a pretty robust series of service offerings that offset the risk, and also have a much larger sample size to consider, that this would make it more

reliable and much more suitable for those reasons.

I'll pivot to the workgroup co-chairs for any additional comments.

DR. BAGLEY: That sounds right.

DR. FIELDS: Yes, nothing from me.

MR. STOLPE: Okay. Thank you, both. Everyone in the room, on the line, having heard what we've heard, does anybody need further conversation before the first vote? Oh, yes.

MEMBER ROBERTS: Yes, sorry. I'm looking at my screen here and it seems to be the workgroup recommendation under the MSSP seems to be different than what's on the screen. It says, conditional support for rulemaking on the screen, and it says, do not support for rulemaking with potential for mitigation, unless I'm looking at this wrong.

MR. STOLPE: So that's for the MIPS measure that's --

MEMBER ROBERTS: Okay. Well, it's actually different. It says it in the shared

savings one. The MIPS one actually says, conditional support for rulemaking. So are they backwards in the document?

MR. STOLPE: We must have got them backwards in the document.

CO-CHAIR HALL: I know mine reads shared savings conditional. I don't know if there's --

MEMBER ROBERTS: Okay. I just want to make sure.

MR. STOLPE: It looks like it's correct inside of the discussion guide.

CO-CHAIR HALL: Sam, can you just please state exactly what the truth is?

MR. STOLPE: Let me pull up the report and actually confirm this, so my apologies for any confusion. I'm looking at the measure here and inside of the report it's listed as MAP conditionally supported MUC2019-37 pending NQF endorsement, so what you see on the screen is correct.

MEMBER ROBERTS: Okay.

CO-CHAIR HALL: You all right with that, Misty?

MEMBER ROBERTS: Yes.

CO-CHAIR HALL: Okay. Anyone else with concerns or questions before the first vote? Okay. First vote is conditional support, condition being, NQF endorsement.

MS. BUCHANAN: Thank you very much. Voting is now open for MUC2019-37. This is for MSSP to move forward the workgroup recommendation of conditional support for rulemaking. And we'll be closing soon, so just -- there are a couple more votes that could come in. Okay. So we are closing voting.

We received 18 votes yes, 0 votes no, MUC2019-37 for SSP moves forward with the conditional support for rulemaking.

CO-CHAIR HALL: Thank you. We'll turn to Part C and Part D STAR category now and we'll start with 19-14.

MR. STOLPE: All right. Very good. And so now we're going to review MUC2019-14,

follow-up after emergency department visit for people with multiple high-risk chronic conditions. This measure was conditionally supported by the MAP Clinician Workgroup for rulemaking, pending NQF endorsement.

Overall, the workgroup was fairly supportive of this measure, noted the importance of care coordination as a CMS priority, and that this measure encourages health plans to think broadly about their beneficiaries and how they are -- how their care is coordinated after they leave the emergency room.

The comments related to this measure followed around, again, fairly comparable to workgroup discussions around concerns, namely that follow-up be better defined.

Then there were some concerns, especially related to special needs plans, related to timeframe, the data source, and the nature of the notifications that go to patients.

Any other comments related to this that came from the workgroup that our clinician

co-chairs can provide?

DR. BAGLEY: This is Bruce. I think that's fair. This looks like a good measure to help get at the care coordination issue.

DR. FIELDS: Nothing in addition to add.

MR. STOLPE: Now we just go to gathering questions.

CO-CHAIR KAHN: Well, do we have any questions or can we go to a vote on the recommendation? Oh, comments?

MEMBER MORALES: Okay. So I have a couple of comments. Number one, a lot of times care coordinators are not in the know -- don't even know when somebody goes into the emergency room, and so we need a lot of interoperability about people who go to the emergency room and then are discharged that have care coordination follow-up with them.

So that's number one concern, and then I totally agree with the comment for special needs plans, and I have a big Medicare/Medicaid

plan and MMP plan, where if this is going to be considered for a STAR rating, then at least those particular Medicare contracts with a large number of SNP members need to be accounted for in some way, because it's going to be more difficult for those members who are discharged from the ER that are Medicare and Medicaid combined and special needs members, to get the follow-up.

And that just needs to be accounted in the STAR measure process.

MR. STOLPE: Okay. Other questions or concerns in this -- at this stage? Yes, Liz.

MEMBER GOODMAN: I would just say that that's consistent with what we heard from the rest of our plans.

MR. STOLPE: Other questions or concerns? Anyone on the phone? Okay.

PARTICIPANT: Is there an open comment on this?

CO-CHAIR HALL: No, not yet. Thank you very much. Mary?

MEMBER BARTON: Thank you. As

mentioned, I'll recuse myself from this vote, but I just want to point out that the population who are these high-risk medical conditions, multiple chronic conditions, is somewhere between, I think, 8 and 14 percent of the population in the Medicare -- in Medicare group, so it's really the sicker end of the spectrum.

And NCQA said it's -- even though it might be hard for patients who have challenges, such as being dually eligible, that that doesn't mean that they're not really even more important to find.

And so that's our support.

CO-CHAIR HALL: Thank you. Okay. I'm not seeing any other flags, so we'll move to first vote, conditional support, and the condition being NQF endorsement.

MS. BUCHANAN: Thank you. Voting is now open for MUC2019-14, for the workgroup recommendation of conditional support for rulemaking.

And we'll give it just one more

second. Okay. We are closing the voting. We received 16 votes yes, 2 votes no. The coordinating committee has voted to move forward with 2019-14 for recommendation for conditional support.

CO-CHAIR HALL: Thank you. 19-21.

MR. STOLPE: Excellent. Transitions of care between the inpatient and outpatient settings, including notifications of admissions and discharges, patient engagement, and medication reconciliation post discharge.

So this measure also received conditional support for rulemaking, with the same condition, pending NQF endorsement of the measure. Now, this was noted that this is designated as a first year measure for HEDIS 2018, and MAP observed that Medicare beneficiaries are at particular risk during transitions of care because of higher comorbidities, declining cognitive function, and increased medication use.

Comments were largely supportive, but

again, comparable to the other measure. Special needs plans were particularly concerned around timing, the data source, and the method of notification related to these measures.

I'll turn it over to our workgroup co-chairs for supplementary comments.

DR. BAGLEY: This is Bruce. This is really the essence of what they're supposed to be doing and it's a great way to measure it. We have pretty good consensus around this.

DR. FIELDS: And no additional comments from me.

MR. STOLPE: Great. Thank you.

CO-CHAIR HALL: Thank you. So in the room, we'll ask for some comments or questions before going to a vote to see where we are. Mary? I'm sorry, Misty?

MEMBER ROBERTS: Thanks. I think some of the same concerns that Esther brought up apply to this measure as well, but probably even more so. I think this is probably the most concerning measure for me as I was reading through.

I just think with the feasibility from a health plan perspective, I think the concern with one of the commenters actually presented it well in terms of, well, who is actually supposed to notify whom of what and by, and how are they supposed to?

So I think there's still some questions around that. The timeliness of the notification is a concern. Right now, it's, for us, a very manual process. We're not going to get claims within 24 hours. The fact that it is claims as well as, basically, a record review.

It's very concerning, really, around the feasibility and the complexity of this, not to mention that there's four measures involved. It's a composite measure.

And then we have to think about the med rec post discharge already in a measure in the program and how we would address that.

CO-CHAIR HALL: Thank you, Misty. Elizabeth.

MEMBER GOODMAN: I would just second

what Misty just said. I would also say that our plans are very concerned about the cost of administering the measure as well as the fact that often rural patients are being seen outside of their communities and the communication patterns are not terrific, and there is no electronic data standard for the transmission of this data at this time.

CO-CHAIR HALL: Thank you. Esther.

DR. FIELDS: I'm sorry. This is Rob Fields. One of the co-chairs of the coordination workgroup, so if it's appropriate, may I respond, based on the context of the conversation, to some of that?

CO-CHAIR HALL: Sure, Rob. Go ahead.

DR. FIELDS: I would just like to point out, just to make sure everyone's aware, and it may be obvious, but we do have representation from the rural workgroup in the clinician workgroup, so we did hear from them as well, and as part of the deliberation, so took that into account, and to the overall -- into the

vote, and to the feelings of the group.

I would also say there was -- with this and other measures, there was general discussion within the clinician workgroup about while there are certainly challenges and interoperability in communication between all sorts of facets of the health system, I don't think anyone can argue with the fact that that is, in fact, our charge, is to coordinate care.

And it does become a little bit of a chicken or the egg thing where if no one plants a flag to define what it is that we're supposed to be doing to achieve coordination of care, then what is the incentive to do it?

And while there were certainly similar concerns that were expressed, I think the overall feeling of the workgroup, as expressed, I think, by the recommendations, is that at some point, you have to plant that flag and move in a direction that leads to better coordination of care in what is otherwise a super broken system.

And many of us that have moved into

value-based care have already tried to solve these problems, and have solved these problems, and to some degree, this is a -- we believe that there needs to be a push to continue to do that across the board.

And I know Bruce and others have felt that we had a different experience, but that's sort of my general take and summary about some of these last couple of measures.

DR. BAGLEY: This is Bruce, I totally agree.

CO-CHAIR HALL: Okay. Thank you, both. We'll continue in the room. Esther.

MEMBER MORALES: I want to speak as an end user of this measure, because I had about 2500 medical records that I had to get for this measure, because two of the subsections of this measure, the notification of admission and the notification of discharge, are done entirely by medical record.

And unless you're an integrated delivery system with a hospitalist, you're

probably never going to be able to make sure that it's in the -- all the requirements for the medical record are in the medical record when you go look for it.

So it is expensive for us to go and it's very annoying for the physician for us to try to find the medical records where you can't find evidence of this happening.

So these two components, the admission that -- the notification of admission and the notification of discharge are very difficult to do. There's no administrative way to do it except for getting a medical record.

And so our position is until that is available, somehow, to do it administratively, that this is a lot of work for very little outcome.

CO-CHAIR HALL: Thank you, Esther. Misty?

MEMBER ROBERTS: Yes, I just wanted to respond to the comment on the phone. I think that we all agree that the intent of the measure

is appropriate, and it does need to be addressed, but I think we're talking about including this in the Star Rating Programs, and I think that's the concern that, where the notification is to come from the hospital to the health plan, so therefore, the health plan is being held accountable for something that the hospital is supposed to do.

So if the hospital doesn't provide the health plan with the information, therefore, the health plan is then penalized, so I think that's important to take into consideration.

CO-CHAIR HALL: Thank you. Other concerns prior to a vote?

MEMBER QASEEM: So this is Amir. I was looking at this measure. I absolutely hear what everyone is saying, that it's going to be burden, but the others who said we need to move in this direction to address it, a broken system, it's about time.

I mean, from medication reconciliation, I'm not really sure if we're

going to be able to get good data and all, but the people waiting for that side of the system to fix itself versus we push it, sort of reminds me of the maternal mortality sort of measure this morning we discussed.

So I hear the concerns, but I think it's time to move it.

CO-CHAIR HALL: Thank you, Amir. Mary?

MEMBER ROBERTS: And again, this is an NCQA measure, which I will recuse myself from the voting lines, but I think that what has -- you know, what Amir said was well put, that it's time to set up those data systems to get the information to flow more easily.

And I'm just trying to find out from my team when, certainly, NCQA's intention to retire the medication reconciliation measure as the transitions of care measure becomes more widely used, and the idea is that there's only one chart review that's required.

I'm not downplaying how difficult that

chart review is today, but it should not always be that difficult. And I don't know of any other way other than starting to get the ball moving in the right direction.

CO-CHAIR HALL: Elizabeth?

MEMBER GOODMAN: I think to Mary's point, right, these -- that I can't emphasize enough how important it is to the plan that we not be doing the measure that just changed last year on med recon, it's a D measure right now, and this measure, that they have to sort of one way or the other, and that it be a display measure for some period of time while the system fixes itself.

So I don't think anybody's disagreeing, I know no one is disagreeing, that this is a laudable goal, but we need some time to implement this.

CO-CHAIR HALL: So, Elizabeth, what I heard from you almost sounded like new conditions that we would consider, so if everyone's okay, we'll move to vote for the group -- the exact

workgroup recommendation in front of us first, the exact recommendation is, conditional support with NQF endorsement only, the only condition, right?

And if anyone would like to have deeper discussion or propose alternate conditional support, or any other part, then you would just vote down this measure now, so we'll vote this first.

Mary, did I catch you already or not? Yes? Okay. So right now, we're voting on the exact workgroup recommendation.

MS. BUCHANAN: Voting is now open for 2019-21. It's to vote to accept the workgroup recommendation as conditional support for rulemaking. And we need just one or two more votes. Okay. So we are closing voting. We received 8 votes yes, 10 votes no.

The coordinating committee does not vote to move forward 2019-21 of the workgroup recommendation for conditional support.

CO-CHAIR HALL: I'd like to propose

that we go right away and vote full support. We've had some conversation anticipating that we'll come back to some other version of conditions to be discussed, so can we -- anyone object to voting full support first? Starting at the top. Okay.

So we'll vote full support.

MS. BUCHANAN: Voting is now open for 2019-21, support for rulemaking. And we need several more votes. Okay. We're going to close the voting in just a minute. Anyone else who hasn't voted, please do so. Okay. We are closing voting. Closing voting now.

For MUC2019-21 vote of support, we received 6 yes, 13 no, the committee does not move forward with support for 2019-21.

CO-CHAIR HALL: That brings us back to the conditional category. Would anyone like to have further discussion or would anyone like to propose a different set of conditions for consideration? Yes. Elizabeth.

MEMBER GOODMAN: I'm happy to go back

to where we were with the proposed condition, that this only be implemented after the D measure is removed and that it be placed -- if it is to be placed in Stars methodology, that it be a display measure for some period until the system can catchup with the information.

The whole one is or the D measure is?

DR. GOLDSTEIN: This is Liz Goldstein from CMS. This is display measure right now and we are required to -- any measure added to Stars rulemaking, we're required to have it displayed for at least two years, or more, before it moves to Stars. None of them move directly to Stars.

MEMBER GOODMAN: Yes. Thank you. I'm sorry, I should have said that at the beginning, the issue is that it not become a Star measure before the D measure is removed.

CO-CHAIR HALL: Elizabeth, could I impose on you to restate what you want to propose the conditions to be?

MEMBER GOODMAN: Sure. Or maybe Misty can state it more clearly.

CO-CHAIR HALL: Okay. Sure, sure.

MEMBER ROBERTS: Well, I actually had a clarifying question, but I think what you're saying is that it does not move to Stars. Apparently, it's on display, which, how long has it been on display?

MEMBER GOODMAN: One year.

MEMBER ROBERTS: One year.

DR. GOLDSTEIN: This is Garcia right now that's on display?

MEMBER ROBERTS: So it would at least have another year, it sounds like, but --

DR. GOLDSTEIN: At least one more year, and often, it's more than two years, depending on, you know, feedback that we get.

MEMBER ROBERTS: And then not be moved to a Stars measure until the current med rec post discharge is removed from Stars. And then my clarifying question is, is it NQF endorsed? Do we know?

CO-CHAIR HALL: It is not.

DR. GOLDSTEIN: It is not NQF

endorsed, and we wouldn't have the existing medication reconciliation measure in this measure, it would be, you know, having it twice, so that one would automatically be removed before this is implemented in Stars.

MEMBER ROBERTS: So I would also suggest that we have NQF endorsement also as a condition.

CO-CHAIR HALL: Great. So you heard three conditions from Misty and Elizabeth. Anyone else with other concerns, questions, or other thoughts?

I'm no seeing or hearing any, so I will support the proposal that we're going to vote now on conditional. Conditions being the existing measure has to go away, the display period has to be completed, and NQF endorsement.

MS. BUCHANAN: Thank you very much. Voting is now open for 2019-21 with conditional support. And we're just going to close it in one moment. Give an opportunity for any additional votes. Okay. We can close the vote. We

received 15 yes, 3 no, MUC2019-21 will move forward as conditional support.

CO-CHAIR HALL: Thanks, everyone. That was good conversation. 19-57, Sam.

MR. STOLPE: Very good. Thank you. Before we get too far down the road in the discussion of this measure, the NQF staff need to make a series of clarifying comments about MUC19-57, use of opioids at high dosage in persons without cancer.

And I'm going to preface these comments with an apology, so there's been some confusion about this measure, some of it was -- is our fault, and we want to own that, so our apologies, sincerely, for any lack of clarity and confusion that we've generated as a staff.

So when CMS submitted these measures for consideration, they stated in their submission that only one of these three opioid measures would be advancing into the Star ratings.

With this in mind, NQF staff had the

impression that the clinician workgroup would be tasked with selecting which of the three measures to move forward.

So NQF staff reviewed the three measures together and provided a preliminary analysis of the measures. The workgroup, for this measure, NQF staff assigned a preliminaries category of conditional support for rulemaking, which you're seeing in front of you.

The condition being that this measure would be supported in the event that the other two measures did not move forward into the Stars. So if, for example, the workgroup would have said, do not support for the other two, the condition would be fulfilled that the other two would not be advancing in the Stars, this would be the preferred measure.

So in a conversation with CMS just before the workgroup meeting, and this was after the preliminary analyses had been sent to the workgroup, it was clarified that CMS would prefer that the workgroup not suggest which of the

measures to move forward, but rather, to consider the three measures on their own merits for inclusion in the program.

Now, in an effort to reduce the confusion for the meeting, rather than update the preliminary analysis and discussion guides and try to explain it over email, we thought that would generate more confusion, so instead, we elected to explain this in person.

During the meeting, staff clarified to the workgroup that each of the measures should be considered individually and the conditional support was based on the other two measures not moving forward.

Now, we've reviewed the transcript of the in-person meeting and the nature of the staff recommendation on the conditions was emphasized several times over by both the co-chairs during the discussion, as well as by staff, and including just before the vote on the measure.

So it appears that it was well understood by the workgroup that they were voting

on the measures irrespective of whether the measures should advance into the Stars.

So you can see how these are two conflicting things. We conditioned it upon moving forward in the Stars and simultaneously told the workgroup not to consider them, whether or not the others were moving into the Stars.

So, in subsequent conversations with the workgroup co-chairs and with CMS confirmed this; however, NQF did not make this change during the vote.

So the workgroup voted to support the preliminary analysis of conditional support instead of voting to support for rulemaking. Now, since NQF staff has subsequently met with the coordinating committee co-chairs, and the MAP clinician co-chairs, we would like to suggest that the MAP coordinating committee for the conditions do not reflect the intention of the workgroup and should therefore be removed.

So NQF suggests moving forward with an initial starting vote of support for rulemaking

for the sake of clarity and to ensure that the wishes of the workgroup are best represented for the MAP coordinating committee.

All three of these measures do carry an NQF endorsement and would be considered as suitable for inclusion in the program for the first two measures, the last one was do not support for rulemaking.

I want to pause here for any clarifying questions that you might have for the staff related to the proposition we're putting on the table.

CO-CHAIR HALL: So let's try to keep it to clarifying questions for the staff. Yes.

MEMBER SCHREIBER: Can I ask a question of Sam?

CO-CHAIR HALL: Michelle.

MEMBER SCHREIBER: Thank you. If I recall, though, the do not support for rulemaking was because people thought that that was basically like a combination of the two above. If we're supposed to vote on these only as they

stand, are we supposed to look at that measure differently than what the group did?

MR. STOLPE: No, so we're just talking about Measure 57 for now.

MEMBER SCHREIBER: Okay.

MR. STOLPE: The other two measures, the workgroup feels comfortable with where they've landed on the recommendation.

MEMBER SCHREIBER: Okay. Thank you.

MR. STOLPE: It's only this first one where the conditional support, the workgroup did not feel that accurately represented the discussion and what they wanted to proffer as their recommendation, which would be support for rulemaking.

MEMBER SCHREIBER: Thank you for the clarification.

CO-CHAIR HALL: Harold.

MEMBER PINCUS: That's actually what I wanted to know, what was their intention, was to support it?

MR. STOLPE: Correct. So our review

of the transcript, our conversation with the workgroup co-chairs, put it firmly in the camp of support for rulemaking as the intended purpose of the workgroup.

MEMBER PINCUS: So not conditional support.

MR. STOLPE: Correct. Given that the conditions truly don't make sense in light of the discussion.

CO-CHAIR HALL: Any other initial queries?

MEMBER PINCUS: So we should apply our same consideration as the workgroup applied.

MR. STOLPE: I'm sorry, could you clarify what you mean by that?

MEMBER PINCUS: So in terms of not taking each one on their own standing rather than looking across all three.

CO-CHAIR HALL: We should take each on its own standing, yes.

MEMBER PINCUS: Okay.

CO-CHAIR HALL: So just technically,

do you want us to vote down the conditional support first or you don't care about that?

MR. STOLPE: So what we would like to do is proffer that as the starting point, unless there is an objection from the coordinating committee.

CO-CHAIR HALL: Conditional support or full support?

MR. STOLPE: Full support as the starting point, unless there is an objection on the part of the committee, in which case, we will begin voting on conditional support.

(Off-microphone comment.)

CO-CHAIR HALL: That's an option. That's an option for us to just start with conditional support, we've heard what we just heard, and we can start with conditional support and change course.

Misty, did you have a question or Elizabeth?

MEMBER GOODMAN: I think we have the same question, which is, that we don't -- our

plans fundamentally have a problem, we're fine with the measure, the issue is that the PQA measure and the NCQA measures don't -- that's in HEDIS, are not identical, creates an enormous burden, in terms of measurement burden, on the plans where they're subject to both HEDIS and the Stars methodology, and so we would like to see them aligned.

I'm just trying to understand, from a technical standpoint, if we're -- the conditioned support, I mean, I'm just not sure which option gets that part of the issue in the discussion.

CO-CHAIR HALL: I think, probably, it sounds like that would be something you would want to offer as a conditional consideration, so what we can do is, we can begin with what's in front of us, conditional support, we've heard from Sam, the staff, that that does not -- did not end up representing all the proper thought that was put into this, so it's on us to sort of accept or reject it.

Our staff has emphasized to us it does

not seem to represent what it was intended to represent, so it's on us now to accept or reject conditional support as offered by the workgroup. Is that okay?

DR. BAGLEY: Bruce. My hand's up.

CO-CHAIR HALL: Yes, I'm sorry. Is that Bruce or Rob? Oh, Jeff, sorry.

DR. BAGLEY: It's Bruce Bagley. Yes, I think that if you're going to debate this, you're going to debate whether we came to a conclusion of support versus that we came to a conclusion of support with the conditional support.

So I don't know how you can debate that unless you're in the meeting. So what we're saying is that we really are trying to have support for rulemaking.

CO-CHAIR KAHN: This is Chip. I would hope that we would vote this down and then get into the regular order, but I think for us, we had a long discussion earlier about, you know, following the regular order regarding what this

was, and even if there was an error here, we can correct the error, assuming that we all swim together, and just vote this down, and then move to the issue of full support, support with conditions, turn it down with mitigation, we have all those choices.

So I think we should not spend a lot of time talking about this, we should just get it off the table and move to the next step.

CO-CHAIR HALL: So let's go ahead and vote the -- I know there's a couple flags up, but I think what we're saying is, we'll have an opportunity for further discussion in just a second, most likely. Let's vote the workgroup conditional support.

We've heard that the -- comments about it.

MS. BUCHANAN: Great. So we are opening voting for MUC2019-57 of the workgroup recommendation, conditional support for rulemaking. And going to give it just another couple seconds to get a couple more votes in.

Okay. We are going to close the vote. We received 0 votes yes, 18 votes no to move forward with the workgroup recommendation.

CO-CHAIR HALL: Okay. So thank you, all. That's off the table and now we will start back on a full support, but first, we'll invite conversation. Harold.

MEMBER PINCUS: So I think I have, sort of, three issues. One is, it's not clear what the issue is, you know, about these. Is it that we're considering only one of them or considering each of them independently, I think that's clear that we're supposed to be considering each one independently.

Number two is, what was brought up by my colleagues from the health plans is that, there seems to be some differences between different ways in which these are operationalized, and I actually didn't see that in the discussion here, and I don't know how that gets brought into the discussion, but I think that needs to be in the discussion in some way.

And I don't know the way to bring it in in terms of just a support, not support kind of thing. Number three is, I do think, and this is for, like, a separate topic, is, I think we need to change the process a bit, because this sort of going through everything in a stepwise fashion rather than dealing with the issues for the measure, you know, across the board, is probably -- would be a lot more efficient in some ways and less confusing.

But anyways, so it's clear that we should deal with each of these separately. Where do we deal with the issue about the differential operationalization of the measure?

CO-CHAIR HALL: And the burden that that creates.

MEMBER PINCUS: Yes.

CO-CHAIR HALL: So the developer would like to make a comment. Mary, I'll invite you to put your comments on the table first and then we'll allow the developer to respond.

MEMBER BARTON: Great. So the --

CO-CHAIR HALL: Mic, please.

MEMBER BARTON: Thank you. So I was not recusing myself, since this is a PQA version of the measure, but the difference between the NCQA measure that's used in health plan reporting for reporting to NQA and the PQA measure, which is used in Part D plans and then is now proposed for the Part C and D Stars, is that the PQA measure requires the patient, for the high-dose measure, the patient has to be at that high dose for 90 or more days, whereas, the NCQA measure looks for people who have been at a high dose for 15 or more days.

So it's a very different bar, and then for the multiple providers measure, which NCQA also has an analog, they look within a six-month period for four or more providers to write prescriptions, or four or more pharmacies to fill prescriptions, and we look over a year for four different entities to either write or fill prescriptions.

So again, it's a more stringent

approach, and I say that without value.

CO-CHAIR HALL: Great. Thank you, Mary. We'll invite the developer. There's a measure developer right there next to Harold.

MEMBER HINES: Thank you. I'm Lisa Hines with the Pharmacy Quality Alliance. PQA's high-dose measure, I'm going to talk about these two together because they are analogous measures by NCQA, where PQA endorsed in 2015, and NQF endorsed in 2017, and have been reported in Medicare Part D patient safety reports at that time.

And are currently display measures in Part D. The high-dose measure is in the Medicaid adult core set. NCQA adapted PQA's measures and as the first measure on the market, the NQF-endorsed measure, we do believe that our measures align most closely with the evidence and have had a great deal of vetting.

We do welcome harmonization and alignment with our colleagues at NCQA, to the extent that they are willing to harmonize with

the PQA measures.

CO-CHAIR HALL: What are we, if this is already as widely established, as noted, and already approved, what specific questions are in front of us? You said it's already on display for Stars.

MEMBER HINES: Yes, sir.

CO-CHAIR HALL: So what's the question in front of us?

MR. STOLPE: So the question is, the display ratings are, of course, quite a bit different than the Star ratings in terms of their application and accountability implications.

So these measures are being considered for migration from the display into the Star ratings directly. So we're to consider each one of these measures, one by one, for their suitability to do so.

So the question in front of you is, essentially, is MUC19-57, use of opioids at high dosage, suitable for movement from the display into the Star ratings.

CO-CHAIR HALL: Thank you for that clarity. I'll go over to David first.

MEMBER GIFFORD: I got a question for, I guess, Michelle, is the creation of the Star rating done through regulation?

MEMBER SCHREIBER: This is the MA's Star rating or no?

CO-CHAIR HALL: Microphone, please.

MEMBER GIFFORD: So do it through the MA Star rating, is an item moved into the scoring through regulation?

MEMBER SCHREIBER: Yes, so do we have Medicare on the phone? Can you answer that? I believe the answer is yes, but I want Medicare to answer it because it's their statutes.

(Telephonic interference)

MEMBER GIFFORD: The answer's yes?

PARTICIPANT: Yes. It would have to be through regulation and on display for at least two years prior to moving to Stars.

MEMBER GIFFORD: And just a separate broad policy question of CMS, and we may want to

think about it, you don't use rulemaking for a lot of the other Star ratings, and compare, is that the only rulemaking.

MEMBER SCHREIBER: But we're starting to change. Remember, hospital Stars ratings go into the rulemaking this year too, so all of these programs will be --

MEMBER GIFFORD: So are you switching all the settings in the rulemaking?

MEMBER SCHREIBER: Yes.

MEMBER GIFFORD: Okay. But I think we may want to think about, though, because adding measures and how they score on the Star rating is a very different methodology, the payment, and the assigning this rule for rulemaking, I mean, as we decide what's for rulemaking, we need to understand how that is because just saying, yes, it's a measure to add on to public reporting is very different, so I would think that that's something we need to tackle and understand.

I've done a lot with CMS and a lot with public reporting and the Star ratings, and

it's not nearly as simple as just saying, yes, rulemaking, so I think we should be educated as a committee to think about that process.

That doesn't affect, I think, our vote today, but I was just curious as to why we were voting on the rulemaking because I'm familiar with provider Star ratings, not the MA plan as well, a little bit, I didn't realize it was in the rule.

MEMBER SCHREIBER: But that's why I had to ask, because it's outside of, actually, our department. This belongs to the Center for Medicare, so that's why the clarification.

CO-CHAIR HALL: Nancy?

MEMBER FOSTER: So I just wanted to ask for clarification on another issue that was raised in the comments, which is that there are patients who do not have cancer, but who have other chronic diseases that require pain management, who have begun to emerge as groups, complaining that they are having challenges getting the pain management that they need in

order to lead their best lives.

And yet, I don't see that incorporated in here, I'm worried about the unintended consequences of this, several of the commenters said as much, several of the commenters with a lot more clinical expertise than I have, which is zero, have said -- commented on that, so aggressively moving forward with this, but put it in Star ratings, without addressing those concerns, seems a challenge to me, and I wonder about the perspective.

CO-CHAIR HALL: Misty?

MEMBER ROBERTS: Thanks. I have a comment and a few questions, so bear with me. First, I think David made a really good point that it doesn't seem like, maybe, everybody in the group understands the implications of some of these programs.

We're voting on measures, but it's not just the measures, there are also implications to these measures being included in certain programs, so I think it's very important that the

group understands that, so if there hasn't been that baseline knowledge, I suggest that, somehow, that gets incorporated into the process.

The other thing is, a couple questions, just to clarify, Lisa, I think you mentioned that the measures are endorsed, all three measures are endorsed, and then, what about the NCQA measures, are they endorsed, Mary? No? Okay.

And then, Lisa, your point I think you made was that they are -- you feel that yours are most closely aligned with the evidence, can you provide any clarification on why you think that's true?

MEMBER HINES: So the average of 90 days is to represent long-term opioid use, so to more reflect chronic opioid therapy, what we call chronic opioid therapy, or long-term therapy for patients with non-cancer common pain, so that's the 90-day duration. So I'm highlighting the differences.

The measure aligns with the CDC

guidelines and the underlying primary evidence, the high-dose measure. The multiple provider measure aligns with evidence indicating an increased risk of overdose.

The six-month time period is reflective of the underlying studies that evaluated multiple prescribers, and the threshold reflects, and of that doctor and pharmacy shopping behavior that most closely correlated with increased risk of drug overdose.

So it's based in the evidence and subject matter expert input.

CO-CHAIR HALL: Lisa, thank you. Were there any other comments that you wanted to give a brief response to that you heard in the last couple minutes?

MEMBER HINES: Just acknowledge the importance of the implications of the program and the Star ratings, and PQA acknowledges that that is a true concern, and it is also a concern of ours, and anything that we can do to ensure that our measures are not misapplied and, you know, we

are open to.

CO-CHAIR HALL: Thank you. Elizabeth?

MEMBER GOODMAN: I just wanted to clarify, Liz, if she's still on the phone, that should this measure be -- come off of the display page and go into the Stars methodology, the HEDIS measure will come off, right?

Because if that's not the case, then we are -- we have two completely different measures in the same measure set.

CO-CHAIR HALL: Do we know that?

MR. STOLPE: That's not the case. So just a quick correction on that. So the HEDIS measure is not currently in the Star ratings. It's just in the HEDIS measure set, to which many health plans are held accountable, both to HEDIS and the Stars.

MEMBER GOODMAN: All right. I misunderstood what you said before. Thank you.

CO-CHAIR HALL: David?

MEMBER BAKER: So I just wanted to comment on the issue that Nancy Foster raised.

So I have voted down measures in the past because of concerns of adverse consequences, and I thought about that a fair amount for this, and I'm less concerned about this, because the way the measure is designed.

90 MMEs is a really high dose. And if somebody is above that, the chance that they would just be kicked off, which is a concern for individual physicians, right, I think that's very unlikely. Most people, they try to taper them down, and so if somebody's at 120, they just have to get down to 85.

So that concern that we're seeing nationally of people just being cutoff, I'm less worried about for this measure. Also, the fact that it's applied at the group level, these large groups will be able to set up taper clinics with people who actually have the expertise to do this safely, so I agree this is a concern, but I'm less concerned about it for this group.

CO-CHAIR HALL: On the phone we have Libby.

MEMBER HOY: Hi. I really do think that the last comment didn't -- definitely hearing from our patients and we believe that they're being set up, they're being discharged from provider groups, and so that is definitely happening.

And I think your comment is, you're saying, that the upper limit is high enough that -- and I think I understand it up there, it's a tapering piece to this measure?

CO-CHAIR HALL: Lisa, why -- I'll have Lisa Hines address that.

MEMBER HINES: Hi. Thank you for your question. There's not a tapering component to this measure. That is a measurement gap. And do want to, again, point out that this is a retrospective, claims-based, population-level measure and wouldn't necessarily be appropriate at a provider level.

CO-CHAIR HALL: Rebecca?

MEMBER HOY: Thank you.

MEMBER KIRCH: Thank you. Rebecca

Kirch, National Patient Advocate Foundation, and I, like Nancy, am actually -- I'm still stuck. I'm not allayed, because I know that patients who need higher dose opioids, even if they don't have cancer, are being cut off, not tapered off.

And so the implications, as Misty mentions here, could be quite significant. So I'm not sure that I'm enough reassured that a Star rating support, that's just kind of bulldozing, especially when we know CDC is re-looking at the guidelines because they've been misapplied, and there isn't sufficient evidence behind it.

CO-CHAIR HALL: Great. We've heard a lot of very deep concerns, a lot of very rational enthusiasm to move forward, so any other -- yes.

MEMBER QASEEM: This is Amir. Can I chime in?

CO-CHAIR HALL: Yes, Amir.

MEMBER QASEEM: Yes, I think I will say this discussion has been a good discussion. My thing is like, there is a lot already that's

happening at the state level anyways to get some of this -- to address the whole epidemic. That's really where the target has gone.

And I'm wondering, do we need to move in the direction of mitigating the damage that's already occurred in the opioid prescribing route and addressing what we're talking about.

And I heard what David is saying, David Baker, I hear the 90 MME is pretty high, but then when I'm looking at the list of the opioid medication, there's some medications that are listed in there that are being used to treat addiction to narcotic pain relievers, David, and I'm a little worried about that that will lead to -- there's some proven intervention, which physicians have stopped using, which will lead to some other problems, right?

Because we already know that some of these medications are not getting prescribed, people are then heading towards getting even stronger narcotics, like heroin and other illicitly obtained opioids. That's an issue.

So I'm struggling still. I mean, I hear some of the discussions. Again, the need for this measure. But then there's some harm that I'm still a little bit worried about.

CO-CHAIR HALL: Amir, thank you. I'm going to have Lisa Hines clarify an issue for you.

MEMBER HINES: So this measure, both of these measures, exclude products that are indicated for medication-assisted treatment, and in fact, all buprenorphine products are excluded from these measures.

MEMBER QASEEM: Oh, because I saw them listed in the list of opioid medications, so maybe I missed that.

CO-CHAIR HALL: Okay. Well, we have the word of the developer, that that's the case. Rebecca, are you okay? Yes. Okay. All right. Amir, did you have any other follow-up question or are you okay?

MEMBER QASEEM: No, and again, you guys know this topic a little bit better, if

someone can tell me, how is this measure going to help above and beyond what the state-run prescription drug monitoring programs are already doing and what are we adding here that's of value?

MEMBER BAKER: So I'll comment on that, Amir.

CO-CHAIR HALL: David.

MEMBER BAKER: I mean, when you get up to these very high doses, there are substantial risks to patients, particularly somebody who's obese, may have sleep apnea, patients with sleep apnea, patients with chronic obstructive pulmonary disease, so it's not like there's no risk if somebody's on 120 MMEs.

If you think about what's happening with the prescription drug monitoring programs in the state, those are really valuable, but there's no sharp edge to those, right?

So this is something that allows -- this allows groups to be able to look at their performance on this measure, and hopefully they

would respond and set up some of these programs.

I think the biggest risk and the biggest danger is for individual physicians to be handling these patients who are seeing multiple providers, or on these very high doses. A lot of these patients have opioid use disorder, they need to be tapered, and they need to be treated for their chronic pain, and they need to deal with their opioid addiction.

So, you know, that just is not really addressed by the state programs of these policies, so it's a very tricky issue. And again, if this was for individual clinician measures, I would vote against it, because they will do the easy thing and they will just say that they won't see the patient anymore. That's what we're seeing nationally.

CO-CHAIR HALL: Thank you, everyone. Great comments all around. We will, just in a second, move to vote for full support. Any other concerns that people haven't had a chance to get out? Not seeing any, we'll go to vote for full

support.

MS. BUCHANAN: Thank you very much. Voting for MUC2019-57, vote for full support is now open. And we are still waiting for some votes. We need a couple more. Okay. We are at 17 votes, so we will close the voting. We received -- oh, we'll close it now, we received 13 yes, 5 no. MUC2019-57 moves forward with support.

CO-CHAIR HALL: Thank you. Thank you, everybody. Good discussion. We'll move to -60.

MR. STOLPE: Excellent. Okay. So MUC19-60, use of opioids from multiple providers in persons without cancer, again, same measure developer. This was very well supported by the workgroup overall and seemed to be that if they were put into the position for which one to move forward, they tend to lean towards this one, because of the unintended consequences that were discussed, associated with the first measure.

But again, largely supportive. Public comments seemed to be largely supportive as well.

I'll pivot to our co-chairs for any other comments related to the workgroup discussion.

DR. BAGLEY: No additional comment.

CO-CHAIR HALL: Great. Thank you very much. Does anyone in the room have -- or online, have any clarifications to request before our first vote? Not seeing any, our first vote will be to accept the recommendation of full support.

MS. BUCHANAN: Voting is now open for 2019-60, moving forward with the workgroup recommendation of support for rulemaking. Okay. We are closing voting. We received 17 votes yes, 2 votes no, MUC2019-60 will move forward with the workgroup recommendation of support for rulemaking.

CO-CHAIR HALL: Thanks, Kate. Thanks, everyone. -61, Sam.

MR. STOLPE: All right. Very good. Thank you. This last measure, when it came under consideration by the workgroup, they followed along comparable lines to what they did when they considered these three measures for inclusion in

SSP last year.

The workgroup saw this particular measure to be largely duplicative of the other two, with not added benefit associated with having both things captured.

Now, each of the preceding two measures is, essentially, captures the entire population because persons to be captured in the numerator of this measure -- excuse me, in the denominator of this measure, need to have both multiple providers and high dosage.

So either of the two measures will capture the full patient population represented by this measure, so the workgroup saw this as essentially duplicative.

Public comments were reflected in the same, but we did receive some supportive comments. Any supplementary information that our two workgroup co-chairs would like to add?

DR. BAGLEY: No additional comment.

CO-CHAIR HALL: Thank you. So it's a little bit of a grey zone to say we're

considering this by itself, and yet, we're calling it duplicative with two others. Does anyone have any clarifying questions or issues they'd like to raise? Yes, Mary?

MEMBER BARTON: It just becomes a very small number, because you have to have both high dose and the multiple providers, and it's just -- it's not always a very clear quality signal to use something that is such a low number.

CO-CHAIR HALL: And so that's a concern that's different than saying it's duplicative. That's a concern around the sample size. Yes. Nancy?

MEMBER FOSTER: Well, I'm a bit confused about how to express this, but I would be remiss to not say at some point, I don't think all three of these should be adopted in the Star program and I -- so if we were to vote each of these independently, then we're going to end up suggesting all three move forward, unless we explicitly say, no, and I don't know how to do that in the context of what we're discussing now.

CO-CHAIR HALL: Yes, the issue might be that we find objections to this that are not related to the other two, so for instance, an objection around sample size, if that's true, would be unrelated to the other two. That's one possible thought, but I'll let, Harold, you put your thought on the table, and then I'll, again, have Lisa respond.

Please use your microphone, Harold. Thank you.

MEMBER PINCUS: How come nobody ever suggested that it be an or rather than an and?

CO-CHAIR HALL: Dave, would you like to throw a thought out first or after Lisa? Okay. Didn't know if you had something maybe Lisa could respond to. Lisa, do you want to respond?

MEMBER HINES: Perhaps hindsight is 20/20, but when these were developed, this was thought to be the most, kind of, egregious, or, you know, highest risk population. As time has gone on, the measure rates are very low, and

we're becoming concerned about the measure reliability.

And in fact, each of these, kind of, numerator areas of focus are separate risk factors for opioid overdose, and so merit measurement in and of themselves, or, you know, multiple rate measure might make sense in the future.

CO-CHAIR HALL: David?

MEMBER GIFFORD: I go back to my original point, I don't know how to vote for this on rulemaking because I don't know how CMS is going to use it in the Star rating. There's Star ratings where they have multiple domains, they have multiple measures, they're weighted differently, if you add this into one of those with multiple measures with low ratings, it really doesn't matter.

If you make this a single measure in a single domain, with lots of weighting, that drives a Star rating, I'm going to pay a lot more attention and worry about what the potential

impact will be on it.

And so understanding that, really is important to the rulemaking decision that we have, otherwise we're just voting -- me, I'm just voting on whether it's a reliable measure or not, and there's a ton of reliable valid measures that CMS, TEPs, and everyone has written, should not be used in Star ratings.

CO-CHAIR HALL: Well, as you know, and as many of us in the room know, who have worked in conjunction with the NQF for years, we've always traditionally been asked to think about measures without worrying about their implementation, and that feels particularly challenging for the role of this committee, as you point out.

MEMBER GIFFORD: But that's not the role of this committee.

CO-CHAIR HALL: Yes, exactly.

MEMBER GIFFORD: I think that's what we struggle with historically is, we try to adopt that philosophy, and that's why we re-litigated

the endorsement process so often over the years in this group, and I think if you look at our statutory authority and what we're doing, it is not to re-litigate that.

And it's why, I think, we moved to the condition where we've just sort of taken it off the table that it has to get endorsed.

CO-CHAIR HALL: And yet, it doesn't seem, and I'll invite Michelle to comment in a minute, but it doesn't seem like we are also in a position of judging a proposed implementation, right? That also feels like it might out of our scope. Just a thought.

Elizabeth, I'll invite your comment and then I'll ask Michelle if she has any comments.

MEMBER GOODMAN: Thank you. I support wholeheartedly what David just said. I think the -- I would offer for consideration, that we think about offering conditions on these measures, that they explicitly not -- that the area of measurement not be duplicative for the purposes

of payment.

I think that it's really -- these are very burdensome for our plans, they're hard to do, we absolutely understand the intent and the goal here, and we absolutely support it, but, you know, adding three separate measurements of opioid addiction to the Stars methodology is really a very high burden.

CO-CHAIR HALL: Thank you. Michelle, are there any parts you would like to comment on?

MEMBER SCHREIBER: Yes, actually, perspective, because I've been thinking about your question, and it's a really very good question, only I don't think I will ever be able to answer it, sadly, because you're absolutely right, your point is absolutely correct, there is a big difference if you're going to put this in, and use hospital Star for using -- a hospital Stars program, and you're going to give it this tremendous weight and it's going to have its own category, because that's going to, really, weight what your Stars distribution is and what

hospitals do well and what don't.

And yet, at the same time, we're kind of in this quandary, because number one, because of law, actual law, around rule writing. We couldn't tell that to you even if we knew it, because that places you at a special advantage that, obviously, we can't do, and that is against the law when it comes to rule writing.

And the second is, okay, we don't always know when these are -- you know, this is something that gets discussed in the program, and we actually don't even know to bring that to you here.

So I'm struggling a bit because I understand, frankly, we'd like to be transparent as much as we can, but I don't know that we'll ever solve that problem, unfortunately, which leaves us, then, with kind of the question of, what's the merit of using this in a payment program?

CO-CHAIR HALL: Great. Thank you. That's very helpful. David, comments?

MEMBER GIFFORD: No, I really appreciate that quandary, but I do think it probably behooves us to be educated and just about how the different Star ratings are done, because they're so different, because then we have some sense about what it is.

And I think most of us have some familiarity with the payment issues, because we're all providers in some way, and we understand the payment issues, most people, I've found, don't understand the Star ratings at all, unless you really delve into it.

So I think if you're moving to rulemaking, I don't think that's a good policy move, but if you guys are moving --

MEMBER SCHREIBER: We don't have any choice. Quite honestly. We don't love it either.

CO-CHAIR HALL: All right. Thank you.

MEMBER GIFFORD: But I think we need to do a little bit more on that, because it's not an all or nothing denominator. I think that goes

exactly within the way that we're going to do it. So with that, realize where it's going to be.

CO-CHAIR HALL: But that's more of a comment that, maybe, this group could be educated next year in preparation for other deliberations.

MEMBER SCHREIBER: So, Bruce, that's what I was thinking, maybe sort of an orientation, even a WebEx, prior to these meetings, we could take on education about the Stars ratings.

MEMBER GIFFORD: And I think we need the MAP workgroups too, because if we're going to -- I completely agree with Leah, we should be giving deference to them, but if they're just reviewing -- and I think we need to give them an instruction, they're just reviewing them to re-litigate the risk adjustment and social determinants of health, then the issue about whether NQF endorsed or not, then we're not -- then I don't believe we should defer to them.

I think that's our responsibility to make sure they've done that due diligence.

CO-CHAIR HALL: Yes, great points. Okay. What's in front of us is the recommendation of do not support. Does anyone else want further discussion before we vote on that first recommendation?

Not seeing any request for other conversation, so we will vote on do not support.

MS. BUCHANAN: Voting for MUC2019-61, the workgroup recommendation of do not support for rulemaking, is now open. We'll give it just a couple more seconds. Okay. We are closing the voting now. We received 19 votes yes, 0 votes no, MUC2019-61 will move forward with the workgroup recommendation, do not support for rulemaking.

CO-CHAIR HALL: Thanks, everyone. I'm going to turn the mic over to Chip.

CO-CHAIR KAHN: Okay. And I'm really going to be strict about this. We take a five-minute break, but we really need to get back, because we're behind, and we need to finish in a timely way. Nancy, do you need speak before the

break?

MEMBER FOSTER: It's a very quick comment relative to this discussion.

CO-CHAIR KAHN: Yes.

MEMBER FOSTER: I know NQF staff tried to collect all the comments, that was a very rich discussion with a lot of concerns, and I think that needs to be reflected, including our concerns about overemphasis of this, depending on how CMS incorporates it into rulemaking, that we would encourage them not to over-emphasize it, as I think what I was hearing.

CO-CHAIR HALL: Thank you, Nancy.

CO-CHAIR KAHN: Okay.

CO-CHAIR HALL: We will reflect that, correct?

MEMBER FOSTER: Thank you.

CO-CHAIR KAHN: Okay. Thank you, Nancy. It's 3:35, so we will -- 3:40, we're going to start, because we know people have schedules and have to leave, and we want to keep our quorum, so please be back at 3:40.

(Whereupon, the foregoing matter went off the record at 3:35 p.m. and went back on the record at 3:40 p.m.)

CO-CHAIR KAHN: And make any comments on MUCs or opportunities to improve the current PAC LTC measure set at this time, if you have suggestions to make, and I think the microphone is over here.

So at least in terms of the microphone, we'll get -- I guess people could send comments to the chat box, but first opportunity is up here on the microphone. Do we have anybody who is not a member of the coordinating committee, or otherwise in the room, who wants to make public comment on long-term care, post acute care?

Okay. I'm not seeing a crowd rushing to the microphone, I'm not seeing anyone rushing to the microphone, so we'll move on and I'll look at Kate and ask, is there anybody in the chat box?

MS. BUCHANAN: No one in the chat box.

CO-CHAIR KAHN: Okay. So we're going to proceed to the measures that we have for consideration and I believe we have --

CO-CHAIR HALL: Amy Moyer is the staffer.

CO-CHAIR KAHN: Oh, where's Amy?

CO-CHAIR HALL: She is telephonic.

CO-CHAIR KAHN: Oh, okay. Amy, can you hear?

MS. MOYER: Hi, this is Amy. Yes, I'm in Wisconsin, but I'm here by phone.

CO-CHAIR KAHN: Okay. Great. So could you -- I'm going to turn it over to you to introduce the chairs of the workgroup and the recommendations.

MS. MOYER: Hello, everyone. I'm Amy Moyer. I'm a director here at NQF. This is my first time doing the MAP process, so hopefully this will go smoothly.

My co-chairs, I believe, are on the line. I know Gerri Lamb was able to join us. I'm not sure if Kurt Merkelz is on the line as

well, but we had some really robust discussion as part of the MAP PAC/LTC workgroup that's here.

We had two measures under consideration, one in the home health quality reporting program, and one in the hospice quality reporting program.

We also filled the rest of the day with some terrific strategic discussions that get into the overarching theme of the meeting.

So we were supportive of CMS' inclusion of patient-reported outcomes in its Meaningful Measures update. Patient-reported outcomes has long been an area identified by PAC/LTC as being an important priority for measurement.

There's a lot of care that takes place in this setting that is important to be aligned with the patient's goals and preferences, and we would solicit that through the voice of the patient.

The discussion we had around measure gaps this year was cross-program and some was

program and setting agnostic, looking at the patient population as a whole, we discussed what were the areas that would be most meaningful and have the highest impact for measurement.

In that area, we identified care coordination as the highest priority measure gap for the program. Patients who received care from post-acute care and long-term care providers have frequently transitioned from multiple sites of care.

And that's really important that we have measures of how well those transitions are coordinated and that the information moves with the patients as well.

In addition, we emphasized the need for alignment of measurement across the full continuum of care, and developed an overarching look at concepts and priorities for performance measurement.

So moving to the first measure under consideration, this is for the -- I think we have these locked. Nope, sorry. So the home health

quality reporting program, we looked at a measure of home health towards end stay, potentially for medical hospitalization measure.

This measure is a measure of any hospital admission occurring across the whole of the home health encounter, which takes a holistic view of the patient's home health stay.

It is only looking at hospital admissions that were considered to be preventable. There was an expert panel that went through a process of looking at admission reasons and refining that.

Public comments were generally supportive of the measure and the workgroup conditionally supported the measure for rulemaking. They would like to see the measure obtain NQF endorsement and in addition, CMS indicated there are two existing program measures that they would be retiring upon an implementation of this measure.

So I'm going to pause there and see if Gerri and Kurt have anything they'd like to add.

DR. LAMB: Good afternoon. This is Gerri Lamb. I'm glad to be with you. I think Amy summarized things well. It was an excellent meeting. Lots of rich discussion with CMS and the two reasons that Amy identified for conditional were the ones that the committee felt needed to be there.

CO-CHAIR KAHN: Good. So any other comments or -- Amy?

MS. MOYER: Nothing more from me.

CO-CHAIR KAHN: Okay. Well, I'll go to the committee now. Do we need a discussion leading into the vote, initial vote, on the MUC19-34, the coordinating committee on the home health quality reporting program measure? Misty.

MEMBER ROBERTS: Yes, quick question. How is preventable defined?

CO-CHAIR KAHN: Amy?

MS. MOYER: Sure. There was a fairly robust presentation around this that CMS provided. I think throughout the workgroup, we were extremely impressed with the level of data

analysis that had gone into the development of these measures.

I know that they had a technical expert panel that looked at it and I can't remember if they had any specific data around what was considered preventable or not, but it was a broad technical expert panel that looked specifically at meaning and this measure.

DR. LAMB: Amy, I believe -- this is Gerri, I'm hearing echoing, by the way, I hope you all aren't.

CO-CHAIR KAHN: We hear you fine.

DR. LAMB: I believe that what they had put forward was preventable by diagnostic category based on many years of research on what are the subsets of diagnoses that are high likelihood preventable.

I don't have the list in front of me, but CMS went through a lengthy discussion of how they selected those conditions.

PARTICIPANT: Yeah, this is Alan Lerner (phonetic) from CMS. I'm not sure if you

can hear me.

CO-CHAIR KAHN: Yes, we can hear you.

PARTICIPANT: But they were based initially on the ARHQ conditions that were setup, but eventually it was a mix of inadequate management of chronic conditions, inadequate management of infections, inadequate management of other unplanned events, and also, inadequate injury prevention.

And so it was the diagnostic categories within all those four major domains.

MEMBER ROBERTS: So just to clarify, essentially, a modified version of the ARHQ PQI avoidable hospitalizations measure?

PARTICIPANT: Right. Based on that, but then expanded out --

MEMBER ROBERTS: Okay.

PARTICIPANT: -- to include other conditions that were more appropriate for post-acute care patients.

MEMBER ROBERTS: Thanks.

CO-CHAIR KAHN: Okay. Other

questions? Okay. Hearing none, none of the phone, then I think we can go to a vote on MUC19-34, and on that one, it was a conditional support for rulemaking.

MS. BUCHANAN: And voting for MUC2019-34 is now open. And give it just one more second. Okay.

CO-CHAIR KAHN: Great. It looks like --

MS. BUCHANAN: Yes, so we received 19 yeses, 0 nos, so MUC2019-34 was following the workgroup recommendation of conditional support.

CO-CHAIR KAHN: Very good. And I think this is the last one. So we're on the last metric at this point. This is a -- this is the hospice MUC19-33, hospice visits in the last days of life, and, Amy, would you take it away to explain?

MS. MOYER: Absolutely. So this is -- there were a couple versions of this measure that CMS did some really impressive data analysis on to determine which sort of hospice visits

correlated with a positive experience for patients, and particular, the caregivers in this case.

Hospice kind of represents the best in class of the measure, and would be replacing two existing measures in the program. The measure would add hospital visits in the final three days of a patient's life, at least two good ways, it is, they are looking for visits from a registered nurse or a medical social worker, and those are in-person visits, not telephone.

The committee also expressed support for this measure and with conditional support, pending NQF review and endorsement, and removal of the existing hospice visit measures from the program.

We did receive several public comments on this. Some of the public comments were questions about this measure versus the existing measures in the program, and some had questions on the, sort of, data that were then answered by CMS for the in-person meeting.

I will, with that, turn it over to Gerri for any additional comments.

DR. LAMB: Sure. I would just like to call this measure out. It was one of the most robust discussions that I recall us having. This was an important measure in a variety of ways, in that, there were public comments and lots of discussion about teamwork, who contributes to patient outcomes, whether it's appropriate to call out specific team members in a interprofessional team.

This is a case of the data that was done being just so comprehensive and so convincing, as well as having a committee that really looked at the implications of this measure for quality in hospice and also using teams effectively.

It was just a great discussion and I think the, as Amy said, vote could have gone either way and I do believe it was the discussion and the data report from CMS that really was tremendously convincing, that this is an

important measure and one that we should move forward.

CO-CHAIR KAHN: Great. So let's bring it here as a discussion. I see Harold.

MEMBER PINCUS: So I had a couple of questions that I have some concerns about. I have a couple questions and concerns about this measure. When you said that the measure could have gone either way, could you say a little bit more about what was the -- what were the two ways and the arguments calling out both ways?

DR. LAMB: I think the critical question that came from both the public comments and the discussion is, how do you identify the last 30 days of live as well as how do you make decisions about which team members are deemed essential in that time period.

We talked about those issues, we talked about the public comments. The data that were presented showed a correlation between symptoms and last days of life that gave credence to the ability to identify that as well as data

that supports which team members are highly correlated to patient satisfaction.

I'll let Alan jump in on that if he's available, but those were really critical pieces of information in supporting this measure.

PARTICIPANT: And this is Alan. First of all, thank you for an excellent summary of the measure, and certainly, I'm here to answer any other questions, but again, as Gerri said, I think the questions that came up primarily were ability to identify patients in that last window, and why we are proceeding from going from the measures that are already adopted in the program, which are based on the assessment, to going to a claims-based, no-burden version of this measure that actually includes the services that tested most importantly for being needed in the last couple days of life.

And the discussion -- and the emphasis from our standpoint was really, we weren't discounting the need for the entire hospice team during the entire hospice stay, but that during

this critical, what I'd almost call the hospice ICU, the last few days of life, that we wanted to ensure that the right services were being provided, and those services are from an RN, primarily, and then also from a social worker.

And our reasons for choosing them were based on the compelling correlations that we found before -- between those hospices that provided those types of services and the family recommendation satisfaction that we're seeing in the CAP survey.

MEMBER PINCUS: So I just had three concerns, one is, if you're looking at this -- looking at, sort of, you know, a patient or family-reported outcome measures in relation to this, when you're already collecting the outcome measure, what's the marginal benefit of adding this process measure over and above, you know, the data you're already collecting in the satisfaction?

PARTICIPANT: Right. And again, we are using the satisfaction measure almost as a

way to validate the importance of this measure.

MEMBER PINCUS: But I guess the question is, why do need it if you already have the data about satisfaction?

PARTICIPANT: Well, again, it's a matter of having a more robust set that just because the outcome is improved satisfaction, how do hospices get there to improve satisfaction? And so it's through different sorts of processes or what they should be providing during that stay.

MEMBER PINCUS: But having had some personal experience recently with hospice, you know, there were -- I've observed that there was a number of visits that were, really, purely perfunctory, in a number of ways, and it seems to me that that wouldn't necessarily be what you want to encourage, is having just visits, it's really the quality of the visits.

Number two is, you know, that whether you're adding some degree of unreliability, because of the difficulty in making predictions

about when the last 30 days of life are, so you have a -- you know, it seems to be a fairly low bar of just saying there has to be a visit.

And also adding some degree of unreliability. And, you know, I'm not sure why you wouldn't go with and strengthen, in some ways, the, you know, family reported outcomes component of this.

PARTICIPANT: We're not discounting the family reported outcomes of it. We are just attempting to make sure that the right services are coming to patients in those last few days of life.

I wouldn't consider those last few days of life if it's as perfunctory. I would consider them important.

MEMBER PINCUS: Well, I can tell you that the ones that we experienced were perfunctory.

DR. LAMB: Yes, I appreciate your personal experience and it's interesting that many of the people on the committee also had

experiences, and we had quite a discussion of the -- I think what you're raising is the quality versus quantity of visits, and why we thought this measure was particularly important is, number one, that what contributes to the patient and family experience is multi-component, and there were compelling data to support these particular providers being significantly related to that satisfaction.

Are there many others? Probably so, but we have data to support that these particular providers, the nurses and the social workers, do make a difference to families.

CO-CHAIR KAHN: Well, why don't I -- Harold, anything else?

MEMBER PINCUS: No, that was it.

CO-CHAIR KAHN: Okay.

MEMBER PINCUS: And I still have a question about the marginal value in this over and above the catch itself.

CO-CHAIR KAHN: Do we have any other comments? Nancy, I'm sorry.

MEMBER FOSTER: I just want to clarify, and I think I understood your point, Harold, the, really, that last sentence you made, you said, if we already know what the value is of the patient's reported experience, or the family's report of the patient's experience, and we have other mechanisms for telling people how they can score better on that, what's the value of having this, a measure, when what you really care about, what you want to report to the public is, how is this hospice versus that hospice doing, and really delivering care that satisfies the needs of the patient.

CO-CHAIR KAHN: Chairs, do we have any other comments from -- I think we've heard about the discussion at the group. I guess if there's no other discussion, do we want to at least call the question on the recommendation and I'm sorry, the recommendation of the conditional support was because of the endorsement, is that correct?

MEMBER QASEEM: So can I just ask, like, a question over here? I'm just curious

about when April discusses the group, what was the final vote? Was it 60/40 or was it 90/10? I mean, it does have an impact on, at least, my judgement to that. Is it something possible? Do we have that information?

CO-CHAIR KAHN: Amy, do you know that or does any of the staff here know that? The staff is going to pull the numbers.

MEMBER QASEEM: Thanks so much.

CO-CHAIR KAHN: While they're doing that, Rebecca, do you have a comment?

MEMBER KIRCH: I can't decide, because I'm supposed to be a discussant, and I was waiting to follow the process.

CO-CHAIR KAHN: Well, while we're waiting, why don't you --

MEMBER KIRCH: I can stretch it out a little longer. I'm torn, like Harold has described, because there are some patients and families who find it intrusive and they don't need that support, and I would have rather seen the patient caregiver reported outcomes measures

move us towards the quality of those visits.

If it's a nurse showing up to pickup the leftover opioids, which we've seen reported, that's not a quality visit, but that would check this box. And so I have some deep-seated concerns, both professionally and personally, having experienced good hospice, bad hospice, and no hospice with different loved ones, as well as what I know just from the patient population we serve.

So this feels a little too easy as it's written to capture what we really want, and I feel like it's moving away from quality instead of quantity, and I feel like it's moving away from patient and caregiver reported outcomes in a way that just gives me some pause.

CO-CHAIR KAHN: While we're looking for the --

PARTICIPANT: This is Alan again, can I just mention again that there is the hospice visits measure that is already adopted in the hospice quality reporting program, that's already

being publicly reported, or on hospice care, one of the pair of these -- of that measure, and this would be a replacement for that measure that's already being reported.

And it would be a claims-based version that would be a overt burden version, and would be, the existing measure that's being reported is being reported on professional visits, which essentially are RN and physician visits that are being done also in the last three days of life, and that this would be replacing with RN and social work visits.

So that would be which, again, tests better.

CO-CHAIR KAHN: Michelle, does CMS have a comment?

MEMBER SCHREIBER: We do. The vote, since Amir asked, was close, it was 9 in favor, 6 opposed.

CO-CHAIR KAHN: Okay. Why don't we, I guess --

MEMBER MORALES: Having that kind of

context is really important and there's a couple of times that this has come up today, so if there's a rule, or there's a MUC that we're talking about that's replacing other ones, that should be at the beginning of the discussion, so we know that there was, maybe, a worse measure before, and now this is a better one, so that we know what the context is.

Because this is now the second or third time today that this has come up and I'm sorry, I thought I read through everything, and I didn't know any of that, so that's just a recommendation for the future, that if it's something replacing other things, that somebody should let us know right away that that's the context for which we're evaluating something.

CO-CHAIR KAHN: Okay. And that was one of the conditions that was placed by the workgroup, so why don't we go ahead and let's vote on it and see where that gets us in terms of the process.

And if we don't approve the

recommendation, then obviously, we'll have a lot more time to talk about the various possibilities of the next step.

So the workgroup recommended conditional support based on the endorsement and based on the removal of other -- of the other measure. So can we have a vote on this.

CO-CHAIR HALL: And that's removal of two hospice measures; two existing hospice measures.

MS. BUCHANAN: And voting for 2019-33, the workgroup recommendation conditional support for rulemaking is open. We'll give it just a couple of seconds. Okay. We are closing the voting. We received 15 votes yes, 4 no, the coordinating committee recommends MUC2019-33 for conditional support in rulemaking.

CO-CHAIR KAHN: Great. So that's an acceptance and that's the final measure for review. I think the point about having, you know, full information is really important and I wonder whether on these brief slides here, next

year, whether we should have, when we have conditional, there should be a bullet that describes what the conditional is.

CO-CHAIR HALL: I agree. Certainly for that, and as well as for the mitigating for the do not supports.

CO-CHAIR KAHN: Right. That way I think we have it all in one place. And I guess the other issue I'll ask the staff about is, we don't have the votes on these items and should we? The vote was asked from the workgroup. Would that be useful?

CO-CHAIR HALL: If this committee thinks it was useful, it's certainly something we could migrate into the --

CO-CHAIR KAHN: Personally, looking around the room, think it would be, because then it gives us some perspective, and we really go into the discussion with context, both in terms of what they meant by conditional, and two, you know, this, you know, 9/6 is important.

CO-CHAIR HALL: I feel just a little

differently, because I think that we -- you know, there's a structure to this process and that group is supposed to land on a decision, and otherwise, it becomes that continuous variable that we're re-evaluating, so obviously, different people are going to feel different ways.

CO-CHAIR KAHN: Well, I mean, frankly, we are re-evaluating, one, and two, but we're not really re-evaluating most of it.

CO-CHAIR HALL: Then we might as well ask, what percentage of that group was in favor and not even ask if they reach a decision.

CO-CHAIR KAHN: I think it's another variable. I think it's a variable that informs us how strongly they felt about it. This is just recommendations.

MEMBER QASEEM: Yes, I see this as just one additional variable. It's just giving us information when we're going to be making our judgement call. It is something that's close and we are all struggling with it, I think then it becomes reasonable and important enough variable

versus if the other one -- the condition recommendation came with 90 percent of the vote.

I have to think twice before we overturn a decision.

CO-CHAIR KAHN: Okay. With that, those recommendations, I'll pass it back to Bruce to go to the next stage.

CO-CHAIR HALL: And I'll pass it to Sam.

MR. STOLPE: I like the buck passing here. This is beautiful. So what we're actually going to do next is have a future direction of the pre-rulemaking process discussion, and this is slated to be a discussion led by Bruce, but basically, what we're looking to capture in the next few moments as we're winding down in this meeting, is what went right and what you see as things that we could potentially do better.

It's really just two simple questions that were proffered for the committee to consider. Now, we do this every year and I'll turn it over to Bruce to facilitate, but those

are the questions that we'd like you to think about.

CO-CHAIR HALL: And there have been a couple of minor suggestions like that just mentioned that I'm sure you guys have already captured and we have those. David.

MEMBER GIFFORD: You know, there is no perfect measure and measure of it is messy, and I think it's gotten better every year, and I've been involved with NQF since the beginning, the whole endorsement process, it just gets better and better every year.

I think this committee gets better and better every year with, you know, refining it down and really, what our charge is, and I think this meeting is better than the previous years as well.

So that's something that's good and I think we, you know, really adopt the philosophy of how to do it better.

I would suggest that we've invested a lot of time in the last couple years refining

these voting categories of conditions and everything else, yet, we have no idea of what's happening with that follow-up.

And I would think it would be very helpful before next year's meeting to get some sense for, like, the last two years, we have made recommendations for conditions. At least, you know, as moderately as efficient, how many actually came back for endorsement?

Because I know in some of my areas, a lot of them have never come back for endorsement. Some of them, we have approved and CMS has never put in the rules, so they're still hanging out there with our support, without any rulemaking, and so maybe, you know, whether we think about whether our endorsement has a time limiting thing before they bring it back.

Because I know there's one, or a couple measures in our area that, I mean, I'm happy they're endorsed and I think they're going to eventually use them in the rulemaking, but it's been four years and they haven't put it in

the rules.

And I know they're working on it, and it takes time, but I think we -- things have changed, and so answer the question, should we come back for this.

So one would be getting some feedback on that technician issue. And it is a little bit more robust going forward. I think the other one is guidance to the MAP committees, less comment about the specifications of measures about, you know, endorsement, if we're going to get endorsement, we know that that's going to go through that.

The question is, are the specification in the measures going to impact how they're going to use them in the rule? And that, I think, we better be robust in deciding what it is, within the context of knowing how it's going to be used in the rule.

And then it's clear, over the years, one of the public comments that we get over and over again in comments putting on the table, is

this understanding of attribution from the physician side, but also, accountability for care after some patient has left that person.

And if we had stated, as a NQF, and CMS, and healthcare in general, that we want better care coordination. We want to move away from siloing. We continually see those comments.

I think it would be helpful going forward, and some, whether it's this group tackle it, but does NQF or CMS tackle with, sort of, a white paper. We're moving in that direction, but how do we -- when it is that it's gone too far that it shouldn't be rulemaking.

Just because we like it, it's not -- and I think the comments would be more robust and our discussion more robust if we were talking about that.

I thought the discussion we had at the psychiatric issue really reflected that today. And I think somehow putting that into a white paper or guide would be helpful for referring to as a status going forward.

And so it's mostly attribution of individual physicians, but attributable across providers, we get at. I guess those are my major comments with it, but, you know, I applaud you guys at the NQF staff.

And what's interesting is, looking at the NQF staff, it's like every year it's a new set of staff, so one thing for the NQF staff is, how do we give institutional memory, because it's clear that some of the institutional memory is by committee members and not by staff on this.

And I think some has slipped through the cracks because of that.

CO-CHAIR HALL: And you already made an earlier suggestion for some education around rulemaking as well.

MEMBER GIFFORD: Oh, yes, understanding if the shift is going to be more measures are coming to us for use in public reporting programs, you know, we all have gone through training, and I don't whether new members get training in all the payment models, but we

did a lot of time educating ourselves about MIPS, when that came to us, because we kind of understood the others.

I think we need the same with this group, as part of the orientation of new committee members coming onboard as well.

CO-CHAIR KAHN: Yes, I think that the group appreciates Michelle offering at the beginning to give us this feedback, and I think it's really, really important, and I don't know whether we -- I don't know -- well, I guess the money may not be there, I don't know, but I don't know if we have to necessarily wait until next year, at some point, when you all will be ready, I mean, we could have a conference call to at least go over the materials.

But I think this issue of the feedback loop is really, really important, and it is one thing that we're really missing, and it's a body of knowledge that you have now as to what happened with all these recommendations and if there is a big matrix in the sky, it'd be nice to

see it.

CO-CHAIR HALL: Harold?

MEMBER PINCUS: I agree with David in terms of this process has sort of continued to move and improve, and especially the interaction back and forth with CMS has really been terrific.

And I think also I would agree with David in terms of also the focus on, sort of, fit for purpose of the measures, you know, is an important way of thinking about it.

I would add to this point, and I especially agree about the follow-up, I would add to his point about follow-up, not just in terms of what happens with the measures, but what happens with the data about the measures that are collected and how that actually has been useful and influenced this, you know, so it's not just, you know, does the measure actually get endorsed, but do the measures, once utilized, provide the useful data, and information, and influencing how the health system operates.

So that's kind of what, you know,

would be good to get back. The other thing is, it might be useful, because, you know, the whole voting, you know, process has gotten, I think, a little bit clumsy in terms of -- and I'm thinking about, you know, when you do an NIH grant review, a lot of times what they do is, at the beginning, you know, they say, like, let's get just the sounding from the two primary reviewers, let's get a, you know, couple of sentences from the two primary reviewers, sort of, up front that helps to orient people to what the issues are.

And I think that might be a good idea, because it could make some, sort of, more use, because we do have assignments of people to be primary reviewers, and it might be good to just get a couple of sentences from them up front to be able to orient people to what it's all about.

CO-CHAIR HALL: Great thoughts. David?

MEMBER BAKER: I'll just give a little countervailing point to what Harold just said. I actually really like the idea of first voting on

whether or not to accept the workgroup recommendation, because some of these measures, they were, you know, re-specification of existing measures and it's just, we shouldn't be spending a lot of time on those.

So it's tricky, because some of the times I think you're right to have that framing would be really helpful, but at the same time, for some of these, it's like, to use the NIH study section, it's triage, right?

MEMBER PINCUS: Yes. Well, that's what I'm saying, I'm just talking about a few sentences, not a, you know, long diatribe.

CO-CHAIR HALL: Other thoughts or suggestions? Cheryl?

MEMBER PETERSON: Just one piece to that, not a long diatribe, but also not overly biased. So we're not here to hear your opinion about it, but to hear the overall issue.

CO-CHAIR KAHN: Well, remember, we did at one point, a few years ago, sort of, have everything clustered together, and then I think

there was concern about the clustering of the measures that were more routine, and then we separate it all out.

I think we -- I mean, if we have two days -- I think we do have to be -- this year we were fortunate that there were a limited number of measures. If we had more measures, we couldn't handle without --

CO-CHAIR HALL: We used to just pull off the consent calendar, right, only talk about things that got pulled. And so I think the current process is a little better. It's a little more uniform, consistent, but we can definitely improve on just trying to make sure we stay efficient and not waste time on discussion where we don't need it, so that's great feedback. Nancy?

MEMBER FOSTER: A couple of comments, one, to sort of reiterate something that I said to you in the hallway, you and Chip did an extraordinary job getting us through a lot of material and thank you and I think maybe you

should give lessons to other chairs.

CO-CHAIR HALL: Thank you. I've had the privilege of learning from Chip for a couple years, and certainly, I don't want to prematurely cut the conversation short, but certainly, Chip and I thank each and every one of you for your expertise, your time or effort, and this incredible staff.

I mean, you think about the amount of background and context that you guys prepared and delivered on the spot, truly fantastic, but also, Michelle, thank you so much for being here and giving us your insights.

And those couple of developers who chimed in too, I know Yale Core, and PQA, but there were others as well, so I wanted to -- did I miss anybody?

CO-CHAIR KAHN: No, this is great. Thank you so much. And I think we had great support from the staff, and great suggestions, so that next year should be even better.

CO-CHAIR HALL: Public comment.

That's yours.

CO-CHAIR KAHN: Oh, do we have any public comment on procedural or otherwise?

CO-CHAIR HALL: Let's check in the room for anyone. On the phones? We did have some in the chat, so --

CO-CHAIR KAHN: The chat box?

MS. BUCHANAN: Yes.

CO-CHAIR KAHN: Okay. Could you give us the chat box report?

MS. BUCHANAN: Absolutely. So this is a comment on MAP MUC19-14 and MUC19-21 measures. Special needs and Medicare and Medicaid plans serve primarily dually eligible complex individuals who have high levels of social risk factors and multiple chronic conditions.

Plans in the SNP Alliance non-profit voluntary leadership organization have approximately 2.2 million beneficiaries they serve. There are two proposed measures under consideration where SNP and MMP measures expressed some concern several years ago when the

measures were under development.

We see that our concerns remain, but based on the minor specifications, the measures are 19-14, follow-up after emergency department visit, people with multiple high-risk chronic conditions, MUC19-21, transitions of care between the inpatient and outpatient settings, including notifications of admissions and discharges, patient engagement, and medication reconciliation post discharge.

While these health plans fully support timely and robust follow-up after ED and poor transitions in care, the key issues of the special needs and Medicare and Medicaid plans, health plans that are expressed about these measures concern the timeframe data source of the notification to whom by whom, and how when and whether these measures are being appropriately applied.

Plans are concerned about the aspects of these processes described within the measure which are outside their control. It seems likely

that the measure assumes an integrated and seamless health information exchange with hospitals or other providers, settings, notifying health plans with a very short timeframe of ED or transition event.

This is not the case, unfortunately. Therefore, it will likely be served. Only certain health plans will be able to meet these tight timeframes, such as health plans that are the insurance portion of a large enterprise or integrated health delivery system, where the plans have access to 24/7 health information exchange on shared electronic health record via electronic platforms.

All other health plans that operate independently and are not part of the integrated provider delivery system will likely show poor rates. They do not have access to the electronic record systems, providers discharged to the ER, or making the transitions between care or settings.

Furthermore, the transitions of care

measure actually requires plans to request charts from providers and context --

PARTICIPANT: Can you slow down just a little bit?

MS. BUCHANAN: Sure. And conduct chart review in order to ascertain performance by the provider, which we are all aware of is a very laborious process.

Because of the higher proportion of complex care members and the SNPs and MMPs have enrolled a much higher proportion of complex chronically compromised members. These plans are expected to be impacted by the challenge of these measures at a higher rate.

That is, these plans have more individuals in the denominator for those measures and thus will be more affected. This will place heavy burden on plans that treat the most vulnerable populations, diverting resources that offer information that is actionable by the health plan in terms of their control to direct faster information exchanged by providers in

their community, or allow the plan to access their electronic health record platforms.

We're wrapping up. In reviewing the MAP criteria, we do not believe these two measures contribute to efficient use of measurement resources, can be feasibly reported, nor are they applicable nor appropriately specified for the program's intended settings of care, level of analysis, and population.

Therefore, we would recommend the measures would not support rulemaking for Part C and D measure set. We see the need for measurement to be retooled and suggest that revised measure testing be done to determine its applicability for provider organizations.

The settings that will be keeper of the information needed for the measure to be calculated rather than applied to health grants.

CO-CHAIR HALL: Thank you.

CO-CHAIR KAHN: Any other messages?

MS. BUCHANAN: That was it.

CO-CHAIR KAHN: Okay. So even though

we --

MEMBER QASEEM: Chip, this is Amir again. Can I just make a comment?

CO-CHAIR KAHN: Sure.

MEMBER QASEEM: So I think the meeting went really well. I totally enjoyed it. I wish I was there in person. One thing I do want to bring up -- oh, one more thing, Bruce's comment, I wholeheartedly agree and hopeful we can adopt those.

One general comment is that when initially MAP was convened, our charge is -- and it still is, that we are supposed to review performance measures. During the process for the past few years, we have a little bit moved away and we started mixing performance measures review with the review of measurement concepts, or you can call them quality, whatever you want to call them.

And I do think it's important for us to differentiate those because if you're reviewing measurement concepts, it has a whole

different standard that we need to keep in mind rather than you give a thumbs up or down versus reviewing the specific performance measures.

Even in today's conversation, a lot of issues were brought up, like for example, the reliability and validity, which many times is not going to apply to the measurement concept, so that you don't even have the information.

I'm looking at some of the measures that we went through today. We don't even have a numerator or denominator listed over there. So somehow I think for my sake, or my understanding, and maybe I am -- you know, you guys know my background, we need to have some sort of a standard methodology.

If you're going to review measurement concepts, then we all need to be on the same page that that has a whole different set of variables we need to keep in mind when we're reviewing it and giving it a thumbs up and down, otherwise we're mixing apples and oranges.

Whether it's NQF that gives us

guidance on this, or whether we come up with it within the committee, I'm fine with it, but we can't say that the measurement concept is okay on one hand, and on the other hand, we are holding some of the measures that were higher level of reliability and validity, and are asking for data, or show me the proof that there is evidence that this works or this doesn't work.

So that's one comment. Second one is, I do think that it is important, Michelle, I don't know if you're in the room or not, that we need to start aligning or harmonizing some of these measures alongside with what CQMT is doing, because I sit on CQMT as well.

Those of you who don't know, it's a core quality measure collaborative for public/private payers, and I know what MAP is doing is for rulemaking and all that, but ultimately, I'm looking at the bottom-line is it's performance measures we are all reviewing, and I'm seeing lack of harmonization of what I'm reviewing and what is getting a thumbs up through

CQMT committee versus what's happening at the MAP committee.

And somehow, now both of them are under the umbrella and so our mission is to harmonize these two as well.

CO-CHAIR KAHN: Thanks, Amir. I think on the first comment, it's something David constantly brings up, is that we have this balancing, because unfortunately, because of the process, we do have a lot of measures coming -- a number of measures coming here that have not been endorsed, that have not gone through that -- the endorsement process, which looks specifically at the issues, it's an omission that you're talking about.

So we sort of have this balancing. I'm not sure, considering what we have to work with, that we can avoid that, but I think it just sort of is what it is.

I think in terms of the harmonization, years and years ago, Gerry Shea and I chaired a strategy committee that looked at the future of

MAP. I don't know, how many years ago was that? Anybody know?

It was probably eight years ago at least, and actually, harmonization was one of our primary goals that we never either had time for or never could fit into our agenda, but I think that's really critical and we spent a lot of time talking about burden, or potential burden, and there, there's not just burden, there's also potential for tremendous confusion or mixed signal, so we really -- I mean, from my view, if we can figure out how to work more towards a single platform where we're -- all the measures are harmonious between the different payers, that could be really critical.

MEMBER QASEEM: And so just to answer to your first one, I absolutely agree it's a balancing act, and I'm not opposed to reviewing measurement concepts, but I do think that as a committee member, all of us need to be on the same page as to what rules apply or what needs to be met -- what criteria needs to be met, for

someone -- for something to become a measurement concept that we give it a thumbs up or thumbs down.

If we are not all on the same page or using the same playbook, I think we're going to end up -- well, I don't even know what rules we're applying when it comes to a measurement concept, is it a national priority area, or do we use what Michelle presented today, that there might be data showing that care is not being provided at a level where it needs to be.

And many times, I don't even have that information, so I'm not opposed to doing the measurement concept, but my ask is that we need to have a rule of engagement when we're going to be looking at the measurement concept.

Otherwise, I worry that we maybe just giving thumbs up to measurement concepts, which may lead to, eventually, developing performance measures in that arena, and lead to proliferation of measures, which may necessarily -- may not improve care.

We believe it will improve care, but we don't even have a feedback loop about what MAP recommendations are being met or not met. We don't have any feedback loop around performance of these performance measures that we have been recommending over the past five years.

We went in with many of these measures and said, we believe this is going to improve quality of care. Five years later, can someone show me data to prove that this measure has been out there, look, we have moved the quality needle.

OPERATOR: I'm sorry, there's been an internal error. You will be disconnected now.

(Laughter.)

CO-CHAIR KAHN: I think the Russians had it in for you. Anyway, I think these are -- I guess he is. Did we lose him?

CO-CHAIR HALL: Sounds like it to me.

CO-CHAIR KAHN: And that was really -- I think he made a very important point, and it is something we have to contend with, because even

if we get a feedback from CMS on what the status of the measures are in the program, that is not necessarily going to give us a good feel for how successful the measures are.

I mean, that's an important question too, but I'm sure that's something CMS worries a lot about as well.

So with that, are there any other comments, thoughts?

MEMBER SCHREIBER: Can I make just one --

CO-CHAIR KAHN: Sure.

MEMBER SCHREIBER: Everybody got a chance to say thank you, so I just want to take an opportunity on behalf of CMS to say thank you to all of you, to NQF, to our co-chairs certainly, but to all of you for spending a tremendous amount of time and providing thoughtful feedback to us.

So that was just my opportunity to say thank you, also, specifically to you.

CO-CHAIR KAHN: Thank you. We

appreciate it. Any other thoughts? Last chance. I think we're ending about 15 minutes early. So we'll adjourn.

MR. STOLPE: Well, we still have some next steps that we're going to review.

CO-CHAIR KAHN: Oh, what next steps?

MR. STOLPE: Before we jump to -- jump for the door, let's go ahead and take a look at that. Kate was going to cover these, but let me just pull them up so I actually can see them in the slides.

So let me just pivot to Kate as soon as she comes back into the room. She's checking on the connection, but -- now, the next steps are fairly limited.

What's going to happen is, NQF will be updating our reports based on the comments and the discussion today. Those will all reflect the new voting categories that we arrived at, as the coordinating committee, as well as the rationale. Those will be provided to CMS and will be in short order.

The only thing that I wanted to say on behalf of the NQF staff is again, to thank our two terrific co-chairs for leading us through the day, to each of you around the table for your thoughtful comments and participation, and would be remiss if we did not thank NQF, or sorry, excuse me, CMS for the --

(Telephonic interference.)

MR. STOLPE: All right. Apologies for the technical glitch there. I'm just offering some closing remarks actually, and it's simply this, it remains to us to say thank you.

Thank you to all of you for participation, to our co-chairs, to the committee, for the public, for our measure developers, the NQF staff, and of course, CMS for your engagement in this.

Very much appreciate the tone that you're bringing to the committee. It means a lot. So thanks to everyone and safe travels home.

(Whereupon, the meeting in the above-entitled matter was concluded at 4:35 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: MAP Coordinating Committee

Before: NQF

Date: 01-15-20

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter