NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP COORDINATING COMMITTEE MEETING

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TUESDAY,
JANUARY 24, 2017

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

PRESENT:

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

DAVID GIFFORD, MD, MPH, American HealthCare Association
RICHARD GUNDLING, FHFMA, CMA, Healthcare Financial Management Association
BRUCE HALL, MD, PhD, MBA, FACS, American College of Surgeons
APARNA HIGGINS, MA, America's Health Insurance Plans
BRANDON HOTHAM, MPH, Maine Health Management Coalition*
GAIL HUNT, National Alliance for Caregiving
WILLIAM KRAMER, MBA, Pacific Business Group on Health
SAMUEL LIN, MD, PhD, MBA, MPA, MS, AMGA
AMY MULLINS, MD, FAAFP, American Academy of Family Physicians
R. BARRETT NOONE, MD, FACS, American Board of Medical Specialties*
SHAUN O'BRIEN, JD, AFL-CIO
AMIR QASEEM, MD, PhD, MHA, American College of Physicians
CHRIS QUERAM, MS, Network for Regional Healthcare Management
ARI ROBICSEK, MD, Providence Health and Services
CAROL SAKALA, PhD, MSPH, National Partnership for Women & Families
MARISSA SCHLAIFER, RPh, MS, Academy of Managed Care Pharmacy
CARL SIRIO, MD, American Medical Association
STEVEN WOJCIK, MA, National Business Group on Health

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, MS
DORIS LOTZ, MD, MPH*

FEDERAL GOVERNMENT LIAISONS PRESENT:

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

WORKGROUP CO-CHAIRS PRESENT:

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

NQF STAFF:

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

ALSO PRESENT:

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

*** present via telephone**

TABLE OF CONTENTS

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

9:06 a.m.

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

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

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

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

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

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

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

CO-CHAIR PINCUS: Okay.

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

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

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

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

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

MEMBER BAKER: David Baker, the Joint Commission.

DR. GOODRICH: Kate Goodrich, CMS.

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

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

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

MEMBER ANDERSON: Rhonda Anderson, American Hospital Association.

MEMBER HIGGINS: Aparna Higgins, AHIB.

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

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

MEMBER HALL: Bruce Hall, American College of Surgeons.

MEMBER BOTT: John Bott with Consumer Reports.

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

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

MEMBER BRESCH WHITE: Mary Beth Bresch

White, The American Nurses Association.

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

DR. HUNT: David Hunt, ONC.

DR. WILSON: Nancy Wilson, AHRQ.

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

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

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

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

MEMBER QASEEM: Amir Qaseem, American College of Physicians.

MS. OGUNGBEMI: Yetunde Ogungbemi, National Quality Forum.

MS. MUNTHALI: Elisa Munthali, National Quality Forum.

MS. IBARRA: Kim Ibarra, National Quality Forum.

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

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

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

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

CO-CHAIR KAHN: Anyone else?

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

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

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

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

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

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

CO-CHAIR PINCUS: So as Chip said,

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

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

discussion.

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

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

metaphor or not.

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

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

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

CO-CHAIR PINCUS: So, Kate.

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

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

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

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

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

So, a little bit about our process.

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

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

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

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

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

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

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

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

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

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

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

the success of this entire process.

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

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

I do want to say for this year, the

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

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

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

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

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

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

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

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

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

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

bright with I think lots of tremendous ideas.

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

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

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

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

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

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

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

CO-CHAIR KAHN: It may feel like that.

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

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

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

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

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

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

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

So thank you.

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

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

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

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

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

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

So, Erin.

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

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

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

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

DR. LOTZ: Yes, this is Doris Lotz.

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

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

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

DR. LOTZ: Thanks.

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

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

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

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

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

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

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

to what matters most through these quality programs?

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

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

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

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

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

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

We did update the decision categories

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

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

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

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

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

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

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

This is really our attempt to preserve

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

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

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

CO-CHAIR PINCUS: And it is worth just

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

Giff.

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

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

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

MS. O'ROURKE: Yes. So --

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

DR. GOODRICH: As opposed to the other committees?

MEMBER GIFFORD: Yes.

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

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

along, and they can use that for their rulemaking.

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

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

So, I'm trying to get a sense where

that is.

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

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

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

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

I don't know how else to answer it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the committee members.

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

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

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

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

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

MS. O'ROURKE: Correct.

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

MS. O'ROURKE: That's it.

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

MS. O'ROURKE: And then finally,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Now we are going to hear from Helen.

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

have Shantanu join us on Monday.

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

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

All disclosures of interest policy is

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

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

Go ahead, Marissa.

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

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

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

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

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

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

you.

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

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

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

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

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

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

other work we do regarding measures.

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

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

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

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

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

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

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

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

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

Our thinking is we would like to try

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

outcomes and the driver measures.

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

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

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

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

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

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

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

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

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

I do think you highlight, though, a

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

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

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

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

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

CO-CHAIR KAHN: Okay, Harold.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

goal-setting.

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

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

So even thinking through how you would

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

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

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

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

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

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

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

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

Okay, do you want to identify yourself?

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

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

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

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

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

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

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

Are there public comments from people on the phone?

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

then the number 1.

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

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

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

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

which was released in December of 2016.

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

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

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

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

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

Thank you.

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

OPERATOR: There are no public comments at this time.

CO-CHAIR PINCUS: Okay, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. McQUESTON: Thank you, Ron. My

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

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

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

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

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

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

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

We will take questions at the end. Thanks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

benzodiazepines are reduced or stopped prior to discharge.

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

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

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

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

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

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

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

The last program that we looked at

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

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

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

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

For HRRP, the workgroup noted that CMS

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

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

Thank you.

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

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

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

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

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

So they did not make specific comments on particular measures?

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

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

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

So any comments about the overall program review, Rich?

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

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

Is it the ED? Is it all the above?

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

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

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

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

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

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

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

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

So the first program is the Ambulatory

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

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

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

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

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

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

MEMBER BARTON: I've just been trying

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

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

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

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

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

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

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

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

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

MS. O'ROURKE: Oh, sure.

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

MS. O'ROURKE: Let me pull up the

guide so that I may follow along with you.

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

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

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

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

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

not doing it right?

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

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

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

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

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

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

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

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

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

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

CO-CHAIR PINCUS: Yes.

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

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

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

And to respond to that person's

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

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

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

CO-CHAIR PINCUS: Giff.

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

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

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

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

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

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

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

DR. BURSTIN: Yes.

CO-CHAIR PINCUS: Other comments, questions?

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

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

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

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

David, is your concern addressed?

MEMBER GIFFORD: Yes. I can --

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

MEMBER BINDER: Leah Binder from Leapfrog.

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

CO-CHAIR PINCUS: Louder.

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

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

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

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

is on the docket, when would it be considered?

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

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

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

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

MS. MARINELARENA: A week.

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

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

CO-CHAIR PINCUS: That's fast.

Okay any further comments about this

measure?

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

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

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

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

Any comments from MAP members on the phone?

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

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

Yetunde, do I need to mention anything

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

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

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

CO-CHAIR PINCUS: So when do we vote?

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

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

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

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

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

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

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

What about 16-309?

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

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

CO-CHAIR PINCUS: So David.

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

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

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

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

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

OPERATOR: He has not joined at the moment.

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

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

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

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

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

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

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

So I would like to save people time.

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

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

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

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

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

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

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

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

MEMBER BAKER: Yes, that would be mine.

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

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

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

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

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

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

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

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

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

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

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

Oh, Rhonda. And then Kate.

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

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

to them.

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

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

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

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

MEMBER BAKER: Okay, great.

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

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

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

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

DR. LOTZ: This is Doris Lotz.

CO-CHAIR PINCUS: Yes?

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

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

WORKGROUP CO-CHAIR WALTERS: Actually

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

CO-CHAIR PINCUS: Other comments.

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

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

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

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

recommendation was do not support.

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

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

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

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

CO-CHAIR PINCUS: Okay so let's go

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

David?

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

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

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

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

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

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

appointments but it is just such an important gap area.

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

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

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

MEMBER ANDERSON: I should be sitting

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

CO-CHAIR PINCUS: Leah.

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

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

list.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

important than what we give a specific rating.

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

CO-CHAIR PINCUS: Yes, Kate.

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

for that

CO-CHAIR PINCUS: Melissa.

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

CO-CHAIR PINCUS: Amir.

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

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

So I would probably still fall under

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

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

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

But I am not sure that it is changing

to a revise and resubmit is the answer.

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

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

And so I -- Doris.

DR. LOTZ: Yes.

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

MEMBER BAKER: I'm fine with that.

CO-CHAIR PINCUS: Okay, Doris.

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

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

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

MEMBER GIFFORD: Hold on. It was pulled.

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

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

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

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

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

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

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

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

Okay?

So let's move on to the next pulled

measure.

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

CO-CHAIR PINCUS: Yes.

DR. ANTONELLI: Okay, thank you.

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

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

think the USPSTF was specific to --

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

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

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

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

CO-CHAIR PINCUS: Right. That is

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

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

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

Let's move to the next one.

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

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

MEMBER BAKER: And it may be helpful to just expand out a little bit in the rationale statement to emphasize and maybe that was there and I missed it but just to emphasize that there is a lack of data for the hospital setting. Because like Amir says, there is a heck of a lot more time to counsel patients in the hospital than in our primary care facilities.

CO-CHAIR PINCUS: And actually there is some data but there is not as much.

Next.

MS. O'ROURKE: Sure, so the next measure pulled is MUC16-263, Communication about

Pain During the Hospital Stay. And this is one I did want to provide an update. We had a real-time update from the published specs on the MUC list. CMS is only moving forward with the first three questions. So they are: During this hospital stay did you have any pain? During this hospital stay how often did hospital staff talk with you about how much pain you had? And during this hospital stay how often did hospital staff talk with you about how to treat your pain?

And I believe Bill Lehrman is on from CMS to give an update about where CMS is going with this since the publication of the MUC list for the Coordinating Committee's information.

DR. LEHRMAN: Hi, thank you. This is Bill Lehrman with CMS. I am the Government Task Leader for the HCAHPS survey.

CO-CHAIR PINCUS: It's hard to hear you. Could you speak closer to the phone, louder?

DR. LEHRMAN: Is that better?

CO-CHAIR PINCUS: Yes.

DR. LEHRMAN: Okay. This is Bill Lehrman. I am the Government Task Leader for the HCAHPS Survey at CMS. As has been explained, we have the three items for communication about pain during the hospital stay that we are proposing to replace the current items in the HCAHPS survey.

We presented this to the MAP Committee back in December. The question was raised about the testing. At the time that the MUC List data was required, we had not completed the testing. So that was not in our package. We have since completed that testing and we have confidence in the reliability and validity of the new measures and how well they test in comparison to the rest of the survey and in comparison to the current measures which will be removed from the Value-Based Purchasing Program beginning in FY2018.

I'm not sure if there are specific comments you would like me to address.

CO-CHAIR PINCUS: Did you have specific comments?

MEMBER BAKER: My concern was HP4.

And since that is not going forward, I am fine. It was the idea that during this hospital stay did you get medicine for pain and the top box scoring would be always. So think about the question did you always get medicine for your pain. So that was the concern that I had.

CO-CHAIR PINCUS: Okay. Any other comments about this measure?

Okay, thanks for the clarification.

MEMBER GIFFORD: Just a broader point for maybe future things. This is a repeat of previous years where between the time something went on the MUC List and was reviewed by one of the workgroups and us, CMS has done additional testing. And yet to say to try to change -- because they are ongoing testing and they are trying to do things quickly, what is the process? Because we don't have a chance to look at -- I mean I have no idea what the data is that CMS has just presented. We didn't get to see it. Is that really our role to go back through and look at the date between the time frame from when they

come or not? I just sort of ask that because my tendency is not to change the vote because I haven't seen the data and not that I don't trust what CMS is saying.

MS. O'ROURKE: It is an excellent point and we recognize this is a little bit of a moving target.

MEMBER GIFFORD: Yes.

MS. O'ROURKE: And we give you the information. The specs that you see in your discussion guide are what was published on the MUC List, since that was the final cleared document. But unfortunately, things have happened in the interim that affects the measure. So we do try to present those as much as we can but we know that does complicate your deliberations. I think that is something we would be interested in hearing about how we can present that to you in the most efficient manner and what you really need to support your decision making.

MEMBER GIFFORD: And my tendency is to

go with what is submitted, what was reviewed and CMS can use that in justification and rulemaking while they are ignoring us.

MS. MARINELARENA: Hi, this is Melissa again. I also want to clarify that from the Hospital Workgroup, when we did these recommendations, refine and resubmit was mostly recommend to measures that had not been through NQF endorsement. They were undergoing testing. Even if the testing was complete, the workgroup did discuss that they would rather have an NQF standing committee review that testing and determine that it was reliable and that it was valid, rather than there are some testing results for some of these measure but, again, they wanted to refer back to an NQF Standing Committee, to determine the reliability and the validity of the measures.

CO-CHAIR PINCUS: And the recommendation was revise and resubmit.

MS. MARINELARENA: Correct.

CO-CHAIR PINCUS: Yes. So, they are,

essentially, revising it.

So moving on to the next one.

MEMBER QASEEM: Before we move on to the next one, can I just make a brief comment about the alcohol use because there is another measure that is in there that was 178 that wasn't extracted but it is about the alcohol use screening. And I am not really getting and some of it might have been discussed. So essentially we are saying we should be screening but don't provide an intervention over there. And screening rationale is a checkbox measure again, typical checkbox measure, did you screen for alcohol use.

So as a clinician I want to find out okay this person needs help. And then I am going to say well, good luck. Which program is that? It is a measure MUC16-179. That is the very next measure, alcohol use screening.

So what I am trying to understand is that how can we say screen but don't provide intervention.

WORKGROUP CO-CHAIR WALTERS: Can I answer that a second? Because that very statement was made in the workgroup, actually. And of course, from a medical practice perspective, you are going to do what is appropriate to be done.

The point was from a major perspective, was there enough evidence to include it in the program. And so they did not disagree with what you just said. They looked at it from a little different slant.

WORKGROUP CO-CHAIR TRAVIS: And this is Cristie. I will also add that we discuss the fact that while the patient is in the hospital, screening for alcohol use would be important to be sure to prevent alcohol withdrawal syndrome. So there was a quote, unquote, treatment perspective for during the hospital stay, not only thinking about post-discharge.

CO-CHAIR PINCUS: So are you saying that you want to pull the measure?

MEMBER QASEEM: I actually do. I do

think that we need to pull the 179 and then vote on it. Because just ask and screening for someone during a hospital stay and again if someone can have a convincing evidence for it, then I would be happy to support it. And just screening is not going to improve outcome in the hospital. I just don't see that happening. And I am not aware of evidence, unless I am missing something. Please let me know if there is some evidence to support that because just screening has never improved the clinical outcomes.

MEMBER BARTON: This is the alcohol withdrawal syndrome. So the workgroup said that the idea is for the very short-term that you screen for alcohol use in order to prevent alcohol withdrawal during the hospitalization. At least that is how I would interpret it.

MEMBER QASEEM: But that is not what the measure is. If you look at the measure description, the numerator and denominator, they are not just talking about specifically for that.

CO-CHAIR PINCUS: What you are saying

is that it doesn't say within the early period of the hospitalization.

MEMBER QASEEM: It's not.

MEMBER GIFFORD: What measure are we talking about?

CO-CHAIR PINCUS: Okay, just to clarify, we are talking about --

MEMBER GIFFORD: Did we move on to a new measure?

CO-CHAIR PINCUS: Yes.

MEMBER GIFFORD: We went back to an old measure?

CO-CHAIR PINCUS: No, I think what Amir has done, he has just explained it, is that he has pulled a new measure.

MEMBER GIFFORD: Okay but we haven't finished the other measure.

CO-CHAIR PINCUS: Yes, we did. We were just in the process of moving on to what would have been the next pulled measure.

MEMBER GIFFORD: Maybe can I just ask, because we have a lot of measure to go through

today, if we are pulling measures, having a discussion and making the same comments that are already embedded in the comments and we are not asking to change the vote, why are we pulling these measures?

We should be pulling the measures, I think, if we want to change the recommendation or we are okay with the recommendation but there is a new feedback we want to give CMS --

CO-CHAIR PINCUS: Right.

MEMBER GIFFORD: -- that is not included in the feedback that is going to them. Otherwise, we are just rehashing the same stuff over and over again.

CO-CHAIR PINCUS: Yes but I think Amir was adding new comments.

MEMBER GIFFORD: Okay, I am just commenting because we have now had like three or four pulled and we have not voted on them.

CO-CHAIR PINCUS: But that is permissible, if you want to add to the comments and I think that is what Amir was doing.

MS. MARINELARENA: So this is Melissa again. The Hospital Workgroup wanted to clarify that when they supported the screening measure it was to be able to capture patients and to prevent patients going into DTs. They were not supporting it as the first step before you did the brief intervention because they are presented as a group. So they were not supporting it for that reason.

MEMBER GIFFORD: Can I just ask are we pulling this for comment or pulling to comment and revote? It would just be helpful to follow the discussion.

CO-CHAIR PINCUS: Amir?

MEMBER QASEEM: I am pulling it for comment and revote.

MEMBER GIFFORD: And revote for what category? You want to change to what recommendation?

MEMBER QASEEM: Yes, to change the category. I think the measure will need to be changed after what I just heard Melissa just

mention.

MEMBER GIFFORD: It is currently recommended as --

CO-CHAIR PINCUS: If you would let Amir --

MEMBER GIFFORD: Yes, I just wanted to know what --

CO-CHAIR PINCUS: Let him fully explain himself, okay?

MEMBER QASEEM: So what I am asking is that we can revote based on what Mary and Melissa just described, that the point of this measure is to any toxic impact that might be happening immediately after admission because of alcohol withdrawal. And that needs to be clarified because that is not how the measure is written.

So it needs to be either changed into conditional support or revise and resubmit. I can live with whatever you guys, the chair recommend but it cannot be just support.

MEMBER GIFFORD: So what you are saying is that the measure specifications do not

specify that the measure be done early in the hospitalization, which would justify that rationale. That is what you are saying.

MEMBER QASEEM: Correct.

WORKGROUP CO-CHAIR WALTERS: They do. Cristie, isn't it 72 hours, 48 hours?

WORKGROUP CO-CHAIR TRAVIS: Yes, I think it is three days.

MEMBER QASEEM: And just if I can add, Harold, unless we can change the intervention measure, as well, that the first one -- and I know I am making it really complicated. Unless we can have an alcohol use brief intervention change, 178, which is right now do not support, then I can live with it.

My problem is there is an issue of you are just screening and not providing intervention.

CO-CHAIR PINCUS: So I am now confused.

MEMBER QASEEM: So what I am saying is that if you are going to leave 178 as do not

support, then this measure needs to change into revise and resubmit. If 178 can get changed to we support, or conditional support, or whatever we want to say, I can live with supporting this as well. Then at least it makes a little more sense.

CO-CHAIR PINCUS: So for purely procedure, so are you -- we have already pulled the previous measure, had a discussion about that and although we didn't vote, we did make a determination that we wanted to give a strong recommendation for trying to address that issue.

So you are asking now for pulling this measure in order to actually change the vote --

MEMBER QASEEM: Correct. This one needs to be revised and resubmitted or whatever the term is.

CO-CHAIR PINCUS: -- to revise and resubmit from the support.

MEMBER QASEEM: Correct.

CO-CHAIR PINCUS: Okay. And Doris has a comment on that. Are there other people that

want to comment specifically on the vote that we are going to make with regard to changing it from support to revise and resubmit.

So Doris is first and then other people can raise their cards.

DR. LOTZ: I think it is fine to support it for rulemaking. I don't think that in the application or in the practice that screening would be the end of the road. I think it is important to incrementally measure change and I think it is well articulated as is. And with respect to 178, as I mentioned before implementation issues, not conceptual issues. So I think this one is fine to go forward, understanding that something will follow. It won't be measured. And at this stage of the game that is okay, provided we encourage the first step, which is to do the screening.

Other comments.

MEMBER HIGGINS: I just want to clarify. So if we are saying this is revise and resubmit, what is the -- what are we -- I get

your point, I completely agree that if you have a screening measure it is important to have an intervention that follows that. But I am just trying to understand if we are going to vote -- if we say revise and resubmit what do we want them to revise. So are we asking for a paired measure that has a screening component and the intervention component.

CO-CHAIR PINCUS: So I think, if I could speak to you, I think the revise and resubmit is to rethink this measure with regard to, number one, whether it should be paired with some sort of brief intervention and follow-up?

And number two, if it is justified on the basis of sort of toxic screen, that the time frame be changed.

MEMBER QASEEM: Correct.

MEMBER HIGGINS: All right. That's helpful. Thank you.

DR. BURSTIN: Just one quick reflection from the Hospital Workgroup and maybe Ron wants to weigh in on this as well but the

issue people raised about screening for the sake of looking for alcohol withdrawal was, I think, in response to concerns on other hospital members of the table of not wanting this measure moving forward.

So I think it is being a little bit conflated as it is the only reason to move this forward. I think there was a body of the people at the table who thought this measure had important medical applicability as well to assess the issue of withdrawal but it was really a back about the broader issue of the measure.

And again, I think this whole issue of screening versus screening and doing something about it is something that continuously comes up in all of our processes. And I think we have heard a lot from at least the endorsement side of a desire for measures that reflect screen and do something as opposed to screen alone.

CO-CHAIR PINCUS: So can I ask a question of Kate?

So given the discussion we have had

about both these measures and when you take this discussion back, how do you think you can respond to that? I mean would it make a difference if voted revise and resubmit on this one?

DR. GOODRICH: So this is the suite of measures because it was obviously put on the MUC List, is one of the ones that we are considering. I think that the conversation that we have been having -- and I was not at the Hospital Workgroup so I didn't hear that whole discussion, is very helpful to us to understand it.

I mean the committee should do whatever they feel is right in terms of the right thing for the committee to do in terms of revoting, whether you revote or not.

I think for us, generally, the discussion is what is really the most important thing in thinking about whether or not we hold off on proposing this or we propose it to seek further comment on it, acknowledging the limitations that have discussed in this group as another path forward. I'm not sure what we will

do.

But to me and, Pierre, weigh in if you feel otherwise or want to add, the discussion we have been having is what is most helpful for us actually.

CO-CHAIR PINCUS: So Amir, do you want to revote on this?

MEMBER QASEEM: Sure.

CO-CHAIR PINCUS: Okay. So is there any further discussion before we revote?

Okay. Was there a comment from the phone?

So this is a different thing.

MS. O'ROURKE: If you could give us one moment while he is queuing up the slide.

WORKGROUP CO-CHAIR WALTERS: If you think you have fun with those, wait until we get to malnutrition.

CO-CHAIR PINCUS: Yes, we are going to address that as a group, have a discussion about that as a group.

MS. OGUNGBEMI: So we are now voting

on MUC16-179, alcohol use screening. Your options are support, conditional support, refine and resubmit, and do not support. The corresponding numbers are 1, 2, 3, and 4. Voting is open.

MEMBER NOONE: Hello?

MS. IBARRA: Doris and Foster, we have received your votes.

MEMBER NOONE: Hello?

CO-CHAIR PINCUS: Yes?

MEMBER NOONE: How do we vote on the phone?

MS. IBARRA: Please use the chat feature to send your vote confidentially to NQF staff and we will record your vote.

MEMBER NOONE: NCS dot?

MS. IBARRA: You can provide your vote verbally, if you prefer or you can send an email to MAPcoordinatingcommittee@qualityforum.org and I will get your vote and record it that way as well.

MEMBER NOONE: May I do it verbally?

MS. IBARRA: Yes.

MEMBER NOONE: Support.

MS. IBARRA: Thank you.

Steve, we also received your vote. And Brandon, we received your vote.

MS. OGUNGBEMI: The results are for MUC16-179 48 percent support, 10 percent condition support, 31 percent refine and resubmit, and 10 percent do not support.

We reached 60 percent consensus in the refine and resubmit category.

CO-CHAIR PINCUS: Rhonda, I was just trying to figure out the arithmetic.

Rhonda.

MEMBER ANDERSON: Just a comment to take back and that is that we have just spent quite a bit of time on all three of these. And it seems as though -- and it is hospital-based. So it seems as though, when the information goes back it would be helpful if we emphasized the fact what can be done in the hospital to deal with the alcohol and substance abuse issues and

what might be a composite that would be appropriate to use and/or is there another place for the attribution. So I just would ask that they think that through that way.

CO-CHAIR PINCUS: I mean I am not going to comment on it now but I have a number of thoughts about how one might do that.

Okay, let's go to malnutrition.

WORKGROUP CO-CHAIR WALTERS: Could I make a request? Cristie has to go to another meeting at 12:00. Can she summarize the Hospital Workgroup for Malnutrition?

CO-CHAIR PINCUS: We are going to deal with the malnutrition measure as a group and go into the revoting. Okay.

WORKGROUP CO-CHAIR TRAVIS: Great. Thanks, Ron. In fact I think I need to leave early.

CO-CHAIR PINCUS: Okay, speak a little bit louder into the phone.

WORKGROUP CO-CHAIR TRAVIS: Okay. Actually I didn't know I was going to be called

upon to do that. So I don't have my notes in front of me.

Can staff start in some way so that I can pull myself together here?

WORKGROUP CO-CHAIR WALTERS: Well I can tell you we ended up with different things for every one of them.

So putting them in order and we did talk about the process. You screen, you assess, you document, and then you plan, even though they are not necessarily listed in that order. And everybody agreed that it was very important to do. This is a population that can benefit from it.

Screening got a refine and resubmit, basically due to evidence as reviewed by the standing committee. Assessment got a conditional support and with the conditional support based on NQF endorsement, documentation which was really another good discussion was a do not support again that evidenced doing the assessment counted but documenting it did not, based on the

evidence. And then the plan, nutrition care plan got a refine and resubmit, again, based on sending it for review of the evidence.

So I can only say that this was a very complicated discussion that probably lasted over to 60 to 90 minutes. You heard about the public comments earlier today and how to reconcile that, I think this is what our committee came up with.

Is there anything else the staff would like to add to that? And then I will turn it back to the chair.

Cristie?

WORKGROUP CO-CHAIR TRAVIS: Yes, this is Cristie and thank you, Ron. I have so many documents open, it was difficult to get the one I needed for this but thank you for that.

I would say that the other issue was that there was some discussion around encouraging the development of a composite with several of these nutrition measures put together in a composite. And there was also discussion about the fact that this is important. There is no

question about that for the information that we heard earlier in public comment but also that it needs to be balanced with the rest of the IQR set. And that was one of the reasons that a composite measure may also be something for consideration in the future.

CO-CHAIR PINCUS: Elisa, did you say that there is some update on the endorsement status?

MS. MUNTHALI: Yes, there is an update on the endorsement status for all three measures. The two that were pulled were not endorsed, as of last week. And I think one of them was conditionally supported and the other was refine and resubmit. And the other one that has remained on the calendar was also not endorsed.

CO-CHAIR PINCUS: So none of them were recommended for endorsement by the consensus development process.

MS. MUNTHALI: Actually, the CSAC endorsed or rendered their endorsement decisions last week. And so those measures go into

appeals. So the process is almost over.

CO-CHAIR PINCUS: So in terms of sort of our process, are we entertaining a motion to vote on all three or to -- David you were one of the people that pulled this but I was unclear whether this was for discussion or for revoting.

So is there any movement to make -- is there any motion to revote or add additional discussion on any of these three measures?

MS. MARINELARENA: Sorry, I can't revote. But just to clarify or just to bring us up to speed on the measures, the one that was refine and resubmit, that recommendation by the Hospital Workgroup, that one, again, failed endorsement. The one that was conditionally supported, which was MUC16-296, completion of a nutrition assessment, that was conditionally supported by the MAP Hospital Workgroup with the condition that the measure was NQF endorsed.

So as of last week, the measure did not receive endorsement so you could revote on that and change the condition because it did not

meet the Hospital Workgroup's conditions.

Other discussion on this measure because we probably should do a revote on the measure that was conditionally supported since the condition now is not available right now.

Rhonda.

MEMBER ANDERSON: This reminds me of the previous discussion in that a composite would probably work well and what is appropriate. This is, again, a very important area but how we can make certain that it links?

And I like the way you described how you thought as a group. But I think it is difficult to refine and submit. This one to me is something to not support and have the package go forward to look at the process that was identified, how it fits in a hospital setting and how an outcome can actually be achieved with whatever the new proposed measure would be.

CO-CHAIR PINCUS: So the only question here -- I mean unless there is any other comments is, I guess, there was revise and resubmit for

two of these measures and one of them was support with conditions but that condition is not going to be met in the near future. The question is, do we need to revote on this or is the message pretty clear, based on this?

Amir.

MEMBER QASEEM: I do think that we need to revote on this because I do think that it is sort of low-value measure. Because if you look at the measure they are talking about, everyone over the age 18, they are not talking about just ICU patients. They are not talking about the patients will benefit like urinary tract infection, pressure ulcers, the elderly population and all.

And I have really looked into these malnutrition measures. I am not going to bore into details but some of the references that were used, even from the references -- I have actually the codes that I -- because this was discussed in the Health Well-Being Committee as well. The nutrition support interventions recommended this

recommendation from one of the organizations. It says nutrition support intervention is recommended for patients identified by screening and assessment at the risk of malnutrition, malnourished through great -- that is C because they don't know if it really is going to improve any clinical outcomes.

CO-CHAIR PINCUS: And which measure are you referring to?

MEMBER QASEEM: The one that is up there.

Thank you.

CO-CHAIR PINCUS: Okay.

MEMBER QASEEM: So essentially, the bottom line is I do think that revise and resubmit is not the -- I agree with Ron. I think we need to send it back and say do not support for this one.

CO-CHAIR PINCUS: So any further discussion about this measure?

Okay, so everybody vote.

MS. OGUNGBEMI: We are now voting on

MUC16-296, completion of a nutrition assessment for patients identified as at-risk for malnutrition within 24 hours of the malnutrition screening.

Your options are 1, support; 2, conditional support; 3, refine and resubmit; 4, do not support. Voting is open.

MEMBER NOONE: On the phone, vote 3.

MS. IBARRA: Thank you.

Doris, we received your vote. And Brandon, we received your vote as well.

Foster, we received your vote. And Steve, we received your vote as well.

MS. OGUNGBEMI: So the results are 13 percent support, 13 percent conditional support, 40 percent refine and resubmit, and 33 percent do not support. We reached consensus. MAP reaches consensus at 60 percent or greater in the refine and resubmit category.

CO-CHAIR PINCUS: Bill.

MEMBER KRAMER: Just a quick comment on how reporting the results -- sorry to raise

this issue again. I understand that we use 60 percent as an indicator of whether we have reached consensus or not but it does not represent consensus.

So I think it might be more accurate to simply say we have reached the 60 percent threshold, rather than implying that that represents consensus. We are voting. We are not achieving consensus.

CO-CHAIR PINCUS: Right. There is lots of different ways to define consensus.

MEMBER KRAMER: Right but it is not voting.

So can I just ask when report it out in the official notes that we are not saying that we reaching consensus, saying that we have reached a 60 percent threshold which I know we are using as a proxy for whether we should -- anyway you understand. Thank you.

MS. IBARRA: That's appropriate. Thank you.

CO-CHAIR PINCUS: So we have been

going at this for quite a while without a break for biology, or for food, or for anything else but we are running behind.

I propose we take a 15-minute break to get lunch and then to come back and sort of have a semi-working lunch to begin the process of going through the last of these for the Hospital Workgroup. Okay?

(Whereupon, the above-entitled matter went off the record at 12:01 p.m. and resumed a

CO-CHAIR PINCUS: We are running a bit behind. Okay, Steve Brotman wanted to say something on the phone.

MEMBER BROTMAN: Can you hear me? I'm sorry.

CO-CHAIR PINCUS: A little bit louder.

MEMBER BROTMAN: Okay. Is this better?

CO-CHAIR PINCUS: No.

MEMBER BROTMAN: Can you hear me? Can you hear me?

CO-CHAIR PINCUS: Yes.

MEMBER BROTMAN: Okay, great.

Hi. This is Steve Brotman from AdvaMed. Thanks for recognizing me. I'm sorry I'm calling in today.

As it was mentioned previously, that the inputs to CMS may be as or more important than the actual vote, I just want to provide some different perspective on the discussion on how important the malnutrition measures are and their far-reaching implications for positively changing landscape in all care settings. So, just bear with me for a minute.

Although I have been a physician for over 30 years, and I have thought that I have dealt with issues in malnutrition and nutrition successfully on my own for all my patients, by recognizing the need for nutrients and supplements, and especially for elderly patients in the hospital. And it was only in the last several years that I was hit with some reality that there has to be a true culture change, a major shift, in the hospital and other care

settings to place some sort of true emphasis on not only identifying those that are malnourished or at risk of being malnourished, but also what exactly to do to address malnutrition in each care setting. Because, as you know, the fragility of the elderly, one small thing goes out of kilter, and all of a sudden, there is a cascade of unintended events.

So without that culture change in the hospitals and every setting, we are forced to see over and over again the repeating cycle of physicians and nurses that I see all the time in charge of patients' care. And they're all very complacent not to fully address malnutrition and nutrition needs heads-on. And this comes from my personal experience. So this is really what I wanted to say.

In the last several years, I have had the privilege of caring for my father in his late nineties. He has suffered broken hips in falls, went from hospital to hospital, facility to facility. Nutrition was rarely brought up in the

hospitals and other settings, and when it was, it was brought up mostly by me, myself, the physician son.

And when I did, the staff's eyes would always roll, and they would repeat the same phrase to me, almost, over and over again: all people in their nineties are malnourished. What should I expect? And after arguing, they eventually took the road of least resistance. They brought cans of Ensure supplements, great, great supplies into the room, but that was it.

You know, my dad had failing eyesight, limited mobility, typical of the elderly. So, these cans got delivered every day on a tray, got removed unopened, and put on the window sill. And I used to call it the wall of supplements. And when I went to see other patients in the rooms next door, lo and behold, they also had a wall of supplements on their window sill.

So, my dad eventually passed, and I thought I would never see the cause of death on a death certificate as I saw for him, but his cause

of death was failure to thrive due to malnutrition. And this is appalling because it is curable.

And so I have been on the Coordinating Committee since its inception over six years ago. All those years, we talked about the immediate need for overarching and cross-cutting measures that could shine a light on this issue and change the thinking and culture in the care setting.

And I believe that, regardless of our discussions, nothing could effect change more than these measures addressing malnutrition. We sit in groups. We split hairs over evidence and validity, and I am not demeaning the process at all. I think that's all great, has great merit.

But malnutrition measures are sorely needed for patients and their families. It is common sense. Importantly, they will save lives, as indicated by the evidence, some of which is new, and there is updated evidence which, unfortunately, did not get presented at the meeting today, which came after the workgroup,

but evidence is there. I think the measure developer is there as well. But that did not get presented.

And so the one thing that is clear is that addressing malnutrition has been demonstrated to improve outcomes for patients and help providers decrease costs. So I just wanted to put it in somewhat of a perspective from somebody else who has had maybe a different experience than others on the Coordinating Committee.

CO-CHAIR PINCUS: Okay. Well, thank you. So now we are going to move ahead to the next measure that was raised for further discussion. It was pulled for further discussion. And that is 16-262.

MS. O'ROURKE: So just to reorient everyone, we are still in the Inpatient Quality Reporting Program, and the next measure, as Harold said, is MUC16-262, Measure of Quality of Informed Consent Documents for Hospital-Performed Elective Procedures.

CO-CHAIR PINCUS: And, Leah, do you want to comment on that?

WORKGROUP CO-CHAIR WALTERS: Let me just give the thinking. Real briefly, the thinking on this one, there is a real burden to collecting this data. It is not all electronic format.

Secondly, I think everybody realizes this is very important. It is certainly a move in the right direction. But the workgroup felt that it hadn't been through any sort of testing. Lord knows what the reliability and validity of this particular measurement would be. So, it needs to go through the process, and that is why they suggested refine and resubmit.

CO-CHAIR PINCUS: Okay. Leah, David, do you want to add to that?

MEMBER BINDER: The comment that I wanted to make, and the reason I wanted it pulled, is that some of the justification for the Workgroup's disposition of this measure was that there was variation among states and regulations,

and that that variation made the measure very difficult and burdensome.

What concerned me about that comment is that I would see that as a reason for the measure. From the point of view of a patient, to be frank, as a non-clinician, I have always assumed that there is standardization of informed consent processes or forms already. And to find that, in fact, there is the opposite of that, and that it is actually of huge variation, is disturbing.

And given the emphasis on patient-reported outcomes and our emphasis on patient-centered care and the need to also ensure appropriateness of care as a major priority for this, for the MAP process, I thought that, while this is not an appropriateness outcome measure, it is certainly a proxy measure that can help us to make sure that, when procedures are undergone, that the patient has fully been informed.

In terms of the testing, I will say that I think the measure is elegant, is very

well-written, and it has components that I think are well-established in the literature. Whether they have been fully tested and vetted, I don't know, but I do think there is a major -- having not been aware of the fact that there was such variation to begin with, it raised a concern for me that this is another measure that should be pursued with some level of speed. So, I would urge, and I would like us to vote, hopefully, to move this up a notch, perhaps conditional, but to really move this along. I think it is critically important.

CO-CHAIR PINCUS: Okay. Kate?

DR. GOODRICH: I know we have our measure, I believe we have our measure developers on the phone.

This is a bit of a different measure. It is sort of a novel measure. We did elect to begin developing it because, I would say, over the years, through the MAP and other venues, we have heard from particularly the patient community, and informed consent is one of the

number one areas that they feel that there is significant measurement gaps.

I noted somewhere in the documentation there was concern this was a checkbox measure. It is not a checkbox measure. And so, I don't know if it would be helpful for the Committee to hear from our developer sort of how this measure works.

The other thing I would highlight is that this measure was developed very much in partnership with patients, actual patients. And so, that is just important for folks. And they are the ones who really helped to identify what are the most important components for patients for the informed consent.

So, given that this is such a, I think, different kind of measure, and not everybody here has had the benefit of hearing about it through the Hospital Workgroup Committee, I didn't know if it would be helpful to have our developers maybe quickly describe how the measure works. Would that work?

CO-CHAIR PINCUS: Sure.

DR. GOODRICH: Okay. Fair enough. We have folks from Yale on the phone.

DR. SUTER: Yes, this is Lisa Suter. Can you hear me?

DR. GOODRICH: Yes, Lisa. Thank you.

DR. SUTER: Thank you, Kate, and thank you all for the opportunity to revisit this measure.

I wanted to just mention one quick thing prior to describing the measure in greater length, about the testing and validity. So, this measure has been tested. The only thing that the NQF staff flagged for the MAP review in terms of its suitability and seeming readiness for NQF endorsement was that we did not have measure score reliability. That information was presented during the MAP through a public comment process, and that has shown high reliability. So from a testing standpoint, we fully expect that this, after review by the NQF staff, will meet criteria for endorsement.

There is not an endorsement project in the calendar year 2017 applicable to this measure. So, we do not anticipate that it will be in front of NQF prior to the 2017 MAP meeting.

So, the measure itself is an assessment of the quality of the informed consent documents. I have heard a lot about burden, and we have thought a lot with hospitals and measure methodologists about the burden of this measure.

Currently, the way it was developed was to have hospitals send us the documents. We envision this measure would be locally abstracted by hospitals. We have worked with 25 additional hospitals to do additional testing on this measure, supplementing the development sample.

That work has demonstrated not only good reliability and testing metrics, but also that we know that hospitals can abstract this data in about three to four minutes per document. So we are currently evaluating the number of documents that need to be assessed at a hospital to give a stable hospital score, but we

anticipate it will be well under 100 documents, which means that the overall burden for hospitals is fairly limited.

The measure itself is scored as a composite of aggregated all scores for the sample of informed consent documents that are rated using an abstraction tool. That abstraction tool is what takes three to four minutes to fill out, and it covers a description of the procedure, so not just the name, cholecystectomy, or whatever, but a description of it in lay terms; how the procedure will be performed, large incision, laparoscopic, small incision; why the procedure is being performed; any patient-oriented benefits. This is probably the single most absent piece of information on any informed consent documents. Procedure-specific risks, both a quantitative and a qualitative assessment of risk, and any alternatives to the procedure.

The last piece is the timing of the procedure. We heard extensively from patients and our Patient Working Group that one of the

largest problems with the informed consent process for measures that are performed electively is that patients do not have an opportunity to review information in a meaningful way. Oftentimes, people are signing these documents at the time of the procedure, oftentimes after anesthesia has started to be administered.

So this is probably the most disruptive aspect of this measure, but it was signaled from the patients as one of the most valuable things. And we are happy to work with hospitals to think about a way to incentivize patients getting information ahead of time, but not necessarily signing the document, and as well, thinking about things like other documents to support, you know, decision aids to support.

But right now, as it is scored, it is a very limited number of questions. It takes a very short period of time for a hospital to evaluate their own documents. And the preliminary information we have received from all

of the hospitals who participated is that this information has been incredibly valuable to them as care providers. And we know that it has been validated with a large group of patients who are very much strongly in favor of this measure.

Thank you.

CO-CHAIR PINCUS: Chip, you had a comment?

CO-CHAIR KAHN: Well, it is more a couple of questions. I mean, if I understand the measure, it basically is looking at the documents and what the documents say.

First, as part of a condition of participation, you have to have these processes, and you have to have these documents. So I guess I don't know whether this is the right place for this to be adjudicated. It seems to me that this part maybe is better adjudicated in conditions of participation because this is overlapping with that.

And second, it is the process that matters, not the documents, although the

documents -- so, the question is, will the documents drive the process? I mean, the question is, is the doctor, or whoever is doing the procedure, talking to the patient clearly, early enough, and providing information the patient needs either to make decisions or at least understand what is supposed to happen. And we are not measuring that. We are only measuring the hospital's documents that the physician will use, if I understand it, when they have this discussion with the patient.

So, maybe if the documents are not up to snuff, then, to me, then the conditions of participation aren't being met. I mean, I just wonder, first, whether we have a venue issue here and then, second, if we really want to get at the process, then we really need to get at what happens between the patient and the person who is responsible for informing the patient.

Because, from my own experience, I never looked at one of those documents. You know, I just listen to them, I mean when I have

had procedures, you know, and maybe I should -- but I just listen to the physician who is describing it to me. And if it doesn't make sense, then I ask questions. Now some people probably don't.

But I don't think the document is going to answer the issue here. I guess your point would be, well, the document will change the culture. I don't think documents necessarily change culture, but that's my two cents.

DR. SUTER: So, as a measure developer, I completely acknowledge that we also would like to measure the process of informed consent. We acknowledge this measure does not measure the process. However, we heard repeatedly from patients that this is a bare-minimum requirement for the process not to be broken, to be able to -- I mean, we all listen and can take in the complex information that our physicians are giving us because we are able to do that.

But many people aren't. They need an

opportunity to have it on paper and to be able to look at it and review it with their family members and then be able to ask questions. Right now, that is not occurring in a way that satisfies a patient. It satisfies the legal requirements of saying that there are certain risks of doing procedures, but it doesn't actually give the information that they need for decision-making.

So, we see this as a first step. It in no way addresses the longer-term goal of improving that process, although, as the measure developer, we are not quite scientifically in an area where we can capture shared decision-making from a meaningful and valid scientific method.

CO-CHAIR KAHN: So I will just conclude by -- because I don't want to go on and on, and other people have got their signs up.

But it seems to me that, from a CMS standpoint, the question is, are the conditions of participation sufficient? Because I just wonder whether this is the right place for this

to happen. It seems to me in the conditioned participation, either you have consent forms that are sufficient, or they are not. And what I am hearing is that the consent forms from your research are frequently not sufficient. If that is the case, then where is the deficit? And I just wonder whether this is the right venue. That is all I am saying.

DR. GOODRICH: This is Kate.

I think that is a valid question. I don't know the details of what is in the CoPs around informed consent. I would suspect, I would expect, you know, that if you look at a representative sample of hospitals and surveyors go in -- and David, you may have to help me with this -- and look at their informed consent forms, they have the requisite information, albeit in a fairly legalese kind of way that is rather difficult to understand. So, they meet the condition of participation, but they remain relatively difficult for folks to understand. It is usually, you know, a page of like size 4 font,

right, of fairly difficult-to-understand information?

And that may still meet the CoP. So maybe we need to go back and revisit the CoPs. That may be true as well. But again, I think for all the reasons that Lisa articulated, we also think that measurement is a lever here to improve this area.

CO-CHAIR PINCUS: Okay. Other comments? So, I have David, Giff, and Leah, and Bruce.

DR. HUNT: This is David Hunt.

One question, can this process be automated? That is to say, can a hospital basically give, in a digital format, the sum total of all of their documents and have it in some machine-readable and have the abstraction tool do basically a machine-read of this? Or will that help lower the burden?

DR. SUTER: This is Lisa Suter.

We are looking into the opportunities to use electronic format documents and use either

natural language processing or electronic reading to do that. We are not in a situation right now to be able to accomplish that, and most hospitals, from our conversations with them, do not have electronic format informed consents integrated into their EMR yet.

CO-CHAIR PINCUS: Giff?

MEMBER GIFFORD: I always find it really difficult as a sort of clinician in pushing quality to talk about topics that are clearly really important for consumers and really necessary, and where we do a bad job in healthcare.

But that doesn't mean measures are the right thing for that, and the measure should do that. And I think there's a lot of problems with it. I would echo what Chip said. You know, is measurement of this the vehicle to improve this process? You have conditions of participation. You have JOIN out there. I mean, this reads very much like a standard of care.

And the other thing is, for informed

consent, and I'm a big believer of informed consent and really not a big believer of signed informed consent, and nowhere does it require signed informed consent, because we know signed informed consent doesn't make sense. And we have all heard the stories.

As a geriatrician, many of my patients are demented to beat the band, and they can barely sign an X, but everyone accepts that as informed consent when they go in. God forbid should they refuse to do something. Then, they suddenly question their cognitive status and say they are not following it. And then, they enlist the family to have them get something they say they don't want, just because they are demented.

And that highlights the point of informed consent is really, the definition of it is having the person who is undergoing the procedure understand the risks and benefits and be able to explain them. Nowhere in here do I see that coming out other than a checkbox list.

The other thing is that this is

supposed to help consumers understand and drive this. This, as best I can tell in the measure, each hospital will get a score between zero and 20, or some average score across the different types of procedures they do. I don't even know how to interpret it.

I mean, I think that this is clearly a topic that we do a terrible job, needs to be improved. This measure, I don't see us improving it, and it reminds me very much back with HIPAA and the early days before HIPAA where we had to do advanced care planning, and we handed everyone the little brochure when they walked in the hospital, whether they had the right to do a DNR, and we checked the box. And everyone was happy, and we solved that problem.

And I think that this is a real problem with this the way this measure is. I think, to Chip's point, if CMS feels that this should be done differently, I don't think trying to get people to practice the measure specs is the way to change this. It could be done through

the conditions of participation. It could be done through other ways. And I think it would be much more meaningful to get information from family or consumers, did they really understand what's going on?

And if we really think that for certain procedures that we are doing a bad job, we have -- you know, why reinvent the wheel? -- we have VIS statements that CDC has developed that are used in informed consent for vaccine, and translated into multiple languages, and everything else.

And so, if there are certain procedures that we really feel we need to have some informed consent, I don't see why there isn't an ability to develop them. So, I would argue very much to, frankly, not only refine and resubmit, I would say this is not ready for rulemaking and would vote such, but would strongly encourage CMS to continue and try to get something further, but use this scoring and checklist thing in a different vehicle to get

that done.

CO-CHAIR PINCUS: So we have now Leah and Bruce and Rhonda and Rich and Carol.

I remind everybody the recommendation is revise and resubmit. And so, please, if you have something additional to add specifically to the discussion, you know, let's try to get to it concisely, because we have a bunch more to go over.

Leah?

MEMBER BINDER: Thank you.

I want to make one more point about this. I'll have to say this, with Chip sitting right here saying the opposite, but I think from my own experience working in a hospital, in a rural hospital network, we did struggle with a lot of documents like consent forms.

To me, this would seem to be a real opportunity and an advantage for hospitals. It gives them a set of standards. It says this is what patients have said is useful. It has been, it sounds like, well-tested by some excellent

measure developers. I think it would be useful, and I don't think -- starting with conditions of participation in Medicare, that is kind of a heavy-handed way of starting with this, with hospitals that have a hundred different consent documents, apparently, in one system. It seems to me that this is a way of helping hospitals reach a higher level of patient-centeredness over time and not hitting them with anvil when they are not there already.

And so, I do think this has some advantages for hospitals, but mostly, I think for patients this is just such a high priority. The issue that I hear most common from patients and from purchasers, that they hear, is that: I was on the gurney being wheeled into the surgery, and they asked me to sign the consent. So I really thought that that was actually a good element of this as well, that it looks at when the signature took place.

CO-CHAIR PINCUS: Bruce?

MEMBER HALL: Thank you.

As the American College of Surgeons, we are certainly one of the largest groups playing in the realm of elective informed consent. And we agree with all the comments that this is a critical area to address. We are thrilled that CMS and our colleagues at Yale have begun to address it, and we certainly respect the quality of work that has come out of that shop. So we are thrilled that the work has begun.

We, however, would feel that this should come down a notch to do not support. And I think it is a matter of whether we are talking about rulemaking or whether we are talking about ongoing development. We are fully in favor of ongoing development.

We think, as it stands, the measure falls short on a number of areas. As a professional organization, we have principles we would love our members to embrace to be more meaningful and more patient-centered in this process of informed consent. And we feel that the measure falls short on some of those.

In particular, we feel there is an important, an increasing role for explicit risk calculation and decision-making aids, but also that being really patient-centered in this area requires us to focus on the relationship between the consenting team performing the procedure and the patient and family and their stakeholders.

And we think the measure as it is focuses a little more on the hospital functions and less on the relationship, which is really the meaningful and patient-centered part to us, or we would like it to be increasingly so.

We have submitted some other comments which I think others have raised. And so I won't be redundant. I would just say that, from our perspective, for rulemaking, we would take this down a notch to do not support, but in every other aspect of development, we would kick it up a notch and fully support its ongoing development.

Thank you.

CO-CHAIR PINCUS: Rhonda?

MEMBER ANDERSON: I won't reiterate everybody's. I would just say I appreciate the comments that Chip has made and others, and add one thing.

Should this be -- I would agree that it should be do not support, but should it go to PROs? Should it be a part of the PRO measure? Helen identified the fact that measures are important, and they are incentives, but where does it really belong? If we are trying to get the patient to understand, the process is good, but what about really knowing whether they did understand or not? So, I would just ask us to consider that if we do vote it to do not support.

CO-CHAIR PINCUS: Rich? And then, Carol. And then, we are going to vote on do not support.

DR. ANTONELLI: That is probably exactly what I was going to say. It seems like this is ideally suited to be a patient-reported measure, not this one.

MEMBER SAKALA: So thanks to the

developer for further clarifying.

We have very well-documented issues with decision-making processes and definitely need a lot of great measures. As one that could potentially could have a broad applicability rather than a lot of specific measures, this one seems to offer a lot of potential from my point of view.

It takes a piece that is standard across our healthcare system, which is widely recognized to be really for the service providers, and it gives us an opportunity to make those pieces much more patient-oriented. And I think that that's a real opportunity right now in this area where we all understand we need to do better, and we are facing challenges around development of other approaches.

CO-CHAIR PINCUS: Okay. Shall we set this up to vote?

MS. OGUNGBEMI: We are now voting on MUC16-262, Measure of Quality of Informed Consent Documents for Hospital-Performed Elective

Procedures.

Your options are: 1, support; 2, conditional support; 3, refine and resubmit, and 4, do not support.

Voting is open.

(Voting.)

MS. IBARRA: Steve, Foster, Brandon, and Doris, we received your votes. Barrett, we received your vote as well.

The results are 7 percent support, 4 percent conditional support, 37 percent refine and resubmit, and 52 percent do not support. So we do not reach a threshold anywhere. But because of the voting procedures or because of the rules of voting, we will land at do not support at 52 percent.

CO-CHAIR PINCUS: Okay. So let's move on. So there were several different cancer --

MS. O'ROURKE: We have one more.

CO-CHAIR PINCUS: One more before that? Okay.

MS. O'ROURKE: The final measure that

has been pulled for IQR is MUC16-167, Safe Use of Opioids - Concurrent Prescribing.

CO-CHAIR PINCUS: Leah, did you have a comment?

MEMBER BINDER: Okay. This is an extremely high priority to purchasers who are in my constituency as well as the public. It is a front-page issue.

CO-CHAIR PINCUS: Get a little bit closer to the mic.

MEMBER BINDER: Sorry. It's a front-page issue. I don't need to repeat any of that.

This measure appears to have some potential. So, it is an opportunity to identify people who have more than one prescription for opioids at discharge.

There is some concern that there could be an unintended consequence because of benzos that potentially could be advantageous and also prescribed along with opioids. But it seems to me that we should at least consider resubmitting this measure, not simply voting it down, because

there are so few ways for us to measure this.

Policymakers across the country in statehouses as well as here in Washington are making a lot of policies around opioid use, and there is so little data that it seems to me that this should be very high priority to move this, to move something along that we can measure.

These folks that are being discharged from hospitals would appear to be perhaps most vulnerable, potentially already addicts or potentially at-risk for addiction. These are folks that can be at least identified. Those are people who are often very difficult to identify for purposes of data.

So I think there is some real potential in this measure, and I recognize that there are some clinical issues with the measure, but it seems to me that those could be addressed and that there ought to be some way to move this forward. And I was pleased to see that the MUC would put this on because I do think that there has to be more ways for us to identify people at

risk or already affected by the opioid epidemic, which, again, is such a high priority to the public.

So, I would like us to consider moving this from -- this was do not recommend. I would like to potentially move it into resubmit.

CO-CHAIR PINCUS: Is there a particular comment you have about how it would be revised?

MEMBER BINDER: I actually don't know, but it seems to me that it could be addressed. I'm not a clinician, but it seems to me that there ought to be ways to address the problem of the certain circumstances under which it is appropriate to have the dual prescription.

CO-CHAIR PINCUS: Further discussion? Bruce?

MEMBER HALL: I would add that the American College of Surgeons feels the same way, that based on the importance of this topic, that it shouldn't be removed entirely, but should be reworked. And we did submit in writing two

suggestions for revision based on exclusion and exception. So, I won't re-read them, but we have submitted some suggestions along those lines to revise.

CO-CHAIR PINCUS: Other comments before we re-vote?

(No response.)

Okay. Could we set up the voting procedures?

MS. OGUNGBEMI: We are now voting on MUC16-167, Safe Use of Opioids - Concurrent Prescribing.

Options are: 1, support; 2, conditional support; 3, refine and resubmit; 4, do not support.

Voting is open.

(Voting.)

MS. IBARRA: Brandon, Doris, Steve, and Foster, we have received your votes. Barrett, we still are looking for your vote. You can also provide it verbally.

MS. McQUESTON: And just to clarify,

it says on the slide it is for outpatient quality reporting, but this is for inclusion in the Inpatient Quality Reporting Program. This measure was also proposed for the Outpatient Quality Reporting Program.

MS. OGUNGBEMI: Results are 0 percent support, 4 percent conditional support, 62 percent refine and resubmit, 35 percent do not support. We reach our 60 percent threshold at refine and resubmit at 62 percent.

CO-CHAIR PINCUS: Okay. So, actually, Erin just raised the issue, to avoid having to re-vote on this, shall we also apply this vote to the OQR, the Outpatient Quality Reporting, as well? Is there anybody dissenting from that?

(No response.)

Okay, good.

So now, what we have remaining are several different cancer-related measures that have been pulled, and more for discussion than anything else.

I don't know, David, do you want to

comment on those?

MEMBER BAKER: I would like to first talk about the hospice measures. So, first, if you look at 16-275, Proportion of Patients Who Died From Cancer Not Admitted to Hospice. And this is recommended for support.

The question for me is why there were no exclusions for patient refusal. That is important because there are still many patients and their families who are not willing to accept hospice. And equally importantly, that varies according to race, ethnicity, literacy level. So it could really create a bias in this measure. So I was curious to know why there weren't any exclusions for this. And if there is no good reason to not have exclusions, then we should be thinking, and perhaps voting, on conditional support after adding an exclusion for that.

CO-CHAIR PINCUS: Other comments on this? Do you have some thoughts about the rationale why there is no exclusions on this?

MR. AMIN: Let me check. Is any of

the staff on who might be able to comment on that?

CO-CHAIR PINCUS: And did this come up, by the way, Ron, in the Workgroup?

WORKGROUP CO-CHAIR WALTERS: Good point. The gap is so large actually that that population is not a major contributor to the gap that needs to be overcome.

And these hospitals, this is, again, a unique program just applicable to 11 hospitals. This has been through the End of Life Steering Committee, and they supported it, and the hospitals supported it. So I think we're very anxious, well, I should say, they're very anxious to get the measure up and running and reporting and then use it for performance improvement also, along the lines you just said.

But your points are valid. There are people who just choose not to, especially in exempt cancer hospitals. So this group of hospitals is willing to accept that as a limitation of the measure and move ahead anyway.

MS. SPINKS: And I'm sorry, this is Tracy Spinks. I'm on the phone on behalf of the ADCC. So, I don't know if now is an appropriate time for me to add a few additional comments to what Dr. Walters said.

But I would note that this is a claims-based measure. All of these measures are claims-based, in which case, we have to accept that there may be some level of precision that we won't be able to have in the measure. And so, again, as Dr. Walters said, you know, this paints such an important picture of what happens to patients at end of life and making sure that we are doing everything we can to give them the highest-quality death.

And it really gets to broader issues about are we delivering end of life care that aligns with patient preferences? But this is a really good starting point for us to look at and create that picture of what happens to our patients at end of life, which, then, as Dr. Walters said, we can, then, use for internal

performance improvement to see, well, what are we doing, and what do we need to be doing to ensure that our patients are appropriately referred to hospice and palliative care services in accordance with their preferences and needs?

MEMBER BAKER: Thanks. I didn't realize this was a claims-based measure. So the answer to my question is it is not possible.

So the second part was essentially dinging physicians if they don't admit a patient to hospice within three days of their death. And as was just said, it is incredibly important for us to be trying to get more patients into hospice. And to turn around and say, well, you tried, but you didn't do a good enough job. You didn't get them in. And I know the literature on the proportion of patients who die within three days of hospice, and it is clear we are too late. But it just seems like we are penalizing people at a point, as was just said, when there is still such a gap in the proportion who are even going into hospice.

And I will tell you, as a clinician, I have had patients come in, one patient with stomach cancer who, you know, would have been dead in three months, but with current treatment, had a year of really good quality of life with chemotherapy and radiation therapy, and came in and had a CT scan with multiple brain metastasizes. I admitted him to hospice the next day, and he was dead two days later. And, you know, we see that.

So it just seems like that is too punitive. So I would like us to have a discussion about whether people support this and whether it should be do not support.

WORKGROUP CO-CHAIR WALTERS: So this is neither a pay-for-reporting nor a pay-for-performance measure.

CO-CHAIR KAHN: But once it is on the path, I mean, the question is, if it is not the right thing to do, you are still putting it on a pathway. I understand what you are saying about where it would fall.

And also, supposedly, those measures are supposed to be meaningful in terms of people making decisions because they are looking at information. The question is, is this a meaningful measure?

WORKGROUP CO-CHAIR WALTERS: And I think once we get the rates of referral to hospice up, this would be a good measure, right? I mean, if we had 80 percent of patients with metastatic cancer admitted to hospice, but then, the vast majority were admitted in the final days of life, then you would say, okay, that is the next step for us to be working on, is earlier. But as was said before, there is still such a huge gap just in the proportion of people who are getting to hospice at all.

CO-CHAIR PINCUS: David?

DR. HUNT: Maybe this is a little bit too picayune, but given that this is claims-based, can we say patients who died from cancer rather than patients who died with cancer? Because we really don't have a cause of death

based on claims. And admittedly, if someone is stage 4 cancer --

CO-CHAIR PINCUS: Well, it depends how it's operationalized in the measure.

DR. HUNT: Yes, but patients with prostate cancer, say stage 1, how --

DR. BURSTIN: I think some of it is because they are PPS-exempt cancer hospitals, is what this is proposed for. So they are already there for that logical reason. It isn't proposed for a wider program. So presumably, they are there for cancer.

CO-CHAIR PINCUS: Giff?

MEMBER GIFFORD: By the way, Dave, you are not making anecdotal, using anecdotes to do policy? I wouldn't want to --

(Laughter.)

But how does your scenario of your patient not fit in the measure? I guess we are talking about 267, right?

MEMBER BAKER: I'm saying that we see a lot of people, especially now with the more

advanced treatments that we have, who are doing well, and then they have a rapid, rapid descent. And the idea that somebody did the wrong thing if they didn't refer somebody -- because that is what the measure says, if you didn't admit, right?

MEMBER GIFFORD: Within the last three days, yes.

MEMBER BAKER: Right. So you admit somebody to hospice, and it frequently takes a day to arrange that, sometimes a couple of days. And then, they die two days later. That you did the wrong thing, I think the message we should be sending across the country is you should be getting patients with advanced cancer into hospice therapy as early as possible, but not necessarily penalizing those, at this point in time, who are admitting patients late in the game, if you will.

MEMBER GIFFORD: So you are concerned because the measure itself shouldn't be 100 percent or 0 percent? And this is the challenges

we are having in a lot of measures where there is no measure that is going to be perfect.

Because, I mean, I have the flip side of that, a number of my patients, or patients I consulted on, that just can't -- you know, they're thrown into the hospice at the last second, and they have been tortured for a while and should have been in hospice a lot sooner. And no one is really talking to them about it.

Or the fact that you can do treatment and hospice concomitantly now --

MEMBER BAKER: Right.

MEMBER GIFFORD: -- allows you to get them in there. I think there's still the belief that you're throwing in the towel. And I think we are really harming a lot of people.

So I would counter your anecdote with my anecdote. So I disagree with you on that.

(Laughter.)

CO-CHAIR PINCUS: Dueling anecdotes.

MEMBER GIFFORD: I've seen your anecdotes, too.

(Laughter.)

CO-CHAIR PINCUS: Further comments? So on the phone?

Okay, Steve?

MEMBER WOJCIK: It seems, looking at all of these measures, and based on the comments that were made with the discussion, it seems like the more relevant measure might not be when they were admitted to the hospital, whether it was never or within three days of death, but the measure that we are going to be talking about next, but maybe that could be modified. The proportion of patients who died from cancer receiving chemotherapy or other forms of aggressive cancer within X days of death seems to probably be a better measure than if or when they were admitted to hospice, especially as I didn't know, but, obviously, there's a lot of advances in cancer treatment, especially with the specialty pharmaceuticals.

And if you can combine treatment with hospice, why are we focusing on where they were,

you know, if they were admitted and where they were? It is more what they received and how aggressive it was within X days of death. And I am not a clinician. I don't know whether it is supposed to be 14 days or some other set of days. But maybe that is the more relevant measure, and maybe these other measures should be recommended to be -- for refinement and resubmission rather than support, given all the discussion. And it seems like there is a lot going on in cancer care right now.

CO-CHAIR PINCUS: Thank you.

So David, do you want to re-vote on this?

MEMBER BAKER: We could take the time to do that, but I don't think that there is any sentiment to change. So I'm fine.

And the other concerns I had, because, again, these are claims-based measures, it is not applicable because it is really the issue about metastatic cancer versus all cancer. I mean, there still are patients who die in induction

chemotherapy, some of which are in the ICU. But there is not good coding for metastatic cancer in claims data.

So, thanks.

CO-CHAIR PINCUS: So we, I think, have completed going through all the pulled measures from the Hospital Workgroup. Anybody want to pull another one?

MS. O'ROURKE: Procedurally, I just want to make sure everyone is clear with where we are.

CO-CHAIR PINCUS: Yes.

MS. O'ROURKE: So, this would be the end of discussing -- let me pull up my list of programs -- the measures for the Ambulatory Surgery Center Quality Reporting Program, the End-Stage Renal Disease Quality Incentive Program. There were no measures under consideration for the HAC Reduction Program. We would have discussed all the measures for the Inpatient Quality Reporting Program, the Outpatient Quality Reporting Program. There were

no measures under consideration for the Readmissions Reduction Program, and we have discussed the measures for the Hospital Value-Based Purchasing Program. So, those are the consent calendars before you. And the Inpatient Psychiatric Facility Quality Reporting Program.

So I just want to make sure there are no additional measures people want to discuss for any of those programs.

CO-CHAIR PINCUS: Yes. So, we need to cast some official vote?

MS. O'ROURKE: If we could just maybe do a show of hands to make sure we have got --

CO-CHAIR PINCUS: Sixty percent.

MS. O'ROURKE: That people understand that the workgroups --

CO-CHAIR PINCUS: Yes.

MS. O'ROURKE: If you have not additionally discussed it, the workgroup's decision would stand. So I just want to make sure people are --

CO-CHAIR PINCUS: So, officially, and

by Robert's Rules of Order, you have to vote on the consent calendar.

CO-CHAIR KAHN: I can move it, I guess.

CO-CHAIR PINCUS: Okay.

MEMBER BARTON: Second.

CO-CHAIR PINCUS: And seconded.

All in favor?

(Chorus of ayes.)

Opposed?

Thank you.

So just less than a few minutes talking about gaps in hospitals.

Rhonda, do you want to say something about what the workgroup sort of came up with in terms of their thinking about gaps?

MEMBER ANDERSON: There are lots of gaps.

(Laughter.)

WORKGROUP CO-CHAIR WALTERS: There is a lot of development to be done in a lot of the programs, and certainly in this one, too. And we

have alluded to that a couple of times here.

Certainly, the care coordination between the hospital measures and other types of programs, we have alluded to in our discussion here and consideration of what the system is responsible for and what the hospital is responsible for. But regardless of that, how can they coordinate their actions better to get the care of the patient improved?

And then, also, I think we will continue to look at opportunities to trim down measures that have topped-out, trim down measures that aren't quite achieving what they are supposed to achieve, and look to the other programs for opportunities to bring into the hospital.

We just talked about one of them, and certainly cancer care is not unique to those 11 cancer centers. There is an opportunity to discuss which of those might be appropriate for hospital inpatient care also, with all the caveats attached that were mentioned.

CO-CHAIR PINCUS: Are there other comments about gaps?

I think, Leah, you had mentioned, yes, about --

MEMBER BINDER: Yes. Would you like to address that? You were -- I'm sorry.

The biggest one that I have heard from talking to some folks is C-section rates or maternity in general, I would say. C-sections is the number one reason for hospitalization in the United States. So recognizing CMS may not always have that as a top priority, concern, it certainly is in the Medicaid program, which pays for half of the deliveries. So, it is a high priority from the point of view of purchasers. We pay the other half. But in general, I think maternity care is a major area that we should be looking mor

CO-CHAIR PINCUS: Other comments or suggestions around gaps?

(No response.)

I mean, beyond what we have so far, I

do think that we do need to revisit the substance abuse measures that we talked about earlier and think about some better solutions for that.

MEMBER BINDER: Yes. So, the other thing that I heard from a couple of folks is -- and we say this a lot, but I guess it is worth saying it for the record -- that having more outcomes measures than we are reviewing today, and perhaps maybe it is time for us to pursue more nuanced outcomes than just mortality. So, I think there is some discontent that we are not looking at a group of measures that are as robust as we would hope at this stage in measurement science.

CO-CHAIR PINCUS: Just a comment, just stepping out of the Chair role, with regard to both the inpatient psychiatric hospitalization one and, also, for people that are not necessarily in inpatient settings. For people with severe mental illnesses to think about potential hospital-based measures that look at the physical comorbidity issues among those

people or the potential for their lack of access to preventive screening and preventive interventions may be something that is worth exploring in terms of an area of needed attention.

WORKGROUP CO-CHAIR WALTERS: I would really like to thank the Committee for having me here and for their very thoughtful input. It is a process, sometimes a laborious process, but, nonetheless, it is a very important process. And the day we don't go through what we went through this morning and into the afternoon is the day we all had better give up.

CO-CHAIR PINCUS: Well, thank you, Ron. We have really appreciated your input and your being here for this.

So now, we can move on to the next Workgroup report.

Oh, Giff?

MEMBER GIFFORD: No, just a quick gap. As a geriatrician, representing nursing homes assisted living, recognition of dementia in the

hospital setting. We are going to see that grow over time, and I think it is a very vulnerable population that deserves some special attention and is overlooked in a lot of the measures in the hospital setting.

CO-CHAIR KAHN: Okay. Now we turn to another public comment period, now on post-acute care/long-term care programs.

And I guess I ask if there is anyone on the phone who wants to comment before we get into a session on that.

Please limit your comments to the post-acute care/long-term care program recommendations. Limit comments to no more than two minutes, and make any comments on MUCs or opportunities to improve the current post-acute care/long-term care measure set at this time.

Actually, I should say, is anyone here that wants to comment?

(No response.)

Okay. There is no one in the room that wants to comment from the public gallery.

Is there anyone on the phone?

OPERATOR: At this time if you would like to make a public comment, please press star 1.

CO-CHAIR KAHN: And I believe Kim is also looking at the chatbox.

(No response.)

Okay, going once, going twice. Anyone in the chat --

MR. HILLMAN: Hello.

CO-CHAIR KAHN: Oh, yes?

MR. HILLMAN: Hi. This is Troy Hillman from UDSMR.

CO-CHAIR KAHN: Okay.

MR. HILLMAN: Is it an opportunity for public comment?

CO-CHAIR KAHN: The floor is yours.

MR. HILLMAN: I appreciate it.

UDSMR appreciates the opportunity to have our written comments considered and to further comment on the pressure ulcer measures that are being considered by the Committee, and

the supporting memorandum that was supplied by CMS and RTI.

While we appreciate the CMS/RTI response to concerns that were raised during the PAC/LTC Workgroup, UDSMR would like to note the following concerns related to this memo:

First and foremost, the reliability and validity analysis and feedback appears to be based on three resources that have limited applicability to current inpatient rehab facility practice.

First and foremost, the MBS 3.0 data, which is collected from skilled nursing facilities, a discussion from a TEP that was convened in July 2016, prior to the implementation of new pressure ulcer items in October, and PAC-PRD data that was collected and reported on nearly 10 years ago. Furthermore, the inter-rater reliability data that is based upon what are considered equivalent or similar items, and not the actual items that are currently being collected for this measure.

Because of this, we continue to question the reliability and validity of the items being proposed for utilization for this measure.

Additional analyses in this memo were conducted on data from, again, equivalent items from October 2014 to March 2015, when the IRF-PAI version was 1.2, and that was in place asking questions in a different manner, and given different instructions via the IRF-PAI training manual. We are currently using IRF-PAI version 1.4, which began assessment in October 2016, where these pressure ulcer items have been redefined and the training materials have been updated with new descriptions.

Additionally, later on in the memorandum, more recent data from October 2016 forward, is utilized and notes that there are differences between the item sets that are being utilized, but goes on to recommend that the M0-300 series of questions which are proposed as part of this change are more accurate than the currently-utilized M0-800 items, indicating that

the current items are understanding the incidence.

However, review of data within the UDSMR database on Medicare cases discharged between October to December 2016 suggests that, of those cases that are currently identified utilizing the current items or the M0-800 items, nearly 114 patients, or 13 percent of those that are currently identified, would not be identified utilizing the new items.

So, while CMS and RTI are suggesting that the current items may be underreporting the measure, it is to be noted that the issue is present within the changed items as well. We would encourage the Coordinating Committee to reconsider the voting on the pressure ulcer measure for all post-acute care sites and not just inpatient rehab facilities, with a recommendation that a refine and resubmit designation or a do not support recommendation be provided.

We would further suggest that in the

feedback to CMS and RTI that they perform a more detailed medical record review to more accurately determine which item bank accurately records a new or worsened pressure ulcer.

UDSMR is also concerned that, by not following the measure selection criteria and associated decision categories to determine whether measures are fully developed and tested, that the NQF MAP process continues to allow CMS to implement unproven and untested quality measures that are negatively impacting providers through the burden of additional data collection or the publication of inaccurate or inconsistent values on quality comparison websites that are available currently to consumers.

Furthermore, while CMS staff continues to suggest during Workgroup deliberations that the IMPACT Act requires that they implement various quality measures by certain deadlines, they fail to acknowledge that the IMPACT Act also affords the Secretary of Health and Human Services the ability to suspend or remove

measures, especially in circumstances where the collection of data for a measure may produce unintended consequences.

Given that all post-acute care measures being considered within the PAC/LTC Workgroup deliberations have not been fully tested, CMS should delay the implementation of these measures until such a time as testing indicates whether or not providers may experience unintended consequences as a result of these measures.

We respectfully ask that the Coordinating Committee consider this and recognize that the measure selection criteria and decision categories would reject recommendations of support or conditional support for all the measures that have not been fully developed and tested for the specific quality programs they are to be considered for.

We further ask the Coordinating Committee recommend that the Secretary of Health and Human Services utilize the authority provided

in the IMPACT Act to suspend or remove measures that are not fully developed and/or tested until such a time as adequate development and testing has been completed and made available to all appropriate stakeholders.

Thank you very much for your time and consideration.

CO-CHAIR KAHN: Thanks.

Any other comments on the phone?

OPERATOR: Yes, you have a comment from the line of Caroline Sparks.

CO-CHAIR KAHN: Thank you.

Would you repeat your name and, then, give where you are from, and then, go ahead, Caroline?

DR. SPARKS: Okay. I am Caroline Sparks. However, I did not submit a comment. I apologize.

CO-CHAIR KAHN: No problem. Just proceed.

DR. SPARKS: I didn't have a question.

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

I'm sorry. I thought she didn't give written comment.

Okay. Anyone else on the phone?

(No response.)

Okay. I guess we can now go into the session.

PARTICIPANT: I'm sorry, I am a colleague of someone who I know is on the phone who is an expert in one of these areas. And I believe that they did have a comment. So, if you could just give it one more second for them to register and queue-in their notification of a comment?

CO-CHAIR KAHN: Yes. What is their name?

PARTICIPANT: Her name is Mary Ellen DeBardeleben.

CO-CHAIR KAHN: Okay.

OPERATOR: Okay, and her line is now in queue, and I will open her line now.

MS. DeBARDELEBEN: Thank you.

CO-CHAIR KAHN: Mary Ellen?

MS. DeBARDELEBEN: Hello. Can you hear me?

CO-CHAIR KAHN: Yes. If you could say your name and where you're from?

MS. DeBARDELEBEN: Oh, yes.

CO-CHAIR KAHN: And then, proceed.

MS. DeBARDELEBEN: I'm not sure why my question didn't go through.

Good afternoon.

My name is Mary Ellen DeBardeleben, and I'm the Director of Quality for HealthSouth.

My comment relates to the IRF pressure ulcer measure 16-143 that proposes changing the measure from using M0-800 items to M0-300 items, which I will refer to as the existing and proposed measure from here on out.

I would like to thank CMS for the thoughtful response to the concerns raised by HealthSouth and other IRF stakeholders regarding the pressure ulcer measure change. It is obvious that significant work went into the creation of this memo, and I respect that time and effort.

We do not believe that the analysis on pages 3 through 12 using assessment items from 2014 and 2015, pulled from prior versions of the IRF-PAI, is an appropriate proxy to the changes we are discussing today, because the questions were different and they were being asked in a different way.

We appreciate this analysis, but would prefer to focus the Coordinating Committee's attention to the analysis that compares the specific components discussed here. This analysis begins on page 12 of the 17 pages of the CMS and RTI memo, and validates the comments from the MAP PAC/LTCH meeting last month and public comments submitted to CMS in November.

CMS and RTI found that changing the pressure ulcer measure from the existing to the proposed results in a 33 percent increase in pressure ulcers, which is a significant difference. Also, while CMS and RTI suggest the existing items underreport the incidence, our analysis, which has found similar results to what

CMS and RTI have presented, show that over 100 patients over the past three months, which are currently defined as having new or worsened pressure ulcers, would not be identified using the new items. So, the suggestion that the proposed items are more accurate than the existing items is not necessarily consistent across the population.

I would also like to note that the voluntary nature of the proposed items listed as one of the potential reasons for the discrepancy only applies to the unstageable pressure ulcer items which were specifically excluded from this analysis.

The CMS and RTI analysis confirms the significant discrepancy caused by modifying this measure and offers a few different possible explanations. However, without further testing at the measure level using current data, it is impossible to know if the new measure is accurate and valid, which is the cornerstone of the NQF MAP approval.

While consistency across providers is ideal, I would urge NQF MAP to not rush to any change to any measure with such a significant change to outcome and would encourage NQF MAP to vote do not support for measure 16-143.

Also, while HealthSouth presented industry data in lieu of company data in both our written and verbal comments, we are proud that the HealthSouth-specific data that CMS and RTI presented publicly shows that HealthSouth facilities have fewer new or worsened pressure ulcers compared to all other IRFs, regardless of the way the measure is calculated.

Thank you so much.

CO-CHAIR KAHN: Okay. Any other comments? Okay. Thank you for the --

OPERATOR: You have a --

CO-CHAIR KAHN: I'm sorry.

OPERATOR: You have a comment from Lane Koenig.

CO-CHAIR KAHN: Okay. Proceed please.

DR. KOENIG: Hi there. Can you hear

me?

CO-CHAIR KAHN: Yes, we can.

DR. KOENIG: Great. Thank you.

My name is Lane Koenig. I represent the National Association of Long-Term Care Hospitals.

I have a comment on the pressure ulcer measure, and I just want to reiterate the other commenters that came before me, that we agree with many of the comments that were said. And so, I am not going to rehash some of the things that have been said.

I want to raise one concern that we have. Others have raised concerns regarding the switch from the 800 series to the 300 series for measuring pressure ulcers, particularly from our perspective on the LTCH care tool. And our concern is really about the way, the inclusion of the unstageable wounds, the way it is calculated in score is that, if you have an unstageable wound, that, therefore, after treatment is revealed to be a stage 3, for example, that the

way the measure is currently scored, that would show a worsening of pressure ulcers because the unstageable pressure ulcer now became stage 3. And so it would indicate a new stage 3 wound. And so, we ask that the Committee sort of ask CMS to revise and correct the coding to deal with that issue.

Thank you.

CO-CHAIR KAHN: Okay. Thank you.

Any other comments?

(No response.)

Okay.

MR. TILLY: Great. Thank you.

I just want to check quickly, is Deb Saliba on the line? I know we are starting a little bit later than we planned.

WORKGROUP CO-CHAIR SALIBA: I'm on the line.

Jean-Luc is going to present, I think, for us today.

MR. TILLY: That's right, great. Thanks, Deb.

So, the MAP PAC/LTC Workgroup reviewed 22 measures under consideration for six federal programs, the three measures for the IRF program, the same three measures for the long-term care Hospital Reporting Program, as well as the SNF Quality Reporting Program. No measures for the Skilled Nursing Facility Value-Based Purchasing Program, although we did discuss the existing measure set; five measures for the Home Health Quality Reporting Program. So, those same three for IRF, LTCH, and SNF as well as two others, which I will go into in some detail later. And eight measures for the Hospice Quality Reporting Program.

The overall themes for our meeting, the first kind of predominant theme is the IMPACT Act and the effect that that has had on measure development in the PAC/LTC space. You know, by encouraging the alignment of measures across settings, we saw that many of the measures submitted -- I just described many of the measures submitted for this -- were the same

across several settings which is by design and which we hope will standardize measurement.

But that also means meeting fairly challenging deadlines. And so, in the case of a couple of measures, the measures were not fully developed before coming to the MAP, which led to a revise and resubmit recommendation. But I think the Workgroup strongly agreed that, overall, the measures submitted were making a really positive contribution to the program and were in line with the IMPACT Act recommendations.

The MAP Workgroup did highlight, however, that there were many opportunities to address quality improvement, so a continuing opportunity for improvement. And many of these same themes you saw reflected in the Hospital Workgroup just now, but, again, an emphasis on patient-reported outcomes and how key they are to understanding quality. And, of course, the presentation on the PROMIS tool was particularly exciting to the PAC/LTC Workgroup which really was enthused about the opportunity for

groundbreaking measurement there.

Other measures of importance, you know, particularly to patients, we heard discussion about nutrition measures, care preferences that extend beyond end-of-life care, but care preferences around procedural things such as turning, and finally, measures around medication management.

Finally, the Workgroup emphasized shared accountability across the care continuum. So, here where we saw measures of transfer of information at admission and discharge, that means that both facilities and hospitals outside of the PAC/LTC sphere are responsible for making some effort to either improve their health IT capacity or their processes of transfer of information to meet those measures.

And then, so we will move into a discussion of consideration for specific programs, starting with the Inpatient Rehab Facility Quality Reporting Program. So, here the specific new opportunities for measurement cited

were CAHPS, or their experience-of-care assessment.

The measures under consideration: first we have the new or worsened pressure ulcers measure which received a conditional support for rulemaking. That is the measure you heard discussed in the public comments just now.

And this recommendation of conditional support for rulemaking is different than the recommendation in the other settings, where it was given a support for rulemaking. Here in the IRF setting, there was, as you heard from HealthSouth, a particular concern about how the measure was being used in the IRF setting and some data that suggested that there were questions around the validity there. So, the condition with the support for rulemaking was that CMS evaluate the impact of the revised specifications specific to IRF patients.

Public comments we received were mixed. Some very much supported MAP's recommendation and others concurred with the MAP

that there was a need for possible reevaluation, even a return to NQF and the CDP for re-endorsement.

CMS submitted a memorandum during the public comment period to address those changes to the measure, and which included some findings from testing that they had done and a specific examination of HealthSouth's data and how that applies to the IRF setting.

So, the other two measures under consideration for the IRF QRP were a transfer-of-information measure at admission and at discharge. That is two measures there. They each received refine and resubmit. And the Committee really underlined that it would be important to refine the measure to include transfers between attending clinicians as well as simply between settings. They asked, of course, that testing be completed and it be submitted to NQF for endorsement.

And finally, our public comments were generally supportive of MAP's recommendations and

added that there are existing regulations that may make this measure somewhat duplicative.

So, in the SNF Quality Reporting Program, a lot of the same as in IRF, because, again, the same measures were submitted here in terms of opportunities for improvement. We have had a few other measures to address, the presence of advance directives and measures of nutrition.

For the new or worsened pressure ulcers measures, we received support for rulemaking, as I said. But I believe that measure has been pulled for a re-vote as well. In fact, I think every pressure ulcer measure has been pulled for re-vote.

And again, the transfer-of-information measures at admission/discharge received many of the same comments, in fact, really the exact same.

In the LTCH setting, a little bit different here. So, in addition to the same new opportunities for measurement, nutrition, and CAHPS measure, there were some suggestions around

refinement of existing measures already in the program. So there, where there are infection-specific measures that exist already that are addressing a specific infection such as C. diff, replacing that with a kind of general measure of infections, and, also, a reconsideration of the ventilator-associated event measure. There was some suggestion from the Workgroup that possibly that measure was no longer needed.

And then, finally, for the SNF program -- and, well, you're familiar with this by now. Pressure ulcers, support for rulemaking, transfer of information at admission/discharge, some of the same comments, transfers between clinicians, between settings.

So, finally, in the Home Health Quality Reporting Program, a little bit different there. So, here we had the same measures around pressure ulcers and transfer of admission, but, then, we also had a couple other measures.

So, here we had a measure, a functional assessment at admission and discharge

together with a care plan. That received a conditional support.

And here, the Workgroup really wanted the measure developer to resubmit the measure to NQF for endorsement in new setting. It is actually not endorsed in the home health setting, but, rather, only in the long-term care hospital setting, is my understanding.

And then, also, a falls with major injury measure, where the recommendation was basically the same. You know, submit to NQF for endorsement in the setting to which it is being applied.

And public comments generally concur with the MAP recommendation, although some suggested expanding the measure to include all falls and not just those with major injury.

So, in the Hospice Quality Reporting Program, there we had several new opportunities for measurement. So, medication management at the end of life, especially after death; the provision of bereavement services; patient care

preferences beyond end-of-life care, and then, symptom management measures. You know, currently, the Hospice QRP includes several symptom management measures around cancer, and the idea was that we could create other measures that would be related to other diseases, such as dementia or other typically end-of-life conditions.

And the idea of the Workgroup there around the existing measure set was to look closely at some of the process measures that were present in that set and to assess their relationship to actual outcome measures and patient satisfaction.

Eight measures were submitted for the Hospice Quality Reporting Program, all derived from the CAHPS Hospice Survey. So, getting emotional/spiritual support, getting help for symptoms, getting timely care, the overall rating of the hospice. They all received a support for rulemaking, and public comments here were basically universally supportive. These eight

measures actually recently received endorsement in the Palliative and End-of-Life Care Project.

And here, I think I will turn it over to Erin to talk about the duals.

MS. O'ROURKE: Sure. So, again, the Duals Workgroup convened to provide some cross-cutting input on the PAC/LTC recommendations. In particular, they support measures that capture the degree to which providers and the care they provide is integrated across settings. They encourage continued development of the role that social risk factors play in care delivery as well as the role they play in performance measurement.

In particular, for PRO-PMs, some considerations include cultural and language barriers; the person's perspective on whether the measure is meaningful, understandable, and achievable.

And some additional gaps the Dual-Eligible Beneficiary Group put forward for consideration include population health and transitions from institutional settings to the

community.

I think, with that, I can turn it back to Chip for discussion.

CO-CHAIR KAHN: First, let me say, just get this right, that before we go over this list, which is the next thing to do, the pulled measures, that Giff added to the pulled MUC16-142 and MUC16-327. And to keep things in order, let's do MUC16-142 first, and can you bring that up on the screen, so we know what it is? I didn't memorize all the --

MEMBER GIFFORD: What was 3-something?

CO-CHAIR KAHN: Well, I was going to start with 142 because the next one is 145, 143.

MEMBER GIFFORD: No, I think I just added 142 and 145 to the already-pulled 143 and 144.

CO-CHAIR KAHN: Oh, I'm sorry, 145 is already --

MEMBER GIFFORD: Pulled? That's the home health pressure ulcer one?

CO-CHAIR KAHN: Yes, home health

patients.

MEMBER GIFFORD: I just pulled the four pressure ulcer ones.

CO-CHAIR KAHN: Okay.

MS. O'ROURKE: Okay. So, to just clarify, there are the four pressure ulcer -- it is essentially the same measure applied across settings.

MEMBER GIFFORD: Yes.

MS. O'ROURKE: So, let me just get the numbers for everybody, just to help clarify.

CO-CHAIR KAHN: Okay.

MS. O'ROURKE: So, for home health, it would be MUC --

CO-CHAIR KAHN: 145.

MS. O'ROURKE: -- 145. For --

CO-CHAIR KAHN: Yes, short stay, it is 143.

MS. O'ROURKE: Yes.

CO-CHAIR KAHN: And inpatient rehab, and then, I guess the SNF is 142?

MS. O'ROURKE: SNF is 144.

CO-CHAIR KAHN: Okay. And then, what is 142?

MS. O'ROURKE: Oh, no, SNF is 142 and LTCH --

MEMBER GIFFORD: No, SNF is 142 and LTCH was 144.

MS. O'ROURKE: Giff was right; I'm wrong.

CO-CHAIR KAHN: Okay. And should we discuss these as a package --

MEMBER GIFFORD: Yes.

CO-CHAIR KAHN: -- since there is commonality between those?

MEMBER GIFFORD: Yes.

CO-CHAIR KAHN: So, Giff, the floor is yours.

MEMBER GIFFORD: And these measures are all exactly the same measure with some minor risk adjustment differences between the setting. Because, recall under the IMPACT Act they have to have standard measures with standard assessment tools.

As you heard on the phone, CMS implemented a standard way of measuring pressure ulcers consistent with the NPUAP, which I think most people applauded, which started in all of our settings, IRF LTCH and PAC, just in October of last year.

As voiced, there were concerns with how the measure is constructed from that and the fact that this is a new assessment tool, that there is not a good sense on the reliability/validity of the underlying data yet, but, also, how the data is collected, making it a little more difficult to assess change in pressure ulcers over time when someone is admitted with more than one pressure ulcer.

And so, again, I find myself in the awkward position of clearly a topic that is of grave importance where there's lots of opportunity in all four settings. And I have heard from all the different settings prior to this meeting that they just don't feel this measure is ready, fully support it, would like to

work with CMS on it further.

And so, our recommendation would be to move this from the support category down to further develop. The other thing is there are already measures developed and specified last year by CMS to meet the requirements of the IMPACT Act. This was the effort to do more alignment with that, and we just think it is moving faster than we would like to see it. And so, our recommendation would be that.

CO-CHAIR KAHN: Good.

Are there other comments? Input? Does CMS want to say anything?

MS. O'ROURKE: So, I just want to jump in and point to something in your Discussion Guide. I know a lot of the public commenters and Giff was referencing some of the new analyses. So, if you click on the measure under the IRF pressure ulcer under the IRF setting, you can see the comments from HealthSouth, UDSMR, as well as CMS. And at the bottom of the comments from CMS there is a link to a memo that has some

supporting analyses.

And, Pierre, I wasn't sure if someone from your team wanted to walk through those.

DR. YONG: Yes. Thanks, Erin.

So, Dr. Alan Levitt or Stace Mandl, do you want to go through the analysis that we provided?

DR. LEVITT: Sure. This is Alan Levitt. I'm the Medical Officer in the Division of Chronic and Post-Acute Care.

I mean, really, the summary to look at, if you could look at, I guess, the attached item, is really go to page 17, and you can see both our summary, but, then, also, look at the items themselves that are being talked about.

What we ended up doing, the reason why we are doing this is really part of our monitoring and evaluation of this measure and all the measures that we do, and was supported by the Technical Expert Panel in the middle of last year.

If you look at the 0300 item, it is an

item that essentially is counting the number of unhealed pressure ulcers. And so, it is counting it at admission and, then, it is counting it at discharge. So, it is a real-time count by usually the nurse, of the number of pressure ulcers.

In addition, on discharge, because it is possible that a patient may heal an ulcer and, then, have another new ulcer, we do also ask whether the count of those unhealed ulcers, whether or not they were present on admission or not. And so, that is how that is done. It is really potentially a real-time count that we do based on the assessment of a patient.

The 0800 items, which, then, come later on in the assessment tool, the question on it just asking the number of pressure ulcers that were not present or at a lesser stage on admission. So, it is just asking kind of a number that is asked on the discharged assessment. That is essentially a retrospective kind of assessment. It is just asking, well, how

many pressure ulcers were not present or present at a lesser stage?

And so, what happened is that the 0300 items in the SNF setting, for example, were being used for payment, and the 0800 items were being used for quality. And there was a discrepancy between those numbers. The numbers that were being used for payment tended to be high. And again, you could get paid more, I guess, based on that, it is possible. And then, the 0800 items, the number of ulcers were low. And so, again, that maybe looked favorably, that you had less pressure ulcers when it came to quality, but more pressure ulcers when it came to payment.

And so, because of that monitoring and evaluation that we did on those items themselves, as well as other monitoring and evaluation, that is why we have the unstageables that have been added as well, based on that. We did bring it to the TEP, and the TEP supported us moving towards the 0300 items.

And so, that was done in the SNF

setting over this past year. And so now, the SNF setting is done that way. And what we have actually done here in terms of bringing these measures which are already in our programs back to the MAP was to harmonize this across the settings, similar to like what we really do want to do within the IMPACT Act.

And also, really to understand that, look at those M0300 items which count the pressure ulcers. Those are assessment items that can be used longitudinally across settings where you could actually take the counts from one setting to another. And they are very useful items, not just for the measure, but also in terms of the assessment of pressure ulcers. Whereas, the 0800 retrospective item that is used only means something in that setting. It doesn't mean anything from there on.

And so, by us going towards an 0300 item that can be used across setting and, then, modifying it, we could, hopefully, eliminate the 0800 item in terms of any sort of duplication and

also get what we would feel to be more accurate results because they could be based on the actual real-time assessment that is being done on the patient both on admission and discharge.

And so, we ended up proposing this. And again, the issue that came up within the Workgroup was, as was mentioned in the public comments, that there was a discrepancy when the calculation was being done between 0800 and 0300 items. And again, that discrepancy really was representative of why we wanted to do this in the first place, because there was really an underreporting of the ulcers when you are using purely the retrospective item.

And what we have showed best, if you go back on the attachment in terms of table 6, if you looked at the stage 2 pressure ulcer line, for example, if you took the difference between the pressure ulcers at stage 2 from discharge to admission, and if they were a greater number, they had to have a new or worsening pressure ulcer. There is no other way they would have

that.

And so, we were able to identify 526 patients that had a greater number. If you looked at those same patients and looked at their 0800 items, only 336 of them said they had a new or worsening ulcer. And so, you only got a 64 percent hit by having somebody retrospectively go and decide whether or not there was a new or worsening ulcer, which, again, corresponded to the reason why we were doing this in the first place.

And I'm not sure if there are any other questions, but that is really why we did it and why we feel you should fully support this measure.

DR. GOODRICH: Thank you, Alan.

CO-CHAIR KAHN: Kate, yes.

DR. GOODRICH: We appreciate it.

No, that's it.

CO-CHAIR KAHN: Okay, Giff, why don't you --

MEMBER GIFFORD: So, a couple of

comments on Alan's comments. I don't disagree with anything he said, except we see the same pattern on the SNF side where this is not used in payment at all. So, the fact that he is alluding to the differences have to do with something like payment may be unique to one setting, but the pattern we are seeing is in other settings where it is not tied to payment.

Second, I think we applauded the creation of the 300 measures for IMPACT, for all the things that he described. However, the way it is constructed, it makes it a little bit more difficult to measure change during the stay because you can't link it. It is sort of an ecologic analysis. You don't know which measure is tied to change or not. And if there are changes going on, you can actually look like you are having worse or not having worse. And so, it is not fully perfect. So, it is good for clinical care, good for quality improvement, not particularly great for measurement. And how they incorporated the unstageable into the measure

calculation also throws the measure off.

So, it is not that we object to a measure here, and this is sort of across all the PAC settings. So, it is home health, SNF, IRF, LTCH, all of us had this feeling that the measure just needs more work. It came out with a new scale, a new rating system in October, and they are trying to apply it to a measure. And we haven't gone back and double-checked to see how it has done in some of the preliminary data. And the clinical way suggests that this is not necessarily accurate at individual facility level. It might be accurate at a national level, but at an individual facility level it is not.

And so, we would just encourage further development on this measure.

CO-CHAIR KAHN: I mean, how do you respond? Or any response?

MS. MANDL: This is Stace.

CO-CHAIR KAHN: Stace?

MS. MANDL: Do you want CMS Central Office to respond or not?

CO-CHAIR KAHN: Please.

MS. MANDL: Sure. This is Stace Mandl, and I believe we have RTI, our measure development contractor on the line as well that can speak to this. I think those are important points, and I just want to provide some clarification.

On the M0300 topic that is sort of being tossed around, it is the assessment of pressure ulcers at the time of admission or on interim assessments or at discharge. And as Alan was describing, it is how many do you have and how many were present on admission, so as to remove attribution. Those M0300 items are used for payment in the run system on the M0300 items for stages 2 through 4.

Another thing I am trying to point out is that the M0800 item used in the nursing home version of the measure actually includes even wounds that have healed. So, part of the rationale for moving in this direction was to not include an overcount when using a stay-based

measure. So, I just wanted to kind of point to those two topics.

Thanks.

CO-CHAIR KAHN: Okay. I don't know how to resolve this other than I guess to vote. But, I mean, are there other comments?

(No response.)

Okay. So, I guess we should vote.

Oh, Deb, do you want to add anything to this discussion?

WORKGROUP CO-CHAIR SALIBA: I think it has been well-covered. The Committee voted to endorse the measure in three settings. And then, when the IRF measure was brought up, there was some public discussion and concerns where conflicting data was mentioned. And the Committee's intent in doing a conditional support was that somebody take a close look at that data, and CMS generated the memo in response to that request, looking at the data.

I think, you know, from the Committee's perspective, there is an expectation

that the distribution of the item would change if the item changes, and that part of the reason for changing an item is that you are going to get a change in the distribution of the base frequency responses.

So, I think that is why the Committee was comfortable voting for support in the three settings, and was really being respectfully responsive to the public comment in saying, well, let's look at the data that has been raised. So, I think Alan has reviewed the data that was presented by CMS in response to that request.

Does anybody have questions that would help them in terms of deciding on this particular measure?

CO-CHAIR KAHN: We didn't really generate much in terms of further queries.

WORKGROUP CO-CHAIR SALIBA: Okay.

CO-CHAIR KAHN: Are there any closing arguments?

Okay. Then, I guess we will go through all four and close this out.

So, I guess first we will do the SNF.

MS. OGUNGBEMI: Yes. We are now voting on application of percent of residents or patients with pressure ulcers that are new or worsened, short stay, MUC16-142.

Your options are: 1, support; 2, conditional support; 3, refine and resubmit; 4, do not support.

Voting is open. Ready to read the vote?

MS. IBARRA: I'm still waiting for remote participants to chat-in their votes. I have not received any yet.

CO-CHAIR KAHN: Have you got it?

MS. IBARRA: No. Foster, Doris, Steve, Barrett, Brandon, we are waiting. None of your votes have come through.

CO-CHAIR KAHN: We're going to give you another 30 seconds.

DR. LOTZ: This is Doris. I have sent it twice.

MEMBER BROTMAN: Yes, this is Steve.

I sent it about a minute ago.

CO-CHAIR KAHN: Okay. Thank you, guys.

MEMBER HOTHAM: This is Brandon. The same situation.

CO-CHAIR KAHN: Okay.

MS. IBARRA: All right. Well, I'm going to refresh.

MEMBER NOONE: This is Barrett. The same situation.

CO-CHAIR KAHN: Okay.

MS. IBARRA: All right.

CO-CHAIR KAHN: Then, Kim is going to have to fix it on our end.

MS. IBARRA: Okay, I'm seeing them now. Okay.

CO-CHAIR KAHN: Oh, the votes are in. The votes are in.

Okay, are we ready for a tally of the vote, everybody? Have you got all the votes?

MS. IBARRA: No. Yes.

CO-CHAIR KAHN: Okay. Let's tally the

votes.

MS. OGUNGBEMI: Results are 59 percent support, 4 percent conditional support, 37 percent refine and resubmit, zero percent do not support. We reached the 60-percent threshold in conditional support, and that is for MUC16-142 in the SNF QRP.

CO-CHAIR KAHN: Okay, let's go to the next one, whichever is the next one that you want. I guess 143.

I think we are going to have to have an Electoral College here.

(Laughter.)

MEMBER GIFFORD: These are exactly the same measures with the same issues in all the settings. So, I would put on the table as a motion to accept that, unless people want to go back and re-vote, because it is the same measure, the same issues. To have different results on different measures, I don't understand what that means.

CO-CHAIR KAHN: Okay, so let me

clarify.

MEMBER GIFFORD: Internally consistent, not that we seem to require internal consistency, but --

(Laughter.)

MS. IBARRA: So, if we have the decision as conditional support, we do want to get some clarifications from the Committee on what those conditions are for the conditional support.

CO-CHAIR KAHN: To me, this is sort of an awkward situation to have conditional support when you are at 59 percent and 4 percent, because the predominance of the body, not the consensus according to the 60-percent rule, I mean, you're only one -- you know, does anybody want to change their vote? We could have another vote. I mean, because I guess --

MEMBER GIFFORD: We didn't do that on other measures.

CO-CHAIR KAHN: No, no, I understand.

MEMBER GIFFORD: We came up with the

system ahead of time.

CO-CHAIR KAHN: I understand. I'm not --

MEMBER GIFFORD: But the initial support is they can go forward. I think they have got the feedback from everything here.

CO-CHAIR KAHN: Okay.

MEMBER GIFFORD: We talked about the feedback. We have gotten it written, support. I don't know what else to say, but if you are going to change it and that, then --

CO-CHAIR KAHN: Yes, I'm with you. I'm with you.

MEMBER GIFFORD: Then, we can go back and re-vote some of the other things that were close.

CO-CHAIR KAHN: I shouldn't have brought that up. I should not have mentioned it.

(Laughter.)

Okay, but I guess there is a suggestion that, since this was the vote on this, that since the other three are parallel issues,

that we would have the same vote. And I guess the question is, one, is there a motion? And then, we will see whether there is any objection in the motion to that effect in terms of taking the rest en bloc.

So, Giff?

MEMBER GIFFORD: I'll make that motion.

DR. HUNT: Second.

CO-CHAIR KAHN: Okay. Any discussion? Is there anyone who objects?

(No response.)

Okay. All in favor say aye.

(Chorus of ayes.)

Anyone object?

Okay, so I guess we would -- oh, good -- we would give conditional support, then, for all four of these, with the understanding of the issues that were raised in the discussion.

Well, no, we can't do that. I mean, I think Giff was right about that because we were actually at 57 percent, if I remember, on some

earlier ones. So, we were at the same -- I mean, the issue arises that we really would have to go back and readjudicate the earlier ones, which I don't think we want to do.

DR. ANTONELLI: But I do think we should clarify what the conditions are.

MS. O'ROURKE: Could I put a strawperson out, maybe for the Committee's consideration on what the condition might be?

CO-CHAIR KAHN: Okay.

MS. O'ROURKE: Perhaps the condition could be that CMS work with providers to educate them on the changes to the underlying data elements and the proper coding procedures, as well as with the public to help the people who are using the Compare sites to understand that the instruments have changed and they may see shifts due to some of those. So, some education for both providers and patients around the changes to the measures.

MEMBER GIFFORD: And I guess the additional add is looking at how unstageable and

people with multiple pressure ulcers might be correctly or incorrectly counted in the measure.

CO-CHAIR KAHN: But is that sufficient, Kate?

DR. GOODRICH: That is more helpful now.

CO-CHAIR KAHN: Yes.

But, with your question -- just a moment on it, Giff -- say it again what you said because I don't --

MEMBER GIFFORD: The scenario runs in when somebody gets admitted with multiple pressure ulcers, it is harder to figure out what is getting better and changing, the way the coding is there. And the way they have structured the unstageable pressure ulcer in the measure is causing some confusion out there for the calculation.

So, what I was asking for is -- I completely agree with what Erin said, that conditional support would be that CMS explores with the measure -- I mean, I think they are

moving in the right direction. I think there is general support here. It is just, basically, going back and validating with those conditions, how is the measure working there. And that is an evolution of the measure over time, and conditional support should not hold them up going forward in putting this in rulemaking with what is out there.

CO-CHAIR KAHN: So, you can do that? Okay.

MR. TILLY: We will make a note of all those comments --

CO-CHAIR KAHN: Okay.

MR. TILLY: -- as the conditions.

CO-CHAIR KAHN: Good.

We're moving on to the clinician programs, is that right?

MS. O'ROURKE: So, I think if we just want to do our final call for any --

CO-CHAIR KAHN: Oh, I'm sorry. So, I need a motion for the en bloc, right, vote on the other measures. And I see a motion from Giff.

MEMBER GIFFORD: Motion.

MEMBER BRYANT: Second.

CO-CHAIR KAHN: And a second over here.

And anybody, any discussion of the en bloc?

(No response.)

All in favor, aye.

(Chorus of ayes.)

Okay. So, the en bloc is now passed. So, does that, then, finish our --

MS. O'ROURKE: Any other cross-cutting conversation?

CO-CHAIR KAHN: Any other cross-cutting conversation, suggestions?

CO-CHAIR PINCUS: I guess, also, about gaps.

MS. O'ROURKE: Yes.

CO-CHAIR PINCUS: Gaps.

CO-CHAIR KAHN: Any gaps?

MEMBER GIFFORD: I would just like to point out the four different PAC settings got

through in a third of the time that the hospitals got through.

(Laughter.)

CO-CHAIR PINCUS: Actually, in terms of gaps --

CO-CHAIR KAHN: Yes.

CO-CHAIR PINCUS: -- Deb, if you are still on, could you say something maybe about what the Workgroup received as gaps?

WORKGROUP CO-CHAIR SALIBA: I think the gaps that were highlighted was the need for increased patient-reported outcome measures, and that was true across all four of the post-acute care settings.

The need for preferences to also be accounted for in measurement science better, I think you have probably heard that not only in post-acute care, but in all of the other healthcare settings.

One person did bring up nutrition in each one of the settings, as was mentioned in the presentation earlier today.

And then, medication reconciliation was highlighted as an important area in which there are significant opportunities for improving care or the lack of appropriate reconciliation could lead to harm. And that had a lot of consensus within the group, that that would be a really important gap to be addressed.

And those were the that I think came up across the four settings.

CO-CHAIR KAHN: Thank you.

Anybody from staff or on the phone? CMS?

(No response.)

Okay, so we will, then, move on back to Harold and look at the clinician program.

All right. I guess we want to take a how many minute break?

CO-CHAIR PINCUS: Yes, a 15-minute break.

CO-CHAIR KAHN: Okay. So, be back here at 2:35.

(Whereupon, the above-entitled matter

went off the record at 2:20 p.m. and resumed at 2:49 p.m.)

CO-CHAIR PINCUS: So, first, we want to hear about public comment on the clinician programs. So, first, is there anybody in the room who wants to make a public comment with regard to the clinician programs?

So, anybody on the phone wishing to make a public comment with regard to the clinician programs?

OPERATOR: And, once again, to make a public comment, please press star one.

And there are no public comments at this time.

CO-CHAIR PINCUS: Okay.

So, Bruce, Eric, John, do you want to begin to sort of walk us through some of the key issues that you discussed?

MR. BERNOT: Sure, yes, I'll take over the slides from here.

So, I'm John Bernot, I'm one of the Senior Directors working on the Clinician

Workgroup.

So, go ahead and go to the -- one more, next slide.

What we're going to do is actually on this, even though we've not been going over the actual program summaries, I'm going to spend just a couple of seconds on the programs, mainly the MIPS program, because it had so many significant changes and it's a little bit of a different animal than the other programs with it, being all these different specialties.

In addition to that, the clinician self-select subset of the measures themselves, so it brings in some different issues than some of the programs that are all encompassing and every one's required.

So quickly, this was established by the MACRA law in 2015 and it was a program that consolidated all of Medicare's existing incentive quality reporting programs for clinicians.

In that, there are two different tracks. One of them is the Advanced Alternate

Payment Models and one is the MIPS. And the MIPS is the specific one that we're talking about here.

Again, they self-select the measures they're going to submit to CMS. And if they participate in the advanced APM model, they are excluded from MIPS.

Go ahead, next slide.

This does have again, I mentioned, there's four different things that it looks at. It's a quality to cost, advance to care information improvement activities.

So specifically there were 18 measures that we reviewed for the MIPS program.

MSSP, this does not have the changes. This is more of a compare and contrast. This is looking at the Accountable Care Organizations so more of the common than what we looked at of the other programs for this. We had just one measure for the MSSP program.

So I'm going to go over some of the themes that came out of the two-day workgroup --

one of them was this move to high-value measures and really just the inclusion of the high-value measures rather than just measures in general, really taking a consideration for burden.

They specifically stated that we want to make sure that we're addressing the NQF's aims and priorities.

The alignment with other initiatives that may not be at the clinician or ACO level, focus on patient outcomes, we've heard that a lot today and again, sensitivity to the burden.

No surprise, more talk about moving towards the outcomes, composites and we also had the promise discussion that the workgroup really found a lot of value in and might be a potential tool to develop more performance-based measures for patient reported outcomes.

The next one, again also I'll try to go through this quickly because it's no surprise, based on what we've heard today but attribution was a big discussion.

And there's a couple of parts to this.

One of them is, are we capturing something that is a team-based measure or a clinician-based measure?

Second point, if it is a clinician-based measure, is it something the clinician feels that they're capable of influencing?

Timeliness was an interesting issue that we hadn't talked about a lot. I hadn't seen that came up with the timeliness of the outcome. And we'll give a couple examples of that on the next slide.

And then this double-edged sword of the accountability that there needs to be consideration for team-based accountability. But at the same point, it also has to be attributed to somebody or some entity. So an appreciation that it can't just follow no one but, it may not be on an individual person that's going to -- you can attribute it.

So those were the two themes that we saw. Specific to the MIPS discussions, this is what the committee had talked about.

Again we mentioned that the high-value measures but, in the outcomes there was some pretty interesting caveats that came up because of the difference in the program that I highlighted in the MIPS.

Some of them are specific to the clinician level. One of them being, is there an adequate sample size? If we're going to look for outcomes, it's one thing at a hospital level but, at a clinician level did they see -- have enough touches to really get up to an adequate sample size?

The attribution again, we've talked about that a number of times. Very important to the -- this is the individual clinicians is whether or not that clinician can make an impact on the outcome there.

And the last one I thought was interesting was the timeliness discussion that came up. And I believe it was Erica, one of our Chairs who brought up as a breast surgeon, the actual time when you'd be able to realize how

good of a job he did is not days to months, it's years and many -- potentially a decade down the road when you're really seeing that.

And is that an outcome that can be captured? Probably in this setting, we'd say no but keeping that in mind, the timeliness of when the outcome would be. So that was a good discussion, I thought.

Also, continuing the partnership because we have the specialty societies in here. So measures that might be -- we want outcomes but, are they outcomes that are the correct one for a particular specialty? So that's something we encourage this continued partnership between CMS and craft and the specialty societies.

The last one was because of those challenges that I just mentioned, when we use process and when there's a need for process measures, what can we do? And the use of maybe considering composite measures or really tying better process to outcomes on the measures. So that was a discussion that came up around that.

We can go to the next slide.

Some of these are more of the themes that I think we've talked about today so I'll try to be brief.

But just addressing the gaps and appropriate use was something that we had a number of discussions about whether or not those were being addressed.

Crosscutting measures, this came up because of the specialties or the things that would apply to all clinicians that would be good markers of performance.

And lastly, I don't believe I've heard a whole of discussion about this other than Helen did make some comments about measurement science in general, was this issue of topped out measures again with that focus on a clinician level measure that can be self-selected.

So when do these get removed? And what's the balancing of these of removing a topped out measure and also having a measure that might be applicable to a specialty?

And then are these rates a little different when you're optional? Because it is really the high performers who keep selecting those measures? And so is it really as topped out across physicians as it might be for just that subset who selected it?

And then just considering, would this regress if we're not looking at it?

So all of these discussions came up in the MIPS program. I think they were good and maybe a little bit different than some of the other programs.

For the MSSP, this is pretty much in line with what we've heard. More outcome measures, they would like the care coordination focus to be on these outcome measures, especially with that ACO level thinking.

They added specific suggestions, measures of avoidable emergency department use. Since they're really looking at a full spectrum for emergency use to inpatient and even the outpatient.

They specifically mentioned the desire for more of the person and family engagement. Also the crosscutting, they mentioned the same thing about the crosscutting measures, something that all clinicians would be represented by and linking the quality and appropriate use.

So those are the themes that came up with a little different spin from the two different programs.

I'll mention just briefly a few notable -- we had a few notable discussions. I just thought it'd be worth bringing up.

This MUC 16-069, the Adult Local Current Smoking Prevalence -- this was actually submitted to both MSSP, this was the one measure for MSSP as well as one of the 18 measures for MIPS.

And there was a lot of discussion about this, a lot of good discussion about the need to engage the clinicians in this public health.

But there was an encouragement that it

needs to be refined due to the attribution level. This was at -- this was proposed at a county level. And the attribution of this is that somebody who can actually make a change on this. And then also trying to look at the accuracy of the data they had.

The next measure on here is MUC 16-398. This is appropriate use criteria of electrophysiology. The main reason I wanted to bring this up well, there was two things.

One because appropriate use was a big topic that came up several times throughout our discussion. And really wanted to make sure that the appropriate use is tied into guidelines. So that was one of the topics that came up when we discussed this.

So that's all on that one, next slide.

And, the last one, we had a measure MUC 16-074. This was a measure about the fixed-dose combination of hydralazine and isosorbide dinitrate therapy.

This is a specific measure for self-

identified black or African-American heart failure patients who are already on a particular therapy. This is one that there was an eMeasure that's been approved for trial use.

The workgroup did note that this is a measure that could address the clinical care and potential disparities and heart failure because it would contract the use of a therapy that can reduce morbidity and mortality in this population.

The workgroup also raised concerns that it's a measure based on fixed-dose regimen and the ACC/AHA Guideline suggested individual components of the combination therapy could be substituted.

So those were the three real big discussions that took a lot of time and were heated discussions in the group.

The Dual Eligible comments, I'll just go through those briefly. This is their perspective on the clinician recommendations. That the model of care and the incorporation

performance measurements of those models must consider those unique needs and the preferences also of the various subpopulations.

And they wanted to provide the feedback or data on a regular basis. So I know that feedback has come up specifically and they actually asked even so far as to go to the data.

And for the PRO-PMS, they really wanted these cultural language barriers to be highlighted to the group. So we're thinking about those and the patients' perspective on whether this measure was meaningful and understandable.

So with that, we'll go into the measures. I'll turn it back over to you, Harold.

CO-CHAIR PINCUS: Any questions here in a general way? And also secondly, I know the Co-Chairs are going weigh in on to elaborate further.

WORKGROUP CO-CHAIR BAGLEY: This is Bruce Bagley.

I think John did a nice job

summarizing the discussion. If anybody has any questions, I'd certainly be glad to attempt to convey the conversation and some of the reasons why we came to these conclusions.

CO-CHAIR PINCUS: Well, seeing no hands raised or questions as I understand it, there were two measures that have been pulled for further discussion.

One is 16-072, Prescription of HIV Antiretroviral Therapy and 16-073, HIV Medical Visit Frequency.

And these were pulled by Amy Mullins.

MEMBER MULLINS: Yes, and I'm going to speak to both of those kind of as a group because I pulled them both for the same reason.

Both of these measures were included in the Core Quality Measure Collaborative's Core Measure Set for HIV and Hep C.

And so I believe they should be included in MIPS with no conditional support or refine and resubmit.

I don't know, anyone -- a show of

hands if you're not familiar with the Core Quality Measure Collaborative work.

Okay so Aparna at AHIP and CMS, the private insurers and, the professional societies got together and said, we have way too many measures measuring way too many things in a whole lot of different ways. We need to come up with some core sets that we all can agree on.

And we got around the table and we hashed it out over about two years and came up with core measure sets, one of which was the Hep C HIV measure set.

And our work included these two measures that I pulled that had not been supported fully for inclusion into MIPS.

So, in the -- this word has been thrown around today and Doug Henley would be so happy in the spirit of parsimony and harmony, we would like to put those on the table for full support for the MIPS program.

So I would like for a re-vote. We can do one vote on both measures because they are

both of the comments for me are the same.

CO-CHAIR PINCUS: John?

MEMBER HALL: Amy, could you maybe 30 seconds on whether you feel that any of the concerns raised here have already been addressed or what the answers might be to the concerns raised here?

MEMBER MULLINS: I feel like we did hash out all of the concerns over the course of two years. Amir, Aparna, Kate, do you recall the specific conclusions that we came to? Is Kate still down there? I can't see.

So he asked if our work at the Core Measure Collaborative level addressed any of these specific concerns that the workgroup came up with? I can't recall the exact answers.

CO-CHAIR PINCUS: Yes, could you just clarify? So what was the vote? The recommendation from the workgroup? And what were the concerns?

MEMBER MULLINS: So in the 073, MUC 073 was refine and resubmit and 0972 was

conditional support.

So -- I must be looking at a discussion group work from two days ago, maybe. Mine says 07 -- oh, I'm looking at 07 -- I'm looking at a different one, sorry.

So, but, they both were supported and included in the core measure sets.

(OFF MIC COMMENTS)

MEMBER MULLINS: So, I pulled 072 and 073, so, yes, so that's 072, yes. Yes, so I just have them backwards on my sheet.

CO-CHAIR PINCUS: Just could we get just some clarity about what was the recommendation from the workgroup and what were the issues of concern that was expressed in the workgroup? John, do you have it?

MEMBER MULLINS: I'm sorry. Oh --

MEMBER QASEEM: So, I can -- well, what I remember, just to chime in over here what Amy's saying and I'm going to take one by one, guys. There's so many numbers over here, I'm getting confused. So, I've been confused all

day.

So 16-072, that's about the Antiretroviral Therapy, is that the correct one? I do remember the discussion we had concerning the new guidelines that everyone should be getting the treatment if they follow the current guideline recommendations. That's the bottom line summary, if I have to summarize it.

So I do think it addresses all the workgroup concerns. So I'm not really sure why this was actually -- why it's resubmit?

CO-CHAIR PINCUS: What were the workgroup concerns? That's the question.

MR. BERNOT: Yes, I'll go through them one by one.

So there was different concerns on the two. The first of all --

MEMBER QASEEM: So just one by one, do you mind just taking one by one?

MR. BERNOT: I'm going to do one by one, correct.

MEMBER QASEEM: Perfect.

MR. BERNOT: Yes, so I'm going to start with 072.

There was two issues on this. The first one so to clarify, this is the eMeasure version of the existing claims-based measure. Both of these are eMeasures.

So the concerns were twofold on 072. The first one was whether this supports alignment. And in the final rule that came out, the corresponding non-eMeasure, the claims-based measure was pulled, the corresponding 072.

So it did not support alignment anymore. That was the first part of the discussion.

The second one was that as it's an eMeasure, it had not been fully tested as an eMeasure yet. And so it was to wait until the eMeasure testing had been complete. So that's 072.

CO-CHAIR PINCUS: Could somebody clarify what's the status of the eMeasure endorsement process?

MR. BERNOT: So that is it's in the process right now. Oh, I'm sorry.

MS. MARINELARENA: Hi, Melissa Marinelarena again.

So I'm working on the infectious disease project that these measures have been submitted to. We're in the process of doing the preliminary analysis. Our in-person meeting is March 14th, I believe, a one-day meeting. So, all of the eMeasures will be -- that are new to us will be evaluated then with recommendations, including the original paper case measures.

MEMBER QASEEM: So Harold, can I ask a clarification question? All the measures that are eMeasures that are reviewed by MAP, aren't they always tested before they come for our internal for approval? So why is that an issue? I mean, that's why, first, this is a two part question.

The first is are all eMeasure tested? And, if they're not, then why would this be an issue with this specific eMeasure? Why do we

have to wait?

CO-CHAIR PINCUS: We don't have to wait. We can make a -- we can make whatever recommendation we want.

MEMBER QASEEM: I'm talking about the workgroup recommendation. They used as a logic that why did it even come up? What was the --

CO-CHAIR PINCUS: But you know, but eMeasures do have to go through the regular endorsement process. There's a sort of separate -- there's kind separate -- a track for it, but they do have to go through the endorsement process to get endorsed.

MEMBER MULLINS: Point of clarity. I'm sorry. The numbers are confusing and I was confused.

So, the one that we -- that I should have pulled, 073 should have pulled. I would retract my pull of 072 and replace it with 075. That is the one that I should have pulled.

So 073 and 075, I retract 072. 072 is not in the core set, 075 is the core set, the HIV

viral suppression.

MS. MARINELARENA: So the status is the same for that one, the original measure has been submitted and I believe for that one, there's the -- this is the eMeasure and that has also been submitted.

MEMBER MULLINS: So, my comments are the same?

MEMBER HIGGINS: Sorry, so, was this the recommendation on just the eMeasure part of it or the measure itself?

MS. MARINELARENA: This is the eMeasure that you have before you. So only the eMeasure version of the paper-based measure was submitted to the program because the other ones are the original measures, the paper measures, are already in the program except for the one that final rule has removed it from MIPS.

But the eMeasures and from an NQF standpoint, we review eMeasures based on paper-based measures separately. So we consider them two separate measures. So you're only looking at

the eMeasures right now.

They're already endorsed, yes. They're in the core set and already -- yes, in different programs. One is being removed from MIPS, as John stated.

CO-CHAIR PINCUS: Now let's -- let's just get clear. So we have the -- so what you're polling is the 16-073 and 16-075, okay? And my understanding that for the 075, that is an eMeasure that is in the queue for evaluation for endorsement in March.

MS. O'ROURKE: 075, isn't that NQF 2082 paper and it's the claims measure?

CO-CHAIR PINCUS: Well is it the same or is it the eMeasure version? Again, just trying to get clarity.

MR. TILLY: So what's in here -- so, let's just be really specific now.

16-075, which is the HIV Viral Suppression measure, as far as the measure specifications that are included here, we have data source includes stated by HHS, the

administrative claims data or administrative clinical data claims, paper records and record review. That's what I'm -- that's -- and it's NQF's 2082.

CO-CHAIR PINCUS: So --

MR. AMIN: John, is that correct? I just want to be clear because this is not -- now, we're talking about a new measure, just want to be specific.

CO-CHAIR PINCUS: Well, so, let me be clear. So this is not an eMeasure and it is not an already endorsed measure?

(Off-microphone comments.)

CO-CHAIR PINCUS: Okay, so, yes, so, I'm trying to get clear about this.

WORKGROUP CO-CHAIR BAGLEY: Harold, this is Bruce Bagley.

If I remember correctly, I don't think the committee had any problem with either one of these measures as a measure. The real problem is that they haven't been properly tested and evaluated in the real life situation.

So I think that's really the only hurdle.

PARTICIPATE: Their issue that was in the report was whether a gap existed.

CO-CHAIR PINCUS: Okay. But let's -- before we start getting comments, I just want to get clarity about what it is -- what's the issue, okay?

So the issue for -- so let's start with I guess, 16-075. So the issue here is that that is -- is that or is that not an already endorsed measure?

MEMBER BAKER: John, do you mind just walking through the conditions that are --

CO-CHAIR PINCUS: So wait, let's get clear. Is it or is it not an endorsed measure?

(Off-microphone comments.)

CO-CHAIR PINCUS: Okay, okay, so, it's an endorsed measure. And let's not -- and, has been proposed by CMS is the use of that endorsed measure, Kate?

(Off-microphone comments.)

CO-CHAIR PINCUS: Yes, that -- what you're proposing in the MUC is the use of that already endorsed measure? Oh, the eMeasure?

DR. GOODRICH: We already have the non-eMeasure form of these measures in our programs. This was to put the eMeasure form, which is in the process of being tested and so forth by HRSA so that they could be included in the program as well.

CO-CHAIR PINCUS: Okay. So, what you're proposing is the eMeasure version --

DR. GOODRICH: Correct.

CO-CHAIR PINCUS: -- to be included. It's not yet endorsed, but it's in the queue?

DR. GOODRICH: It's eMeasure form is not yet endorsed, right?

(Off-microphone comments.)

DR. GOODRICH: I'm pretty sure, that is -- okay, yes. It's coming to you guys soon.

CO-CHAIR PINCUS: Okay.

DR. GOODRICH: Yes.

CO-CHAIR PINCUS: So, we're clear

about the current status of it. So what were the issues that were raised?

MR. BERNOT: Okay so I can go through --

CO-CHAIR PINCUS: And was it conditionally supported?

(Off-microphone comments.)

MR. BERNOT: So I'll go through those. There's two different measures. So 07 --

CO-CHAIR PINCUS: Let's just start with the -- let's just do 075.

MR. BERNOT: 075, okay. 075 is conditionally supported. And the issues were even though the same issues came up, the reason the committee and Bruce or Erica can weigh in on this, the reason the committee went with conditional support on this was because of the fact that it was an outcome measure and they wanted to have -- the outcome was one of the issues that came up.

It was the same testing issues though. It still has not been through and the condition

was that it passes the -- or completes the eMeasure part of the endorsement process. So that was 075.

CO-CHAIR PINCUS: Okay. So let's discuss that first. So all right, do people want to discuss that 075?

Carl?

MEMBER SIRIO: I mean my comments will be relatively simple. One is, it gets me a little uncomfortable when we have a group this size trying to figure out what we're even talking about. That leads to a potentially disservice to the work that's been done in terms of the clarity of the question, to your point.

The second thing is, I think that the testing issue is a real one insofar as -- I mean that's one of the principles that we have really upheld over time which is, is that the wisdom of a process, at least with true testing in a field where the implications are real.

So the bottom line is, I would submit, that the workgroup did a lot of legwork on this

with clarity, I know we support the workgroup for this and the second measure.

CO-CHAIR PINCUS: Other comments?

Rhonda?

MEMBER ANDERSON: I think we have seen this question from a very large number of workgroups when it's going for e-testing that they want to be certain that the testing is completed.

A question that I have is, if we have any data on those that have been already endorsed on paper and now have gone for e-testing, is there a correlation or a percentage that with the e-test issue that they actually are -- they have issues or problems?

I'm not quite sure what the results have been when they've gone for e-testing. So I just wondered if anybody has that information?

DR. BURSTIN: I don't think we have any --

MS. MARINELARENA: No, we don't. So that will be a discussion that the standing

committee has in March.

Now just to make things a little more confusing, we consider these legacy measures, the eMeasures. Right? Because they're based on existing paper-based measures that are in a federal program.

So our testing requirements are a little bit different. We will not have performance. They're not in use yet, of course. We don't have any performance rates for them.

I know that HRSA is in the process of testing them. We will -- we accept only -- we accept, at a minimal, Bonnie testing or using synthetic patients. So, I believe that's what we're going to be looking at. We haven't finished looking at our preliminary analysis yet.

For a legacy measure, that is the minimum that we require is Bonnie testing. This is the conversation that standing committees have every time, if you care to join us about the correlation between a paper-based measure and an eMeasure. But that discussion I'm sure, will be

had in March. But we don't have that information right now.

CO-CHAIR PINCUS: Aparna?

MEMBER HIGGINS: So do we have a sense for when HRSA might finish their testing or do --

DR. BURSTIN: Well it's being -- I mean, it's being submitted to us for review in March. So this is eminent.

MEMBER HIGGINS: Oh, okay.

DR. BURSTIN: And also you know -- again, David can certainly speak to this, but laboratory data is readily available on a eMeasure. So I can't imagine it's a huge lift compared to some other potential eMeasures -- with actually not large requirements because it's a legacy eMeasure.

Now new de novo eMeasures have a much higher lift than legacy measures.

MEMBER HIGGINS: Okay. Well, I think I just want to -- you know echo what Amy said about alignment with the Core Measures Collaborative. And you know -- the importance of

making sure that you know -- public and private programs, we have the same set of measures.

So I think there was a question earlier about gaps in performance, I can't remember who raised it I mean -- we had -- and Amy can correct me and Kate as far as these discussion too, we had some of those discussions in the HIV Hep C Workgroup when we were going through the Core Measures Collaborative.

We actually had physician representatives from both HIVMA as well as the Infectious Disease Society. And, these were practicing physicians as well and they talked about how they do see variations in care and practice and they had cited some studies which I don't remember right now, which is one of the reasons why we had included these measures in our core set.

So, I wanted to share that as well.

CO-CHAIR PINCUS: So Amy, are you still proposing that we re-vote on this?

MEMBER MULLINS: If this is a

conditional support and the condition being that it passes the eMeasure specs, then I am okay with that on 075.

CO-CHAIR PINCUS: Okay. Sounds like that's the way it is.

MEMBER MULLINS: Okay.

CO-CHAIR PINCUS: Okay, Bruce?

MEMBER HALL: And I just want to confirm them because the workgroup did ask whether performance gaps continue to exist. So Aparna has weighed in on that and I'm wondering, does the existing paper legacy measure also weigh in, that there are still gaps?

MS. MARINELARENA: So for the maintenance measure which is the paper-based measure, we do require performance over time. They have submitted that information to us. We're in the process of doing the initial analysis and then giving it to the committee. The committee will talk about it. But without looking at all of them, there probably is a gap.

And then we also asked for, once a

measure is topped out often, we'll ask -- we look at the -- for you know, gender, race, is there different gaps looking at that? So they've provided a lot of information, we're in the process of analyzing it.

CO-CHAIR PINCUS: David?

MEMBER BAKER: I think that last point was really important that, for determining whether a gap exists, it's the old chart-based measures. Because if we're seeing a gap on the eMeasures, that's a pseudo-gap. That's a problem with the eMeasures.

And that's what we've seen with some of the measures that have been submitted on a pilot basis to the Joint Commission. You know -- organizations that were at 99 percent, 99 percent, 99 percent and then, all of a sudden they're well less than 95 percent on the eMeasures.

CO-CHAIR PINCUS: So sounds like we can move on to consider actually 16-073.

MR. BERNOT: Sure. I can give the

brief introduction.

So 073, this is the same situation, the eMeasure of an existing measure. This was given a different assignment though. This one was given refine and resubmit, not the conditional support that 075 had.

So even though it's in the same situation and again, I'll ask Bruce and/or Eric if they'd like to contribute but, my understanding of the discussion was that they felt that the outcome measure, one -- that they wanted to get the outcome measure moving. They wanted to take more time on the process measure. And that was the difference.

Otherwise, it's in the same exact stage of testing, same time we'll have the testing data back that Melissa already mentioned.

CO-CHAIR PINCUS: So what exactly was the problem with it as a process measure that there was some inadequacy of the data in support of it?

MR. BERNOT: No, there's no difference

in the adequacy of the data between the two. That's just my recollection of the discussion. But again, I'd rather if Bruce or Eric wants to say anything to make sure that you recall this the same way that I do.

WORKGROUP CO-CHAIR BAGLEY: Yes, this is Bruce.

I think the main thing was that if you're successful on 075, it's not as important whether they went once to the doctor or 20 times to the doctor. If they have viral load suppression, they had to go to the doctor to get that done.

WORKGROUP CO-CHAIR WHITACRE: This is Eric.

And I do recall that that was the emphasis of the discussion. I also don't remember, and I may just have forgotten the issue about the consensus core set.

As I recall, that didn't come up because we do want to be sensitive to alignment and other measurement programs. And I just don't

remember if that was mentioned.

MR. BERNOT: Eric, just to clarify, that was just for 072 and she withdrew that one, the alignment issue. So we're okay on that.

WORKGROUP CO-CHAIR WHITACRE: Oh, I see, okay, okay.

MS. MARINELARENA: Sorry, this is Melissa again.

And another clarifying, CDP process is we review the legacy measures first. If it fails on any of the must-pass criteria such as evidence, which could be -- you know the case here or gap, then the legacy or the eMeasure version would not pass as well.

MEMBER MULLINS: Can I move that we vote on this? And I would like to submit that this get conditional support much like 075?

CO-CHAIR PINCUS: Chip?

CO-CHAIR KAHN: This whole discussion has gotten so much in the weeds, my mind has trouble getting in there.

But I think it really is important

here that we just keep in mind two things. You know -- one thing is, I guess, does it technically work?

And two, beyond it technically working, which I guess the Bonnie thing determines whether if it fits the logic, does it work in such a way that isn't a problem considering how EHRs work?

And I don't know -- I don't have a complete sense that the second is completely confirmed in these cases, even if the first is.

On the other hand, you know I'll go with the flow, but I think we have to be very careful when we're converting or moving from measures that are accepted and used in one area, you know, into EHRs because it -- the transfer, even if all the work is done on the very technical side doesn't necessarily carry.

So I think we have to be really careful here. But that's all I have to say. I don't think there's anything else to add.

CO-CHAIR PINCUS: Yes so I think for

this issue, the question is -- as I see it is, you know, is it, you know -- if the other measures or the other viral load measure actually passes you know, gets endorsement, is this really necessary?

MEMBER MULLINS: Yes.

CO-CHAIR PINCUS: Yes, that's the issue.

MEMBER MULLINS: Yes, because it's core set.

DR. BURSTIN: Right, but I think MAPS specifically talked about it in the context of, if you have an outcome measure, do you still need the associated process measure? And that came up multiple times during the earlier MAP work with their discussions as a MACRA initiative.

CO-CHAIR PINCUS: So let's let Amir go and then you, Kate, in case there's a response you have to make to that.

MEMBER QASEEM: So this measure has got problems beyond this. This is not the current standard anymore. I don't know if you

guys noticed or not.

The two CD4 counts is not normal with the current standard. So I think we need to go back and look at the basic evidence behind it and actually look at the newer --

CO-CHAIR PINCUS: Which measure are you referring to?

MEMBER QASEEM: It's not 16-073?

CO-CHAIR PINCUS: No. Yes, that's visit frequency.

MEMBER QASEEM: Okay, hold on, let me just --

WORKGROUP CO-CHAIR BAGLEY: It is actually viral load and not CD4 count.

CO-CHAIR PINCUS: Yes, right, and that's what we're discussing.

MEMBER QASEEM: So that's what I'm talking about that you're not supposed to come and get the CD4 count on every visit. You're supposed to actually follow up with a consistent viral load suppression over the forms or any other virtual visits or something like that.

This is actually not evidence-based measure any more. So it's beyond that discussion we are having right now.

DR. GOODRICH: But I think that's a discussion for the NQF Endorsement Committee, for one. I mean -- I'm not disagreeing with you on that, I don't know the evidence at the tip of my fingers, but I think that that's --

MEMBER QASEEM: So if we approve this measure, then it's going to get implemented, right? So, we have to --

DR. GOODRICH: Well I mean, we have a condition for NQF endorsement and this one where it would be very critical to go because they're eMeasures to go through the testing, which is what we're waiting on primarily I think before it goes through endorsement.

The other comment I wanted to make on this one that I recall from the conversation in the Core Measures Collaborative, but Aparna, correct me if I'm wrong, because this came -- this issue came up about, if you've got the

outcome measure, why do you need this one?

I think the points that were made by people around the table during that discussion was, for the viral load suppression measure, in your denominator, you have to have people that you're seeing and drawing blood on.

And there's definitely a quality problem or a quality gap within the HIV community and I think a lot of folks felt like this was particularly the case in FQHCs and other types of clinics that serve you know, low income vulnerable populations that just getting people in to see clinicians to even get tested was just a major first hurdle.

And so, because there was a gap in that measure, as was described to us at the time, they felt like that having this measure was still needed.

Now I don't want to quibble with you over the evidence, you may well be right in that maybe that we shouldn't go forward with this measure. But I think we'd need more review of

that to understand.

MEMBER QASEEM: So what I was suggesting was we can keep it as refine and resubmit and let the group address this issue because I don't think we will be able to resolve it over here.

DR. BURSTIN: Although that's what we do conditional support for. If we know this is a measure that's coming forward, it could be conditional. I think that's the point.

CO-CHAIR PINCUS: Aparna?

MEMBER HIGGINS: So to -- I'd echo with what Kate said and that's exactly the discussion our HIV Hep C Workgroup had. And again, it was a lot of them were clinicians who you know, specialists who were treating patients who had seen this and saw this as a problem, which is why we included both measures in our, you know, in our core set.

So I would agree with Amy that you know, given that the other measure was conditional support and this is going through

ECQM testing, we should consider this in the same way.

CO-CHAIR PINCUS: So you're proposing that we pull it and we re-vote. Now if we're voting for conditional support, we're talking about it going -- it is up for review, correct? As an eMeasure or as a paper measure? Both? As both?

MS. MARINELARENA: But the one before you right now is the eMeasure for now.

CO-CHAIR PINCUS: Right. But it's coming up for review in March as well. So why don't we vote with the understanding that that's the condition, if we vote for conditional support?

MS. OGUNGBEMI: All right, voting is open. We are voting on MUC 16-073, HIV Medical Visit Frequency in the MIPS Program.

Your options are one, support, two, conditional support, three, refine and resubmit, four, do not support.

Voting is open.

MEMBER GIFFORD: I'm abstaining from voting for a conflict of interest.

MS. IBARRA: Brandon, Dora, Eric, Foster and Steve, we received your votes, thank you.

MS. OGUNGBEMI: Results are 4 percent support, 65 percent conditional support, 26 percent refine and resubmit and 4 percent, do not support.

Our 60 percent threshold is met and conditional support.

CO-CHAIR PINCUS: Any further discussion about any of the measures on the -- in the clinician group?

MEMBER QASEEM: The couple of measures, if I can just hear some of the comments, one is the 16-398, the Cardiac Electrophysiology. I think it's refine and resubmit and I just wonder, I wasn't really clear, why is that refine and resubmit?

I think it seemed like, at least to me, it's a great measure. There's a lot of

inappropriate use. It's incredibly expensive. It's evidence-based based on the current guidelines by ACC and AHJ.

CO-CHAIR PINCUS: Could you repeat what measure that was?

MEMBER QASEEM: It is 16-398.

DR. BURSTIN: No testing data has been done yet, yes.

MEMBER QASEEM: The second one I wanted to ask is just, give me one second, let me get the right number here, guys. This is -- it's 16-287. It is the, hold on, I'm scrolling down, it's the bone density one.

So that again, is it the duration? Because again it's -- because it seems like it would improve clinical outcomes based on the guidelines as well. It's evidence-based. It's here, I read as a good measure.

MR. BERNOT: There was -- so there are two issues on that, the data was the big one.

MEMBER QASEEM: It's the same issue as --

MR. BERNOT: The second one was the populations, that whether inclusion or exclusion of populations were adequate.

MEMBER QASEEM: Okay. Sorry, and my list is long. Sorry guys, but we have until 5:00 to discussion clinical measures right, clinician measures?

16-069, the smoking one -- I was surprised that it didn't go through. Can you just tell me what happened?

MR. BERNOT: Yes, just the -- this was the attribution issue, plus testing data. This was the county level attribution that whether an individual clinician or, even in the case, so that was for the MIPS side, could influence that.

Or whether the ACO and the MSSP could effectively be held accountable for that measure.

MEMBER QASEEM: Okay. But it is a MIPS measure though, right?

That's it.

CO-CHAIR PINCUS: Okay. Now we do have one public commenter that was unable to get

through earlier. And so can we hear from that public comment?

OPERATOR: Okay, and the comment comes from Soeren Mattke.

DR. MATTKE: Hi, can you --

CO-CHAIR PINCUS: Hi, Soeren, it's Harold Pincus.

DR. MATTKE: Hi.

CO-CHAIR PINCUS: Can you --

DR. MATTKE: Hi, Harold.

Yes, Soeren Mattke, SRM. We have the developers of 16-151 which received conditional support by the workgroup and the conditional support was pending the clarification of one question. I wanted to do that.

The measure which is NQF endorsed looks at whether patients receive risk assessment for febrile neutropenia prior to assumption of chemotherapy.

And the question that the workgroup had was whether a protocol-based risk assessment system would meet our criteria? And our answer

is yes, if that system gives appropriate consideration to both patient level and regime level risk factors.

The rationale is that current guidelines recommend use of CSF prophylaxis to avoid febrile neutropenia if the expected risk of febrile neutropenia is greater than 20 percent.

That risk depends, on the one hand, on the inherent toxicity of the chemotherapy regime but also on patient risk factors like age, prior treatment and, comorbidity.

So you're going to have regimes where you have an inherent toxicity risk always greater than 20 percent just because the drugs are that toxic. But there are also regimes for which the risk will be above 20 percent only if you are talking about higher risk patients like elderly or frail patients.

So our answer is, if a protocol system is able to incorporate both the regimen level and the patient level factors, it is perfectly compliant with how we specified the measure.

We want to make one other clarification. The workgroup correctly pointed out that the measure will make it more likely that patients with higher risk receive beneficial CSF prophylaxis.

But we wanted to emphasize that the measure will also make it less likely that lower risk patients receive an extensive treatment with potential side effects and potentially low value.

And for those reasons, we would request that you reconsider and re-vote on the measure to give it full level unconditional support.

Thank you.

CO-CHAIR PINCUS: Thank you, Soeren.

Is there comment, discussion from the task force or from the coordinating committee?

Is there a move to make any change?

Okay. Any other comments on any other issues from the task force, from the coordinating -- yes, I'm going back to my Medicaid task force role.

Okay, well, so we pretty much finished then, the agenda for today.

DR. BURSTIN: We have the consent --

CO-CHAIR PINCUS: Oh, yes, the consent calendar, right.

So, we'll accept people want to -- anybody want to nominate the acceptance of the consent calendar?

MEMBER SAKALA: So moved.

CO-CHAIR PINCUS: Okay. All in favor?

(Chorus of ayes.)

CO-CHAIR PINCUS: Opposed?

(No response)

CO-CHAIR PINCUS: Okay so we finished our agenda for today. So Erin, do you wanted to discuss what -- how things are going to go tomorrow?

MS. O'ROURKE: Sure. So for tomorrow, we are actually going to focus more on some crosscutting issues that arose from the workgroup's deliberations.

First, we're going to present some of

the findings of NQF's recent attribution expert panel. As John was noting in his presentation, we heard a lot of concerns about how MAP should be handling attribution issues. And in particular, who has the locus of control for a measure and a patient's outcome.

So we wanted to highlight some of the findings of that committee to perhaps allow the coordinating committee to give some more guidance to the workgroup on concerns about attribution.

We also will have an update on the Medicaid Task Forces. In particular, we're doing some work to improve that process that we need approval from the coordinating committee.

In particular, John is going to show you a preliminary analysis algorithm that the task forces would be using, similar to what the workgroups used for the pre-rule making recommendations.

We want to ensure that MAP's doing all of its work as consistently as possible.

We will also have presenters from ASPE

here to share with you some of the findings from the Impact Act study.

I will also be giving an update on NQF's trial period for risk adjustment for SDS factors. And we'll be looking for discussion and any thoughts the coordinating committee might have on a potential path forward on that issue.

We know we are unlikely to resolve such a topic but, did want to keep you abreast of developments in the field and potential implications for MAPs work.

And then finally, in the spirit of process improvement, we'll be having a session to get feedback from the committee on what worked and what didn't and, some areas where we'd like guidance from the coordinating committee to improve the process for next year's approval making work just to get you think about that.

In particular, we welcome some comments on how we can better clarify the distinctions between the decision categories. We'd also welcome any thoughts you have on how we

could better do the review of the measures that are currently in the program set in particular, what's the most useful information that MAP members need to make recommendations on the measures that are currently in the sets.

And then finally, we'll be sharing with you some information on the feedback loop pilot that we tested with the post-acute care, long-term care workgroup this past fall as a way to keep MAP up to date on some of the developments that have happened to the measures since MAP has made their recommendations as a way to show that we are getting progress on some of the refines and resubmits, if you will.

So we want to hopefully roll that out across the workgroups. So we'd welcome input from the coordinating committee members on how we can do that most effectively.

So that's all for tomorrow but did want to just put some of those issues in your minds for mulling over tonight.

Helen, anything else?

CO-CHAIR PINCUS: So you have a little bit of extra time. And want to thank NQF staff, thank the committee, thank my Co-Chair Chip and also the workgroup Chairs, as well.

We will reconvene tomorrow morning at breakfast at 8:30.

(Whereupon, the above-entitled matter went off the record at 3:40 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership Coordinating Committee Meeting

Before: National Quality Forum

Date: 01-24-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP COORDINATING COMMITTEE MEETING

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WEDNESDAY,
JANUARY 25, 2017

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

PRESENT:

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

BRUCE HALL, MD, PhD, MBA, FACS, American College of Surgeons
APARNA HIGGINS, MA, America's Health Insurance Plans
BRANDON HOTHAM, MPH, Maine Health Management Coalition*
WILLIAM KRAMER, MBA, Pacific Business Group on Health
SAMUEL LIN, MD, PhD, MBA, MPA, MS, AMGA
AMY MULLINS, MD, FAAFP, American Academy of Family Physicians
R. BARRETT NOONE, MD, FACS, American Board of Medical Specialties*
SHAUN O'BRIEN, JD, AFL-CIO
AMIR QASEEM, MD, PhD, MHA, American College of Physicians
CHRIS QUERAM, MS, Network for Regional Healthcare Management
ARI ROBICSEK, MD, Providence Health and Services
KORYN RUBIN, American Medical Association (for Carl Sirio)
CAROL SAKALA, PhD, MSPH, National Partnership for Women & Families
MARISSA SCHLAIFER, RPh, MS, Academy of Managed Care Pharmacy
STEVEN WOJCIK, MA, National Business Group on Health*

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, MS
DORIS LOTZ, MD, MPH*

FEDERAL GOVERNMENT LIAISONS PRESENT:

DAVID HUNT, MD, FACS, Office of the National Coordinator for Health Information Technology (ONC)
NANCY WILSON, MD, MPH, Agency for Healthcare Research and Quality (AHRQ)

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ELISA MUNTHALI, Vice President, Quality Measurement
MARCIA WILSON, Senior Vice President, Quality Management
TAROON AMIN, NQF Consultant
KIM IBARRA, Project Manager
YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst
ERIN O'ROURKE, Senior Director
DEBJANI MUKHERJEE, Senior Director

ALSO PRESENT:

NANCY DE LEW, ASPE/HHS*
KATE GOODRICH, MD, CMS
RENEE FOX, MD, CMS*
KAREN JOYNT, MD, MPH, ASPE/HHS*
ROBIN YABROFF, ASPE/HHS*
PIERRE YONG, MD, CMS
RACHEL ZUCKERMAN, ASPE/HHS*

*** present via telephone**

C O N T E N T S

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

9:09 a.m.

CO-CHAIR KHAN: So I think we have the same crew. I think Gif had some family issue or something, had to leave. But pretty much the same crew as yesterday. It's really great having entertainment.

I thank the NQF staff for providing that. I feel like when I was be in high school, I grew up in New Orleans and we would out in August doing football practice, and you know it was like 95 degrees. But, you know, in terms of the real heat it was probably 120.

The coaches would yell and scream that this was fun in the sun. People paid thousands of dollars for this, and we were getting it for free. So since all of you are paying so much to come today, are being paid so much to come today, either way you look at it, we've given you free entertainment up here.

So I hope everybody got their before pictures and we'll see what happens in terms of

when the -- we can take a break when the banner comes down and everybody can go take their after pictures.

So moving on, I think in terms of yesterday, I guess what is there to say but we accomplished most of the major areas, and went through a number of measures and had votes, and I think successfully completed a good bit of our task. I don't know what -- do you want to add anything?

CO-CHAIR PINCUS: No, I think we did a great job yesterday. I think we've gone through everything, had a complete discussion. I think the discussion we had yesterday will inform some of the discussion planned for today, in terms of thinking about some of issues around attribution.

We're going to get an update about some of the Medicaid processes which are being conformed to be more closely with how we've been operating in terms of the Coordinating Committee, and we're also going to hear about some of the

issues around various risk-adjustment scenarios.

CO-CHAIR KHAN: So just without further ado, why don't we, I guess Harold will facilitate this, but we go to Erin and Helen now for the Pre-Rulemaking Cross-Cutting Issues colon Attribution.

MR. AMIN: Great, Chip. Erin and I will take the lead on the attribution discussion, and I encourage Helen to jump in as we go forward.

So one of the interesting things with this attribution work is that, you know, as we had our conversation yesterday around the consensus-development process, and some of the learnings that we've had with the measure selection process here with the MAP, many of these measurement science, basic science issues that emerged through our conversations, and many times our committees don't really have enough time to really dig deep into them.

We identify them both through the measure evaluation process and also through the

very thoughtful comments of our members and stakeholders through our commenting process. The discussion around attribution has been one that's sort of plagued us for several years and, you know, there are many of you in the room who have had the opportunity to be part of these conversations in many different forums.

You know, a few that come to mind, Bruce your work with the Readmissions Committee, Amir, all your work with the, you know, the clinician measures and as we think about, you know, how do we think about shared accountability and at the same time be able to have clinician-level measures that are meaningful.

Actually in a lot of ways, Carol, your work with the linking cost and quality work that you led several years ago sort of at the same time led to some of these initial discussions around how do we think strategically about the question, the measurement science question of attribution.

And so we embarked on a project over

the last year to at least start to really identify, from the guidance of the NQF Board, around a path forward for some of the measurement science issues with attribution. So the purpose of this morning's conversation is to give you a summary of some of our discussions, which are in some ways very preliminary.

We've identified that there's, you know, at a very high level that, you know, there's a tremendous amount of variation in terms of attribution models that exist, as Erin will talk through in some of the environmental scan undertaken by Andy Ryan's group at the University of Michigan, who helped support this work.

Essentially, we agreed that a good path forward would be to identify guiding principles about the evaluation and selection of attribution models, and then develop a selection guide to help users, both public and private users of measures, to identify best practices for attribution as place to start from.

And again, those of you who are

measure developers in the room who have been thinking about this quite a bit and have struggled with attribution models as you're developing your measures, we would certainly welcome your thoughts and feedback as we discuss the work here.

So you know again, some of the other inputs. Legislation such as the IMPACT Act and MACRA continue to focus on developing and pushing forward value-based purchasing programs by realigning incentives, and again, the question here as we think about shared accountability in an environment of pay-for-performance models, there needs to be a decision made around how and who to hold accountable for the results of quality and efficiency measures to ultimately judge performance.

Increasingly as we are looking toward measuring outcomes, this question of attribution becomes even more important. When we think about the question of attribution, it really is the methodology used to assign patients and their

quality outcomes to patients or clinicians, and helping to identify the patient relationships that we're trying to measure.

And as we again move the system away from fee for service to alternative payment models, the question about how we attribute performance again becomes increasingly important.

So this project scope was taking into account these trends, just moving to the next slide please, was taking into some of these -- taking into account some of these trends, and our overarching goal which has come up through the MAP process over this last several years, and is one of our guiding principles around shared accountability.

We've brought together a multistakeholder group to really be able to advance the measurement science of this area, first by identifying the key challenges in attribution that have been identified in the field, but also have been identified through all of our work. Again, the MAP selection process

and the CDP, develop a set of guiding principles, identify elements of an attribution model.

Again this -- I have to say this was one of the elements that I thought was one of the key components that I was really surprised by is that we look forward into what we describe as an attribution model, there is a lot of variation in terms of what's even included in an attribution model.

So it's really setting a foundation of what are the key elements of what we -- when we describe an attribution model, what are the key elements, exploring some strengths and weaknesses as you're developing tradeoffs, and then identifying some recommendations for developing, selecting and implementing attribution models.

So Erin will talk us through some of the project, you know, activities in more detail.

CO-CHAIR PINCUS: Taroon, one quick question. When you say model, what do you mean by a model?

MR. AMIN: I think that's inherently

what we were trying to define when we talk about the elements, and I think we'll get into that in a moment. Again, we struggled -- actually we struggled with that particular question quite a bit through this project.

MS. O'ROURKE: Thanks, Taroon. So on this side, you can see who served on the committee. I won't read all the names, obviously, but just to give you an idea that it was a multistakeholder committee that included clinicians, providers.

We tried to get providers from across the care continuum, in addition to public and private sector payers, purchasers, a consumer representative.

It was chaired by Ateev Mehrota from Harvard and Carol Raphael, a former member of the MAP Coordinating Committee. So we did want to make sure someone could share some of the measure selection challenges the MAP has faced over the years and bring forward some of the discussions you've had about attribution.

So as Taroon was saying, we started this project by commissioning an environmental scan from Andy Ryan and his team at the University of Michigan, to see what they could find in the literature about what's currently being used as far as attribution models go. They found about 163 models that are either in use or proposed for use.

The vast majority actually were not in use. Only 70 percent were currently in use. Of what they found, 89 percent used retrospective attribution, and 77 percent attributed to a single provider, generally a physician. As Taroon was saying, we really struggled on how you even define an attribution model.

Some of the elements that they used to categorize a model were the stage of the program, the type of provider that results were attributed to, the timing of the attribution calculation, clinical circumstances, the payer or programmatic circumstances.

If the attribution was exclusive to

one provider or clinician or was shared among multiple, which measures they used to determine who would be responsible, as well as the minimum requirement to make attribution and the period of time for which a provider is responsible for a given patient.

MR. AMIN: Erin, before you move on from this slide, going back to Harold's question, I think what we tried to actually put forward here on the left side of this slide was that if you think about the specifications of a measure, of a performance measure that's submitted to NQF, we were sort of thinking about what's on the left side of the slide as the specifications of an attribution model.

Again, we understand, and Erin will get into this, there was no best practice. But these are the elements that we would want to evaluate as you're looking at -- or, yes, evaluate as you're looking at an attribution model.

MS. O'ROURKE: Next one. So some of

the key findings that we wanted to highlight for you from the Commission paper, as Taroon was saying, one of the author's main conclusions was that best practices for attribution have really not yet been determined.

They found that the existing models have been largely built off of what was previously used, without a lot of consideration of the different tradeoffs and the development of attribution models that need to be explored and made transparent to all the stakeholders.

They found there's really no standard definition for an attribution model, and this lack of standardization really limits the ability to objectively evaluate the models and compare them to each other, to eventually get to that evidence base that would allow us to make determinations of best practices.

So some challenges that the Committee wanted to start to tackle in this work. First, greater standardization is needed among the models so that we can start to make these

comparisons and allow best practices to emerge. They found there's little consistency across models, but there's actually quite a bit of evidence that changing the rules of attribution can dramatically alter the results on how a clinician or provider might look on the results of a program or a measure.

This lack of transparency on how results are attributed really means there's no way to appeal the results of an attribution model that could wrongly assign responsibility to a particular clinician or provider.

Next slide. So to start to address these challenges, the Committee came up with a number of different products in this work, if you will. They developed a set of guiding principles.

They made a number of recommendations about attribution models going forward, and they created a tool for calling the attribution selection model guide that Taroon will get into in greater detail.

These products allow for greater standardization, transparency and stakeholder buy-in. The Committee was aiming that, in the future, this would allow for the evaluation of attribution models and to start to lay the groundwork so that we can develop the necessary evidence base to determine what the best practices may be.

MR. AMIN: So as we get into the guiding principles, before we get any further, Helen, is there any other sort of introductory sort of comments about the group's work here and sort of the importance or the background that you want to get into before we go --

DR. BURSTIN: Just to highlight two things I think we'll do here shortly, which is really surprising there is no gold -- there is no gold standards, which is why we thought having an approach that everyone could use consistently was really important.

And secondly, just there's also a lack of transparency in the way the attribution models

are discussed, thought about and then shared with those who would be measured. There's a real opportunity here to just be very transparent, and try to have a consistent approach. But a lot more to do in this phase, for sure. I think this is really just a way for us to begin working in this space.

MEMBER ROBICSEK: Quick question and maybe this will become clear as we describe this more. But in a world where there's no gold standard, against what sort of reality do you validate these models against?

MR. AMIN: So I think, let's try it -- let me try to get to that through this work, through the discussion here, because I think the use and intent is really what we are comparing the components of an attribution model against. But again, let's try to get to that and if we don't hit the mark, this is where we're interested in the feedback from the group.

MEMBER QASEEM: You guys also had that evidence review done by the Michigan people.

MR. AMIN: Absolutely.

MEMBER QASEEM: Did you find anything even in terms of evidence, because you're talking about the, you know, attribution model evidence base. It goes back to what Erin was saying. I'm not sure that there is much there.

MR. AMIN: Well, yes. I mean actually what Erin just described at the beginning of this around the, you know, the review of all the attribution models, that was from the evidence review from the University of Michigan, and that's what the Committee used as their starting point.

MS. O'ROURKE: And to your point, I think that's what Andy and the other authors were really trying to highlight, is people just developed their models based on what's been previously done, without any objective evidence of if it's working or if it's really attributing correctly.

DR. BURSTIN: And as far as evidence, it's evidence -- there also very little testing

of the different models to see their impact. So that's our key issue too.

CO-CHAIR PINCUS: I think there's somebody on the phone who has a question.

MEMBER BAKER: I am still struggling with this, because I would think you would want to be able -- the gold standard would be if you actually looked at the clinical situation, and said yes, this person was truly responsible for the care. That would be the gold standard. That's incredibly hard to do.

(Off mic comment.)

MEMBER BAKER: That's a good question. I think, you know, you'd have to. It's the question of who's responsible. Is this the primary care physician, for example, who refers to a specialist, and then the specialist carries out a variety of things, or the primary care physician still had some involvement in that?

But what about the situation which is very common, where patients can go to a specialist, right, and the results are coming

back to the primary care physician and the specialist already did a whole bunch of the expensive wacky things, right, and some of which I need to follow up on.

This happens all the time in the emergency department. Somebody comes in, gets a CT scan. They have multiple incidental findings and the recommendation from Radiology are follow-up CT scan every six months for two years, that these endocrine tracks, and I've just spent $10,000 on something that was really the original test was not appropriate.

So that's the type of thing. It's just really hard to get into, you know, who is really -- especially I'm thinking about cost. Who's really the drivers in that?

DR. BURSTIN: I think we'll come to that.

(Off mic comment.)

CO-CHAIR PINCUS: But I do think it's a very complex question that seems, because in some -- and it depends on a number of things.

Number one is that in some cases, you know, it's like a projective test. You know, you talk to a group of people that are involved with the patient and you are not necessarily going to get a unanimous opinion about who's responsible for what.

DR. BURSTIN: I think that's why you'll see what we've laid out as a series of questions that should be part of a dialogue to begin getting to that. Jack Resnick, who's on the Committee, who's a dermatologist from UCSF, gave an excellent example of how he treats a lot of psoriasis as UCSF.

He tends to see those patients fairly frequently because they come in for treatments. So depending on the attribution model, at times he is labeled as the one who's the person's principal physician because he seems them most, and all the costs of their associated CHF, pulmonary disease, anything goes to him. But he truly has no actual role in controlling or thinking about any of that.

So I think when you see the principles and the recommendations, let's come back and see if we've answered some of these. Go ahead.

CO-CHAIR KHAN: I'd like to propose on other thing as we get into the next discussion, which is here we're talking about specific sort of measures regarding a particular care. Let's look at readmissions.

What some of the global measures or the cost efficiency measure that's so, to me horrendous inside of value-based purchasing, it just assumes over a 38 period, or is it 30 days, whatever the period is, that the hospital, which is going to be judged, is somehow in control of those costs.

Now if there's a readmission, maybe there was a hack and it's the hospital's fault. But you know, in terms of who really is the decision-maker, well you know in a voluntary medical staff, heavens knows who's the decision-maker.

MR. AMIN: Right.

CO-CHAIR KHAN: So the trouble is it's with the global issues as well as --

DR. BURSTIN: Absolutely.

CO-CHAIR KHAN: On the global measures, as well as the ones that are --

DR. BURSTIN: Correct, and we actually used that measure as a case study, Chip, in the report, to work through the decision guide.

CO-CHAIR PINCUS: And I just want to say, I don't think it's more complicated when you add in the population-based measures that have been --

DR. BURSTIN: Oh yes. We have another case on that one too.

CO-CHAIR PINCUS: Okay, good.

MR. AMIN: So I think as we just sort of wanted to set the foundation, I think as we talk about this, there's a tremendous amount of complexity that I think we've just started to unpack here. But I think what the Committee wanted to do was to at least set some baseline sort of parameters, if you will, so guiding

principles, first to acknowledge the complexity and the multidimensional.

They were very particular about the language here, which is why I typically don't like to actually read the actual language. But they were very particular about the language, and I want to make sure that we're all on the same page or I'm not mischaracterizing it.

The multidimensional challenges with implementing attribution models, as they can change depending on their purpose and the data available. They should be grounded in the National Quality Strategy, as attribution can play a critical role in advancing these goals. And again, this is where, you know, we talk about the importance of measures, measures alignment and measure selection.

But attribution, which can refer to both the attribution of patients for accountability purposes and the attribution of results of a performance measure are both equally as important.

They also highlighted the absence of a gold standard for designing or selecting an attribution model, and must understand -- you must understand the use and the goals of each use case, and then the key criteria for selecting attribution are the actionability of the accuracy, fairness and transparency.

So as we go to the principles on the next slide, the attribution model should fairly and accurately assign accountability. Attribution models are an essential part of measure development, implementation, policy and program design. Consider choices among available data are fundamental in the design of an attribution model.

Attribution models are not stagnant, and they should be reviewed and updated regularly, particularly as data, enhanced data assets become available. Attribution models should be transparent and consistently applied, and attribution models should align with the stated goals and the purpose of the program.

Again, this is where some of the work as it relates to MAP comes in.

So the second component here of what the Committee wanted to develop is this attribution model selection guide, and the current state here is that there's a tension for the desire for clarity around an attribution model's fit for purpose and the state of the science related to attribution model.

There is a desire, and this is a lot of what we heard through the NQF endorsement process and a lot of what we heard from the Board, to clarify which attribution models should be used in a given circumstance, you know. When should we hold certain -- some actors accountable in certain situations.

But there is not enough evidence to support the development of such rules at this time. So the goals of the attribution model were really to aid measure developers, measure evaluation committees and program implementers on the necessary elements of an attribution model

that should be specified a priori, and represent the minimum number of elements that should be shared with those being held accountable.

So on the next slide, I know this is really small to read, but I want to just sort of point out on the next slide. So on the left side, these are the elements, and I'll walk through, you know, what the Committee was actually recommending as you think about attribution models.

So on the left side I'll walk through what is the context and goal of the accountability program, and Ari, to your point earlier, you know, I think this was a key part of the discussion around what are you measuring against. The second component is how do the measures relate to the context in which they're being used, which is a lot of the conversation we have in the MAP.

You know, as we think about new measures coming in, what are the current measures in the set, what are the goals of the program,

which units will be affected by the attribution model, and then how is the attribution performed. And then so as we go through each box here, the context and goal of the accountability program is really what are the desired outcomes and goals of the program.

Is the attribution model evidence-based? Is the model aspirational? Are we trying to incentivize certain delivery system behaviors through the attribution model? What is the accountability mechanism of the program? Is it, you know, is it a pay-for-performance program? Is it, you know, is there dollars assigned, you know? How is the program designed with a strict cutoff in the readmissions example, and which entities will participate and act under the accountability program?

The second component, how do the measures relate to the context in which they're being used? What are the -- this sort of gets into some of the measure specification challenges.

What are the inclusion/exclusion criteria, and does the model attribute enough patients to draw fair conclusions, and this is getting toward the scientific acceptability sort of components.

Which units will be affected? To which units are eligible for the attribution model? To what degree can the accountable unit influence the outcomes, and I think, Chip, to your point on the readmission discussion, that was a key part of the discussion, you know. What's the level of influence, and that's a little bit of a tradeoff to the aspirational question earlier.

Do the units have sufficient sample size to meaningfully aggregate, and are multiple units to which -- are there multiple units to which the attribution model will be applied, getting to the shared accountability discussion. Then the last component is how will the attribution be performed, and this sort of is the nuts and bolts, the data that's being used. Do

the parties have access to the data? What are the qualifying events for attribution? What are the details of the algorithm used to assign accountability?

Were there multiple methodologies considered, and that should be made transparent in why and how certain models were selected, and then the timing of the attribution computation. So I'll turn it over to Erin to walk us through the final recommendations of the Committee.

CO-CHAIR PINCUS: Taroon, can I just go through the question about, I guess in some ways, the model that you described in terms of, you know, selecting. If we go back, can you go back one slide?

Yes, if you go back one slide. So is this design to be applied, sort of thinking about it from different levels of abstraction? Is it designed to be applied at a program level or at a measure level? So we talked about that. In some ways, it's kind of the intersection of both, you know. We talked about, you know, as we think

about selecting measures into programs, but then also individual measures also include attribution models in terms of how you're designing the attribution model within the measure itself. So we've talked about it at both levels.

CO-CHAIR PINCUS: I can imagine a program that is designed to, you know, like a quality program that is designed to hold hospitals accountable, and you could look at whether or not the assumptions about that program are correct. But then you also have to look at each measure, to see whether each measure is actually appropriate for holding hospitals accountable.

MR. AMIN: In the structure, in the structure in which the program is designed, absolutely. Helen, did you have anything else?

CO-CHAIR KHAN: And then that gets to be almost multidimensional chess if you have composite measures, because then you have the question of does each measure know? Is the gestalt really what people assume it is, since

simply by smashing a bunch of measures together?

(Simultaneous speaking.)

CO-CHAIR PINCUS: You can look at, you know, measure data elements to the extent to which the source of those data elements actually, you know, can be attributable.

DR. BURSTIN: And part of the reason for this work is the lack of consistency in this space, and feeling like sometimes measures bake in the attribution model. Sometimes it's only part of the programmatic approach. Sometimes it's baked into legislation as you know well, Jim. I mean there's all different ways to do this.

I think the key thing was to try to add some consistency. We think the questions will be very useful in terms of developers developing measures, groups like this looking at measures in the context of programs. But also very much so even outside the context of the federal government, you know.

We know a lot of these discussions

happen on the ground as well between health systems and payers. So having again a consistent way to have that dialogue is really our goal.

CO-CHAIR PINCUS: But I think this is very useful, because it sort of enforces for any program or measure, it forces the developer or the person developing the program to be -- to actually lay out in a purposeful way and a formal way of here's what we're thinking in terms of attribution.

MR. AMIN: Yes.

CO-CHAIR PINCUS: And here's how we're making that attribution.

MR. AMIN: The only other comment I would make on your question, Harold, is that in some ways we've walked into the challenge of attribution both here in the MAP and then also in the CDP process at the measure level, because all of this is not really always transparent.

And so we've tripped on this question a number of times because all -- well again, it's not transparent. So we're hoping that this level

of structure will be able -- we will then now be able to think about how it fits within our two different processes, and add to this contextual question.

So Erin, can you just walk us through the remaining part, and I think there's some more questions on the phone.

MS. O'ROURKE: Yes, absolutely. So building on these, the principles and the attribution model selection guide, the Committee made a series of recommendations that they intended would apply broadly for the development, selection and implementation of attribution models in the context of public and private sector accountability programs.

They attempted to recognize the current state of the science and consider what we can achieve right now, as well as what would be the ideal state they'd like to see in the future as far as attribution goes. The recommendations really stressed the importance of aspirational yet actionable recommendations to drive the field

forward.

Next slide. So their first recommendation, fairly self-evident -- to use the attribution selection model guide and to evaluate the factors to consider in the choice of an attribution model. Here, they really stress there's no gold standard. Different approaches may be more appropriate, depending on the situation.

Model choice should be dictated by the context in which it is used and supported by evidence and measure developers and program implementers should be transparent about the potential tradeoffs between the accountability mechanism, the opportunity for improvement, the sphere of influence of the accountable entity over the outcome being measured, as well as the scientific properties of the measure being considered for use.

The Committee noted that attribution models should be tested. In particular, attribution models of quality initiative programs

must be subject to some degree of testing for the goodness of fit, scientific rigor and unintended consequences. The degree of testing may vary based on the stakes of the program, and attribution models would be improved by rigorous scientific testing, and making the results of this testing public.

In particular, the Committee recommended when used in mandatory accountability programs, models should be subject to testing that demonstrates adequate sample size, appropriate outlier exclusion and/or risk adjustment to fairly compare the performance of attributed entities, and sufficiently accurately data sources to support the model.

Next slide. The Committee recommended that attribution models should be subject to multistakeholder review, and here they really highlighted the lack of current evidence and the lack of a gold standard, so that a stakeholder perspective could really influence what is the best approach and maybe, you know, which approach

is best maybe in the eye of the beholder.

So recommended that attribution models, selection and implementation in the public and private sectors should use a multistakeholder review to determine which attribution model may best serve their purpose. Attribution models should attribute care to entities that can influence care in outcomes.

The Committee recognized that currently, attribution models may unfairly assign results to entities that have little control over, influence over the patient outcome. Helen used the example of a dermatologist being held responsible for CHF.

For a model to be fair and meaningful, an accountable entity must be able to influence the outcomes for which it's being held accountable, either directly or through collaboration with others. The Committee did want to highlight the need to get to shared accountability and attribution as a way to move us forward.

As care is increasingly delivered by teams and facilities become more integrated, models should reflect that what accountable entities are able to influence rather than directly control.

Then finally, attribution models used in mandatory public reporting or payment programs should meet minimum criteria. In particular, they should use transparent, clearly articulated, reproducible methods of attribution. They should identify accountable entities that are able to meaningfully influence the measured outcomes. They should utilize adequate sample sizes, outlier exclusion and/or risk adjustment.

They should undergo sufficient testing, they should demonstrate accurate enough data sources to support the model, and be implemented with adjudication processes that are open to the public and allow for a timely and meaningful appeal by the measured entities.

MR. AMIN: Erin, before you move on from that, I just want to underscore that third

to last bullet, undergo sufficient testing at the level of accountability being measured, which is again something that we've struggled with at times with measures. For the goal of aligning measures across different programs at different levels of analysis, we want to make sure that they've been tested at the level of analysis that they're being implemented at.

MS. O'ROURKE: I think with that we'd like to open up for questions or discussion by the Committee.

CO-CHAIR PINCUS: So we have Chip, we have Doris on the phone. We have Marissa, we have Rich, we have Rhonda and we have Andy and we have John. Aparna, is your -- is your thing up too?

MEMBER HIGGINS: Yes.

CO-CHAIR PINCUS: Okay. So Chip and then Doris.

CO-CHAIR KHAN: So what strikes me about the development here is that we seem to be at sea a lot over whether measures, when they go

through the endorsement process or they go through our process, are really fit for a certain purpose. With the discussion this morning, it seems to me provides is at least one really important criteria that I'm sure is generally considered but not necessarily specifically considered with the depth that you have now sort of developed, and it seems to me that an attribution is like one of the --

I mean is like a key in terms of whether -- it may be a great measure, but what's the purpose? I mean does it fit a purpose and depending on how it fits in terms of this attribution, it could be a determining factor. So I guess my question is, and maybe this is a question for the end, is where do we go from here because what you've developed is something that I think ought to affect the endorsement process and begin to allow the endorsement process to have various levels of approval based on a perception of, you know, what it's fit to do.

Because if something is sort of

loosey-goosey on meeting your standards in terms of where the root is of that attribution, then do we really want that measure being used for pay for performance, I mean just in the most simple assessments? So where do we go with this?

DR. BURSTIN: Right, and we'll be happy to come back to this at the end. Obviously we very much welcome your thoughts about next steps. So we've been proposing some potential next steps, one of which is to review and revise what we already do on the CDP and MAP side, to consider how this fits in. So we recognize that's an issue.

There are also a lot of unresolved issues here, so I think there's more work to be done. I feel like we've scratched the surface of a really big issue. Somebody recently referred to attribution to me as the soft underbelly of value-based purchasing. Like we've got to figure out how we all agree on this to really move forward, particularly to move towards population-based measurement and all the rest of it.

So great questions. Just keep them coming. We'd love to --

CO-CHAIR PINCUS: Doris on the phone.

DR. LOTZ: I think this is fabulous work. I agree, Helen. I think this is the soft belly of, you know, value-based purchasing.

What I'm not hearing in the discussion yet is, inasmuch as the Committee work, the work today has talked about differences between who might actually be the provider of the service or have ability to implement a measure, being somewhat different than accountability, I'm not clearly hearing in the discussion around the slides how there might be some way of reconciling different attribution measures, strategies rather, or having some sort of a hierarchy.

From the position of a payer, you know, I think that the payer desire is -- and those of you who again I apologize for not being able to be in the room -- but I have accountability for the Medicaid program in New Hampshire as well. And, you know, the interest

is in paying at a fairly high level and then letting some of the individual decisions around service utilization or priorities or integration occur at a smaller unit of analysis, either a provider group or a geographic level.

So if you have different attributions for different measures, how do you potentially reconcile them into some more cohesive payment strategy?

DR. BURSTIN: Doris, I think it's a great question, one we'd love to have more discussion on. Certainly, I think as we think about potentially attribution being at a higher level, and allowing more of that internal attribution to be ferreted out, that's fine. I do still think these questions are even useful internally then, as part of that discussion, even if it doesn't influence the topic.

DR. LOTZ: Yes, agreed. Thanks.

CO-CHAIR PINCUS: Amir, then Marissa.

MEMBER QASEEM: Just to follow up I think what Chip just said, and I just wanted to

go back to Helen. I mean to a certain degree, when we're reviewing the measures at NQF level, we do look at attribution.

I mean it's a little bit buried in there, but the measures that do come forward do have a very clear attribution there.

I think the problem that happens is that we don't have any of the CMS colleagues right now here. I would love to get their feedback. They're somewhere, okay.

DR. BURSTIN: They gave a lot of feedback to this. So this not, you know, this is work we did --

MEMBER QASEEM: No, no, no. My point is what we endorse the measures for, we do have it in minds what level we're endorsing the measures, and then these measures end up getting implemented.

That's where I don't think it's they're being taken into account the attribution part, right. Have you had that sort of discussion with CMS or any of the folks, what

happens with attribution?

So even when we're reviewing it at ACP, we come to you guys and we say well, this attribution is perfectly fine at this level. But then the measure ends up getting in an expanded role, and you don't never hear about the attribution part. So you have had any conversations or --

DR. BURSTIN: Absolutely, and in fact one of the specific recommendations, and I forget where it was, specifically said at the level at which it will be used is that this really needs to be discussed. So we've been having some ongoing discussions with CMS, for example, about the use of the readmission measure and the physician program, and are working with CMS to try to get some of the testing done at that level.

But you're right. I mean -- you know, at least on the endorsement side we clearly require that. Testing is required at the level at which the measure will be used, and I think we

need to understand how that relates to the attribution when it's not as clear.

MEMBER QASEEM: And just to wrap up on it, I think you guys did a very good job with this attribution paper. I really, really enjoyed it and I think you have pretty much taken into account some of the major principles. But it's still very high level. I think it's a lot how it's going to get operationalized.

I think it will be still be good that if you very clearly state in there that the clinician or whoever is being measured, they should have some sort of influence on the process or the outcome that's being measured. I still feel like after reading that report it's really buried in there. It does not come out as clearly in some of the principles, but thanks.

CO-CHAIR PINCUS: Marissa.

MEMBER SCHLAIFER: First just thank you for starting this work. It's definitely something very important and some of my comments are from participating in the American

Pharmacists Association Policy Committee meeting, where we were talking about the pharmacists' role in value-based purchasing, and spent some time talking about attribution.

Not trying to like solve anything, but talking about it as an issue. I think one of the things to -- that I'm sure you thought about, that I should point out, as David talked about, he talked about, you know, when you see physicians and specialists, with primary care physicians and specialists, there's some kind of handoff potentially.

Those times where there's truly shared responsibility with no -- with several providers that may not even know that the other exists, and specifically as we get into more and more medication of care and medication management type measures, obviously the physician or NP or PA has a very important role.

At the same time, a pharmacist is doing their role in making sure that the patients are taking medications appropriately in maybe the

medication adherence space. It may be in identifying gaps in therapy and notifying the prescriber about those gaps in therapy.

It also may be in those potentially bad handoff situations, as a patient goes from hospital back to outpatient and there's a pharmacist that identifies, you know, the medication misadventures that often happen there. So I think as you go through your work and I don't have any answers, it's more questions, you know, thinking about when there's definitely shared attribution or there needs to be shared attribution, and this is something especially I'm sure to many of the allied health professions, you know, it's important.

Right now it's pharmacies talking. Pharmacists aren't providers under Medicare Part D today but hope to be in the not-too-distant-future. But also as pharmacists are contracting with ACOs and with physician groups, when we look at improvement in ACO measures and MSSP measures or MACRA measures for physicians, PAs and nurse

practitioners.

While pharmacists may not be getting paid by Medicare, they're looking at how they can identify to those medical groups that they have had a role. So I think this is something that's very important to the pharmacy profession and I'm sure others also. Is there any chance we can get these slides? That would be nice. They are in there? Okay. If they are, okay.

CO-CHAIR PINCUS: Rich.

DR. ANTONELLI: I also want to acknowledge and thank you guys for setting this work on this path. I usually restrict my comments to strategic framing, but I'm actually going to get into the grassroots with this. So to the degree, the couple of comments that I'd make, one is the attribution model versus a process.

For those of us, and right now in the name of Romneycare in Massachusetts, we are going forward with serious ACO development. Conversations of attribution are happening

literally in real time. I don't know that that's something that has really any relevance for this body, in terms of being prescriptive about what needs to happen, because we still have to develop what the evidence is in that space.

So what I want to call out to people is, and I think the example that we raised about the readmissions work, right. Here's the measure. If we had spent a lot of time in this room and in the MAP thinking about attribution, I don't think we would have made as much progress as we did.

So the way I would think about an approach, maybe not the singular approach to attribution but an approach to attribution is thinking about attribution at the tactical level. This is going to have significant implications, and I think, Marissa, you raised an issue that we're thinking about a lot in pharmacy, is still at the level of implementing a model of care.

So for example, pharmacy is relatively easy because it's still in the medical silo.

We're starting to get into some serious work on the Massachusetts and several other states that I'm providing some support for in integration, around social determinants and community so-called CPs or community partners, long-term and social, LTSS subpopulations.

I think for the MAP to actually think about measures and attaching attribution methodologies or worse, an attribution model, would slow the process down. So I just want to call that out. I think this is great. This will inform our work at a tactical level.

But the same thing that works for SDOH intervention in Roxbury, Massachusetts may not be how it's going to play out in Indianapolis. And so -- and then the last thing I'd like to react to is the notion of the measure developers being mindful of attribution. To the degree that that's desirable, that's okay. But frankly, especially thinking about being responsive to the Vital Signs report of the NAS/IOM, where we're actually talking about things beyond singular

medical resources.

I would like to have the ability to think about attribution across a community. So please, please let's not make attribution a component of endorsement, if we're trying to get to some of those holistic community-based population health measures. Not at all saying we shouldn't discuss it, but I for one would not care about, you know, endorsing if we haven't worked out the attribution methodology de novo.

DR. BURSTIN: One quick response. I think the Committee intentionally said the model can be labeled as aspirational, and then the discussion can proceed.

But at least it's labeled as such, recognizing that some of this may not be within the current purview but there's a recognition that's where people want a signal to go, and then you would logically think through the next set of steps, perhaps with a slightly different eye, knowing it's aspirational. We intentionally put that in there.

DR. ANTONELLI: Yes, and thank you for that. I think the optics. So I'm very mindful of what comes out of this Committee, and the NQF in general often gets -- I'll even use a somewhat provocative term on purpose -- over-interpreted in the street. Well Rich, why would we want to use that measure out here in the XYZ Medicaid program? It's not NQF-endorsed.

So I think if NQF and the MAP in particular could manage the optics of conversations around attribution because they are aspirational, hugely important by the way. But I do think some of these measures that get into LTSS and get into population health and social determinants, there is no a priori way, there's no -- there's no best model for that yet.

So Helen, I think if we can capture the spirit of what you just said and have that be attached to discussions around attribution, that would actually be very helpful.

CO-CHAIR KHAN: To respond, I think you really need to discriminate between your

measures, because when you're shooting with real bullets on a CMS basically fee-for-service measure, or set of measures, and I would argue value-based purchasing is a fee-for-service aspect of Medicare for hospitals, I don't think -- I think this really is an essential component to whether or not we go, you know, of any kind of design of the set of measures.

I agree. You don't want to hold up necessarily looking at a global situation, but everything isn't a global situation. So I think that's why I really think in the endorsement process, you may want to discriminate as to the -- and this goes back to fit for purpose -- what is the purpose of the measure?

If it's a population-based measure, it may have a different purpose and attribution may be dealt with at a different level than it would if we're talking about measures that are going to be used in either a real, either a fee-for-service environment or even, I would argue, you've got to be a little bit careful about your,

you know, beautiful ACOs on the hill environment, because not all that's population.

A lot of that is simply, you know, moving a fee-for-service measure into a different environment and it's basically the same thing, and you've got to make sure that it's fair. Because at the end of the day, it's three things: transparency, accountability and improvement. If it really can't be used for improvement, then so what to transparency and accountability?

CO-CHAIR PINCUS: Rhonda.

MEMBER ANDERSON: I would underscore what Chip has said. I think there is a balance there between what Rich and Chip have said. So I hope that we consider both, because I was going to comment on the endorsement piece. So Chip, thank you for that.

But the question, other question that I had for Helen is you alluded to the fact that to do a little testing with one of the measures. I was wondering if any additional testing really has been done, based on the principles and if

that you could share that with us?

DR. BURSTIN: Yes. I mean again, I think what Andy Ryan was able to find with his colleagues was this, there's actually very little testing done of attribution models per se. I think we've been trying to make sure that as measures are in use perhaps at different levels that are originally intended. Sometimes the MAP has referred to it as off label measure use.

We want to make sure there is in fact the ability to make sure it's tested at every level it's used for scorecard purposes.

MEMBER ANDERSON: And as we, and I really want to commend you, because this is such a difficult area. But it's so important. Somebody used the underbelly; I use the elephant in the room concept.

But the question I guess then I have is as you bring this forward, and it maybe goes to the next steps, will you select a few measures and if I look at what our conversation was yesterday, we had the opioid discussion; we had

the alcohol and substance abuse discussion, and there were a lot of questions about attribution, et cetera.

Will you take a couple of those and try to do some of our own testing, so that we get some of that information back to us about the use of the principles and how this -- how you at NQF have found those principles to be usable and maybe some changes even to them?

CO-CHAIR PINCUS: Aparna.

MEMBER HIGGINS: I'm actually going to -- she put up her card before me. I don't know if you noticed, but I'd have Amy go first.

CO-CHAIR PINCUS: Okay.

MEMBER HIGGINS: She had her card up before I did.

MEMBER MULLINS: So thank you for the work here. Thanks, Aparna, for that. One of the things primary care physicians get frustrated with is the duplicity and all the measures they have to report on, and likewise all of the attribution methodologies that come with all the

programs they participate in.

So, much like we have core measure sets, I think that there is something to be said for maybe some core methodology around attribution. So I'm hoping that this is where this work is going.

I think that one of the things, the conversation from me is getting a little confusing, because I don't think we attribute -- we don't need to attribute measures. I think we need to attribute patients and people.

So when I think of attribution, I attribute patients to physicians and providers. I don't attribute measures to programs. So for me, it's kind of -- the conversation kind of took a turn, because attribution is for patients. It's not for measures. So for me, that's kind of weird how we were speaking about it.

Perhaps attribution is for measures. I don't know. But for me as a provider, attribution is for patients to providers. I don't know when the discussion, when the

Committee was having the discussion if they considered all the methodology that was written into the final rule with comment for MACRA around provider codes, patient codes that where providers can -- is everyone in the room familiar with this? Am I just being redundant?

Providers can assign a code to their patient to describe the relationship that they have with them, to prevent the confusion around how much responsibility they have in order to get the cost correct. So if that was taken into account, I'd like to hear a little about that.

DR. BURSTIN: I'll answer the second part first. It was literally coming out as the Committee was meeting. So there was nothing to reflect on. I think it was out for comment I think at the time. So I think the Committee recognized that was something to keep an eye on as something potential.

In fact, there have been other things written as well, and in fact with Healthcare Learning and Action Network, sort of more look

towards a patient-based attribution model. We looked at all of those different models. Again, not having a gold standard is one of the difficult things.

But in terms of your first point, it is very much -- you can go back to the definition of attribution. It is all about assigning patients. It is not about measures. But the idea is the way measures are used and the concept of value-based purchasing is you are essentially assigning patient results to providers.

So that's what we were thinking. But actually one of the key things that came out, and we just did our member webinar last week and Carol said this really eloquently is at the end of the day, the most important thing here is that the patient is true north. We want to do nothing that hurts the patient by having everybody go it's their responsibility, it's their responsibility and nobody takes responsibility.

So that is truly the true north, is making sure everybody is really making sure

somebody's accountable at the end of the day, but also trying to do it in a way that there is at least an assessment of fairness.

MEMBER MULLINS: Yes and I would just -- and I totally agree with that. I would just caution against trying to bake methodologies or attribution methodologies into measures, because then you would have different methodologies in different measures, and then you have a mess when you try to report different measures with different methodologies built into them, because reporting is already a burden enough, and if you have to report using different methodologies for attribution, then I can see this becoming a mess, even bigger than it already is.

CO-CHAIR PINCUS: Aparna.

MEMBER HIGGINS: So I just want to build on some points that Amy and Rich and Amir have made. So I want to apologize for being late. I got stuck with the whole drama outside the window with the traffic, and I know I missed a lot of the conversation earlier. So if I'm

saying something somebody already discussed, I apologize for that.

So I want to build on what Amy said. I think in my mind too, I always think of attribution of a patient not a measure. I understand and I feel like maybe there's sort of two concepts here that we're trying to address. One is who's accountable for the patient, which is the attribution piece, and more and more the field is moving towards using patient attestation as the gold standard for that.

So you no longer use, relying purely on claims-based. So I think at some point, a patient's going to say yes, so and so is my physician and you don't have to be here talking about attribution.

I think so -- and then the other concept to me, at least as we've been discussing, and Rich I heard you sort of bring it up, is the fit for purpose, which is, is it, you know, is it useful for QI, it is useful for public reporting, it is useful for payment.

To me, attribution is patient-level accountability and fit for purpose is is the measure useful for payment? Is the measure appropriate for, you know, public reporting, which in my mind are sort of two different things. Also I think, you know, would agree with both Rich and Amy that, you know, I don't think it's a good idea that attribution be part of the measure endorsement process that you want to have the measure be evaluated for.

It's already being evaluated for a number of scientific criteria, including as Amir mentioned, you know, sort of the level of analysis, which tells you what the appropriate setting is.

One of -- a couple of other things I want to bring up. I know Amy brought up the MACRA. The LAN has obviously done a lot of work on attribution, so I don't know where the Committee, you know, what kind of input they had or review they did of the LAN papers.

You know, they've put out a model for

attribution which I think, you know, kind of got broad input. They went through a public comment period. As part of that, they had actually talked to people who had tested various attribution models empirically, and had included some of that data work in their paper.

You know, so okay. So there is quite a bit of empirical testing that's ongoing, in terms of trying to figure out what the optimal methods are. So I just want to make sure we're not reinventing the wheel. I think that was sort of my set of comments.

CO-CHAIR PINCUS: John.

MEMBER BOTT: Yes. I actually submitted comments on the draft report when it was out, so if you can bear with me, I'll just read what my general comments were on that, and then I will probably tack on one comment. But an excerpt from one of my general comments on the draft report, which are still germane to the final report in having read it, is a large portion of the report is dedicated to relaying

the attribution model selection guide.

This guide is followed by several recommendation, where the first suggests using the guide to evaluate attribution models. However, the guide is less of set of evaluation criteria and more of a set, a list of nice to know facts about a methodology.

These facts solicited about a given methodology do not add value, to truly evaluate a given attribution methodology. Of the questions posed in the guide, I would estimate that less than half would be of utility in the evaluation of an attribution model. So I'd recommend that if indeed we want the guide to serve in an evaluation capacity tool to revisit and refocus the questions comprising the selection guide.

Just one thought on that to try to be helpful. I really liked a couple of the past NQF reports where they -- where it was posed here's the NQF-given criteria, and here's how the composite measures and PROMs fit within those evaluation criteria. So I liked when criteria

were discussed in relation to the NQF criteria. That might be helpful here.

And just one other thought is about a year ago, CMS had a measure and NQF endorsement process and it largely was voted down if you sit there and read like I do, the steering committee's rationale, and it was largely shot down because of the attribution methodology.

You know, we all know this is a very contentious area, and I thought the criticisms were rather soft and not well-founded. So if I were to put myself in CMS' shoes, to say oh great, here's some guidance coming out, this really -- if I was CMS and I'm not speaking on behalf of CMS, I don't really see this as going nearly far enough as helping a measure steward, measure developer in guiding them on what's acceptable and what's the parameters for evaluation principles.

So while maybe this is a nice start, a nice part one and addresses a number of issues about attribution, I guess I would encourage, as

Amir hinted at, some more specificity and perhaps a part two report. Thanks.

CO-CHAIR PINCUS: Thank you. So Carl, then Jennie, then David, and then I have a comment.

MEMBER QUERAM: Just a quick one, since much of what I was going to say has been said. But I want to pick up on just the Amir-David-Chip kind of thread, when compared to some of the threads on attribution that have said, well, maybe not so much.

Alan, to the point, if we were to look forward, given the comments you made about aspiration, what do you anticipate we would see in this conversation a year from now when we look at next year's measures, as some practical, tangible changes to the process that we would actually feel and see?

DR. BURSTIN: That's a super question, Carl. I don't know that we know that yet. I think part of what we'd like to think through with you today is at least part of the question.

So that I agree: they didn't go far enough. They weren't specific enough, and frankly, as you guessed, there's not enough out there on which to base additional principles or recommendations, to be perfectly frank at this point.

I think the question would be, does some of that get baked into at least the discussions that we have here about measures? Do we at least perhaps, as part of our preliminary evaluation of measures, go through some of the elements of the guide to answer some of those questions to again try to have a more -- have a discussion that's perhaps more informed?

Again, not the intent to say more measures go down; really, the intent is to say, to have a very transparent discussion, and then the Committee should make a decision based on having that information on hand. But we'd welcome your thoughts on that as we finish this discussion.

CO-CHAIR PINCUS: Jenny.

MEMBER BRYANT: Thanks. This has been

a fascinating conversation for me. It's my first meeting, so I'm now exposed to the -- how far we have to go in the science related to attribution. One thing that -- I mean many of the things I was going to say have been said.

But one thing that occurs to me as we think about sort of next steps in the work would be that if you go -- if you think back to the principles that you articulated in selecting attribution models, they're very -- my sense based on the conversation is there can be very challenging -- it's challenging to meet, right.

So most folks who are developing an attribution model won't be able to meet all of those principles. So they're by themselves really aspirational, and it struck me that it could be useful to begin to articulate where the risks are higher and lower of being successful.

So you know, it's sort of -- I think it builds on and gets related to some of John's points of something about it being more tactical thinking about this, and taking it down to the

next level so that folks who are developing attribution models in some ways could have a set of -- a set of, I don't want to say criteria, but it's almost like warning signals.

If you're dealing with a measurement problem that has these characteristics, you're much more likely to not be able to satisfy these principles. So beginning to parse the principles and the challenges a little bit more finely, because I think talking about it at the 100,000-foot level does a disservice to the level of thinking that you have actually already done.

So you're going to find very different challenges when you're talking about attribution for clinician models than when you're talking about attribution of outcomes in the hospital setting, and it will be worth talking about the specific pitfalls, since I think that's where we are, is realistically we're going to be doing a lot of work on attribution, and we need to do it better.

So I think setting sort of some

incremental goals about how to improve attribution models which are clearly imperfect and not well-tested at the moment would be a place to start.

I was, say, also really struck by the conversation about how this relates to fit for purpose, and it does seem that there's an inherent tension here with the notion of fostering shared accountability across the system and moving to team-based care, and a desire to drive toward pinpoint attribution. And maybe was just worth acknowledging that the biggest challenges we have in the system are around hand-offs, where attribution is going to be really contentious.

So I think that gets to why it might be important to continue to, in the endorsement process, identify places where measures are critical to develop but almost unattributable, and not then decide that they're not -- that that means that they're not important measures, but that it might mean that we have IT challenges,

infrastructure challenges that need to be focused on as a way of making progress on those measures.

You know, I think there is a -- there is a rush to using every measure for payment that does a disservice to the development of the measures. I think it's important in the endorsement process. I think maybe this is part of what Rich was saying, like to not assume that they only have one purpose.

CO-CHAIR PINCUS: David.

MEMBER BAKER: So I think that you don't want it to be rigid, but I do think this should be part of the endorsement process, at least to have the measure developers give some idea of what their intent is, and I'll give a couple of really concrete examples.

One really simple one are diabetes measures. When we were doing the group physician reporting option, if you looked at our endocrinology practice at Northwestern in general medicine we did really well. But we had all these people with diabetes who are coming in to

see dermatologists, orthopedic surgeons, and you said, well everybody with diabetes who touched the system, we weren't doing well at all, right.

And for the developers to say, you know, there has to be some way of identifying those physicians who are truly responsible for caring for that patient's diabetes, that would help us tremendously. Another example is for some of these measures that were designed for hospitals, to apply those to an individual hospital was well. Most patients who are cared for by hospitals are cared for at least two, sometimes by three, and sometimes with input by the primary care physician.

So you know, it's really problematic to apply some of those things to an individual physician. So just for developers to give some statement of their philosophy, not necessarily a detailed model and not something that's prescriptive and says, you know, it can't be used in these other settings. But just to at least begin that conversation, I think, would be

helpful.

CO-CHAIR PINCUS: I had a couple of comments that I wanted to make, actually three. So one is, you know, we've been thinking about attribution as a binary concept, but it's not. It's really in many ways proportional, and I think it gets to some of the points, David you made and Jennie made, in terms of the determination of that proportionality is very, very difficult and may not be even possible in many cases.

So that's one issue to think about in terms of how to do that. I mean the typical example I think about is in terms of shared accountability. If I have a patient with schizophrenia and diabetes, at some level I'm responsible for both the schizophrenia and diabetes, and I should be thinking about the fact that there's this comorbidity. And while I'm primarily focused on treating the schizophrenia, if I see that the patient's gaining weight because of the medication I'm using, I need to

think about what kind of intervention.

I need to certainly communicate with their primary care physician or their diabetologist. So that that's a -- so how to think about that is complicated.

Number two is, when the report talks about testing, I'm trying to think about what do we mean by testing. How does one determine the validity of an attribution model? What would be the methodology for doing that? Would you convene all the providers and say, you know, well what do you think is your responsibility?

You know, how would you actually test the validity of the assumptions in a formal way? I think some work, further work on what are some of the research methodologies for assessing the assumptions about attribution would be sort of a worthwhile endeavor.

Then third, I think that -- so I'm sort of in between in terms of whether you would include attribution as a criterion or not. I think it would vary by the kind of measure or

program you're looking at. I think, for example, for a structural measure, there obviously is accountability that is quite clear, and for many process measures, that would be the case.

For outcome measures, it's much more complicated certainly. So those are the kind of things in terms of how -- you know, so that it would -- but certainly I agree with David and I think Jennie that there should certainly be a discussion about assumptions being made about accountability, both in terms of the endorsement process and also in terms of the MAP process in that way.

DR. BURSTIN: And just quickly this time, we have a list, a running list of the issues we've not -- we weren't able to really resolve as part of that, and certainly this question of what is attribution model testing? What are the methods? How would you interpret the results?

The data issues, we didn't talk a lot about that today, but it was a big cornerstone of

the discussion of the Attribution Committee. If you're looking at claims versus paper records versus patient attestation versus physician or other clinician attestation, how does that all come together? What's the integrity of the data source? This whole issue of team approaches, and Marissa raised this earlier, is something we've not really -- particularly around non-physicians came up a lot.

And then the attribution challenges in special settings and special populations. Patients with multiple chronic conditions are a whole lot harder than a patient who primarily sees one specialist for their one given disease. Then one of the things we did include, there was something about an ability to have adjudication or feedback, and how that even gets operationalized.

Again, many of the things we think we just didn't get to but I think are important questions.

CO-CHAIR PINCUS: Bruce, Amir and

Nancy and Rhonda.

MEMBER HALL: Thank you. I'll build on a couple of comments. Harold, I think ultimately the way we judge whether the attribution works is whether the feedback of information improved care, and we rarely ever reach that point with any measure anymore.

Having read this document a couple of weeks ago, I think it's a fantastic opening gambit. I agree with John and others that there's much more than we need to dive into, but it's a great opening gambit. I would just argue, and I'll sort of go even farther and harder than David did a minute ago.

I would argue that attribution has to be explicitly concretely specified in a measure. You don't have a measure if you haven't attributed. In the document itself, we talk about some related principles that are not all exactly attribution. The document talks a little bit about eligibility of data for a measure. Are these data points eligible to be in this measure?

And those data points may represent people or other pieces of information.

And then are these providers eligible for this measure, and those are sort of issues of accrual into the measure. Then inside of the measure, you decide how you attribute cases or information to the units you're evaluating, whether those units are individual providers, groups of providers, institutions or whatever they might be.

And then once you've done that, you have to return to the issue of fit for purpose, which several people have raised. But I would argue you cannot discuss and contemplate fit for purpose until you have a measure, and you don't have a measure until you've attributed the information internally in the measure and done the modeling.

I think the real challenges, one of the biggest challenges will be how, at what level of testing do we require a measure to be evaluated in the measure development process?

Because you can have very different measures, very different performance if you simply attribute the results of your calculations to an individual versus to a group.

I would argue that each of those levels has to be separately contemplated and tested, evaluated, approved, whatever. The history of what we've done here at the NQF, having contributed to these processes myself for 15 years or more as well, was that at first, we used to say we refuse to talk about that. That's an implementation issue. That's not in our scope.

Then we evolved towards saying we'll specify measures at different levels. The individual provider, the institution, the system. So that was an advance forward.

I think where we're heading now is to say we're realizing that the measurement science argues that until you've clearly said how you're going to accrue, attribute and then use, you can't do the evaluation of that measure in its

complete, in its completeness so to speak. So thank you.

CO-CHAIR PINCUS: Thanks. Amir, Nancy.

MEMBER QASEEM: So I'm just going to come back to what's already been said, and I think Chip started this discussion. He hit the nail on the head in terms of these measures are a high stakes game at this point right, and this report is very good. You guys did a great job. But I still think this report is not even at 10,000-foot level. This is like at hundreds of thousand foot level, because the practical applicability, there's -- I have some concerns about it.

And then -- and Chip again is absolutely right. The transparency, you have that as a principle. It's not going to really matter if you cannot really apply some of these principles, and I'll give you an example of that.

You have a principle in there, considered choices among available data are

fundamental in the design of attribution model. After I heard Helen talk about the discussions about the current limitations of the data and the availability of the data, that kept on coming up in the work core measure set confidence as well. All the time, right?

But there was -- seems like there was very rich discussion during that meeting, Helen, but if you read that principle and underneath the text underneath the principle, it does not even mention the issues with the data availability and the limitations of the data, and that concerns me.

Now I'm coming to a point of, yes, I really like the report. But again, that's why I said 100,000-foot level or feet level. I think again, you need to remember it is a high stakes game. Look, I mean CMS is using them for reimbursement and all that purpose, something what Bruce has just mentioned I think. We need to start keeping that in mind, and I think we need to really look into this report, now that --

is it -- how can it practically applied.

The first step is going to be make attribution part of the endorsement process before we can even go beyond that. And then go from there.

CO-CHAIR PINCUS: Nancy and then David.

DR. WILSON: Well, I'll be quick. I want to weigh in on agreeing with Rich and Aparna and Amy that I see attribution as a person-centered function. And I remember ten years ago, Mark McClellan, remember Mark McClellan, saying I just want to know who the team is that's taking care of the person. I don't care how they distribute the money that we're going to give them.

I mean, and I hope he doesn't mind me, because I am paraphrasing a little. But it was basically, who's caring for the person? Who's caring for the community? Who's caring for --- you know, I tend to think of it as ZIP codes and counties and things like that for the social

services, et cetera.

Being very person-centered and that gets you into a provider attribution model for payment. But I think that really focusing on people, the person and the patient as opposed to even providers is where we need to -- is the gold star. I think that part of what Mark was saying and I agree with is that it is tactical to figure that out.

I thought it was great to see the principles and what are kind of the things that should be in an attribution model. If I were trying to -- if I were sitting in a seat trying to create one for whatever the entity is that I'm trying to create it for, I'd run through that, because it would be -- I never remember everything that I should think of, and here's this astute body that came up with all these things.

So I see this being very useful, but translating and operationalizing it I think has to be at a very tactical level, depending on what

you're talking, who you're talking about. Thanks.

CO-CHAIR PINCUS: David. Rhonda, did you put yours down? Okay. Okay, David.

MEMBER BAKER: So Bruce and Amir talked about that this should be part of the endorsement, and I'd just like to hear what that means. I think testing actually the attribution model is just a step way too far, particularly like you were talking about. I mean, we don't even know how to do that accurately or what the best practice is.

So what do people mean when they talk about that, as opposed to again, saying that you should be -- it's interesting. You think about the testing, and when organizations do testing of their measures, they're making assumptions about the attribution, just by who is in that population.

So I think for them to make a statement of the philosophy and explain why they chose the test population is one thing. But I

just wanted to hear from the two of you whether you really think there should be any testing of the accuracy of the attribution, because I think that will be very difficult.

MEMBER HALL: Well I support what you just said. I think in almost all cases when we're sitting at the measure development level and we're evaluating a measure, you're actually evaluating -- whatever the testing's been done, it's been done at some level by those developers. I think most developers develop a measure thinking it will be applied at one level or the other. It's true, some measures come through and they might say this could be applied at physician- or system-level.

But I think almost all the information that I've seen over the years that will come in on a measure will represent testing at some level, and that's why I said until you've attributed, until you've accrued, attributed, and sort of stated what your intended purpose is, you don't have a measure to evaluate.

Maybe the intended purpose is the one that is the softest, because people might feel if they get through all those preliminary steps, then that they're then approved to use it for different purposes. I would argue against that. And I would say that usually when we're doing measure development evaluation, we are looking at results that a developer has done at a particular level.

So they have attributed it at a particular level, at a particular unit of performance, individual, group, system, you name it, and that's usually what we're contemplating. That's probably -- that should be the extent of the approval, unless they've truly submitted, here's how this measure performs on individuals, where the reliability will be an entirely different picture than it is for groups.

So I think your question reaffirms my feeling, which is, you don't have a measure until you've specified those things, and usually when we're evaluating a measure, those things have

either been implicitly or explicitly specified. I would argue that's the level the approval should sit at.

MEMBER QASEEM: Just to add to that, what I'm trying to get to, David, you already nailed. I'm trying to avoid the off-label use of the measure that's happening a lot, and I think we need to start acknowledging there is a fundamental problem with the current measures. We all know that.

I think this seems like we're oversimplifying the process and how they're getting used and becoming a high stakes game. We're all aware of it, but I think we need to be aware of it and start investing resources to understand how we can improve the whole performance measures process. The point is to improve the quality of our patient. You keep on hearing, Amy mentioned patients. We're all providers over here.

If that's not happening, what's the point? I mean are we just -- it starts feeling

like it's checkbox. And I know CMS is struggling, and they have to meet certain requirements and all the law and all that. But you don't want to make it, again, a checkbox, just we implemented the measures.

We need to be fundamentally behind to improve the quality of our patient care. If that's not happening, we need to start looking at it. I think, sometimes I feel like when I sit at these meetings, it seems so oversimplified that these measures are going to go, and we endorse them, and now certainly patient care is going to change.

We endorsed a lot of measures yesterday. Do you really guys believe that some of those measures are going to improve the quality of care? I'm not sure. I can actually list some of the measures, and without going back, and I know you guys are going hate me if I start extracting the measures again. But that's essentially the point.

I think I absolutely agree with Bruce,

and I think we need to start investing resources to learn a little bit more.

DR. BURSTIN: Sometimes there's also, it's interesting. Somebody said sort of implicit versus explicit attribution. So we oftentimes hear from committees when they look at health plan-level measures, for example, and I'm sorry Mary left the room, that we keep reminding them it's only at the health plan-level of analysis.

We frequently hear, particularly from the providers at the table is, well, you say that, but then the health plan sends those results to me at my level and expects me to respond. But again, we've not looked at the measure at that level. So I think the explicit versus the implicit is something we want to make sure we understand, too.

MEMBER BAKER: For those physicians, if something's in the measure set that shouldn't be applied at the physician level, right? Because they may go ahead, the organizations may go ahead and do it anyway, but at least, you

know, you could come, and physicians could say this isn't supposed to be applied at my level.

CO-CHAIR PINCUS: It sounds like, in terms of this issue of a criterion for endorsement that there's pretty much a consensus about it should certainly be discussed and detailed. Whether it should be a checkbox or not is a whole other issue. But it certainly requires some degree of intense discussion. Aparna.

MEMBER HIGGINS: I don't feel like we're -- there's different set of -- so there's the measures and then what I think of as the measurement methodology. And so part of that is the attribution, the small numbers issues, all of the things that we were all familiar with.

I feel like some of the comments that have been made here fall in this sort of -- some of it is small numbers issues, because I know the concept of reliability was brought up, and I think that's important to address if we're going to use a measure for a particular purpose.

I feel like a lot of what we talked about is fit for purpose, and how do you move measures and identify measures that are good for particular kinds of purpose, and not so much attribution, because that's still, as Nancy said, it's the patient, and who does this patient belong to.

I think the challenge of putting it in the endorsement process also is that, to Amy's point, it's not just different methods from different developers, but could be slightly methods depending on what payment model you're talking about. So now you're talking about a measure that could be applied in a specialty setting; it could be applied in a population setting. And then you've kind of, sort of even multiplied that complexity even further.

I just worry that we're going to get away from evaluating measures for their scientific properties, and then also looking at sort of what's the appropriate level of analysis, which is part of the current endorsement process.

CO-CHAIR PINCUS: So Helen, Taroon, Erin. Do you want to sort of summarize your own thoughts at this point?

MR. AMIN: So this was a very, very rich discussion. We really appreciate all the thoughts related to this conversation. As a recap, we embarked on the work of the attribution effort because of our experience, both in the measure endorsement process -- and I think Bruce characterized a lot of the challenges that we have in that sort of structure very well -- and also within the MAP process.

So this effort was to be a first step, to understand the state of the science first, and then second to characterize what the elements are that we may want to consider. I think the conversation we had today was very rich in terms of providing input about how the endorsement may consider the elements of an attribution model, and then how we might consider this going forward in the MAP process.

I think we're going to still have to

take this back and try to figure it out. Operationally, I think we heard this very loud and clear in terms of making this tactical in terms of what are the expectations of both of these processes. I think we quite frankly haven't yet done that work, and I think that's clearly the next step.

There's also been this underlying conversation around what are some of these scientific components around testing? What does that mean in the context of attribution? And again, that's partially what we're going to have to go back and think about in the next phase of work for these activities if we're really going to be including them in the next phase of evaluation.

Helen, are there any other sort of high level takeaways that you have? I mean obviously there's a lot of rich discussion here, and we'll make to represent it in the discussion and as we think about our next steps. Also, if there's any thoughts from CMS in particular, we

welcome those as we close up the discussion.

DR. BURSTIN: Just a great discussion. It gave us lots to think about. I think we'll be kind of bringing back a lot of these issues to our CSAC and other groups as we think through next steps.

MEMBER QASEEM: Can I ask a clarification question? So right now the testing is happening at a certain level right?

MR. AMIN: Yes.

MEMBER QASEEM: So maybe I'm not really get it. Going back to what Bruce said, wouldn't that be a low-hanging fruit to implement what Chip just said? So if the testing is happening at a clinician level, or whatever level it's happening, that it becomes a requirement? What's there to discuss for this one? I mean why can't we just really quickly move on this?

MR. AMIN: Well, so there were some discussions around testing different attribution models, and the criteria of what we would be looking at there, I think, is still not

completely clear. The second, and I don't mean to speak for Bruce, but I think where we're not going all the way to the level of testing the reliability and validity sort of cut-offs that are included in the context of the program that it's being used.

And that's sort of hinted at in some of these components that have been laid out here, which is, a lot of it is the measure evaluation context of the program. That's a step that we haven't taken yet. It's not that it's difficult to do. It's just whether it's the, you know, the next step that we should take.

MEMBER QASEEM: So what I'm asking, I mean that's going to take a while to do all that, and since we have -- we have a little bit of a simplified performance measure evaluation process right now in place in the country anyways. What I'm asking is if a measure is being endorsed at a certain level right now, and I know NQF already does that, why can't we move that little bit forward, that that's going to become one of the

criteria?

At this point, more knowledge that if the measure has been tested at this level, this is what is being endorsed right now. It's buried in the text when you're endorsing the measure. But what I'm saying is that because one of the criteria that this is all we're endorsing it for.

MR. AMIN: So technically that is the way the current endorsement works.

MEMBER QASEEM: But it's buried.

MR. AMIN: Yes. I mean we definitely --

MEMBER QASEEM: It's buried. It is there. What I'm asking is to make it your criterion.

MR. AMIN: Yes, and make this whole off-label use, meaning if it's used at different levels, more transparent and clear. There's obviously what we could do that. And you're right. It is straightforward. It's not what the testing supports. So we could certainly bring that back.

DR. ANTONELLI: I promise this will be 30 seconds. In terms of language, so I know at the IOM or NAS, whatever we're calling it now, earlier this month, they were talking about child health measures. In fact, some of those measures are actually readiness for kindergarten, high school graduation, so really community measures.

So to the degree that you bake into your discussions use of the term patient versus person, I would really appreciate it.

CO-CHAIR PINCUS: Okay.

DR. ANTONELLI: Because when I think about population health, you're a person who happens to become a patient. I recognize that in this group, because we're thinking about CMS all the time, your ticket to the dance is that you're a patient. I actually am excited about this attribution discussion, because of the potential bridge it builds into the world of true advancement of health.

So could you bake in some components of your language going forward around person, not

just patient.

CO-CHAIR PINCUS: Yes, yes. We realize that we did not leave room for public comments on this, so just at this point, let's open it up. Are there any comments from the public participants in the room?

(No audible response.)

CO-CHAIR PINCUS: Any comments from public participants on the phone?

OPERATOR: At this time if you'd like to make a comment, please press star then the number one.

(No audible response.)

OPERATOR: There are no public comments at this time.

CO-CHAIR PINCUS: So why don't we take a break now and reconvene at 5 to 11:00.

(Whereupon, the above-entitled matter went off the record at 10:39 a.m. and resumed at 11:04 a.m.)

MS. O'ROURKE: While we reconvene, I did want to just kind of jump in for a few

minutes for some of our newer MAP members, who actually may not be familiar with the work of the MAP task forces, and to give some background that MAP does have responsibilities outside of the pre-rulemaking rule.

So obviously the pre-rulemaking work that we've done over the past two days constitutes one of MAP's largest charges, but if you recall from the org structure that we show during the orientation, we do also have the ability to convene time-limited task forces to tackle particular challenges or to do work outside of the scope of pre-rulemaking.

So historically, we've looked at a wide range of topics. We've provided some input on the health insurance exchange's quality rating when that was getting set up. We also created families of measures around the different NQF priorities, and one of the more enduring task forces has been the work of the Adult and Child Medicaid Task Forces, to provide input on the core sets of measures used by the states.

So what we're hoping to do today is to shift the focus of the Coordinating Committee for a bit to the process that the Medicaid Task Force, forces I should say, have been using to make those recommendations, and to help us continually improve them and perhaps bring the more in line to the way that MAP makes its pre-rulemaking recommendation, so that CMS and others can see a consistent process and product from MAP and to know that all the recommendations are made equally rigorously. So, I think, Taroon, if you have anything to add or --

MR. AMIN: No, just to say that this next conversation obviously builds on the conversation we had in September, related to the preliminary analysis algorithm. So you'll find the goal here is to create more alignment in the approach that's being used across the work groups. So that is the purpose of today's discussion.

CO-CHAIR PINCUS: And actually let me just say a word. In some ways and I may be

wrong, but in some ways the first meeting of the group that reviewed the Medicaid measures actually predated the MAP process. In that way, it became kind of the model for how MAP operated.

I was there at that meeting and participated in it, and it was really sort of an interesting process to see how one does that, that came out of the CHIPRA rules, and so it's kind of come full circle now to now sort of get more joined up with the MAP process. So Debjani.

MS. MUKHERJEE: Thank you. So I would like to thank Harold and everybody, and especially the MAP Coordinating Committee for this opportunity to present some of the MAP Medicaid process refinements here today, and what I'll do first is provide a background, and my name is Debjani. I'm the Senior Director for the Medicaid Adult and Child Core Set, and I'd like to acknowledge our chairs here today.

Harold is the chair for our Medicaid Adult Task Force, and which is -- Rich Antonelli is the chair for our Child, and he's our new

incoming chair, replacing Foster Gesten. So with that, what I'd like to do is, the first couple of slides will be foundational, providing some background on the core sets and sort of the task force charge and sort of the goal of the core sets.

Hopefully, that will set some context for the ensuring discussion about the preliminary analysis. So the Adult Core Set came out of the Affordable Care Act, and sort of that was the genesis of creating an initial Adult Core Set, and since then it has been updated annually with recent iterations reflecting the input from MAP.

Similarly, the Children's Health Insurance Program Reauthorization Act of 2009 provided for the identification of a core set for children enrolled in Medicaid and CHP. And the CMS and AHRQ, Agency for Health Care Research and Quality, jointly came together with a group of experts and created the initial core set in 2009, and just a point about this core set.

The measures cover children ages 0 to

18, as well as pregnant women to get pre- and post-natal care needs. So the core sets must be updated annually, and the way this happens is the Medicaid Task Forces come together. They discuss potential recommendations for addition, as well as measures for removal from the core set.

These recommendations are sort of blessed by this MAP Coordinating Committee in August. Then they are sent forth to CMS HHS, where they get feedback from their various internal/external stakeholders, and the final annual updates for that year to both the core sets are published in December.

So what is the core set's charge/purpose? The purpose is to get states' experiences in implementing and reporting on the core set measures, and in a way, that functions as a feedback loop and gives us experiential data regarding sort of the feasibility and sort of the difficulties with respect to implementing.

The core set purpose is also to sort of gather concrete recommendations for

strengthening and sort of addressing measure gaps, potential measures that should be considered, as well as measures that are ineffective and should be removed.

Together, the input provided helped CMS formulate strategic sort of direction and sort of policies with respect to Medicaid.

So as mentioned before, the task forces are time-limited bodies, and it's an interesting point, because the Medicaid task forces have been around for a couple of years, and what they -- what the goal of the task force is is to come together, provide guidance on a very specific topic, and then they get disbanded.

Just because of their annual updates, the Medicaid task forces have been around for a while, and one of the caveats is that the task force membership is drawn, has to be drawn from the current MAP work groups, as well as the Coordinating Committee. This is also another reason why that the Medicaid work happens off-cycle, so that we can let the MAP pre-rule work

be completed before we start tapping the same individuals for the Medicaid work.

So the core set data or sort of reports on measures from the core set are used to create a snapshot of quality across Medicaid and CHP. The data is provided annually in the Health Quality Report. There are two reports, one for child, one for adult. There's also a chart pack that has state-specific data and other analyses, and altogether all of this, again, is used to inform policy and program decisions.

Again, a quick recap of the task force's charge. Review states' experiences in reporting measures to date; refine; identify measure gaps, and sort of, usually it's growing the measure gap on a yearly basis; recommend potential measures for addition to the set; as well as recommend measures for removal based on loss of endorsement and/or ineffectiveness within the program.

This provides you with a quick time line. The Medicaid work again is off-cycle. It

starts in March with a web meeting. Then the in-person meeting always happens in May, late May. Report development happens June through August. Mid- to late August is when all the recommendations as well as comments are brought forth to the MAP Coordinating Committee for review and approval.

The final reports are completed by August 31st on a yearly basis, and then the core set updates are provided usually by December of that year.

So the project evolution. The whole point of sort of undertaking this process improvement is to sort of align with the expansion of Medicaid and sort of the impact in importance of Medicaid and health care, standardize the work flow, as well as the assessment of measures and recommendations across project tiers, as well as systematically review measures.

The current processes of document review considers the gaps within the Medicaid

population and sort of the needs of the population, as well as being guided by the measure selection criteria. What is being recommended and sort of put forth for discussion today is the introduction of a standardized way of discussing potential measure recommendations based on a Medicaid-specific algorithm and preliminary analysis.

And just to note that what staff has done is take the MAP pre-rulemaking algorithm and preliminary analysis and has adapted it for Medicaid on core sets. Hence, the edits are not drastic. It's more sort of a clarification of what Medicaid needs might be and how they might be different from MAP pre-rulemaking Medicare needs.

So in the next couple of slides, what I want to do is quickly talk about some of the Medicaid decision criteria before I go into the actual edits of the algorithm, and the preliminary analysis tool with the edits has been distributed. It's a draft copy. So everybody

should have a copy of it at your table right now.

So the decision criteria starts with support, and support criteria basically addresses a previously identified measure gap, measures that are ready for immediate use and promotes alignment across programs and settings. The other decision criteria is conditional support, and that's for measures that are pending endorsement from NQF, pending change by the measure steward, pending CMS confirmation of feasibility of implementation reporting, and other such considerations, practical considerations.

And finally, the do not support criteria are for measures and/or measure focus that are inappropriate are a bad fit for use for the Medicaid core sets. There's a duplication of efforts, resource constraints, which is a big issue, and Medicaid agencies at the state level will need to tweak and/or vary the level of analysis to increase measure adoption and implementation.

So with that, the next couple of slides talk about where changes have been introduced to the MAP pre-rulemaking preliminary analysis tool. So for the first couple of assessments, all we have done is add high impact area with a focus on the Medicaid population. So that's more of a clarification. And then the major adaptations or deletions are, if you want to follow along in the paper copy that's been handed out for Assessment Number 5.

The Assessment Number 5 for pre-rulemaking says the measure can be feasibly implemented. For Medicaid, it has been changed to operational feasibility because we want to make sure that it's implementable. From reports, sorry, the pre-rulemaking says reporting feasibility. The Medicaid one says operational, because we want to make sure that it can be implemented and operationalized before we get to sort of the reporting aspect.

And then the final one is number seven, which for the pre-rulemaking is sort of

asking for end user feedback on measures that are already implemented in other programs, and that has been deleted for the Medicaid.

That's one of the questions I have for the MAP today: should this assessment still be done? Because the Medicaid program is unique in having the data of how feasible -- or sort of user feedback from PQS and some other program, I don't know if that's going to be very helpful for the Medicaid-specific core set.

But if this group feels like it should be put back, all we'll do is just add it back. With that, those were the only two sort of big edits done. I want to open it up to say what other factors or considerations should be added to this Medicaid-specific preliminary analysis? Any additional edits? Any additional comments? Sort of your thoughts on sort of adapting something that's for pre-rulemaking to something that's for Medicaid.

I just want to keep this to this part brief so that we can have time for discussion.

Harold.

CO-CHAIR PINCUS: So any comments, any thoughts? I know, you know, Rich, you are coming into the process. You've been involved in the process, but coming in as chair, and Carol's been very involved as well. And others have been involved in the Medicaid Task Forces.

So maybe we could -- people would have some thoughts in terms of some of these changes. Important points about, just to reemphasize, is that it's interesting in that this is a voluntary program, and so that states have the option of participating in it or not participating in it. States also have the option of choosing which measures they want to implement.

So there's a balance in terms of thinking about both what are individual state needs? What are the needs across the Medicaid program? What capacity states, individual states, have in terms of the implementation of these programs. And also there's a real opportunity to have very good interactions

between people involved in running state Medicaid programs, as well as other stakeholders in getting some of the back and forth about how they -- the difficulties and barriers they have in implementing some of the measures, but also in terms of how they're using the measures within their states to improve care.

So it really provides an interesting sort of laboratory of what actually goes on in other areas of other programs that MAP oversees. So comments. Rich, did you want to say something?

DR. ANTONELLI: I have a couple of comments, but I'm going to anticipate a question. Debjani, could you say a little bit more about the rationale for deleting number 7?

MS. MUKHERJEE: Sure. So I think from sort of the staff perspective, we wanted it to be as Medicaid-focused as possible and sort of really attuned to the specifics of needs of the Medicaid population. And from our point of view, we didn't know if looking at other federal

programs that have already implemented the measure, whether that sort of information is translatable to the Medicaid population.

So if it worked in some sort of pay-for-performance, is it going to sort of translate easily to sort of the Medicaid population? And Medicaid is voluntary. Also, a lot of the issues we hear in Medicaid as resource constraints are political, sort of, will-related issues. I don't know if that, especially the political will issue, is going to be captured in sort of the states' experience in reporting.

And that's why I said staff is open to putting it back in if the MAP Coordinating Committee thinks that it is something we should at least hear from and consider, even if it's not directly relatable or translatable.

DR. ANTONELLI: So thank you, and I don't know whether Foster is listening in today, but I have huge shoes to fill. But I'm honored to be asked to be able to do this, and I'll make a couple of comments. I'll keep them brief. So

first of all, I think in general, the document, the tool that you've shared with us for comments, I think aligns very nicely with being able to look at some of the core principles around validity and parsimony harmonization, usability, and feasibility.

Last year what we did is we had, for the child and the adults, actually there was like a three day meeting with overlap between the child and the adult for two of those three days. So I really liked that, and one of my core principles with respect to care coordination and integration measures is to try really hard to promote a single approach to integration that is not age-specific.

So I really like this approach, and I like the criteria. This will be especially important as we try to identify and then promote measures to fill gaps in the area around behavioral health assessment and integration as an example. So I really appreciate the ability to have the child and the adult task forces to

co-convene, and to look at experience.

The other piece though that I found valuable last year, and I wanted to bring up with our CMS colleagues in the room, we have qualitative experience from selected states that will come in to talk a bit about their measures. I want to make sure that that continues. That's very helpful.

It also would be really helpful for us to be able to see some data from the states that actually are using some of these measures. What I'm particularly mindful of is, because a state isn't using a measure, if I don't have any more information than that, I don't know is that was because of lack of resources, lack of political will, or whether in fact it speaks to the usability, feasibility, or applicability of the measure.

So I think if CMS could consider getting some data to the task forces when we have that component of measure review, that would make our -- that would inform our deliberations that

much more. Then I think it would be -- I'm also keen to hear a little bit about Item 7. Full disclosure, this is the first time that Harold, Debjani and I are talking about this.

But I am mindful, being a provider myself. There may be measures that I have experience with that aren't necessarily in the Medicaid space yet. So while I agree with the need to have relevance and comparability, we may want to have some criteria by which we will either rule in or rule out the content, if you will, for Element 7, or make sure that those comparability criteria fold into another element. Those are my, those are my comments.

CO-CHAIR PINCUS: Carol?

MEMBER SAKALA: Yes. So I've been through this process for three rounds and heading toward a fourth. I'd like to second what Rich says I think about the structure, which I think is really valuable and rich to have the task force members, NQF staff, people from CMS. Very rich presentations, feedback from the states,

which do give some of the feedback about measure use issues in the context of Medicaid.

And also, having a day of overlap where the child and adult groups meet together. So I think it's really fundamentally a very excellent process, and I support the effort for continued alignment with the overall, the MAP process. I just wanted to follow up. Leah made a comment yesterday that I think might have seemed a little strange. She mentioned maternity and cesarean in the context of a conversation which is framed around Medicare.

Last year we had the VBAC measure, but it wasn't an all-payer measure. So I just wanted to share a little bit of -- like be sure that everyone's aware of what I would call an imbalance right now, because the Medicaid is really, there are facility measures, clinician health plan, but they're aggregated to the state level.

So the potential for improvement is very different from the Medicare measure. So I

just wanted to be sure that everyone understands that, and as Harold said, it's voluntary, and it is at the state level. And it's also confidential, so that we don't even get the state performance results there. And the three aims are that over time, more states should be collecting -- more states should be involved.

States should collect an increasing number of measures, and states should use them for quality improvement. But that is very different from the various federal programs that we've been talking about, and there were some public comments this time around directed to the hospital draft report, saying that on the model of the elective delivery measure, that is an all-payer measure that is in the inpatient quality reporting program and in Hospital Compare.

Maybe it's time to think about how we might fix this imbalance between the two programs. So in the context of discussing Medicaid, I just wanted to rise that, because conditions that apply to younger populations,

pediatric, maternity, other things, really are pretty left out of the federal programs.

CO-CHAIR PINCUS: Marissa.

MEMBER SCHLAIFER: So some of my comments very much mirror Rich's comments and Carol's comments. I'm only -- I've been through just two years going on Year 3, and one thing I just want to reiterate, the importance of having the Medicare/Medicaid program directors, state directors here to share information.

There's some of us on the Committee who have strong managed Medicaid background and not fee-for-service Medicaid background, and I think explaining the feasibility of why things can't be collected. I think I learned so much over the last two years about why measures that made sense to me don't really make sense, or make sense in the managed Medicaid world and don't make sense in the fee for service Medicaid world.

So I just would encourage that, and that's originally what I thought this question was, and now I'm understanding I guess that it's

more people that are non-Medicaid. I just wanted to say that.

One question, and I don't expect it to be answered here, but I think that came up briefly at the end and Kate, I don't know that this is something that CMS has gotten to yet. But one of the interests that I know on the management Medicaid plans have is with the new managed Medicaid quality measures that will be rolling out in I think 2021, and we are still pretty far away, I think trying to --

One of the questions that was asked at this past go-round of the meetings was whether a MAP or MAP-type entity would have input on those managed Medicaid measures, and whether those managed Medicaid measures could be -- we would be assured that they would mirror the state Medicaid measures.

So I think that's just something that hopefully we can talk about a little more at the upcoming this year's meetings, and maybe CMS will have had time to think about that by then.

CO-CHAIR PINCUS: Other comments? I just have a few. Oh, Doris.

DR. LOTZ: Yes, thanks. A couple of general comments. I wouldn't want too much departure from the MAP process, you know, inasmuch as the MAP process we've just discussed, you know, evolves the contribution about attribution. Other conversations we've had over the last day and a half, applying those to any approach taken for Medicaid to me would be, you know, should be done.

I think there are some unique aspects of the Medicaid population, you know, the population, some of the services maybe. But as far as measurement is concerned, I would strongly encourage just keeping the same approach, the same standards, maybe with a few additional standards, but without substitution.

You know, the past physiology is the same. We're moving more and more towards integrated payer models, where Medicaid is most effectively affecting changes to population when

thinks its service delivery across payers, and not as some sort of unique payer. So you know, the ACO models, some of the models that came out of SIM, these are looking for Medicaid to partner with the commercial sector and with Medicare.

If we create too different a set of standards for measurement, we're going to have a hard time, you know, introducing payment models and some assessment of value and change. That said, I do think we need to think about some unique needs of the populations. But I see that almost as, you know, secondary to creating the gold standard in a measure so to speak, that I kind of like to think of coming out of this process.

I think absolutely feedback on measures, though, is good. So I'm not, I'm not clear, and I don't have the full document. I only have the slides that were distributed. But number seven it says regarding feedback, delete number seven regarding feedback.

I would speak against that. I've had

a chance to talk to the Medicare MAP group a couple of times in my capacity as CMO for Medicaid, and pointing things out that, you know, we have a good portion of our population going to places called Institutes for Mental Disease, which are the state psychiatric facilities or otherwise, you know, psych facilities that are dedicated primarily to the public sector.

Historically, these were taken out of the payer mix so Medicaid didn't pay for them. They were primarily funded through other state reimbursements. But as we've kind of evolved our Medicaid practices, we look at, you know, the measures that deal with discharges from mental health facilities, certain follow-up criteria, et cetera, as definitely applying to the IMDs or the Institutes of Mental Disease.

So this is a variation in Medicaid that I think enhances the use of the measure, and that the MAP process ought to be familiar with. But it certainly doesn't require a different approach to creating that measure, and certainly

not a different measure.

So I would speak against deleting the feedback, and I'm also similarly befuddled about why separating operational feasibility from reporting feasibility. As been said before it's voluntary, so where there's politics, where there might be resource constraints, that's on the states to sort through.

To take them somehow formally out of the discussion, it seems prematurely to take them out of there because politics and resources change, and you know, I would rather see for Medicaid a robust set of measure sets. It allows us to capture local opportunities and capture integration where we can, rather than to have them sort of presorted before the measure set is complete.

So I know that was a lot, but 15 years I've been working with the Medicaid program primarily with quality improvement and specifically with measures. I would rather at a philosophic level have the measure set reflect,

you know, the general delivery of medicine, as I said, the pathophysiology that we're trying to address, rather than have it be some sort of separate set of criteria that leads to Medicaid measures. I'll go back on mute now.

CO-CHAIR PINCUS: Thanks, Doris. I had a -- oh, Aparna.

MEMBER HIGGINS: Sorry, I had a quick question. On the operational feasibility aspect, are there -- I know when we do our MAP selection criteria, we have subcriteria. So is that something? That's actually a question? So do we have subcriteria in terms of how the Committee looks at operational feasibility? So I mean kind of looking at it --

CO-CHAIR PINCUS: And maybe explain the difference between operational feasibility and implementation and reporting.

MEMBER HIGGINS: Reporting, yes.

CO-CHAIR PINCUS: What are the -- because it seems like a fuzzy mentality there.

MEMBER HIGGINS: And then I have a

comment after that, after I get an answer to my question. So go ahead.

MS. MUKHERJEE: So the way we were looking at it is can it be adopted as specified without additional resources being needed at the state level, and if additional resources are needed, does the state have access to that? Also we're looking at the implementation. Is it at the state level, at the plan level and sort of what is the feasibility of doing that?

But again, all of this is up here today for sort of input, refinement. So if anybody has other thoughts, other subcriterias that should go other than sort of the level of analysis, operationalizing at the level of analysis, and sort of the resources of adopting it as specified, I think we're open to any and all suggestions at this point.

MEMBER HIGGINS: Because one thing I would -- I mean this probably came up in discussion is the availability of data, right, for calculating all the measures. Depending upon

how the state defines the benefit, you know, some states carve in behavioral health, some don't. You know, it's just going to vary in terms of what states are going to be able to do.

So you probably want to make that explicit. I think I'll say the same thing as what Doris said for seven. I think it's still useful to get feedback from current measure users, because if say implementing the measure in the commercial population they run into some challenges, I think it would be good for the committee to understand those.

People might say oh yes we have the same problem because we don't have X, Y or Z. So I think there's value in that. And then just to, you know, sort of comment on what Marissa said about Medicaid managed care, and looking at what the states are doing, you know, I mean there's variations on a theme.

I mean I think we're all familiar with the buying value project. We looked at use of measures at the state level and there were, you

know, over 1,000 measures and variations on those as well. I think, and again it's also driven by the benefits and what the states decide to do. So that's -- I mean it's a huge challenge and I just say more power to the committee so --

CO-CHAIR PINCUS: So just a couple of comments. One is with regard to the two issues about the changes, it seems to me that, you know, one of the sort of real things I like about the program is the fact that it is voluntary, and it allows, you know, more flexibility in a sense in terms of how one applies this.

There's always going to be a balance between having the flexibility versus having standardization, you know. While, you know, at some level the goal is to have every state report on every measure, there's also an understanding that every state's going to be very different, and if you look at where the Medicaid program is heading, there's going to be even more variability.

So that, you know, during this period,

especially when there's going to be this transition, I think having flexibility may be important. So that different states applying different models having different capacities can get their feet wet in reporting in some way. At some levels, we want to encourage people to come in, states to come into this.

And they may -- with the understanding that they may not be able to report on every measure, but still to participate and to begin to be able to sort of evolve over time, particularly from the point of view of what they find useful in participating in this.

Because one can think of feasibility from a number of different perspectives, feasibility in terms of reporting, actually collecting the data. But also feasibility of the ways in which they might use the data. They have different capacities to do that.

So I would, you know, be more general in terms of thinking about, in terms of Assessment 5 to say that that's something that

should be explored, but it should be, you know, with not, you know, we shouldn't set the lowest possible capacity to do that as the standard, that we should have some, you know, allow some flexibility.

With regard to Item 7, you know, I think that it's always useful to have this kind of information. I don't see a reason to exclude this kind of information. So you know again, it's input and it's useful and I think, you know, members of the task force think about these things anyway, because they may have been exposed to the use of these measures, you know, in other ways.

So we should probably be explicit that, you know, we welcome this kind of additional information. But I think, you know, as I said before, given the current political issues going on around Medicaid, this is going to become, you know, increasingly important as a program. I think we also want to sort of generate as much interest as possible from the

states themselves, in understanding as they move towards these more, you know, potentially more flexible and potentially more innovative arrangements, how they can sort of understand where they are in relationship to other states and how they, you know, can use this kind of program to improve what they're doing and learn from the experiments that are going on.

MS. O'ROURKE: Could I jump in with a perhaps suggestion of a path forward? So it sounds like from Doris' comments and Aparna's, perhaps maybe we want to adopt the same seven assessments for both pre-rulemaking and the Medicaid work, and then allow for the necessary customization in the definition of those assessments, so that now we'll have a consistent preliminary analysis algorithm across the board when you look at the overarching assessments that every measure will be subject to.

And then versus pre-rulemaking versus the Medicaid at work, there will be the need for the customization. Again, just to highlight why

we're bringing this to you, is we want the Coordinating Committee to feel comfortable with the process, that the task forces will now go use to make their initial recommendations to you, because we'll be bringing the findings of the task force to you at your August web meeting, to finalize. Similarly to the charge of the Coordinating Committee to finalize the pre-rulemaking recommendations.

So again like we discussed in September, the process for pre-rulemaking, we want you all to feel comfortable with the process the task forces are about to embark on for their work. So we would perhaps put that suggestion out for the Committee's consideration as a potential path forward.

CO-CHAIR PINCUS: I think that makes a lot of sense. Rich.

DR. ANTONELLI: Yes. I don't know whether our CMS colleagues didn't respond to the Medicaid MCO, or whether you were just being polite. So I would absolutely respect you not to

feel comfortable, but I'd love to hear what you would say about, you know, what would the lines of sight be between this work and the Medicaid MCO measure sets.

DR. GOODRICH: I think we need our Medicaid colleagues to answer that question up here. We need our Medicaid colleagues to answer that question. Peter and I work on the fee for Medicaid service side. I don't know if there's anybody on the phone.

MS. O'ROURKE: Oh okay, okay.

DR. GOODRICH: So if we have somebody from CMS on the phone who can answer that.

MS. MUKHERJEE: Renee, are you on the phone? Gigi, Renee?

DR. FOX: Debjani, can you hear me?

MS. MUKHERJEE: Yes, we can hear you. Do you hear the question? Do you want to take sort of an --

DR. FOX: So I'm going to -- I'm not the managed care rule guru, and I'm going to defer the question. I think we would be happy to

discuss it in the -- maybe we can add that to the agenda for the MAP meeting in March.

CO-CHAIR PINCUS: That makes sense. I mean it's certainly something that we want to discuss and --

DR. FOX: Great. We'll make sure that --

CO-CHAIR PINCUS: And we can prepare for that.

DR. FOX: Yes. Thank you.

(Off mic comments.)

CO-CHAIR PINCUS: Other comments, other questions? Any other comments from the CMS Medicaid participants?

(No audible response.)

CO-CHAIR PINCUS: Okay. So why don't we move on to the next section. Is there any other -- that's good. Let's move on. Let's move on to the next section. So there's an opportunity for public comment on this Medicaid presentation. Okay. Are there any comments on the sort of Medicaid task forces discussion that

we just had from the public in the room?

(No audible response.)

CO-CHAIR PINCUS: What about the public on the phone?

OPERATOR: If you want to make a comment, please press star then the number one.

(No audible response.)

OPERATOR: There are no public comments at this time.

CO-CHAIR PINCUS: Okay, thanks. So Chip, I think we're going to move on to discussions about process improvement of the work that we've been doing over these two days.

(Pause.)

MS. O'ROURKE: Sure. So we can -- the presenters from ASPE can be available at one o'clock.

CO-CHAIR KHAN: Okay. Well then let's barrel through. So I'll turn to Kim to present this process.

MS. O'ROURKE: Thank you. Do you want to at this -- sure. So again, this is something

we've done with the Coordinating Committee every year. We want to hear your feedback on what worked about the pre-rulemaking process, both what the process, the work groups used to make their recommendations, as well as the process for the Coordinating Committee's meeting.

So Kim's going to be taking you through an exercise there. She's also going to be highlighting a few areas where we'd really love your feedback on some potential ways to do this a little better next year. In particular, we're looking for feedback on the decision categories. If you need to further clarify the differences between the refine and resubmit and the conditional support, and if the Committee thought that having these four categories worked for this year.

We also want any input you might have on building out the process to look at the measure that are currently finalized for the set, any ideas about data we could bring into the Committee for their consideration, potential

sources for that data.

Kim's also going to give you a refresher on the feedback loop that we've piloted with the PAC/LTC group and some suggestions from the Coordinating Committee would be most welcome as we roll that out across all the MAP work groups.

DR. GOODRICH: Thanks, Erin. So we'll do a warm-up process improvement exercise. It's the round robin plus delta. This is something that the Clinician Work Group used. Yes, the Clinician Work Group used in their December meeting. So what we'd like to do is to go around the room and have each Committee member talk about something that worked really well over these last two days, and what could be improved.

NQF staff will be taking notes and we'll use this to help inform the process that happens next year.

MEMBER BAKER: I thought the decision categories worked well. I particularly liked -- for the conditional support, I thought all of the

groups did a good job at saying what were the conditions that needed to be met. I thought that was really helpful.

In terms of what could be improved, I think just to be able to come up to that higher level and be able to understand the existing measure set and what niche does this fill. I think we need to get more information on that, a couple of very concrete things. We talked about some of the measures for end stage renal disease and how --

It wasn't apparent from the materials that they were -- you had a dig a little bit to see that they were addressing specific problems in some of the existing measures, and the same with one of the other ones, where you were shifting, essentially replacing ECQMs, chart-based measures with new ECQMs. So just to be able to give that higher level view I think would be helpful.

DR. GOODRICH: So I think the prep materials and having this online, which we've had

now for a couple of years for me works very well. I felt like there was a button missing this year that allowed you to get back to the top really easily. So a tiny little thing, but I just thought I'd say that. I looked for it a couple of times. I remember it being there before.

The one thing that for me was a little, I don't know if it came out in previous years or not, but was the process by which when you had multiple votes in multiple categories, that it would roll down to the, you know, to get to the 60 percent. Sometimes we saw a couple of examples of this yesterday.

That was just awkward, because you ended up having most in one category, but you did have a couple of like in refine and resubmit sort of roll down to refine and resubmit, which didn't always make sense for the measure if it was fully endorsed, fully specified.

So I would just think through that a little bit for next year. So that's one area I would point out. I feel like we struggle with

this every year, like what does consensus mean, you know. Should it just be a simple majority? Now we've come to the 60 percent, and I know why we got where we did each time. It continues to be a struggle. I do not have a suggestion. I'm sorry.

DR. YONG: So along with Erin and Helen having sat here now for eight days of MAP meetings, over the course of the past two months. Just from my own observations, I think -- I think the -- at the work group level and at the Coordinating Committee level, I think what has worked really well is both having a chance to dig into the measures on the MUC list.

But then also having these cross-cutting conversations even at the work group level, I think they -- we've heard a lot of comment, feedback that that worked. The members really appreciated that opportunity to think about sort of broader cross-cutting issues.

I also agree with Kate. I think the prep materials have been really helpful too, and

so I really appreciate the work the staff has done just to get those done and out to the Committee.

MEMBER ROBICSEK: On the plus side, I felt like the chairs did a very good job of stimulating conversation, helping it move, making everybody wanting to comment and feel comfortable doing so. I also thought the materials that were prepared were very thorough. On the delta side, I did feel like the kind of relative proportion of discussion about procedural things and discussion about the kind of material that we're talking about was maybe not as favorable as it could have been.

There was also I felt like, at least for me maybe, because I'm new, ambiguity about what was the what that was in scope for us to be talking about? What would be excessively duplicating work that was already done by the work groups, and what's discussion that should happen here?

So kind of what level? Should we stay

at that 100,000 foot level? Should we get down into the details that again, at least as a -- for a newbie wasn't totally clear.

And then I just want to reemphasize David's point about it would be helpful to see what the existing measure set is, so that we can know where this fits in.

MEMBER FLAMM: So I would just, I guess, pile on on the positive side about the materials. A lot of information, very easily accessible. So I think that worked well from my perspective as well. On the opportunity to improve piece, perhaps and others have mentioned this, that is getting clearer around the category purposes and definitions for conditional versus refine and resubmit.

I know we kind of touched on that, and I noticed when we were reviewing the MAP Medicaid Task Force, they only had the conditional category. As we're looking to kind of align these processes, maybe there is another opportunity to really clarify whether we really

need both and how to -- do we use them at the same time or not, you know.

DR. ANTONELLI: I can make this quick because three of the things will be affirmations. But I guess I'll start first by once again complementing the staff. You guys are just amazing and thank you for the prep and your positive energy and support in general. It's wonderful to work with you.

The voting thing I found a bit disturbing as well. I think we have to discuss and decide, you know, do we need to achieve consensus on things because sometimes the outcomes didn't really make sense. This one I think that you just raised, Carol, is also key. Indeed, the deny is sort of was reflected in the conversation I think we had yesterday about would we want to send a statement about opioid dependence or assessments. So there should be a refine and resubmit.

But it was really a significant pivot from what the spirit of the measure was. And

then I think the other one that I'd like to reflect on, and this may actually come -- I don't know if it's going to land here at the MAP or not, but I was really mindful of how important the conversation was about the quality of the informed consent for the elective surgical procedure.

There was a sentiment in the room that that's a process measure that may or may not reflect the patient experience. I really was quite impressed by Bruce Hall's notion of the relationship between the surgeon and the patient and family et cetera. I reflected on that. The measure developer put a lot of thought into that, and by the time it lands here a lot of us said but that's not really where we want to go.

So I don't know, you know. If we're identifying a gap here, how does that information get out there to the world of people that provide resources and do measure development, because I really -- I don't know if the measure developer was expecting to get the pushback they got from

us. I think we landed in the right place.

Probably several years' worth of work went into something that kind of came in here and hit the wall. So I don't know what I'm calling out. Maybe it's an issue of better alignment or synchronization around gap identification and work that's being done to actually fill those gaps.

MEMBER ANDERSON: I will just say that I appreciate all my colleagues' comments, so I'm not going to reiterate those. But I am going to add just a couple. One is in reflecting on all the materials which I felt were very well done, it seems as though in some of our discussions, when we pushed a little bit more with our questions, the group's decision in what they were putting forward was not fully articulated in that comment.

We found out more about what the group's discussion and decision was and why. So if we could refine that a little bit, I think it would help us in an overall discussion. I know

this was hard because it's probably our fault as members. But having the pulled measures at really the eleventh hour was very difficult. To then do all the cross-referencing and everything.

But that's our fault. So we need to respond to you a little earlier, and make certain that we get those pulled measures in when you ask for us to pull them, and I think I'll apologize for all of us. But it isn't -- we can't have the same in depth discussion if we're at the last minute trying to do all the cross-referencing. So I would just add those comments.

MEMBER HIGGINS: So just like everyone else, I want to, you know, thank the staff and congratulate all of you on great work, and having been at the MAP from the very first year, I think we've come a long way in terms of our tool kits and discussion guides, and I think it's so much easier now than it was when we first started doing this so we've learned a lot.

So I want to echo some of the things others have said. So I agree with Kate in terms

of the decision to have a voice in voting up and voting down. We're a small group so one person could really lost the vote, I think. I don't have the answer to it just like she said, but I think that's a concept we need to come back to just like she said, so it's what the majority of us think to some extent.

And then I kind of want to echo what Ari said about trying to figure out what's the right level for us as the Coordinating Committee and not wanting to relitigate all the discussions at the work group level. I think it's challenging sometimes, you know, but we're getting better at it but I think we should pay more attention to.

MEMBER MULLINS: I agree with everything Aparna just said, so I'm not going to restate all of that. I do appreciate not carrying about three or four big huge white binders of information to everyone in these meetings. That's great. Completely different subject on things that were great. The hotel was

within a wonderful walking distance of the office so yay on that decision.

One thing that I thought was a little confusing for me, it was hard to about the pulled measures. I think it was hard to see what the whole measure list was and then which ones had been pulled for discussion. Then when you're in the measure index on the discussion guide, the measures were arranged by alphabetical order and not numerical order.

But then we were talking about them in numerical order and not alphabetical order. So I got confused. I think several other people may have gotten confused. So maybe numerical order might work better for us. I don't know. It would have worked better for me.

MEMBER KRAMER: Thanks. Just to reiterate, I agree with all the comments that were made so far. I wanted to quickly point out I thought the co-chairs did a great job of managing the discussion and the process. This is a big room, complicated topics, and I appreciate

all the work you did to keep it on track and get us to decisions.

One suggestion I had would be around the agenda. We've talked about this offline. We just kind of slid around a little bit and just keeping everyone informed, and making sure that we get everything done at the right time with the right people. It's important. I hope we can do that better the next time.

MEMBER HALL: Yes. From the top down, I really appreciated the conversation management by the co-chairs, and the pre-work done by all the working groups was phenomenal. The organization of that pre-work by NQF staff again was phenomenal.

The organization of the materials was great. The one thing I kept looking for, and I've already talked to Erin and Taroon about this, I kept looking for that one link that said here's the conceptual picture. Here are all the measures in this program or here are the ones you're thinking about and how they would relate

to this program, even to the level to say hey, there were 18 here. Two got full support, four got conditional support. All the rest got, you know, do not support or whatever. Just the big picture. Even to the point of like a super-graphic that ties all the programs together with some lines. That's the one piece of context I was struggling to really assemble. So all good on the organization of the materials, but for that one small nitpick.

Even better if I think we, and others have said this, if we could maintain our focus in this conversation on the suitability for rulemaking, and not be revisiting measure development. I think the measure development was done even before the work groups and if anything was reexamined in the work groups. So we should try to maintain that focus.

And then the only other big question I had was is there any role for us thinking about removal of metrics? Again I think maybe the big, big conceptual picture of what metrics and what

programs would help us think about the questions of removal of metrics.

But I don't think we went anywhere into a conversation about metrics that are in programs that should be discussed for removal, you know, metrics that we've put forward in the past but at this point might want to reconsider.

I don't know if that's in our scope or not in our scope, but we didn't -- we certainly didn't get that far. Thank you.

MEMBER BOTT: On the positive side, I was really happy and really impressed with the responsiveness of NQF staff when I asked a myriad of questions in that last week before the meeting. People were very quick to get back in touch. So that was really appreciated with the chart and the time we had to review materials.

On the potential improvement side would be I am a devil in the details kind of guy, but it would have been nice at least in the initial version that I primarily used to prepare, would be to have a link to the technical

specifications, such as if the measure had a completed NQF endorsement form it would really help.

Sometimes it would help in review because you see what the comments were from the work group and sometimes you don't have enough context. I know there's a summary of the numerous and denominator. Also sometimes measures get labeled as a process measure and sometimes it's confusing. Is this an inappropriate/overuse measure or is this a process measure in that the higher numerator rate the better, and sometimes you just a quick look at the specifications can get to that.

Oftentimes, a description of the measure, like in the Excel file, doesn't necessarily reveal that. Also I think having the full tech specs may have helped truncate some of these conversations we're having in this precious time we have together, where people ask about what's the data source. Is this risk-adjusted or not and then other people have to be pulled in

who are down at that detail level.

If we would have readily had that, we might have been able to avoid taking this meeting time with those conversations to fish around to find the specifications. One other comment on the documents. So we're, especially on Day 2, we're referring to several reports. So I had to root around to find the reports.

So I had to root around and find the reports. It would have been nice to just simply have a link to them. It would save some time and save calls to NQF staff on where is the final report. So thanks.

MEMBER BRESCH WHITE: This is my first meeting, so I'm feeling a little underwater, just in terms of trying to -- the learning curve is huge. But I do want to thank the staff and commend them for the great work and keeping the conversation going. I thought they were very articulate and clear explaining particularly the change in the rule process for voting. The online access was very helpful.

I agree with David's comments about understanding, particularly on the dialysis part, why we were looking at that measure. If we had understood that at the beginning, it would have limited our conversation.

I agree with Rich in terms of the voting. I thought it was a little awkward, and I thought sometimes that the way the votes came out didn't legally mesh with the conversation in the room. So and that's it. Thank you.

MEMBER BRYANT: Thanks. Also my first time through this process, and I'll just pile on and say really the staff work, sorry the staff work providing us with background materials was really impressive I've got to say. It sort of sets a very high bar for how to get detailed feedback from a group of disparate folks quickly. Maybe not at lightning speed, but effectively.

So I think in terms of things that could make it work even better, I'd just like to reinforce the things that have already been said about attention to the broader context. So the

summary information about the measures that we're looking at and what the work group recommendations were I think that Bruce was alluding to, but also the interaction between the measures we're looking at and the existing set and to what extent --

I mean just even a few sentences about to what extent the measures we're looking at would change the emphasis of the existing set, would make big changes, small changes. Just frame a little bit the context or magnitude of change we might be looking at.

You know, in that vein I'd note that it's particularly challenging to sort of think holistically about the measure set which I understand MAP wants to be doing more. When you're thinking about say MIPS, where there are multiple pathways for reporting, including the QCDR measures which I don't even -- I assume we're not making decisions about those measures but we don't even have a list of what has been considered or might be coming up through other

pathways, you know, around those data registry measures.

So but obviously as part of the context, we're thinking about what the changes that we're looking at here. So this is an example of how more context, so that we can put in, we can have the right frame for what we're looking at.

MEMBER LIN: Well ditto, ditto, ditto to everything that's been said but, let me say something in addition. I don't think we can ever over-compliment enough the work of the staff, and I've been seen this for a number of years and the time frames in getting materials out so we commend them.

Number two, I want to commend the chairs for what I'm going to call their unbiased chairing. We really appreciate that, and that's very important. Materials are good. We've said all that already. One of the things I suggest is on the agenda is that perhaps staff could stamp every agenda before the agenda comes out the day

before with draft.

I came with five agendas at this meeting and I had to figure which one I really wanted to pay attention to. So, and I know there's, you know, 5.1, 6 point, you know, 10 point whatever but --

CO-CHAIR PINCUS: Sam, the agenda is changing as we speak.

MEMBER LIN: Yes sir, I appreciate that. I appreciate that.

(Laughter.)

CO-CHAIR PINCUS: Even what we're doing now.

MEMBER LIN: Okay, sorry. But I would suggest just a simple way to solution is a quick optic or visuals, stamp them all draft until the one that comes out the day before, and probably the one we'll bring along to the meeting.

I think having decided to attend, sit through in December at least two of the work groups, where the granular activity takes place, I have to, you know, compliment those work groups

on the directions they took. Best as I could tell in reading through the materials, you know, it really did capture the essence.

It's not easy to capture all of it. The chairs, of course, did a good job and Ron in particular on the hospital. So I have to encourage it, and as a group here we are sort of at the 50,000 foot level. But if you really want to hear some of the nitty-gritty and the intricate materials, if you can, you know, listen in or attend one of the work groups.

The thing that I noticed, particularly starting with the work groups was that we are moving a little more towards the trend of patient experience or patient outcome or patient empowerment, whatever word is, you know, the hot one of the day. That's good, because that sort of is going to keep pace with something called outcomes which is, as we all know, you know, structure and process are wonderful and important, but the patient cares about outcomes.

They expect us to do structure and

process. So I would encourage, certainly from CMS, to be thinking more of sending us things where there is the patient experience, since we now sort of understand that the patient actually has a role in their own care.

Yes, I was going to say just lastly, the logistics is always, at least within the room, not outside in the streets, but in the room has been excellent. Again I thank staff, and I don't think we can over, ever over-compliment staff. Thank you.

DR. HUNT: Well, I think I'm going to be a bit of a contrarian. I've been to a lot of these types of meetings before, and I find it singularly unhelpful that we can't scapegoat or blame the staff, because any problems we have then falls back on the Committee itself. So I think we should change that in some way.

(Laughter.)

DR. HUNT: The prep materials were absolutely great. I think links to the current NQF endorsement status of a particular measure

may be helpful, as well as the full tech specs. It can be arranged to have it in a hyperlink, such that if we wanted to look for it, we could.

I was completely impressed with the pace of the meeting yesterday at 10:30. I never would have dreamed that we would have left by 6:00, and it picked up. So I think that goes to the co-chairs in particular.

I don't know what to do as far as the voting, but not having the skin in the game for voting, it does seem unsatisfying sometimes when things don't work out. We might want to beforehand consider something like two rounds of voting when a clear yes or no wasn't decided, in which case the category that got the least amount of votes was thrown out and perhaps you would tend towards something more definitive. But again, I'm no expert in this. That's just my two cents.

DR. WILSON: Well, I have to echo that the work of the staff and the chairs is phenomenal, and I also really appreciate that the

Committee takes its role so seriously. This Committee takes its role so seriously. I will say that this is the first year where I actually listened all day, each day to every work group and man, is that very helpful.

So I think that -- I mean it's huge commitment of time, but listening in on the work groups or attending in person is very, very helpful, and I think helps us with the let's not rehash what the work group did, because I --

There were moments yesterday when I thought well this is like the old days with the CSAC and the Board, you know, where we're rehashing with the CSAC, and of course, you know, we eventually said CSAC rules. So just throwing that out.

And I had it written on my piece of paper too about thinking procedurally about, before we start. Well, do we want to do two votes? Do we want to revote? Do we -- how do we handle it when it gets a little awkward? So again, I go with David. You know, that's a

procedural issue for you guys to think through. But we couldn't do it when we needed to do it, when we wanted to do it because we hadn't done it all day, you know. So which I think was the right decision.

I think just a little bit of clarity on, you know, like okay. Like here's the whole current list or a link to the whole current list, and now we're going to look at these four substantive measures. We're going to talk about all four of them, so you're going to have to really pay attention.

Whether it's 172 or 173 or, you know. But having the conversation as a group, and being able to think about how those either work for, as additions to the current stat or replace them. That kind of thing would be really helpful. So I love the idea of being able to kind of link to the current set of measures. That's it.

MEMBER SAKALA: So again, kudos to the overall quality from staff and co-chairs, and also of the materials. I want to echo what Bruce

and others have said about the -- getting to the high level of a view, bringing a view in this room of the federal programs, their composition and how we might be altering them with the work that we do over these two days.

I think that would be, you know, very -- a very helpful frame for us, and I think that is consistent with our charge. I felt during the hospital work group discussion yesterday a little bit like we were swimming in molasses, and I don't know how to fix some of that because there are so many factors that come to bear that came into that conversation.

But it was frustrating and yes, people were saying I'm not going to know their evening plans, notifying people that there are going to be changes. And also the tension between the voting and the qualitative comments that, you know, maybe we need to smooth out the voting, but also to realize that it's all good.

And just one more thing, the attribution discussion was extraordinary. I

thought very helpful and rich, and advancing my knowledge and also I think the process moving forward. It's the right time for the iterative step, so thank you for that.

MEMBER SCHLAIFER: I'll just start out by reiterating the attribution comment. It was definitely the fun part of, you know, hearing what was going on there and being able to -- having it explained in a way that we can take it back to others that have been very interested in what you're doing here I'm very excited about.

First just want to say yes, thank you to the staff and thank you for all the process improvements over the years. I know the staff that prepared this, you know, five-six years ago put just as much work into it, but it wasn't as easy to use. Having the links and being able to jump back and forth between the programs and measures, especially for those of us that when we're talking about programs that I know nothing about, you know, when it gets to inpatient psychiatric care or something that I know nothing

about, it really helps to be able to jump back and forth that way, especially for those programs.

I mean all of us are very into certain programs and not so much into others. So having the existing measures, especially in those programs we're not as familiar with would be very, very helpful. So that would be the only one improvement I would say with all the links and everything there.

I think as far as the voting, just a couple of really -- some that's been kind of measured to get into the weedy parts of it, and from someone who -- as speaker of the house for various pharmacy associations, very into the minutiae of Roberts Rules of Order, we're looking for consensus.

So I think when someone said, you know, we can't revote. Well in a consensus discussion, you can keep discussing until you get to consensus. So I think I would suggest that when we got to a point where we had a vote we

weren't comfortable with, that it would have made sense to revote until we got to a vote that we were comfortable with.

Not that you want to do that often, but there's -- I don't think there's any rule that says we can't revote. So that's just a suggestion. I think it would have gotten us to where we wanted to be. I also just wanted to mention there was one comment at one point about why are we pulling measures when we're not going to vote on them and we're not going to change the recommendation?

And I think that the pulling of measures to get to the discussion to make everyone comfortable to support what the work group did serves a purpose, and I think we should continue to be comfortable with that and not think you can't pull a measure if you don't disagree. I don't know if I just said that or whatever. I think you know what I meant there.

So I just -- just thanks again for all the pre-work. It was just fabulous to be able to

jump back and forth and get to exactly what we need.

MS. RUBIN: Koryn Rubin. I'm filling in now for Carl for the AMA. Thank you for all the pre-work and, as someone who's been intimately involved with this process for several years and having a seat on the Coordinating Committee since the inception, it's gone a long way. I think we got the materials maybe like one day earlier than last year, which is always helpful. The more time the better to prepare.

With the -- in general, I think the new categories were effective. But at the -- whether it's here at the Coordinating Committee or at the work group, there are sometimes some inconsistencies based on like the approved kind of definitions in terms of what can and cannot apply. So if there's a way, you know, preliminarily to, you know, highlight which categories apply based on the status.

So you know, this has NQF endorsement so it, you know, falls into two of the three

categories as opposed to four of them. Then also in terms of with the pulled measures, it would be helpful if they can be more easily identified. So maybe they just even go in the head, the email that said, you know, these are the measures that were pulled. If you could just put it front and center and then also who pulled the measure.

There was a little inconsistency with pulled measures from last year to this year. I recall last year there were some kind of rules to the road in terms of pulling measures, and you had to provide a little bit of an explanation with your pulled measure. That would be helpful, especially since that information comes late, so that you're aware of what you're looking at and can come a little bit more prepared in a short time frame.

MEMBER QUERAM: Thank you. Going this late in the process, I reminded of a saying that others have used when they're in this position. Just about everything that can possibly be said about the subject has been said, but not

everybody has had a chance to say it.

So I will just align myself with comments about the quality of the staff and quality of the materials, and Marissa's comments about the voting procedure.

MEMBER BARTON: I'm going to pile on my thanks for the staff and the chairs, and about the measures. I've heard, you know, we have things sorted by title and the suggestion maybe sort them by number, and this is just like a radical idea. There may be some software solution out there that would allow this to be.

You know, I'm thinking Excel but I'm old, right. So where you could sort it several different ways and you could have a field for if it was pulled and field for how it had been voted by the work group, and then we could sort them however we wanted.

MEMBER QASEEM: Well, let me just start out by what works. I think it's -- I have to agree with everyone that NQF staff, it's amazing under the leadership of Helen and Alyssa.

But I have to say that Erin, Taroon and Yetunde sitting next to me really kept me on track, and she has promised me that I'll always sit next to her, because I didn't know what measures or what are we doing. So it is my seat guys. No one can take this one. And then of course thanking Harold and Chip.

(Off mic comments.)

MEMBER QASEEM: Harold and Chip, you guys ran an amazing meeting, keeping us on time. They always say the best meetings are the ones that finish ahead of time. I think we're heading in that direction. So I'm not going to get into the numerical orders and all that. I already mentioned it to you guys. I think that's an easy fix.

Two suggestions that I'd like to make are one is I'm still struggle with this whole revise and resubmit category and do not approve category. You guys saw the struggle yesterday, and we're not going to of course come up with a solution right now. But I'd really strongly

encourage you guys to look into this, as to how we can differentiate, because I don't think that the measures we voted, we were inconsistent ourselves, right. This is something to really start thinking about.

And the MAP Coordinating Committee voting, I've been thinking about it. I feel like that, you know, many of us are on various governance committees and all. Maybe we should just have a thumbs up and thumbs down vote, and let me tell you why. I think that the subgroups of MAP are spending really ample amount of time.

We do not spend that much amount of time when we're discussing those measures. They have all the detailed information in front of them, and I really hesitate overturning their decision without really having full knowledge of depth of knowledge what's going on.

I think what we need to start thinking about as a Coordinating Committee is that we discuss the measure. I'm not saying that. But we vote just thumbs up and down, and if it's a

thumbs down and essentially which means it's to be sent back to the Committee. They heard the concerns from this Coordinating Committee and what do you think based on these comments? Do you still stand by those?

I just don't think we spend enough time over here, and I don't think we should be turning thumbs, giving thumbs up or down to any of the measures that were here unless we do have all the information and we start reviewing the measures in detail. I'm very uncomfortable with this process, to be honest with you, in overturning the --

I think the hospital group and all the clinician group, they spend like almost -- because I have been in those groups and Amy you too, right. So you guys end up spending like maybe 45 minutes to an hour on just one single measure.

I think it's just unfair. Then why do we even have those subgroups if we don't trust their judgment? So something to think about,

that maybe we need to revise our policy in terms of voting.

CO-CHAIR KHAN: Anyone I guess on the phone? So it's Doris and --

DR. LOTZ: Yes. My travel was cancelled at the last minute, and it may have been a matter of routine for staff to be so well prepared to integrate folks remotely into the meeting. But they did a fabulous job, so I want to thank them for that.

But also specifically thank the chairs. I never felt like I wasn't part of the discussion, and sometimes that also happens when you're working remotely. So I really appreciate that. Also, the folks around the room. I always feel like more meaningful content will come from a large gathering like this when people are comfortable disagreeing with each other and speaking their mind, and I felt like that was the case as well, so many thanks to go around the table there.

With respect to doing things a little

bit differently or contemplating kind of how things could be otherwise, I think about our title as being that of the Coordinating Committee, and yet it seems like we approach things still in their programmatic silos. There's a tremendous amount of imperative to look for some economies in measurement.

I think that's, you know, looking to purge the structural process measures, to look for outcome measures. One mechanism to go about doing that would be, you know, we talked a little bit about feedback on implementation in the Medicaid space. But it seems to me that feedback on implementation could be good across the whole board, and perhaps it's done.

But I didn't, I didn't see it if it was there in the preparatory materials. And also, you know, it's very hard, I think, for maybe the work groups to think about what to eliminate. I totally concur with what everyone said about them being subject matter experts around the table.

But I'm wondering if to be deliberately provocative, to suggest in advance of the work groups. Perhaps it has to come out of a balanced committee like this; perhaps it comes from NQF staff to say have some substantive discussion about the elimination of the following measures. Are they still serving their purpose? Are they being used appropriately?

Maybe the sword in that discussion is just to wholesale think about eliminating all structural and process outcomes. That's very provocative, I realize that. But some way of getting their input in that regard, and then expanding the Coordinating Committee role in looking across programmatic silos. Someone mentioned already, and I'm really sorry. I don't know voices and names, so it's hard to coordinate.

But the idea of taking more of a patient perspective was mentioned. That's, I think, a very good way to think across measure sets, to look at the patient experience, which

wouldn't necessarily compartmentalize things to outpatient hospital, inpatient hospital, renal disease, that sort of thing. That might be a way to also become both more meaningful and to have a more strategic measure set that, you know, could be adopted broadly and implemented broadly, and hopefully be meaningful as well. So thank you for that.

CO-CHAIR KHAN: Thanks. Barrett.

MEMBER NOONE: Hello. Can you hear me?

CO-CHAIR KHAN: Yes.

MEMBER NOONE: I just wanted to echo what everyone has said. I think that the staff deserves a lot of credit, especially when we are tuning in remotely and they've been terrific in following this whole conversation.

Congratulations to the leadership and chairs of the committees who have really guided us through these two days of deliberations. So thank you very much for letting me participate remotely.

CO-CHAIR KHAN: Thank you so much. Foster.

MEMBER GESTEN: Thanks Chip. Again, I just, you know, want to put my thumb down on all the positive things that were said about staff and you Chip and Harold as co-chairs. The one thing I didn't hear that in terms of a suggestion going forward was in terms of getting this larger picture, what I called sort of the 20,000 foot view, all the measures in the program which would help understand what the place is of new suggested measures or perhaps invite conversations about eliminating measures, the one thing I think that would be useful is to better understand what happened to previous suggestions to CMS, and get that feedback about measures that were maybe recommended that weren't taken up, or measures that were recommended to not be taken up that were taken up.

Again, I don't think it has to necessarily change the process or the criteria that the Coordinating Committee or the groups use

in evaluating the measures. But I think sometimes it's -- I know we found it helpful in the Medicaid Task Force to better understand how CMS was thinking and using and what some of the constraints were.

I think that might be just useful context, you know. If it comes out in some fashion that I've always missed, then you know, my apologies. But it always feels like a bit of an unknown to me.

CO-CHAIR KHAN: Thanks. Steve Wojcik.

MR. WOJCIK: Yes, hello. I agree with most of the comments. I just had one and I apologize. I had to go away for ten minutes to talk to a reporter, so I hope this wasn't covered. But following up on the reaching consensus, I'm wondering if when the process, when we don't reach 60 percent and our decision then is contradictory to or especially if it's the exact opposite of what the work group recommended, I wonder if we should treat that somewhat differently than where we don't reach

consensus but it's in the same direction or the same recommendation as the work group, because I believe that might have happened once yesterday towards the end. I can't remember which measure, and it was treated the same way as one where it's in the same direction.

It just seems to that that's a bigger issue than if our failure to reach consensus just is settled around confirming or close to what the work group decided. Apart from that, I thought it was great and I was glad to be able to participate and have the opportunity. Thank you.

CO-CHAIR KHAN: Thanks. Brandon.

MEMBER HOTHAM: Yes, can you hear me?

CO-CHAIR KHAN: Yes.

MEMBER HOTHAM: Okay, yes. I will echo a huge thanks to you, the staff. My travel was also cancelled at the last minute due to inclement weather and they were exceptional in helping me to actively participate remotely. So I greatly appreciate that. I will also, in terms of a delta, agree on the voting process.

You know, I think there's been some mention of, you know, a possibility of moving to a structure that allows maybe getting rid of one of the categories that got the lowest volume of support.

I would just agree with reevaluating the voting process to make it more clear in terms of category truly gets consensus from the group. But other than that, you know, I agree with all the comments that have been made by the rest of the Committee members, and thanks.

CO-CHAIR KHAN: Thanks, and finally Steve Brotman.

MEMBER BROTMAN: Hi Chip, thanks. There are so many things that worked well and they continue to just get better each year. Integrating us remotely, this is the first time I've been remote and it was actually a great experience. I appreciate from the staff. They did everything they could and really worked very hard on it.

We had wonderful discussions around

the room, very robust discussions around the room. I was very impressed this year. The decision guide with links this year was excellent. The link the NQF status would be helpful, but other than that kudos to the staff. It's really a hard thing to do. It's very much appreciated from our point of view.

Decision categories worked fairly well with some hiccups, you know. But it's still, I think, a work in progress. So but that's going to continue to evolve. Also there was great flexibility to pull measures for discussion ad hoc and have the measure developers available for questions. That was really appreciated. The work of you guys the co-chairs was truly amazing, and you really deserve tons and tons of credit. Thank you for everything.

The attribution presentation was excellent. That was one of the best presentations we've seen, I think, and on the side of what could be improved, I parrot the remarks about the consensus process, but I don't

have any. Those comments were made early. I don't have any direct solutions.

And also, this is probably a new comment that I haven't heard. When a measure is pulled, it would be helpful and this happened most times but it wasn't always consistent, and that is what is presented should be a concise history of the measure issues that the work group had and some clear questions from the onset of when it's being pulled.

So maybe there's a structural organization way to address this, to state that point of contention when a measure is being pulled, so that everybody is on the same page from the get-go and there's not a lot of discussion, and then the contention points come afterwards. One piece of advice I have for new members, since I've been doing this for quite a number of years.

I would wholeheartedly recommend that new members sit in as much as possible or listen to the individual work groups. Over the years,

I've found that to be one of the best ways to sort of integrate into the Coordinating Committee and just come with your feet ready to run, so that all the issues are not new to discuss. It really helps out a lot.

I would also encourage to pull, continue to pull measures for discussion even if there's no vote, because that's a great opportunity to provide additional information and flag some issues, and other than that, I want to thank everyone. This was a wonderful cycle.

CO-CHAIR KHAN: Thanks, Steve.

CO-CHAIR PINCUS: So I have a couple of comments. Number one is the staff is incredible, I mean in terms of the way in which they facilitate and helped this and put together behind the scenes so much material and information and condense it. Yetunde, Ken, Erin, Taroon, Helen. Just really remarkable.

Also, I think the engagement of the members of the Coordinating Committee is really incredible. I mean really people feel passionate

about a lot of these things, and they're willing to discuss it intensively and intelligently.

I think that's really important, and obviously also the work group members as well, and also CMS has really, you know, engaged in this process fully and receptive to the discussions and engages in discussions, I think. So it's a very, very productive process that we have.

A couple of things in terms of improvements. I think what people have suggested in terms of having some way of displaying sort of each program, the overall context in terms of the measures, what's been added, what's been removed, what's been the response, you know, as opposed to sort of the response to previous suggestions.

I mean we get that in the Medicaid Task Force. We sort of get that. It's only one program so it's easy to do. But to sort of get that succinctly over time would be very helpful. I think the voting is a problem, but you know, I'd like -- it would be useful to hear back from

CMS about what would be helpful to them in terms of the vote.

How much does the vote really matter, especially the fact whether it reached the consensus on support versus these other categories that are less than support. How important are these distinctions, because it's not a, you know, there's not really a strict threshold for those, I mean for the conditional one.

It's clear that if you know specifically what you want, and we can try to get that done. But for the revised use of NIT, which is a replacement for the support direction, you know, it gives a little bit more specificity but it's, you know.

And maybe just having that it may give consensus for support and if not, here's the distribution across the other categories. That may be sufficient, I don't know. But that's something that would be helpful to get CMS' response to.

Having a discussion about a cross-cutting issue like accountability was incredibly useful. I think it would be useful to have something like that, more specifically something -- I'm not totally satisfied with how we deal with gaps.

I think having some way of addressing gaps, both within programs but across programs and linking that to a more in depth discussion about what is in process within the development process that CMS is doing would I think be a useful thing to have, almost in the same vein as the accountability discussion we had, and so I would make that suggestion.

CO-CHAIR KHAN: Okay. Well I'll close out, I guess. We got everybody in terms of the members commenting and, you know, just restate our appreciation, I think the whole Committee's appreciation to the staff for really making the meeting possible, by lining everything up in a way that could be comprehended and discussed.

Second, I know it's always an issue

whether a body above the bodies that spend a lot of time on a matter should have the power to, in a sense, veto.

But on the other hand, I think if we look at the number of measures considered overall, and we look at the focus that we put on really, except for the hospital area but even there very few regarding the total end, and I think we do have a fairly expert group here, and you know, even though it might not have been as explicit enough, there was a sense for the context that most of us had.

I guess I think I would err on the Coordinating Committee taking action, although I do think we need to reexamine the vote. I think if you look at the votes, and this is only my head which is by its very nature not scientific, we sort of had two kind of votes.

We had a vote that was completely flat. It was like -- like it was just spread across the four, or we had these votes, and I think we had at least two if not three that were

above 55 percent for one. On that last one, when the one was 57 percent and we went and took the four percent below it, I thought wow. That just doesn't look right.

I think we need to reexamine that, and I'm not saying that 60 is the wrong threshold, or maybe we should just be voting, you know, it should be binary. I don't know, but I think we do need to reexamine that, and whether we have a vote like that where you're within shouting distance of 60, whether we take the vote again just to see whether anybody would change, considering where we are. Maybe that's what we do.

But other than that -- oh, let me say one other thing. No one, I don't think anyone else has commented on this. Gerry Shea and I many, many years ago chaired a strategic planning committee for the MAP, and I can't even remember which year it was now, and one of the major recommendations we made was the, I guess it manifests on the slide that Helen talked about,

the feedback loop.

I think just as with the gaps, I don't think we're there yet in terms of a process for identifying it clearly that we can all feel comfortable with. I think, I'd like to stress that I think that this notion of the feedback, like what's really happening with all those things that are out there that we can get our teeth around.

I'm working on a presentation right now on the Medicare fee-for-service, pay-for-performance and other programs for a speech I'm giving in Israel, and I'm having really -- and I've asked a number of people to help me look at the literature. There's not much of a feedback loop in terms, you know. There's great stuff about how readmissions we're reducing, but there's not that much literature about what that really means.

And then with the other metrics, we can just go on and on. So I think that that feedback loop is something we really need to work

on, and I'm not sure that this is the place that can be done, but that we need to think about. So with that, I'll conclude. It's now 20 minutes to 1:00. I think we're going to reconvene at 1:00, is that right?

MS. O'ROURKE: If everyone could come back a few minutes before 1:00. We have some hard stops at 1:30 and ASPE is a 30 minute presentation. So we want to get to a few people before Karen and Nancy begin their presentations. So maybe if we --

CO-CHAIR KHAN: Okay. So why don't we say literally 15 minutes, which will get us back here about three or four minutes before 1:00, and then we'll start there. So get your lunch and we'll see you in a few minutes.

(Whereupon, the above-entitled matter went off the record at 12:39 p.m. and resumed at 12:55 p.m.)

CO-CHAIR KHAN: If everybody could return to their seats, and we'll get started with the last part of our program, and we're going to

have -- Nancy's coming.

MS. O'ROURKE: She'll be here at one.

(Off mic comments.)

CO-CHAIR KHAN: Okay. So just I guess for 30 seconds, I will -- before we go to that, just say that this process is very important to me, and I really appreciate everybody's participation. I guess back many years ago, it was probably mine, but other people's brain child was this meeting and this process that we have today, when we -- when Jordy Cohen and Dick Davidson and I many, many years ago formed the Hospital Quality Alliance.

That was sort of a multistakeholder group, but still has been started by the hospitals. We envisioned a process like this, working with CMS and hopefully with other payers, and it's great to see it actually in place and working. In the -- obviously it had to find another home, and NQF was the logical home.

And so some of us, I think, you know, want to see this continue, and we are going to

actually need to get funding at a point in the near future, because we're at the point of the cycle again.

And so to help that process and to inform people, because I don't think it's always clear to everyone, even though we've got so many hundreds of people that are very active in the NQF committees and task forces and work groups and then -- and the board, I'm not sure the outside world every really understands quite what NQF does.

So the Federation is funding a project with Kristine Martin Anderson and her team that Booz Allen's going to undertake, to do sort of an analysis of how NQF does meeting its various missions, and also what the cost of achieving that should be going forward, and hopefully when that's completed in about two months, it will be helpful.

So I don't know whether any of you necessarily will be interviewed. Some of you may be, because they will be talking to some of the

stakeholders in the process of doing the survey, or they will be surveying people. So you may be queried and if you do, I hope you'll be cooperative and obviously open about your point of view, but cooperative.

So I just wanted to let you know that we're doing that, and that we will be beginning a process. There's a thing called Friends of NQF that I hope all of you will be active in in the upcoming months, as we gear up to make sure that the funding continues. So with that, let me pass it over to Erin and let her start.

MS. O'ROURKE: Thanks Chip, and thanks to all of you for sticking with us for one more session, and having a working lunch that hopefully we can let you out a little bit early. But we did want to bring up one more cross-cutting issue, obviously a topic we've spent a lot of time grappling with over the years.

In particular, we're looking for some guidance from the Coordinating Committee on the consideration of sociodemographic factors, as we

move to an era of value-based purchasing and there's obviously strong sentiments across the stakeholder spectrum on this issue, and how MAP can really do its work most effectively and ensure that we're making fair recommendations that will really work to improve health care for everyone.

We know this is a very challenging topic. We don't expect any solutions to come here today. But rather we want to just keep you abreast of some developments in the field, and look for any guidance you might have on how we should consider some of these new findings and new research as we continue to do the pre-rulemaking work.

So I think we with that, we are going to have a presentation from ASPE on the findings of the IMPACT Act study. But before that, we have a few Committee members with hard stops that we want to hear from, so Bill, if I could turn to you and then Pierre and Kate, if you wouldn't mind giving a brief update on the 21st Century

Cures Act and some of the implications of that law.

MEMBER KRAMER: Thanks very much, Erin. This is a little bit out of order. I'm reacting to a presentation that we haven't seen yet. But I did read the ASPE report, so I'm reacting to that, as well as the discussions we've had about this at NQF Board and many, many committee meetings and so on over the last several years.

First, I want to express appreciation for the excellent work that ASPE did, as well as the great work that Helen Burstin and her team have done here at NQF, and the work that Kate Goodrich and her team at CMS have done on this issue over the last several years.

I think the ASPE study makes a significant contribution to our understanding of the interplay between lower socioeconomic status, clinical risk factors and disparities in care. It occurred to me in reading this that the deeper we go into this issue, the more we realize that it's

very complex and in some ways the solutions now are less clear than we may have thought previously. But our understanding of the issues and therefore what we should do about it hopefully is advanced.

In the discussion of this issue, one topic keeps coming up that is a very sensitive one, but I think needs to be addressed head on, and that is -- the question is often framed what factors are within a provider's control?

It's often stated that providers should not be held accountable for factors not entirely within their control and I understand this. It's a very natural human response. I just had my performance review meeting with my boss, and we had this exact discussion. How much were we able to influence CMS regulations?

So but I'm concerned that framing the issue this way may be a dead end, and I'd like to suggest some alternatives. In a patient-centered health care system we should be asking instead whether the patients got the care and services

that they needed.

For example as we know, some low income patients live in neighborhoods that have poor public transportation. They might not have access to a car. They might not even -- so it makes it more likely they'll miss a follow-up appointment after hospitalization.

Should the provider say well, too bad, that's not my problem? Of course not. Most providers are going to do whatever they can to try to provide those -- arrange for those additional services that would help them get the care that they need.

Is that totally within their control? No, that's the wrong question to ask. The question asked is what can we do to encourage and support physicians who are trying to do the right thing for their patients, and that includes those kind of supports that they need, in addition to the immediate and direct clinical care.

So my concern is that narrowing the focus into things that are just under the direct

control of providers, what is the risk of overlooking the other services that may be needed to provide care to patients, taking into account their special circumstances?

So I would recommend that we shift the conversation from is this in the provider's control to is the patient getting the services she needs, and figure out how to do that, solve that problem.

One of the important findings in the ASPE study was the point they made about the work, the existing state of the art in terms of clinical risk indicators, and the observation that while we've relied on these for years, there in fact still needs to be improvement in the science of clinical risk indicators and clinical risk factors. So I strongly encourage us to support that.

I wanted to make sure we're all clear that there's a fundamental difference between socioeconomic factors and clinical risk factors. While the statistical analysis of those has some

similarities, there are fundamental differences. For clinical risk factors, we accept the fact that sicker patients have worse outcomes. We understand that, we accommodate that and we adjust for -- we adjust some things for that appropriately.

However, for socioeconomic risk factors, I believe we should not and do not accept that people of different socioeconomic categories should get different outcomes. Now we observe that they do get different outcomes, but I don't think they should. I don't think anyone believes that they should get different outcomes, so it's a fundamental difference.

So we should not automatically say since there are differences, we should adjust for them in the measures the way we do for clinical risk factors. They need to be treated separately. Even though the statistical methods might be similar, they're fundamentally different in what we, I think all of us as involved in the health care system believe should be done.

Finally, I was pleased to see the recommendation regarding financial support for providers, to achieve better outcomes for beneficiaries with socioeconomic status risk factors. This makes sense to me. We recognize, I think, that caring for disadvantaged patients probably requires additional resources, and we ought to pay providers accordingly.

The last thing we want to do is make it more difficult for the outstanding providers, physicians, nurses, hospitals and so on who are doing good things for these patients. The flaw in the current system is in the payment models, not in the measurements. So accordingly, I think we ought to be focusing on fixing the payer models explicitly, rather than trying to do it indirectly through the risk adjustment of the measures.

So the bottom line, my recommendation, my recommendation based on my understanding of the issues and further enhanced by this ASPE study is that we ought to keep the measures pure,

so that we can clearly observe disparities in outcomes. Understand what's causing those disparities and address them.

Second, that we risk adjust the payments to providers to recognize the higher cost of caring for disadvantaged patients. That's obviously beyond the scope of MAP's work, but we can make that recommendation to somebody who's working on the payment models. I think we ought to all be working explicitly, as ASPE recommends, on the goal of improving health equity.

I'll speak, I can speak I believe on behalf of most if not all consumers and purchasers here and outside this room, that we would be very happy to work with physicians, hospital systems and others on the payment models to get this right, so to make sure people get the care they need.

CO-CHAIR KHAN: Thanks, Bill.

MS. O'ROURKE: Pierre, did you want to give people just a quick update on the 21st

Century Cures Act?

DR. YONG: Sure. Thanks Erin, and I think the comments beforehand actually nicely lead into just this quick update for folks who aren't familiar with the Cures Act, which was passed in December of last year. There is a provision in Cures Act which addresses SES in particular relative to the hospital readmissions reduction program.

What it says is that -- it says that the HRRP program, which includes all the readmission measures which are not currently risk adjusted for SES, they'll have been part of the NQF pilot, that the program be restructured a bit so that we group hospitals into like groups. So you may have heard of the stratification sort of approach, which MedPAC put forward a couple of years ago as a recommendation.

But essentially you stratify providers or hospitals in this case by full eligible dual status. So the proportion of full eligible dual seen by that provider. So you are then comparing

hospitals with similar, seeing similar proportions of dual eligibles. So it's this like compared to like sort of approaches, as some people call it.

So that's what it's done. It says we can also consider the ASPE recommendations relative to risk adjustment of the measures, but the first sort of step forward is this stratification in terms of assessing the penalties not on the measure side. The other piece of this is also that the program and this adjustment is done in a payment, in a budget-neutral fashion.

So there's no change in the overall sort of penalties assessed on providers at the overall program level, compared to the current approach. There are also some other provisions in there. MedPAC is required to do a study relating to readmissions, but the main pieces are what I described so --

CO-CHAIR KHAN: Thanks. I guess just in response to Bill, I think in an ideal world or

a world where we had confidence that there would be an ongoing reconsideration of policy, I agree with you. But I think in the reality of what is, I think that the last thing you want to do in an admission policy that's fixed is penalize the very people you want to be reaching out, and worrying about the social determinants of health of their patient population, as well as worrying about the care inside the four walls of the hospital.

So I think, you know, in an ideal world it's great to talk about having risk adjustment that includes social determinants on DRGs, but that ain't going to happen any time soon and we have to deal with the reality of are we penalizing the wrong hospitals in the way that readmissions work.

So I agree that it's good to have the pure measure, because we don't know necessarily why certain hospitals are being penalized. I mean whether or not it's what they do inside the four walls or because of the situation of these

other patients. But they do tend to be patterns, and I think we need to recognize that in the current policy mix, which can be done under current authorities if CMS chose to do it.

That's sort of the problem we face. I mean it worries me too not to have, you know, everybody sort of measured the same way in terms of readmissions. But I think -- I think considering realities, I guess that would be the position that hospitals would take, and I think it's a sensible one considering that we don't have a process to do what you described yet. That's just sort of my response. But what do we do next?

MS. O'ROURKE: So we should have Karen Joynt and Nancy De Lew on the line. They're going to provide an overview of the findings from ASPE's study that came out of the IMPACT Act. Karen and Nancy, do we have you?

MS. DE LEW: Yes. It's Nancy De Lew. I'm on the line. Karen, you're on?

DR. JOYNT: Yep, we're both here.

MS. DE LEW: Terrific. We're in different parts of the country, so we're not sitting next to each other. I want to thank you all for welcoming us to the conference today, to the meeting today.

I'm going to start, do a couple of slides. Then I'm going to turn it over to Karen. We also have other members of our team who are with us, and I know that we may well have folks who helped us on this report.

We had a number of people participate on our technical expert panels as we pulled this material together, and if any of those participants are on the line, we want to thank them as well.

So I want to start. Let's go to the next slide please. I want to start by talking about the big picture, why social risk is important as we move to value-based purchasing in the Medicare program, a topic that many of you are very familiar with, and know intimately. Social risk factors we all know, play a major

role in health.

As we began this work, we were thinking about some of the discussion that's taken place about social risk factors. You see several of those items on the slide right here. Some people have thought that beneficiaries with social risk factors have worse health outcomes, because the providers they see provide low quality care, that value-based purchasing could be a powerful tool to drive improvement in care, and to reduce disparities. That's one argument that we've heard.

We've had others argue that if those beneficiaries have worse health outcomes due to factors beyond providers' control however, the value-based purchasing could inappropriately penalize providers that care for them, or could result in providers becoming reluctant to care for these populations.

CO-CHAIR KHAN: I'm sorry. Could you all speak into the phone, because we're having a little trouble on this end.

MS. DE LEW: Sure. So I'll try to speak a little louder. Is that a little better?

CO-CHAIR KHAN: Yes.

MS. DE LEW: Okay. So as we began this work, we know that these relationships need to be better understood, so that we can align payments and ensure that the value-based purchasing programs we have achieve their intended goal. So that's the big picture as we began this work.

Next slide, please. The Congress in the IMPACT Act asked ASPE to provide a series of empirical analyses and provide considerations for providers, for policymakers, I'm sorry. The study that we're going to report on today, the IMPACT Act had several different pieces, and we're going to talk to you about Study A today.

What I just want to review here for a moment is the various provisions in the IMPACT Act and tell you where we are in our work, and what's coming over the next number of months and years. So Study A, the study that we'll report

on today, is looking at the impact of socioeconomic status on quality and resource use in Medicare, using existing data. So I want to just underline that word "existing data." That's what we'll be talking about today.

Study B will tell you a little bit about our thoughts for Study B. We will welcome your input for those today, as well as we've got a mailbox set up. We would welcome your input later as well, about our thoughts for Study B. So in Study B, the Congress has asked us to look at measures using data that we don't tend to use right now in our program, looking at measures like education, health literacy.

We'll be looking at income at both the individual income as well as income of the area where that person resides. So that will be our work on Study B. Again, we'll invite your input both now and later. The Congress also asked us to do qualitative analyses of potential data sources, and looking at the broader context surrounding defining socioeconomic status.

The Congress asked us to develop recommendations and determine payment adjustments drawing upon all of that work that I just outlined. So a final report is due to the Congress in October of 2019. So what I want to just underline is that the report that we've made available, that we're going to be talking about today is Study A, and then we have additional work that we'll be doing and we welcome your input.

So with that, I'm going to ask Karen to start walking through the report.

DR. JOYNT: Great. Thank you so much. I've never been accused of talking quietly, but if you can't hear me tell me to -- tell me to speak up. Okay. So I'm going to give an overview of what we did in the report, and I'm going to try to give sort of a mix of a broader review, where we saw similar themes, and as well as some specifics to give you sort of a flavor for what we did on each program.

I would invite you to look in the

report and the appendix for any specifics you might want on any particular program. So the way that we set up the project was to take a consistent set of social risk factors, and to examine the relationship between those factors and performance under the measures that constitute each of the Medicare payment programs you see there on the slide.

The programs certainly vary, and the number of measures they have and then how those are translated into payments. But we tried to be as consistent as possible in our analyses across programs. You can see here we grouped them into hospital programs. So the very familiar readmissions reduction program, value-based purchasing and hospital-acquired admission reduction programs are three programs that contain a number of very similar ambulatory quality measures.

So the MA Quality Star Rating Program, Medicare Shared Savings Program and the new Physician Value-Based Program which will sunset

and be replaced by MIPS in a few years, and then three programs in the facility setting, doctor office facilities, nursing facilities and home health agencies and home health agencies, with the caveat that the nursing facility and home health agency program are in the measurement and not payment phases. So we only looked at measures for those and didn't have programs to evaluate.

Next slide, please. So across our analyses, we had really two main findings. I think the consistency of our findings is important. We found that across most measures, beneficiaries with social risk factors, excuse me, had worse outcomes than quality measures, regardless of the providers they saw. Meaning we are looking predominantly within provider analyses, and dual enrollment status was the most powerful predictor of poor outcomes.

So typically dual status explains a fair amount of the racial and economic disparities, for example, intended to dominate

most of the measures though not all.

Our second finding, moving to the provider level, was that providers that disproportionately served beneficiaries with social risk factors also tended to have worse performance on quality measures, even after accounting for their beneficiary mix. Under all five value-based purchasing programs in which penalties are currently assessed, these providers experienced somewhat higher penalties than did providers serving fewer beneficiaries with social risk factors.

So as I think was set up quite nicely by these pre-comments, I think we had gone into this set of analyses thinking we might find a simple answer, that this would be a beneficiary issue. There would be a very specific quality signal we could relate directly to the beneficiary characteristics, or that it would be a provider issue and the poor outcomes we see would be all about provider quality.

And instead, really across settings,

we found that those are true, and you'll see that echoed in the way we sort of took this in terms of next steps. But also you'll see it in the analyses that we'll walk through in a moment. We did not find a simple answer, but rather that this is a complex combination of both beneficiary and provider characteristics and performance. Next slide, please. Rachel, do you want to do a slide or two here?

MS. ZUCKERMAN: Sure. So I will sort of walk through these two findings in some of the readmissions program, and then I'll go back to Karen. So this first finding that beneficiaries with social risk factors had higher readmission rates, regardless of the providers they saw, and we found that dual enrollment status was the most powerful predictor of a higher rate of readmission, as Karen just explained.

So if we look -- if you're looking at this table here, in the first column we're looking just at the social risk factor alone, and you can see that the odds ratio is highest for

dual status. Dually enrolled beneficiaries have a 24 percent higher odds of being readmitted, just looking at the raw readmission rates.

Then if we go to the middle column, we also adjusted for the medical risk that is contained in the readmission measure, and we see that the odds of readmission for duals goes down to 13 percent greater odds. And then finally when we adjust for other social risk factors, that drops to ten percent greater odds.

So we do see that each of these things, the social risk factors and the medical risk, decreased the odds of readmission, and that across the board dual status is the strongest predictor and in fact once we adjust for both medical and social risk, only dual status and urban beneficiaries were more likely to be readmitted.

So if we go to the next slide. Can we go to the next slide please? Yes, thank you. So the second finding is looking more at the provider side of things. So this looks very

similar in terms of the odds ratio, but here we're looking at providers treating beneficiaries with social risk factors, and in this case for the hospital measures, we looked at hospitals with the highest 20 percent, the highest 20 percent of hospitals based on their Disproportionate Share Hospital or DSH index.

Just looking at this first row, heart attack, we see that hospitals -- these safety net hospitals had a 20 percent higher readmission rate than other hospitals, or sorry, beneficiaries. Yes, beneficiaries going to these hospitals had a 20 percent higher readmission rate, and then when we adjust the comorbidities, that goes down to 14 percent, and again adjusting for safety net status brings it down to nine percent.

So patients who are at safety net hospitals have five to nine percent higher odds of readmission after controlling for all measured medical and social risk factors. So this is similar to what we saw at the beneficiary level,

looking at the provider level.

Go to the next slide. Then when we look at how the program affects this, we're comparing safety net hospitals, again top 20 percent of the disproportionate share, and that's to all other hospitals, and we see that a larger proportion of hospitals are penalized, and their penalties were slightly higher, about $40,000 higher over the year.

So safety net hospitals were more likely to be penalized and had slightly higher penalties than other hospitals. So again, we see that the -- in this case, the program itself has a much smaller impact than the measure, and that sort of changed throughout. The findings at the measure level were consistent; the findings at the program level depended on the program itself.

Go to the next slide. And I'm going to hand it over back to Karen at this point.

DR. JOYNT: Thanks, Rachel. So if we think those three slides that Rachel just talked through, and we sort of have equivalent ones in

the report for all of the programs, we ended up, as we mentioned at the beginning, with pretty consistent findings. We found, for example, the odds associated with readmission to be consistent across ACO analyses, physician group analyses and hospital analyses.

We found that hospitals that we considered to be the safety net were more likely to be penalized in the hospital readmissions reduction program, in the hospital-acquired condition reduction program and the value-based purchasing program. So we found consistent findings across the programs, and again, we'll defer to the report for details in the interest of time.

But overall, we found that beneficiaries of social risk factors have poor health outcomes regardless of the providers they see, and providers serving these beneficiaries have poorer performance regardless of the patients they serve. Of course now we come to the complexity, which is that these analyses

can't determine why patterns exist.

As was brought up in the speakers prior to us, beneficiaries may have poorer outcomes due to higher levels of medical risk, worse living environments, challenges in adherence and lifestyle or bias, and providers may have poorer performance due to fewer resources or a mismatch between resources and clinical workload, lower levels of community support or worse quality of care.

Unfortunately, many of these factors on both the beneficiary and provider side are not easily measured with our current data.

Next slide, please. So what are some potential policy solutions? And I'll just walk through a few here to set up some of our simulations. As many of have discussed, we can simply adjust the quality and resource use measures, which some would argue could make comparisons more equitable and reduce the risk of decreasing access to care for high risk beneficiaries.

Others might argue that that makes it more difficult to track and address disparities by varying the disparities within the measure, and could excuse low quality care if the adjustment is done broadly. Here, there's clearly no right answer. We simulated it anyway, so we'll show you that. But the answer here likely differs by measure.

Another adjusted solution has been to stratify measurement or payment, which largely has the same pros and cons in terms of potentially making comparisons more equitably, but running the risk of making it difficult to address disparities or excusing low quality care if done broadly.

Finally, creating bonus opportunities for improvement if a program does not already have such an opportunity, or equity, or anything else that one might want to do to sort of tweak the structure of value-based purchasing in a way that's felt more -- perhaps to add on some opportunities to address some of the social risk

factors.

Next slide, please. Some of the policy options that have been proposed were already mentioned. So MedPAC has proposed stratifying hospitals into ten groups by social risk, and in the 21st Century Cures Act, as Pierre noted, it suggests stratification into groups by proportion of fully and dual enrolled, and also has a consideration about the IMPACT report, and excludes certain patients and certain readmissions, to try to make the measure a little bit more precise.

Next slide, please. Well here, I'm going to talk through what we did in the report in terms of simulations, without placing any value judgment on any of these three options for now. I'm going to show you an example of each of those three types of solutions.

So if you start in the first column there, you can see the current average HRRP penalty in thousands of dollars, that the state committed 191,000 and all other hospitals at

150,000 and the difference on the bottom there in bold at 41,000.

Adding dual status to the risk adjustment model, which is Simulation 1, narrows the gap between safety net and all other hospitals to about $16,000. Stratifying hospitals into ten groups, which is similar to what MedPAC had proposed and similar, although not with quite the same variables, as is in 21st Century Cures.

Simulation 2 you can see actually flips the penalty difference between safety net and all other hospitals because it's by definition distribute the penalties across the very different groups of hospitals, and Simulation 3 in this case was simulated adding an improvement bonus, in which we allowed each hospital to buy down its penalty based on its improvement in the prior year.

You can see that all hospitals were able -- not all. On average, hospitals were able to buy down a penalty a little bit with both

groups dropping.

So the safety net dropping from 191 to 176 and all other hospitals dropping also, that did not reduce the difference between safety net and all other hospitals, because the safety net was not in fact improving faster than other hospitals were.

Next slide, please. Here we're showing a very similar set of simulations, this time in the Medicare Advantage Program. So the Medicare Advantage Program rewards quality stars based on performance across a wide array of both patient level and contract level measures, and in the current program, the average star rating for a high dual or low income subsidy status contract is 3.48 stars, which you can see in the left-most column.

Below that you can see the average star rating for all other contracts, which is 3.78 stars. Now with four stars, you get a bonus. So in the Medicare Advantage Program, about 26 percent of the contracts in the highest

group of duals compared to 53 percent of other contracts actually meet that four star threshold.

So again, an example of a difference in performance that correlates with proportion dual. As we can see at baseline, there's about a .3 star difference between those two. If you go to Simulation 1, in which the adjusted measures, only the clinical measures, not the contract level measures for dual status, you can see that it narrows the gap only minimally, in part because those measures only make up a subset of the scores that go into this program, and in part because the differences on many of the measures were fairly small.

If you move one more column to the right to Simulation 2, you can see the categorical adjustment index, which is an adjustment index that takes into account both dual status and disability status, as the original reasons for Medicare entitlement, and that will be implemented as an interim adjustment in Plan Year 2017.

You can see that narrows the gap a little bit also, by giving a small bounce to the high duals or LIS contracts. In the third column, you can see a simulation for adding an equity bonus, which I will say right now we made up as sort of a back of the envelope idea, in which we measured the disparity, the average disparity on the clinical measures, and awarded contracts extra stars if they had a low average disparity.

You can see here that that led to a narrowing of the gap to some degree, with more of an extra equity bonus being received by the high dual contracts than the other contracts.

Next slide, please. But, and herein lies the complexity that was presaged in the comments prior to us and then brought up by Nancy as well, one solution will not address all the causes. We can talk about certainly the multitude of factors that lead to beneficiaries with social risk factors having worse outcomes.

I had mentioned those before, but

they're on this slide again. If we think about how pervasive, persistent and deep-seated of a problem this is, I think it becomes pretty apparent that just talking about adjusting the measures probably misses the opportunity sort of inherent in value-based purchasing, to think about how these both measures and programs might be leveraged in a way to really to start to change that conversation.

So the next slide, please. As a result, we came up with the help of our CMS colleagues and lots of other folks around the department, with sort of a broader strategy and how we can start thinking through how to account for social risk in Medicare payment programs.

These are much more considerations for future development and discussion than they are highly specific recommendations, but we do hope that they dovetail with a lot of what you all have been thinking as well. So the first part of the strategy is to measure and report quality for beneficiaries and social risk factors, which is

very germane to this group.

The second is to set high, fair quality standards for all beneficiaries, again it will feel familiar to this group. The third is to reward and support better outcomes for beneficiaries with social risk factors. So I'll walk through each of those in turn.

Next slide, please. So the first strategy is to measure and report quality for beneficiaries with social risk factors. The first consideration is to consider enhancing data collection, developing statistical techniques to allow the measurement and reporting of performance for beneficiaries with social risk factors on key quality and resource use measures.

We realized in doing this that we've created a, I don't know, 600 plus page document full of really an enormous amount of information, that could be really instructive to track over time and to help us understand the changes in the patterns of quality and of disparities. We felt like this shouldn't be a one-off, but rather sort

of a start in thinking through how, what we might need to do from a data and statistics standpoint, to make it feasible to actually see what our disparities are and what our performance is for these beneficiaries.

The second consideration is to consider developing and introducing health equity measures or domains into existing payment programs, to measure disparities and incent to focus on reducing them. I'll again admit that we don't know what this means or what it looks like, but we'll very much look to input and guidance from all of you.

And third, to prospectively monitor the financial impact of Medicare payment programs and providers disproportionately serving beneficiaries with social risk factors. As these programs continue to broaden and as they move into multiple different types of beneficiaries in different types of specialties and models, keeping this front of mind will be important.

The second component is to set high

fair quality standards for all beneficiaries. First, measures should be examined to determine if adjustment for social risk factors is appropriate, and the determination for any measure will depend on the measure and its empirical relationship to social risk factors, which is exactly what NQF has been leading the charge in doing.

Certainly, all measures should not be considered to be the same when it comes to this particular consideration. So we sort of leave this here as an invitation for continued discussions on this issue.

The second component we've also brought up before, which is that the measure development community should continue to study program measures to determine whether differences in health status might underlie some of the historic relationships between social risk and performance, and whether perhaps adjusting for health status might improve the ability to differentiate true differences in performance

between providers.

That would be things like frailty, functional status, disease severity, things in which there are likely differences between subpopulations and the better we can understand them both, the more equitable the measures and programs can be, and the better idea we'll have about the types of beneficiaries that might benefit the most from quality improvement and intervention.

Next slide, please. Finally, the third strategy is to reward and support better outcomes for beneficiaries with social risk factors. The first consideration is to consider creating targeted financial incentives within the value-based purchasing program, to reward the achievement of high quality and good outcomes or significant improvements among beneficiaries with social risk factors.

Certainly, we've seen some encouraging news, I think, from the hospital readmission reduction program for the Massachusetts

Alternative Quality Contract, suggesting that perhaps beneficiaries with social risk factors might gain the most from these programs. And so kind of really leveraging that could be an area with a lot of promise.

The second consideration would be to consider using existing or new quality improvement programs to provide targeted support and technical assistance for providers that serve beneficiaries with social risk factors. For example, one thing that we found in a few programs, particularly the physician value-based payment modifier program is that physician groups serving high risk populations were less likely even to successfully report.

So if their infrastructure needs or technical assistance or support needs to even make sure that all providers that serve vulnerable beneficiaries can be part of these programs, there really may be some things that using the existing technical support resources could potentially really help some of these

groups.

Third, considering developing demonstrations or models focusing on care innovations may help achieve better outcomes for beneficiaries with social risk factors. We need to know more about how we can do the things that these beneficiaries need, and some of those may require some creativity and innovation that sort of aren't easy within current systems that might be more feasible within demonstration models.

And finally, further research to examine the cost of achieving good outcomes for beneficiaries with social risk factors, to determine whether current payments adequately account for differences in care needs, and this is certainly the idea behind DSH payments, for example, and could be an important area to learn more about in the future, particularly under alternative payment models.

We'll turn now to Robin to tell you a little bit for our next piece of work.

MS. YABROFF: Great. Thank you,

Karen. Hi, this is Robin Yabroff, and I'm going to give you a very quick overview of some of our plans for Impact Study B. As a reminder, this is -- the goal of this study is to evaluate social risk factors and performance using new measures of social risk, new data sources.

So to give you a quick overview, we plan to build on the first report to Congress, the framework that Karen has described so well. We'll be looking at a number of different social risk factors at the beneficiary, provider and program level, and we will use the conceptual framework in a series of recommendations for data sources and measures from reports from the National Academies, and there's a series of five reports the picture is showing here on the right side of this slide, Accounting for Social Risk in Medicare Payments.

We will also explore new measures of social risk, and this is part of the conceptual framework that the National Academies came up with, which include things like socioeconomic

position, race-ethnicity, gender, social relationships and residential and community context. We will also be evaluating medical or social risk factors that are prevalent in dually eligible beneficiaries, things like frailty and disability, and then finally examining program impact and policy solutions.

Next slide, please. So just to give you a better sense of exactly what we will be doing within our evaluation of new measures of social risk, we have a series of survey database projects using the Medicare current beneficiary survey, which is about 15,000 beneficiaries a year, and also the American Community Survey, which looks at both the individual and area levels.

We'll be doing a series of parallel analyses to evaluate which social risk factors are the strongest predictors of poor outcomes. We'll also be evaluating interrelationships between individual and contextual measures of social risk and outcomes, to give us a better

sense of how well these measures correlate, but also which -- where it's most important to include these sorts of measures, and then how the risk factors influence provider performance.

We're also going to be doing a series of claims-based data projects, where we are going to be identifying and validating new measures of medical risk factors that are prevalent in dually eligible beneficiaries, and then similarly assessing relationships with outcomes and evaluating the influence on provider performance.

Next slide, please. So with that, I want to open it up for questions. I also want to note that I just sent a note to everyone, which includes the contact information for any feedback you might have on this report or any other suggestions you have, and that is aspeimpactstudy at hhs.gov.

So that is a new mailbox we recently started that we'll be using to collect feedback from anyone who has comments. So with that, I'm looking forward to your feedback and questions.

Thank you.

CO-CHAIR KHAN: Thank you so much, guys. Okay who? I see David and Harold right now.

MEMBER BAKER: This is David Baker. I just want to thank you for a really incredible presentation. It was just so clear and thoughtful. So my first comment is you talk about these unmeasured health factors, and I can't stress how important that is. There is incredibly robust literature on the importance of health status.

You talk about frailty, but even self-reported overall health. As simple as that one question is, it's an incredible predictor of hospitalization, mortality, et cetera. Before you do a lot of research, you should look at the studies that have been done using the health and retirement study, and I'd be happy to share some of the work that I've done and that others have done using that, because that's a great source of data for looking at this.

MS. YABROFF: Thank you very -- this is Robin. Thank you very much. I appreciate that, and certainly we'd be interested in you forwarding those studies. And when you refer to this, the simple one item question how would you rate your health; excellent, very good, good, fair, poor, correct?

MEMBER BAKER: Exactly.

MS. YABROFF: Yes, yes.

MEMBER BAKER: But you know, it's just a start obviously, but it's so important to recognize that a lot of these measures that you're using for socioeconomic status, they are almost certainly, as you pointed out nicely, they're proxy measures for differences in health status. If you look at patients, for example, with diabetes and what proportion of patients, you know. You adjust for comorbidities.

But what's the prevalence of microvascular disease in those patients? Again, huge differences. When we were using the health and retirement study data about 15 years ago, we

were looking at people who are sort of in the ten years before hitting Medicare, and overwhelmingly the most important predictor of their health outcomes we're looking particularly at race-ethnicity but also socioeconomic factors.

Overwhelmingly, it's a baseline health status, right. So if you don't have that information, you know, really you're missing the boat on ability to adjust, and really understand what the differences in this is.

MS. YABROFF: Yes. Thank you for that suggestion. It is something that we are considering, and we do in fact have, that question in the Medicare current beneficiary survey.

MEMBER BAKER: Oh great.

MS. YABROFF: Yes, and we plan on using it. So yes, go ahead.

MEMBER BAKER: Just the other things. You talked about rewarding achievement, and that's great. But I'll give an example of Mount Sinai Hospital in Chicago. One time their CEO

said that they measure their cash on hand not on days but sometimes in hours. So you know, to reward organizations for performance improvement, they don't have the cash up front to implement the programs, many of which are evidence-based programs, community health workers and such.

They don't have the money to implement those, to be able to get the bonuses later on. Which gets to Bill's comment right at the start, you know, about the need to have adjustment for the payments right up front. So you know, I applaud that idea, but the reality is much different.

CO-CHAIR PINCUS: Really an incredibly sophisticated approach that you've used to this, and I'm really thinking through all, both the scientific and the policy questions in a really good way. One question I had, both in the I guess Study A and your plans for further studies. To what extent did you look at the extent to which behavioral health conditions had an impact on this, both behavioral health conditions that

were identified in claims, but also ones that were not -- that were or might not be identified?

DR. JOYNT: This is Karen. That's a great question. We didn't in quite the sense that you ask. We certainly noted when we examined patient characteristics based on claims across programs, that typically most of the individuals with social risk factors have significant higher proportions of prevalent mental health diagnoses in claims.

My recollection is two to three times higher in the dual versus non-dual group. I believe some of the quality measures incorporate some pieces of that, but certainly not in the kind of detail that you're asking, and we didn't do any additional looks at other data sources in terms of where one might find that information outside of claims.

But I think it's a tremendously important area to think about, especially as we think more about many of the alternative payment models and other systems, really thinking about

how to integrate behavioral and medical type health services. So it's a great point.

MS. YABROFF: Hi, this is Robin. I just want to add to that and say that it is a great point and your timing is perfect, in that it is something we can think about carefully as we start exploring some of the different measures of not only self-rated health but different measures of a lot of our other health status measures.

CO-CHAIR PINCUS: Just to say that we'd be glad to talk to you further about it. We've recently been just completing a Commonwealth Fund study around kind of the interface between behavioral health and general health, and some issues around quality measurement.

MS. YABROFF: Hi, this is Robin again. I just want to make sure. Could people please announce their names when they're asking questions? So it make it a lot easier for us --

CO-CHAIR PINCUS: This is Harold

Pincus at Columbia, okay.

MS. YABROFF: Got it. Thank you.

CO-CHAIR PINCUS: Aparna.

MEMBER HIGGINS: Okay, thanks. This is Aparna Higgins. So I have a couple of questions and one suggestion, so I'll kind of go through them. So I think one of the earlier slides you had presented, you had talked about how after adjusting for some of the provider characteristics, you still found differences -- I mean so after adjusting the beneficiary characteristics, you still found differences in the performance of these hospitals.

So when you looked at the data, do you see a lot variability among hospitals that had a higher proportion of DSH? And I have a follow-up question to that, based on your first -- answer to that first question.

MS. YABROFF: Sorry. Can you say that one more time? So did we find a -- are you asking the disparity difference across hospitals?

MEMBER HIGGINS: Right. So if you

look at hospitals that have, you know, a higher proportion of DSH patients, you know, at usually the 20 percent threshold. So I'm wondering if you looked along a continuum, did you see, you know, if it's five percent versus 20 percent versus, you know, 50 percent? You know, do you see a lot of variability in terms of when you move that threshold like you were -- I don't know if you modeled it, but I was curious.

MS. YABROFF: Yes. So I'll answer that in a couple of ways. It differed a little bit by programs. So there's a couple of graphs in the report looking at either DSH index or a proportion of dual as a continuous variable and relating that to performance.

And perhaps from a value-based purchasing, or if you look at a combined performance across the three hospital programs, which is at the beginning of the hospital section, it's a reasonably linear relationship. There's not an obvious threshold where we made the cut for DSH index, use a presentation of

having a specific group. But the relationship was visible across the entire spectrum.

One thing we found that was very interesting was that in the Medicare Advantage Program, the line was instead shaped a little bit like a swoosh, for any Nike enthusiasts out there, in that there was clearly a negative relationship between proportion of dual and performance out to the end, and then it did seem like at the highest proportions of dual low income subsidy individuals, there was really an uptick in performance, suggesting that perhaps the contract that had really focused on providing the types of services or interventions or whatever that these folks might particularly benefit from have had some success in doing so.

Certainly that will be, I think, an interesting area for us and others to learn more about in the future. In terms of the disparity, we did look in a couple of settings to find out if disparity varied by proportion duals with high or low disparities. That was -- that was pretty

all over the map. We didn't find a very obvious connection between proportions or quality and the magnitude of the disparity.

MEMBER HIGGINS: Okay, thank you. Then just real quickly, I think you mentioned your Study B, you were going to be looking at survey measures. You mentioned MCBS. I think the other you might be looking at this already on the MA side is the HOS survey, where they do ask questions about, you know, health status. So something you might want to think about.

MS. YABROFF: Yes, thank you. We looked at performance on those measures in the Medicare Advantage Program, but we didn't use those to examine other measures, if that makes sense. So we sort of took the first step into the medical and/or what is it, physical and mental health measures and looking at them, and certainly differences by dual status, but did not apply those to other measures within MA. That's a terrific idea.

MEMBER HIGGINS: Okay.

CO-CHAIR KHAN: Okay, other questions? Do you have any other questions?

DR. ANTONELLI: This is Rich Antonelli from Boston Children's Hospital. This is -- if I was empowered to give out an Oscar, you guys would get it. Congratulations. Thank you for the inspiration and the good work. This is something that we're thinking about a lot in Massachusetts, where we're developing methodologic approaches to embedding social determinants of health into our Medicaid program across the age spectrum.

That said, I'm especially interested in your comparison about the provider performance on certain measures. To the degree that we could get data, that you could get some data that isn't necessarily the same Medicare population, I'm wondering what's the impact on a delivery system that has a Medicare service line and a non-Medicare service line? Does this caring for this population, if there's a substantial commercial presence, in fact elevate performance across the

board or drag it down?

It would be interesting to see the comparability and then also I want to build on what Bill's wisdom was at the beginning. It isn't just an issue of giving more money to the providers; we have to think very creatively because a one-size-fits-all intervention won't work. So I'll stop there, but I wonder if you can comment about that.

MS. YABROFF: Yes no. We appreciate that. Certainly Massachusetts has had -- has been the home of a number of very interesting programs and efforts to try to think through this. I think -- I honestly don't know the answer to your question, but it sure would be a great thing for someone to figure out.

You know, there's efforts within the Department to try to harmonize and think through what multi-payer programs would look like, or how we could have a system -- quote-unquote system in which various incentives from various purchasers sort of augment one another.

I don't know that we have the data right now to know what those patterns look like. We certainly don't. I don't know if other folks do, but it's certainly a tremendously important area. You can imagine that depending on what proportion of your practice is Medicare/Medicaid, a whole slew of different private purchasers, whether or not those are in Medicare Advantage or not, whether or not they're in alternative quality contracts could really change the benefit for investing in the kind of systems it might take to do some specific interventions.

So that's obviously -- that was the great comment, and if you know the answer, please tell us.

DR. ANTONELLI: Well I have a suggestion, and it actually is to build on a comment I made to the NQF staff at the break, and we were -- a study was done with the Massachusetts Blue Cross/Blue Shield alternative quality contract, and the headline was that this approach in fact reduced disparity.

But the problem that I had with that, and I wasn't connected with the study although I am a clinician in Massachusetts, the problem is that those patients were able to be commercially insured to begin with. So to the degree that you can reduce disparities for a commercially insured population, that's wonderful. But you know, I really have significant concerns about the representativeness of low resource populations that are commercially insured versus a vulnerable population.

So here's my suggestion. If your analytic team could actually look at some of the data elements that were reported in the BCDS Massachusetts AQC, to see if any of those things cross-walk into the measures that you were looking at. It wouldn't be definitive, but it may be directional.

MS. YABROFF: That's a terrific idea. I saw that study, and I will go back and look at the details with that eye.

CO-CHAIR KHAN: Okay, Bruce. Okay,

Bruce. Oh Mary?

MEMBER BARTON: Hi. This is Mary Burton from NCQA. I was curious that on the slide where you mentioned the pros and cons of risk adjustment, you said that the issues with stratification would be the same. That strikes me as not immediately apparent, why presenting in a group just to a straw person, you know, all the high duals I'll say health plans, because that's my world, and comparing them to each other and creating benchmarks within that pool, would not have the effect of showing -- it would still show everybody's actual rate, but you would be going to pay because of the way that, you know, the payments are based on benchmarks on -- with a different threshold. So that you would not be changing the measures, but you would be facilitating a change in the payment.

So I'm curious, how do you see that as being subject to the same cons as risk adjustment, which by itself would obscure the actual performance?

MS. YABROFF: That's a great point. I think the devil is in the details, and that is to say that when and where you adjust versus pay versus compare, do you report unadjusted performance, do you report relative performance? How you operationalize any of these fixes could address some of the cons and augment some of the pros, and I would suspect there are better and worse ways to implement many of these things.

So that is to say it would depend how it were done. Certainly if you gave everyone just a score, a within stratum score or something like that, that would be very different, showing actual performance within strata. So I think it would depend how these things would be operationalized, which is obviously a much bigger challenge in many ways.

CO-CHAIR KHAN: Thanks. Bruce.

MEMBER HALL: Bruce Hall from the American College of Surgeons. Thank you all, Robin and Karen and Nancy and teams for doing this work. Fantastic work, generating important

insights for all of us. These are topics that all of us measurement folks worry about and lose sleep over.

You said at one point early on, I forget which piece of the presentation it was, that you noticed that even after adjusting for beneficiary mix, providers still had -- these providers still had some performance gaps. But then you correctly, I think, go on to say those may be associated with other resource issues and other operational issues.

I think that's correct, and I think what that shows us is that, you know, maybe we're at a time where we should flip this paradigm around. So those of us who are measurement wonks, we always think that some day we're going to be able to tease out enough factors that once we've adjusted for all those factors, we'll be left with some true performance gap for that provider, showing, proving to all of us that that provider was, you know, a bad person to begin with.

It's just a matter of teasing out what the proportions of different populations are and whether they have resources or not. But the end of the day, the numbers that are left are going to be the residual, and that residual is going to indicate that that provider was bad.

If we could just flip from the start and say to ourselves whenever we notice performance isn't reaching a benchmark, we're going to assume that those are good people, good teams who don't have the resources, and then we start teasing out the ways they don't have the resources.

They don't have the resources to address dual eligibles. They don't have the resources to address literacy, so on and so forth. We would find ourself in a very different policy position. We'd be finding ourself wanting ways to correct for those deficiencies, instead of trying to make sure that we've removed enough factors that we justfully penalize somebody.

So that my pie in the sky comment.

Now I'm going to switch to a granular comment that's concrete. As the recent chair of the Readmissions Standing Committee, along with Sherrie Kaplan, and I'm still on that committee but no longer chair, we had a number of our measures in the recent round go through the SDS trial period.

For those of you who noticed the announcement, only a couple, only I think two of the measures ended up with any SDS adjustment in the final version. But I want to make it clear to everyone in this committee and everyone listening that I think that's because the available metrics tested just weren't on the mark.

I think everyone acknowledged that. There just wasn't a lot of data at that time easily available to roll into that trial period, and so we didn't see a lot of factors with big influence on those metrics. But that's because there just, I think, wasn't a fully developed approach. It was the opening salvo.

But those results should not be viewed as the Readmissions Committee or anyone in NQF saying SDS adjustment is not important. That would be the wrong message. The message should be we tried it this first round. We weren't sophisticated enough to really show the impact. That work is ongoing and continues, and it is not a statement that SDS adjustment is not important.

The final -- the final approvals for the readmissions and other measures recently came along with four qualifications or recommendations from CSAC, and I think those are important for everyone to read and think about. But still at the end of the day, they are mostly centered on the measurement challenge, on the wonk challenge of did we get all the factors we could have gotten.

I would ask all of us to go back to either Karen or Robin's Slide No. 72, which showed this multicolored circle with six, you know, different circles and different colors around it. Go back maybe one more or yes,

something like that, which shows that, you know, risk adjustment is just a little piece of what we should be shooting for here, and until we can get the policy support to be paying attention to all of these colors, I think we're going to be falling short of our charge for our patients. With that, I will shut up.

CO-CHAIR KHAN: Okay. Rhonda.

MEMBER ANDERSON: I really appreciate the work that's been done, and this follows up actually. My question was going to -- my comment was going to be what Bruce made about the trial period. But my question is I think probably to Helen or someone from NQF, in terms of these findings and this work to date, how is it going to affect the work that you have been doing, and maybe an extension of the trial period. I'm not exactly sure of the next steps.

MS. O'ROURKE: Sure. We actually had a couple of slides that we put together. If you could go to Slide 84, which shows some of the results of our trial period. 83's a background

on the trial period.

DR. BURSTIN: Basically for those of you who aren't aware, we've been doing this trial period now for about a year and a half, I think, overall looking and actually it's at all measures that come before NQF, to consider whether there's both a conceptual and empiric basis for adjustment.

We were actually very heartened to see, I think, that the IMPACT report said that same mantra, conceptual plus empiric. I think what we generally found though is that many measures for which there was a conceptual basis, vis-a-vis saying it in English, a logical reason why you think social class, social risk could be a factor, we have not seen very many measures where the empiric data supports that.

Meaning the available variables, as we just heard from Bruce, and I think eloquently described by the ASPE folks, are not yet available to show some of that difference. And so as you could see this here, very few of the

measures to date have gone through with adjustment, you know.

One example, there was a measure that looked at the coordination of care for children with special health care needs, where the education of the parent was such a critical factor in it. That measure was in fact adjusted for that. There was a SNF measure that adjusted for marital status and insurance status.

So there were a couple where it did logically come through. So I just want to put up these four statements that Bruce had mentioned. So when those -- the readmission measures in particular came through recently, the CSAC and then ultimately the executive committee of the board recommended that those endorsements, move forward with these four statements attached to them.

The first was that we recognized this is not a closed door, as I think you just heard. As better data get, become available, we do see it as something that, as part of the annual

update process that measures come forward, measures that had a conceptual basis, that didn't have an empiric basis will be asked to consider what new adjusters can you potentially update your analyses?

The second thing is that I think we actually put this forward a while ago, but I think very much bolstered by the IMPACT report as well, is this idea that it's really time to think very much about this next generation of risk adjustment broadly, considering better clinical factors, clinical complexity, health status. We very much want to take that and we'd love to do that in partnership obviously with our federal partners.

I think the third is that given the concerns about the potential unintended consequences on the safety net, and this was before the 21st Century Cures Act came out, we specifically wanted to encourage MAP and the NQF Board to consider other approaches like payment, again very clearly outlined in the IMPACT report.

Measurement and risk adjustment is not the only approach here to fix concerns about unintended consequences, but it is one certainly. And then finally, as some of you know, we have a Disparity Standing Committee actively doing work, creating a measurement road map to think about how you can reduce disparities through measurement.

One of the things they've been specifically tasked with is considering some of these questions that kept coming up with our committees, about should you potentially adjust for hospital or community level factors. So we will, we will tee that up for them. In terms of next steps for the Disparities Committee, they will have a formal review of all the measures that have been part of the trial period at their May-June in person meeting.

We'll then have them make a recommendation to the NQF Board for their meeting in July, as to whether NQF would make this a permanent change to our policy, to allow measures

to be considered for social risk factors. At least in talking and very much supported by the IMPACT report, it seems that we have not seen any evidence of a down side to necessarily allowing the discussions to happen.

I think our bar is probably pretty high, given how difficult it's been for measures to get through. But that will be a final change in July. But I do think, just as a take-home for us at least, the IMPACT report was very, I think, affirming, that our approach of requiring both conceptual and empiric basis was right.

I do think though, which we've also agreed with, that it can't just be about measurement and risk adjustment. You've got to think about the payment levers, and whatever other levers could be done. And then finally something else we'll ask the Disparities Committee to address, and this committee as well if you'd like, is one of the other really important recommendations I think of the IMPACT report is the idea that we need a set of health

equity measures.

That's something we're going to have the Disparities Committee really begin to help us think through. We've done some of this work over the last several years. But I, you know, very much would welcome your thoughts about what would be an important starter set of what those health equity measures would look like, as we continue to move forward in this.

CO-CHAIR KHAN: I guess thank you Helen, and I guess it's, you know, the whole thing is very troubling, as Bruce pointed out, and as the study showed. The lower income tend to have a double whammy. They tend to be sicker and they tend to go to institutions that, at least right now, are not as good -- don't have as high quality care as other institutions treating other populations of Americans. So a lot to do with -- we need to do to improve on that. So with that, have we I believe done our work?

MS. O'ROURKE: We're done.

CO-CHAIR KHAN: Okay. I think with

that, we're done. I want to thank ASPE -- are they still on the phone?

MS. O'ROURKE: Yes, they're still on the phone.

CO-CHAIR KHAN: Okay. I want to thank them for super work, and we'll look forward to the next edition of your work. Obviously some people have made suggestions here, and I think everyone here now is really keyed in.

So I'm sure you'll be getting cards and letters and suggestions, as well as hopefully maybe some other gifts of -- to help you along as you do the next part of your task. So with that, Harold anything else? Oh I'm sorry, I'm sorry. I forgot about public.

CO-CHAIR KHAN: Any public comment?

OPERATOR: At this time, if you'd like to ask a comment, please press star one.

(No audible response.)

OPERATOR: And there are no public comments at this time.

CO-CHAIR KHAN: Okay. I'll pass the

baton to Harold.

CO-CHAIR PINCUS: Well again, let me just thank certainly ASPE staff, NQF staff, and probably most of all the members of the Coordinating Committee, because it's been a very efficient and substantive and I think effective way in which we've met our mandate. So thank you all. Safe travels.

DR. BURSTIN: I'll just add my thanks to everybody as well. We recognize you're volunteers. You put an incredible amount of work on your plates and I'm just delighted that all of you are willing to participate. Your suggestions for improvement are really heartwarming to us. We continue to want to make this a better process.

In fact, we did some things with the work group we'll need to bring to you, including the holistic review of the measure sets. We made sure of that to follow, since that will be in the final report. Not in the spreadsheets, but in the final report that we put forward to CMS. So

we'll make sure all of you have an opportunity to review that, and we'll think about ways to incorporate that further into the process for the Coordinating Committee going forward. So thank you all and safe travels.

CO-CHAIR KHAN: Great. So I guess we are adjourned. Thank you.

MS. O'ROURKE: I just want to jump in and thank you so much, Chip and Harold, for your leadership over the past two days in getting us through this incredible volume of work.

I echo my thanks on Helen's for all of the work all of you have done over the past few days. We greatly appreciate it, and safe travels home and our next meeting will be in August, to review the work of the Medicaid core set task forces. That will be a web meeting, and then we will keep you updated on the release of the pre-rulemaking reports in the coming weeks. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:11 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership Coordinating Committee Meeting

Before: National Quality Forum

Date: 01-25-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter