

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

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

9:06 a.m.

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

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

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

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

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

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

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

5 CO-CHAIR PINCUS: Okay.

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

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

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

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

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

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

22 DR. GOODRICH: Kate Goodrich, CMS.

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

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

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

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

9 MEMBER HIGGINS: Aparna Higgins, AHIB.

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

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

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

16 MEMBER BOTT: John Bott with Consumer
17 Reports.

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

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

22 MEMBER BRESCH WHITE: Mary Beth Bresch

1 White, The American Nurses Association.

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

4 DR. HUNT: David Hunt, ONC.

5 DR. WILSON: Nancy Wilson, AHRQ.

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

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

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

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

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

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

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

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

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

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

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

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

7 CO-CHAIR KAHN: Anyone else?

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

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

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

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

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

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

22 CO-CHAIR PINCUS: So as Chip said,

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

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

1 discussion.

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

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

1 metaphor or not.

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

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

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

14 CO-CHAIR PINCUS: So, Kate.

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

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

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

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

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

22 So, a little bit about our process.

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

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

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

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

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

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

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

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

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

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

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

1 the success of this entire process.

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

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

22 I do want to say for this year, the

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

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

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

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

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

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

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

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

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

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

1 bright with I think lots of tremendous ideas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 So thank you.

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

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

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

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

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

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

4 So, Erin.

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

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

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

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

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

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

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

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

10 DR. LOTZ: Thanks.

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

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

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

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

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

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

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

1 to what matters most through these quality
2 programs?

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

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

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

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

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

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

22 We did update the decision categories

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

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

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

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

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

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

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

22 This is really our attempt to preserve

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

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

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

22 CO-CHAIR PINCUS: And it is worth just

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

9 Giff.

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

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

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

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

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

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

3 MEMBER GIFFORD: Yes.

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

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

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

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

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

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

1 that is.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the committee members.

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

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

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

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

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

10 MS. O'ROURKE: Correct.

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

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

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

22 MS. O'ROURKE: And then finally,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 Now we are going to hear from Helen.

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

1 have Shantanu join us on Monday.

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

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

22 All disclosures of interest policy is

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

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

15 Go ahead, Marissa.

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

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

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

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

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

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

1 you.

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

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

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

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

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

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

1 other work we do regarding measures.

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

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

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

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

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

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

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

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

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

22 Our thinking is we would like to try

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 outcomes and the driver measures.

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

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

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

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

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

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

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

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

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

22 I do think you highlight, though, a

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

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

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

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

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

5 CO-CHAIR KAHN: Okay, Harold.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 goal-setting.

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

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

22 So even thinking through how you would

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

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

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

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

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

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

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

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

10 Okay, do you want to identify
11 yourself?

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

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

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

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

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

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

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

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

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

1 then the number 1.

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

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

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

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

1 which was released in December of 2016.

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

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

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

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

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

14 Thank you.

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

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

19 CO-CHAIR PINCUS: Okay, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MS. McQUESTON: Thank you, Ron. My

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

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

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

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

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

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

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

17 We will take questions at the end.

18 Thanks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 benzodiazepines are reduced or stopped prior to
2 discharge.

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

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

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

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

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

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

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

22 The last program that we looked at

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

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

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

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

22 For HRRP, the workgroup noted that CMS

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

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

8 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So the first program is the Ambulatory

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

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

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

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

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

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

22 MEMBER BARTON: I've just been trying

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

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

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

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

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

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

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

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

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

16 MS. O'ROURKE: Oh, sure.

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

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

1 guide so that I may follow along with you.

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

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

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

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

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

1 not doing it right?

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

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

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

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

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

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

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

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

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

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

19 CO-CHAIR PINCUS: Yes.

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

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

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

22 And to respond to that person's

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

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

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

14 CO-CHAIR PINCUS: Giff.

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

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

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

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

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

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

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

13 DR. BURSTIN: Yes.

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

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

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

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

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

12 David, is your concern addressed?

13 MEMBER GIFFORD: Yes. I can --

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

16 MEMBER BINDER: Leah Binder from
17 Leapfrog.

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

20 CO-CHAIR PINCUS: Louder.

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

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

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

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

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

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

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

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

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

16 MS. MARINELARENA: A week.

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

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

21 CO-CHAIR PINCUS: That's fast.

22 Okay any further comments about this

1 measure?

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

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

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

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

10 Any comments from MAP members on the
11 phone?

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

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

22 Yetunde, do I need to mention anything

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

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

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

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

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

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

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

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

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

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

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

1 What about 16-309?

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

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

15 CO-CHAIR PINCUS: So David.

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

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

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

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

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

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

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

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

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

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

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

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

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

4 So I would like to save people time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Oh, Rhonda. And then Kate.

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

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

1 to them.

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

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

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

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

18 MEMBER BAKER: Okay, great.

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

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

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

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

12 DR. LOTZ: This is Doris Lotz.

13 CO-CHAIR PINCUS: Yes?

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

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

22 WORKGROUP CO-CHAIR WALTERS: Actually

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

4 CO-CHAIR PINCUS: Other comments.

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

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

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

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

1 recommendation was do not support.

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

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

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

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

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

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

5 David?

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

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

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

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

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

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

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

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

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

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

22 MEMBER ANDERSON: I should be sitting

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

11 CO-CHAIR PINCUS: Leah.

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

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

1 list.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 important than what we give a specific rating.

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

16 CO-CHAIR PINCUS: Yes, Kate.

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

1 for that

2 CO-CHAIR PINCUS: Melissa.

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

9 CO-CHAIR PINCUS: Amir.

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

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

22 So I would probably still fall under

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

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

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

22 But I am not sure that it is changing

1 to a revise and resubmit is the answer.

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

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

9 And so I -- Doris.

10 DR. LOTZ: Yes.

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

15 MEMBER BAKER: I'm fine with that.

16 CO-CHAIR PINCUS: Okay, Doris.

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

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

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

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

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

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

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

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

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

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

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

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

21 Okay?

22 So let's move on to the next pulled

1 measure.

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

9 CO-CHAIR PINCUS: Yes.

10 DR. ANTONELLI: Okay, thank you.

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

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

1 think the USPSTF was specific to --

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

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

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

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

22 CO-CHAIR PINCUS: Right. That is

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

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

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

19 Let's move to the next one.

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

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

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

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

20 Next.

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

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

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

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

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

21 DR. LEHRMAN: Is that better?

22 CO-CHAIR PINCUS: Yes.

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

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

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

20 CO-CHAIR PINCUS: Did you have
21 specific comments?

22 MEMBER BAKER: My concern was HP4.

1 And since that is not going forward, I am fine.

2 It was the idea that during this hospital stay
3 did you get medicine for pain and the top box
4 scoring would be always. So think about the
5 question did you always get medicine for your
6 pain. So that was the concern that I had.

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

9 Okay, thanks for the clarification.

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

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

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

8 MEMBER GIFFORD: Yes.

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

22 MEMBER GIFFORD: And my tendency is to

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

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

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

21 MS. MARINELARENA: Correct.

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

1 essentially, revising it.

2 So moving on to the next one.

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

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

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

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

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

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

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

22 MEMBER QASEEM: I actually do. I do

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

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

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

22 CO-CHAIR PINCUS: What you are saying

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

3 MEMBER QASEEM: It's not.

4 MEMBER GIFFORD: What measure are we
5 talking about?

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

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

10 CO-CHAIR PINCUS: Yes.

11 MEMBER GIFFORD: We went back to an
12 old measure?

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

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

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

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

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

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

10 CO-CHAIR PINCUS: Right.

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

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

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

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

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

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

14 CO-CHAIR PINCUS: Amir?

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

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

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

1 mention.

2 MEMBER GIFFORD: It is currently
3 recommended as --

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

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

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

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

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

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

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

4 MEMBER QASEEM: Correct.

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

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

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

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

19 CO-CHAIR PINCUS: So I am now
20 confused.

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

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

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

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

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

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

20 MEMBER QASEEM: Correct.

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

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

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

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

19 Other comments.

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

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

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

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

17 MEMBER QASEEM: Correct.

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

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

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

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

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

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

22 So given the discussion we have had

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

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

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

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

1 do.

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

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

8 MEMBER QASEEM: Sure.

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

11 Okay. Was there a comment from the
12 phone?

13 So this is a different thing.

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

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

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

22 MS. OGUNGBEMI: So we are now voting

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

6 MEMBER NOONE: Hello?

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

9 MEMBER NOONE: Hello?

10 CO-CHAIR PINCUS: Yes?

11 MEMBER NOONE: How do we vote on the
12 phone?

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

16 MEMBER NOONE: NCS dot?

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

22 MEMBER NOONE: May I do it verbally?

1 MS. IBARRA: Yes.

2 MEMBER NOONE: Support.

3 MS. IBARRA: Thank you.

4 Steve, we also received your vote.

5 And Brandon, we received your vote.

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

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

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

14 Rhonda.

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

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

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

8 Okay, let's go to malnutrition.

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Cristie?

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

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

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

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

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

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

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

1 appeals. So the process is almost over.

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

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

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

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

1 meet the Hospital Workgroup's conditions.

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

6 Rhonda.

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

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

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

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

6 Amir.

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

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

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

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

10 MEMBER QASEEM: The one that is up
11 there.

12 Thank you.

13 CO-CHAIR PINCUS: Okay.

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

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

21 Okay, so everybody vote.

22 MS. OGUNGBEMI: We are now voting on

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

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

8 MEMBER NOONE: On the phone, vote 3.

9 MS. IBARRA: Thank you.

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

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

14 MS. OGUNGBEMI: So the results are 13
15 percent support, 13 percent conditional support,
16 40 percent refine and resubmit, and 33 percent do
17 not support. We reached consensus. MAP reaches
18 consensus at 60 percent or greater in the refine
19 and resubmit category.

20 CO-CHAIR PINCUS: Bill.

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

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

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

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

12 MEMBER KRAMER: Right but it is not
13 voting.

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

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

22 CO-CHAIR PINCUS: So we have been

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

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

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

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

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

16 CO-CHAIR PINCUS: A little bit louder.

17 MEMBER BROTMAN: Okay. Is this
18 better?

19 CO-CHAIR PINCUS: No.

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

22 CO-CHAIR PINCUS: Yes.

1 MEMBER BROTMAN: Okay, great.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 CO-CHAIR PINCUS: Okay. Kate?

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

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

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

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

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

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

1 CO-CHAIR PINCUS: Sure.

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

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

6 DR. GOODRICH: Yes, Lisa. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Thank you.

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

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

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

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

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

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

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

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

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

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

22 But many people aren't. They need an

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

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

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

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

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

9 DR. GOODRICH: This is Kate.

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

1 right, of fairly difficult-to-understand
2 information?

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

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

12 DR. HUNT: This is David Hunt.

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

20 DR. SUTER: This is Lisa Suter.

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

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

7 CO-CHAIR PINCUS: Giff?

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

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

22 And the other thing is, for informed

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

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

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

22 The other thing is that this is

1 supposed to help consumers understand and drive
2 this. This, as best I can tell in the measure,
3 each hospital will get a score between zero and
4 20, or some average score across the different
5 types of procedures they do. I don't even know
6 how to interpret it.

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

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

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

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

13 And so, if there are certain
14 procedures that we really feel we need to have
15 some informed consent, I don't see why there
16 isn't an ability to develop them. So, I would
17 argue very much to, frankly, not only refine and
18 resubmit, I would say this is not ready for
19 rulemaking and would vote such, but would
20 strongly encourage CMS to continue and try to get
21 something further, but use this scoring and
22 checklist thing in a different vehicle to get

1 that done.

2 CO-CHAIR PINCUS: So we have now Leah
3 and Bruce and Rhonda and Rich and Carol.

4 I remind everybody the recommendation
5 is revise and resubmit. And so, please, if you
6 have something additional to add specifically to
7 the discussion, you know, let's try to get to it
8 concisely, because we have a bunch more to go
9 over.

10 Leah?

11 MEMBER BINDER: Thank you.

12 I want to make one more point about
13 this. I'll have to say this, with Chip sitting
14 right here saying the opposite, but I think from
15 my own experience working in a hospital, in a
16 rural hospital network, we did struggle with a
17 lot of documents like consent forms.

18 To me, this would seem to be a real
19 opportunity and an advantage for hospitals. It
20 gives them a set of standards. It says this is
21 what patients have said is useful. It has been,
22 it sounds like, well-tested by some excellent

1 measure developers. I think it would be useful,
2 and I don't think -- starting with conditions of
3 participation in Medicare, that is kind of a
4 heavy-handed way of starting with this, with
5 hospitals that have a hundred different consent
6 documents, apparently, in one system. It seems
7 to me that this is a way of helping hospitals
8 reach a higher level of patient-centeredness over
9 time and not hitting them with anvil when they
10 are not there already.

11 And so, I do think this has some
12 advantages for hospitals, but mostly, I think for
13 patients this is just such a high priority. The
14 issue that I hear most common from patients and
15 from purchasers, that they hear, is that: I was
16 on the gurney being wheeled into the surgery, and
17 they asked me to sign the consent. So I really
18 thought that that was actually a good element of
19 this as well, that it looks at when the signature
20 took place.

21 CO-CHAIR PINCUS: Bruce?

22 MEMBER HALL: Thank you.

1 As the American College of Surgeons,
2 we are certainly one of the largest groups
3 playing in the realm of elective informed
4 consent. And we agree with all the comments that
5 this is a critical area to address. We are
6 thrilled that CMS and our colleagues at Yale have
7 begun to address it, and we certainly respect the
8 quality of work that has come out of that shop.
9 So we are thrilled that the work has begun.

10 We, however, would feel that this
11 should come down a notch to do not support. And
12 I think it is a matter of whether we are talking
13 about rulemaking or whether we are talking about
14 ongoing development. We are fully in favor of
15 ongoing development.

16 We think, as it stands, the measure
17 falls short on a number of areas. As a
18 professional organization, we have principles we
19 would love our members to embrace to be more
20 meaningful and more patient-centered in this
21 process of informed consent. And we feel that
22 the measure falls short on some of those.

1 In particular, we feel there is an
2 important, an increasing role for explicit risk
3 calculation and decision-making aids, but also
4 that being really patient-centered in this area
5 requires us to focus on the relationship between
6 the consenting team performing the procedure and
7 the patient and family and their stakeholders.

8 And we think the measure as it is
9 focuses a little more on the hospital functions
10 and less on the relationship, which is really the
11 meaningful and patient-centered part to us, or we
12 would like it to be increasingly so.

13 We have submitted some other comments
14 which I think others have raised. And so I won't
15 be redundant. I would just say that, from our
16 perspective, for rulemaking, we would take this
17 down a notch to do not support, but in every
18 other aspect of development, we would kick it up
19 a notch and fully support its ongoing
20 development.

21 Thank you.

22 CO-CHAIR PINCUS: Rhonda?

1 MEMBER ANDERSON: I won't reiterate
2 everybody's. I would just say I appreciate the
3 comments that Chip has made and others, and add
4 one thing.

5 Should this be -- I would agree that
6 it should be do not support, but should it go to
7 PROs? Should it be a part of the PRO measure?
8 Helen identified the fact that measures are
9 important, and they are incentives, but where
10 does it really belong? If we are trying to get
11 the patient to understand, the process is good,
12 but what about really knowing whether they did
13 understand or not? So, I would just ask us to
14 consider that if we do vote it to do not support.

15 CO-CHAIR PINCUS: Rich? And then,
16 Carol. And then, we are going to vote on do not
17 support.

18 DR. ANTONELLI: That is probably
19 exactly what I was going to say. It seems like
20 this is ideally suited to be a patient-reported
21 measure, not this one.

22 MEMBER SAKALA: So thanks to the

1 developer for further clarifying.

2 We have very well-documented issues
3 with decision-making processes and definitely
4 need a lot of great measures. As one that could
5 potentially could have a broad applicability
6 rather than a lot of specific measures, this one
7 seems to offer a lot of potential from my point
8 of view.

9 It takes a piece that is standard
10 across our healthcare system, which is widely
11 recognized to be really for the service
12 providers, and it gives us an opportunity to make
13 those pieces much more patient-oriented. And I
14 think that that's a real opportunity right now in
15 this area where we all understand we need to do
16 better, and we are facing challenges around
17 development of other approaches.

18 CO-CHAIR PINCUS: Okay. Shall we set
19 this up to vote?

20 MS. OGUNGBEMI: We are now voting on
21 MUC16-262, Measure of Quality of Informed Consent
22 Documents for Hospital-Performed Elective

1 Procedures.

2 Your options are: 1, support; 2,
3 conditional support; 3, refine and resubmit, and
4 4, do not support.

5 Voting is open.

6 (Voting.)

7 MS. IBARRA: Steve, Foster, Brandon,
8 and Doris, we received your votes. Barrett, we
9 received your vote as well.

10 The results are 7 percent support, 4
11 percent conditional support, 37 percent refine
12 and resubmit, and 52 percent do not support. So
13 we do not reach a threshold anywhere. But
14 because of the voting procedures or because of
15 the rules of voting, we will land at do not
16 support at 52 percent.

17 CO-CHAIR PINCUS: Okay. So let's move
18 on. So there were several different cancer --

19 MS. O'ROURKE: We have one more.

20 CO-CHAIR PINCUS: One more before
21 that? Okay.

22 MS. O'ROURKE: The final measure that

1 has been pulled for IQR is MUC16-167, Safe Use of
2 Opioids - Concurrent Prescribing.

3 CO-CHAIR PINCUS: Leah, did you have
4 a comment?

5 MEMBER BINDER: Okay. This is an
6 extremely high priority to purchasers who are in
7 my constituency as well as the public. It is a
8 front-page issue.

9 CO-CHAIR PINCUS: Get a little bit
10 closer to the mic.

11 MEMBER BINDER: Sorry. It's a front-
12 page issue. I don't need to repeat any of that.

13 This measure appears to have some
14 potential. So, it is an opportunity to identify
15 people who have more than one prescription for
16 opioids at discharge.

17 There is some concern that there could
18 be an unintended consequence because of benzos
19 that potentially could be advantageous and also
20 prescribed along with opioids. But it seems to
21 me that we should at least consider resubmitting
22 this measure, not simply voting it down, because

1 there are so few ways for us to measure this.

2 Policymakers across the country in
3 statehouses as well as here in Washington are
4 making a lot of policies around opioid use, and
5 there is so little data that it seems to me that
6 this should be very high priority to move this,
7 to move something along that we can measure.

8 These folks that are being discharged
9 from hospitals would appear to be perhaps most
10 vulnerable, potentially already addicts or
11 potentially at-risk for addiction. These are
12 folks that can be at least identified. Those are
13 people who are often very difficult to identify
14 for purposes of data.

15 So I think there is some real
16 potential in this measure, and I recognize that
17 there are some clinical issues with the measure,
18 but it seems to me that those could be addressed
19 and that there ought to be some way to move this
20 forward. And I was pleased to see that the MUC
21 would put this on because I do think that there
22 has to be more ways for us to identify people at

1 risk or already affected by the opioid epidemic,
2 which, again, is such a high priority to the
3 public.

4 So, I would like us to consider moving
5 this from -- this was do not recommend. I would
6 like to potentially move it into resubmit.

7 CO-CHAIR PINCUS: Is there a
8 particular comment you have about how it would be
9 revised?

10 MEMBER BINDER: I actually don't know,
11 but it seems to me that it could be addressed.
12 I'm not a clinician, but it seems to me that
13 there ought to be ways to address the problem of
14 the certain circumstances under which it is
15 appropriate to have the dual prescription.

16 CO-CHAIR PINCUS: Further discussion?
17 Bruce?

18 MEMBER HALL: I would add that the
19 American College of Surgeons feels the same way,
20 that based on the importance of this topic, that
21 it shouldn't be removed entirely, but should be
22 reworked. And we did submit in writing two

1 suggestions for revision based on exclusion and
2 exception. So, I won't re-read them, but we have
3 submitted some suggestions along those lines to
4 revise.

5 CO-CHAIR PINCUS: Other comments
6 before we re-vote?

7 (No response.)

8 Okay. Could we set up the voting
9 procedures?

10 MS. OGUNGBEMI: We are now voting on
11 MUC16-167, Safe Use of Opioids - Concurrent
12 Prescribing.

13 Options are: 1, support; 2,
14 conditional support; 3, refine and resubmit; 4,
15 do not support.

16 Voting is open.

17 (Voting.)

18 MS. IBARRA: Brandon, Doris, Steve,
19 and Foster, we have received your votes.
20 Barrett, we still are looking for your vote. You
21 can also provide it verbally.

22 MS. McQUESTON: And just to clarify,

1 it says on the slide it is for outpatient quality
2 reporting, but this is for inclusion in the
3 Inpatient Quality Reporting Program. This
4 measure was also proposed for the Outpatient
5 Quality Reporting Program.

6 MS. OGUNGBEMI: Results are 0 percent
7 support, 4 percent conditional support, 62
8 percent refine and resubmit, 35 percent do not
9 support. We reach our 60 percent threshold at
10 refine and resubmit at 62 percent.

11 CO-CHAIR PINCUS: Okay. So, actually,
12 Erin just raised the issue, to avoid having to
13 re-vote on this, shall we also apply this vote to
14 the OQR, the Outpatient Quality Reporting, as
15 well? Is there anybody dissenting from that?

16 (No response.)

17 Okay, good.

18 So now, what we have remaining are
19 several different cancer-related measures that
20 have been pulled, and more for discussion than
21 anything else.

22 I don't know, David, do you want to

1 comment on those?

2 MEMBER BAKER: I would like to first
3 talk about the hospice measures. So, first, if
4 you look at 16-275, Proportion of Patients Who
5 Died From Cancer Not Admitted to Hospice. And
6 this is recommended for support.

7 The question for me is why there were
8 no exclusions for patient refusal. That is
9 important because there are still many patients
10 and their families who are not willing to accept
11 hospice. And equally importantly, that varies
12 according to race, ethnicity, literacy level. So
13 it could really create a bias in this measure.
14 So I was curious to know why there weren't any
15 exclusions for this. And if there is no good
16 reason to not have exclusions, then we should be
17 thinking, and perhaps voting, on conditional
18 support after adding an exclusion for that.

19 CO-CHAIR PINCUS: Other comments on
20 this? Do you have some thoughts about the
21 rationale why there is no exclusions on this?

22 MR. AMIN: Let me check. Is any of

1 the staff on who might be able to comment on
2 that?

3 CO-CHAIR PINCUS: And did this come
4 up, by the way, Ron, in the Workgroup?

5 WORKGROUP CO-CHAIR WALTERS: Good
6 point. The gap is so large actually that that
7 population is not a major contributor to the gap
8 that needs to be overcome.

9 And these hospitals, this is, again,
10 a unique program just applicable to 11 hospitals.
11 This has been through the End of Life Steering
12 Committee, and they supported it, and the
13 hospitals supported it. So I think we're very
14 anxious, well, I should say, they're very anxious
15 to get the measure up and running and reporting
16 and then use it for performance improvement also,
17 along the lines you just said.

18 But your points are valid. There are
19 people who just choose not to, especially in
20 exempt cancer hospitals. So this group of
21 hospitals is willing to accept that as a
22 limitation of the measure and move ahead anyway.

1 MS. SPINKS: And I'm sorry, this is
2 Tracy Spinks. I'm on the phone on behalf of the
3 ADCC. So, I don't know if now is an appropriate
4 time for me to add a few additional comments to
5 what Dr. Walters said.

6 But I would note that this is a
7 claims-based measure. All of these measures are
8 claims-based, in which case, we have to accept
9 that there may be some level of precision that we
10 won't be able to have in the measure. And so,
11 again, as Dr. Walters said, you know, this paints
12 such an important picture of what happens to
13 patients at end of life and making sure that we
14 are doing everything we can to give them the
15 highest-quality death.

16 And it really gets to broader issues
17 about are we delivering end of life care that
18 aligns with patient preferences? But this is a
19 really good starting point for us to look at and
20 create that picture of what happens to our
21 patients at end of life, which, then, as Dr.
22 Walters said, we can, then, use for internal

1 performance improvement to see, well, what are we
2 doing, and what do we need to be doing to ensure
3 that our patients are appropriately referred to
4 hospice and palliative care services in
5 accordance with their preferences and needs?

6 MEMBER BAKER: Thanks. I didn't
7 realize this was a claims-based measure. So the
8 answer to my question is it is not possible.

9 So the second part was essentially
10 dinging physicians if they don't admit a patient
11 to hospice within three days of their death. And
12 as was just said, it is incredibly important for
13 us to be trying to get more patients into
14 hospice. And to turn around and say, well, you
15 tried, but you didn't do a good enough job. You
16 didn't get them in. And I know the literature on
17 the proportion of patients who die within three
18 days of hospice, and it is clear we are too late.
19 But it just seems like we are penalizing people
20 at a point, as was just said, when there is still
21 such a gap in the proportion who are even going
22 into hospice.

1 And I will tell you, as a clinician,
2 I have had patients come in, one patient with
3 stomach cancer who, you know, would have been
4 dead in three months, but with current treatment,
5 had a year of really good quality of life with
6 chemotherapy and radiation therapy, and came in
7 and had a CT scan with multiple brain
8 metastasizes. I admitted him to hospice the next
9 day, and he was dead two days later. And, you
10 know, we see that.

11 So it just seems like that is too
12 punitive. So I would like us to have a
13 discussion about whether people support this and
14 whether it should be do not support.

15 WORKGROUP CO-CHAIR WALTERS: So this
16 is neither a pay-for-reporting nor a pay-for-
17 performance measure.

18 CO-CHAIR KAHN: But once it is on the
19 path, I mean, the question is, if it is not the
20 right thing to do, you are still putting it on a
21 pathway. I understand what you are saying about
22 where it would fall.

1 And also, supposedly, those measures
2 are supposed to be meaningful in terms of people
3 making decisions because they are looking at
4 information. The question is, is this a
5 meaningful measure?

6 WORKGROUP CO-CHAIR WALTERS: And I
7 think once we get the rates of referral to
8 hospice up, this would be a good measure, right?
9 I mean, if we had 80 percent of patients with
10 metastatic cancer admitted to hospice, but then,
11 the vast majority were admitted in the final days
12 of life, then you would say, okay, that is the
13 next step for us to be working on, is earlier.
14 But as was said before, there is still such a
15 huge gap just in the proportion of people who are
16 getting to hospice at all.

17 CO-CHAIR PINCUS: David?

18 DR. HUNT: Maybe this is a little bit
19 too picayune, but given that this is claims-
20 based, can we say patients who died from cancer
21 rather than patients who died with cancer?
22 Because we really don't have a cause of death

1 based on claims. And admittedly, if someone is
2 stage 4 cancer --

3 CO-CHAIR PINCUS: Well, it depends how
4 it's operationalized in the measure.

5 DR. HUNT: Yes, but patients with
6 prostate cancer, say stage 1, how --

7 DR. BURSTIN: I think some of it is
8 because they are PPS-exempt cancer hospitals, is
9 what this is proposed for. So they are already
10 there for that logical reason. It isn't proposed
11 for a wider program. So presumably, they are
12 there for cancer.

13 CO-CHAIR PINCUS: Giff?

14 MEMBER GIFFORD: By the way, Dave, you
15 are not making anecdotal, using anecdotes to do
16 policy? I wouldn't want to --

17 (Laughter.)

18 But how does your scenario of your
19 patient not fit in the measure? I guess we are
20 talking about 267, right?

21 MEMBER BAKER: I'm saying that we see
22 a lot of people, especially now with the more

1 advanced treatments that we have, who are doing
2 well, and then they have a rapid, rapid descent.
3 And the idea that somebody did the wrong thing if
4 they didn't refer somebody -- because that is
5 what the measure says, if you didn't admit,
6 right?

7 MEMBER GIFFORD: Within the last three
8 days, yes.

9 MEMBER BAKER: Right. So you admit
10 somebody to hospice, and it frequently takes a
11 day to arrange that, sometimes a couple of days.
12 And then, they die two days later. That you did
13 the wrong thing, I think the message we should be
14 sending across the country is you should be
15 getting patients with advanced cancer into
16 hospice therapy as early as possible, but not
17 necessarily penalizing those, at this point in
18 time, who are admitting patients late in the
19 game, if you will.

20 MEMBER GIFFORD: So you are concerned
21 because the measure itself shouldn't be 100
22 percent or 0 percent? And this is the challenges

1 we are having in a lot of measures where there is
2 no measure that is going to be perfect.

3 Because, I mean, I have the flip side
4 of that, a number of my patients, or patients I
5 consulted on, that just can't -- you know,
6 they're thrown into the hospice at the last
7 second, and they have been tortured for a while
8 and should have been in hospice a lot sooner.
9 And no one is really talking to them about it.

10 Or the fact that you can do treatment
11 and hospice concomitantly now --

12 MEMBER BAKER: Right.

13 MEMBER GIFFORD: -- allows you to get
14 them in there. I think there's still the belief
15 that you're throwing in the towel. And I think
16 we are really harming a lot of people.

17 So I would counter your anecdote with
18 my anecdote. So I disagree with you on that.

19 (Laughter.)

20 CO-CHAIR PINCUS: Dueling anecdotes.

21 MEMBER GIFFORD: I've seen your
22 anecdotes, too.

1 (Laughter.)

2 CO-CHAIR PINCUS: Further comments?

3 So on the phone?

4 Okay, Steve?

5 MEMBER WOJCIK: It seems, looking at
6 all of these measures, and based on the comments
7 that were made with the discussion, it seems like
8 the more relevant measure might not be when they
9 were admitted to the hospital, whether it was
10 never or within three days of death, but the
11 measure that we are going to be talking about
12 next, but maybe that could be modified. The
13 proportion of patients who died from cancer
14 receiving chemotherapy or other forms of
15 aggressive cancer within X days of death seems to
16 probably be a better measure than if or when they
17 were admitted to hospice, especially as I didn't
18 know, but, obviously, there's a lot of advances
19 in cancer treatment, especially with the
20 specialty pharmaceuticals.

21 And if you can combine treatment with
22 hospice, why are we focusing on where they were,

1 you know, if they were admitted and where they
2 were? It is more what they received and how
3 aggressive it was within X days of death. And I
4 am not a clinician. I don't know whether it is
5 supposed to be 14 days or some other set of days.
6 But maybe that is the more relevant measure, and
7 maybe these other measures should be recommended
8 to be -- for refinement and resubmission rather
9 than support, given all the discussion. And it
10 seems like there is a lot going on in cancer care
11 right now.

12 CO-CHAIR PINCUS: Thank you.

13 So David, do you want to re-vote on
14 this?

15 MEMBER BAKER: We could take the time
16 to do that, but I don't think that there is any
17 sentiment to change. So I'm fine.

18 And the other concerns I had, because,
19 again, these are claims-based measures, it is not
20 applicable because it is really the issue about
21 metastatic cancer versus all cancer. I mean,
22 there still are patients who die in induction

1 chemotherapy, some of which are in the ICU. But
2 there is not good coding for metastatic cancer in
3 claims data.

4 So, thanks.

5 CO-CHAIR PINCUS: So we, I think, have
6 completed going through all the pulled measures
7 from the Hospital Workgroup. Anybody want to
8 pull another one?

9 MS. O'ROURKE: Procedurally, I just
10 want to make sure everyone is clear with where we
11 are.

12 CO-CHAIR PINCUS: Yes.

13 MS. O'ROURKE: So, this would be the
14 end of discussing -- let me pull up my list of
15 programs -- the measures for the Ambulatory
16 Surgery Center Quality Reporting Program, the
17 End-Stage Renal Disease Quality Incentive
18 Program. There were no measures under
19 consideration for the HAC Reduction Program. We
20 would have discussed all the measures for the
21 Inpatient Quality Reporting Program, the
22 Outpatient Quality Reporting Program. There were

1 no measures under consideration for the
2 Readmissions Reduction Program, and we have
3 discussed the measures for the Hospital Value-
4 Based Purchasing Program. So, those are the
5 consent calendars before you. And the Inpatient
6 Psychiatric Facility Quality Reporting Program.

7 So I just want to make sure there are
8 no additional measures people want to discuss for
9 any of those programs.

10 CO-CHAIR PINCUS: Yes. So, we need to
11 cast some official vote?

12 MS. O'ROURKE: If we could just maybe
13 do a show of hands to make sure we have got --

14 CO-CHAIR PINCUS: Sixty percent.

15 MS. O'ROURKE: That people understand
16 that the workgroups --

17 CO-CHAIR PINCUS: Yes.

18 MS. O'ROURKE: If you have not
19 additionally discussed it, the workgroup's
20 decision would stand. So I just want to make
21 sure people are --

22 CO-CHAIR PINCUS: So, officially, and

1 by Robert's Rules of Order, you have to vote on
2 the consent calendar.

3 CO-CHAIR KAHN: I can move it, I
4 guess.

5 CO-CHAIR PINCUS: Okay.

6 MEMBER BARTON: Second.

7 CO-CHAIR PINCUS: And seconded.

8 All in favor?

9 (Chorus of ayes.)

10 Opposed?

11 Thank you.

12 So just less than a few minutes
13 talking about gaps in hospitals.

14 Rhonda, do you want to say something
15 about what the workgroup sort of came up with in
16 terms of their thinking about gaps?

17 MEMBER ANDERSON: There are lots of
18 gaps.

19 (Laughter.)

20 WORKGROUP CO-CHAIR WALTERS: There is
21 a lot of development to be done in a lot of the
22 programs, and certainly in this one, too. And we

1 have alluded to that a couple of times here.

2 Certainly, the care coordination
3 between the hospital measures and other types of
4 programs, we have alluded to in our discussion
5 here and consideration of what the system is
6 responsible for and what the hospital is
7 responsible for. But regardless of that, how can
8 they coordinate their actions better to get the
9 care of the patient improved?

10 And then, also, I think we will
11 continue to look at opportunities to trim down
12 measures that have topped-out, trim down measures
13 that aren't quite achieving what they are
14 supposed to achieve, and look to the other
15 programs for opportunities to bring into the
16 hospital.

17 We just talked about one of them, and
18 certainly cancer care is not unique to those 11
19 cancer centers. There is an opportunity to
20 discuss which of those might be appropriate for
21 hospital inpatient care also, with all the
22 caveats attached that were mentioned.

1 CO-CHAIR PINCUS: Are there other
2 comments about gaps?

3 I think, Leah, you had mentioned, yes,
4 about --

5 MEMBER BINDER: Yes. Would you like
6 to address that? You were -- I'm sorry.

7 The biggest one that I have heard from
8 talking to some folks is C-section rates or
9 maternity in general, I would say. C-sections is
10 the number one reason for hospitalization in the
11 United States. So recognizing CMS may not always
12 have that as a top priority, concern, it
13 certainly is in the Medicaid program, which pays
14 for half of the deliveries. So, it is a high
15 priority from the point of view of purchasers.
16 We pay the other half. But in general, I think
17 maternity care is a major area that we should be
18 looking mor

19 CO-CHAIR PINCUS: Other comments or
20 suggestions around gaps?

21 (No response.)

22 I mean, beyond what we have so far, I

1 do think that we do need to revisit the substance
2 abuse measures that we talked about earlier and
3 think about some better solutions for that.

4 MEMBER BINDER: Yes. So, the other
5 thing that I heard from a couple of folks is --
6 and we say this a lot, but I guess it is worth
7 saying it for the record -- that having more
8 outcomes measures than we are reviewing today,
9 and perhaps maybe it is time for us to pursue
10 more nuanced outcomes than just mortality. So, I
11 think there is some discontent that we are not
12 looking at a group of measures that are as robust
13 as we would hope at this stage in measurement
14 science.

15 CO-CHAIR PINCUS: Just a comment, just
16 stepping out of the Chair role, with regard to
17 both the inpatient psychiatric hospitalization
18 one and, also, for people that are not
19 necessarily in inpatient settings. For people
20 with severe mental illnesses to think about
21 potential hospital-based measures that look at
22 the physical comorbidity issues among those

1 people or the potential for their lack of access
2 to preventive screening and preventive
3 interventions may be something that is worth
4 exploring in terms of an area of needed
5 attention.

6 WORKGROUP CO-CHAIR WALTERS: I would
7 really like to thank the Committee for having me
8 here and for their very thoughtful input. It is
9 a process, sometimes a laborious process, but,
10 nonetheless, it is a very important process. And
11 the day we don't go through what we went through
12 this morning and into the afternoon is the day we
13 all had better give up.

14 CO-CHAIR PINCUS: Well, thank you,
15 Ron. We have really appreciated your input and
16 your being here for this.

17 So now, we can move on to the next
18 Workgroup report.

19 Oh, Giff?

20 MEMBER GIFFORD: No, just a quick gap.
21 As a geriatrician, representing nursing homes
22 assisted living, recognition of dementia in the

1 hospital setting. We are going to see that grow
2 over time, and I think it is a very vulnerable
3 population that deserves some special attention
4 and is overlooked in a lot of the measures in the
5 hospital setting.

6 CO-CHAIR KAHN: Okay. Now we turn to
7 another public comment period, now on post-acute
8 care/long-term care programs.

9 And I guess I ask if there is anyone
10 on the phone who wants to comment before we get
11 into a session on that.

12 Please limit your comments to the
13 post-acute care/long-term care program
14 recommendations. Limit comments to no more than
15 two minutes, and make any comments on MUCs or
16 opportunities to improve the current post-acute
17 care/long-term care measure set at this time.

18 Actually, I should say, is anyone here
19 that wants to comment?

20 (No response.)

21 Okay. There is no one in the room
22 that wants to comment from the public gallery.

1 Is there anyone on the phone?

2 OPERATOR: At this time if you would
3 like to make a public comment, please press star
4 1.

5 CO-CHAIR KAHN: And I believe Kim is
6 also looking at the chatbox.

7 (No response.)

8 Okay, going once, going twice. Anyone
9 in the chat --

10 MR. HILLMAN: Hello.

11 CO-CHAIR KAHN: Oh, yes?

12 MR. HILLMAN: Hi. This is Troy
13 Hillman from UDSMR.

14 CO-CHAIR KAHN: Okay.

15 MR. HILLMAN: Is it an opportunity for
16 public comment?

17 CO-CHAIR KAHN: The floor is yours.

18 MR. HILLMAN: I appreciate it.

19 UDSMR appreciates the opportunity to
20 have our written comments considered and to
21 further comment on the pressure ulcer measures
22 that are being considered by the Committee, and

1 the supporting memorandum that was supplied by
2 CMS and RTI.

3 While we appreciate the CMS/RTI
4 response to concerns that were raised during the
5 PAC/LTC Workgroup, UDSMR would like to note the
6 following concerns related to this memo:

7 First and foremost, the reliability
8 and validity analysis and feedback appears to be
9 based on three resources that have limited
10 applicability to current inpatient rehab facility
11 practice.

12 First and foremost, the MBS 3.0 data,
13 which is collected from skilled nursing
14 facilities, a discussion from a TEP that was
15 convened in July 2016, prior to the
16 implementation of new pressure ulcer items in
17 October, and PAC-PRD data that was collected and
18 reported on nearly 10 years ago. Furthermore,
19 the inter-rater reliability data that is based
20 upon what are considered equivalent or similar
21 items, and not the actual items that are
22 currently being collected for this measure.

1 Because of this, we continue to question the
2 reliability and validity of the items being
3 proposed for utilization for this measure.

4 Additional analyses in this memo were
5 conducted on data from, again, equivalent items
6 from October 2014 to March 2015, when the IRF-PAI
7 version was 1.2, and that was in place asking
8 questions in a different manner, and given
9 different instructions via the IRF-PAI training
10 manual. We are currently using IRF-PAI version
11 1.4, which began assessment in October 2016,
12 where these pressure ulcer items have been
13 redefined and the training materials have been
14 updated with new descriptions.

15 Additionally, later on in the
16 memorandum, more recent data from October 2016
17 forward, is utilized and notes that there are
18 differences between the item sets that are being
19 utilized, but goes on to recommend that the
20 M0-300 series of questions which are proposed as
21 part of this change are more accurate than the
22 currently-utilized M0-800 items, indicating that

1 the current items are understanding the
2 incidence.

3 However, review of data within the
4 UDSMR database on Medicare cases discharged
5 between October to December 2016 suggests that,
6 of those cases that are currently identified
7 utilizing the current items or the M0-800 items,
8 nearly 114 patients, or 13 percent of those that
9 are currently identified, would not be identified
10 utilizing the new items.

11 So, while CMS and RTI are suggesting
12 that the current items may be underreporting the
13 measure, it is to be noted that the issue is
14 present within the changed items as well. We
15 would encourage the Coordinating Committee to
16 reconsider the voting on the pressure ulcer
17 measure for all post-acute care sites and not
18 just inpatient rehab facilities, with a
19 recommendation that a refine and resubmit
20 designation or a do not support recommendation be
21 provided.

22 We would further suggest that in the

1 feedback to CMS and RTI that they perform a more
2 detailed medical record review to more accurately
3 determine which item bank accurately records a
4 new or worsened pressure ulcer.

5 UDSMR is also concerned that, by not
6 following the measure selection criteria and
7 associated decision categories to determine
8 whether measures are fully developed and tested,
9 that the NQF MAP process continues to allow CMS
10 to implement unproven and untested quality
11 measures that are negatively impacting providers
12 through the burden of additional data collection
13 or the publication of inaccurate or inconsistent
14 values on quality comparison websites that are
15 available currently to consumers.

16 Furthermore, while CMS staff continues
17 to suggest during Workgroup deliberations that
18 the IMPACT Act requires that they implement
19 various quality measures by certain deadlines,
20 they fail to acknowledge that the IMPACT Act also
21 affords the Secretary of Health and Human
22 Services the ability to suspend or remove

1 measures, especially in circumstances where the
2 collection of data for a measure may produce
3 unintended consequences.

4 Given that all post-acute care
5 measures being considered within the PAC/LTC
6 Workgroup deliberations have not been fully
7 tested, CMS should delay the implementation of
8 these measures until such a time as testing
9 indicates whether or not providers may experience
10 unintended consequences as a result of these
11 measures.

12 We respectfully ask that the
13 Coordinating Committee consider this and
14 recognize that the measure selection criteria and
15 decision categories would reject recommendations
16 of support or conditional support for all the
17 measures that have not been fully developed and
18 tested for the specific quality programs they are
19 to be considered for.

20 We further ask the Coordinating
21 Committee recommend that the Secretary of Health
22 and Human Services utilize the authority provided

1 in the IMPACT Act to suspend or remove measures
2 that are not fully developed and/or tested until
3 such a time as adequate development and testing
4 has been completed and made available to all
5 appropriate stakeholders.

6 Thank you very much for your time and
7 consideration.

8 CO-CHAIR KAHN: Thanks.

9 Any other comments on the phone?

10 OPERATOR: Yes, you have a comment
11 from the line of Caroline Sparks.

12 CO-CHAIR KAHN: Thank you.

13 Would you repeat your name and, then,
14 give where you are from, and then, go ahead,
15 Caroline?

16 DR. SPARKS: Okay. I am Caroline
17 Sparks. However, I did not submit a comment. I
18 apologize.

19 CO-CHAIR KAHN: No problem. Just
20 proceed.

21 DR. SPARKS: I didn't have a question.

22 CO-CHAIR KAHN: Oh, oh, I'm sorry.

1 I'm sorry. I thought she didn't give written
2 comment.

3 Okay. Anyone else on the phone?

4 (No response.)

5 Okay. I guess we can now go into the
6 session.

7 PARTICIPANT: I'm sorry, I am a
8 colleague of someone who I know is on the phone
9 who is an expert in one of these areas. And I
10 believe that they did have a comment. So, if you
11 could just give it one more second for them to
12 register and queue-in their notification of a
13 comment?

14 CO-CHAIR KAHN: Yes. What is their
15 name?

16 PARTICIPANT: Her name is Mary Ellen
17 DeBardeleben.

18 CO-CHAIR KAHN: Okay.

19 OPERATOR: Okay, and her line is now
20 in queue, and I will open her line now.

21 MS. DeBARDELEBEN: Thank you.

22 CO-CHAIR KAHN: Mary Ellen?

1 MS. DeBARDELEBEN: Hello. Can you
2 hear me?

3 CO-CHAIR KAHN: Yes. If you could say
4 your name and where you're from?

5 MS. DeBARDELEBEN: Oh, yes.

6 CO-CHAIR KAHN: And then, proceed.

7 MS. DeBARDELEBEN: I'm not sure why my
8 question didn't go through.

9 Good afternoon.

10 My name is Mary Ellen DeBardeleben,
11 and I'm the Director of Quality for HealthSouth.

12 My comment relates to the IRF pressure
13 ulcer measure 16-143 that proposes changing the
14 measure from using M0-800 items to M0-300 items,
15 which I will refer to as the existing and
16 proposed measure from here on out.

17 I would like to thank CMS for the
18 thoughtful response to the concerns raised by
19 HealthSouth and other IRF stakeholders regarding
20 the pressure ulcer measure change. It is obvious
21 that significant work went into the creation of
22 this memo, and I respect that time and effort.

1 We do not believe that the analysis on
2 pages 3 through 12 using assessment items from
3 2014 and 2015, pulled from prior versions of the
4 IRF-PAI, is an appropriate proxy to the changes
5 we are discussing today, because the questions
6 were different and they were being asked in a
7 different way.

8 We appreciate this analysis, but would
9 prefer to focus the Coordinating Committee's
10 attention to the analysis that compares the
11 specific components discussed here. This
12 analysis begins on page 12 of the 17 pages of the
13 CMS and RTI memo, and validates the comments from
14 the MAP PAC/LTCH meeting last month and public
15 comments submitted to CMS in November.

16 CMS and RTI found that changing the
17 pressure ulcer measure from the existing to the
18 proposed results in a 33 percent increase in
19 pressure ulcers, which is a significant
20 difference. Also, while CMS and RTI suggest the
21 existing items underreport the incidence, our
22 analysis, which has found similar results to what

1 CMS and RTI have presented, show that over 100
2 patients over the past three months, which are
3 currently defined as having new or worsened
4 pressure ulcers, would not be identified using
5 the new items. So, the suggestion that the
6 proposed items are more accurate than the
7 existing items is not necessarily consistent
8 across the population.

9 I would also like to note that the
10 voluntary nature of the proposed items listed as
11 one of the potential reasons for the discrepancy
12 only applies to the unstageable pressure ulcer
13 items which were specifically excluded from this
14 analysis.

15 The CMS and RTI analysis confirms the
16 significant discrepancy caused by modifying this
17 measure and offers a few different possible
18 explanations. However, without further testing
19 at the measure level using current data, it is
20 impossible to know if the new measure is accurate
21 and valid, which is the cornerstone of the NQF
22 MAP approval.

1 While consistency across providers is
2 ideal, I would urge NQF MAP to not rush to any
3 change to any measure with such a significant
4 change to outcome and would encourage NQF MAP to
5 vote do not support for measure 16-143.

6 Also, while HealthSouth presented
7 industry data in lieu of company data in both our
8 written and verbal comments, we are proud that
9 the HealthSouth-specific data that CMS and RTI
10 presented publicly shows that HealthSouth
11 facilities have fewer new or worsened pressure
12 ulcers compared to all other IRFs, regardless of
13 the way the measure is calculated.

14 Thank you so much.

15 CO-CHAIR KAHN: Okay. Any other
16 comments? Okay. Thank you for the --

17 OPERATOR: You have a --

18 CO-CHAIR KAHN: I'm sorry.

19 OPERATOR: You have a comment from
20 Lane Koenig.

21 CO-CHAIR KAHN: Okay. Proceed please.

22 DR. KOENIG: Hi there. Can you hear

1 me?

2 CO-CHAIR KAHN: Yes, we can.

3 DR. KOENIG: Great. Thank you.

4 My name is Lane Koenig. I represent
5 the National Association of Long-Term Care
6 Hospitals.

7 I have a comment on the pressure ulcer
8 measure, and I just want to reiterate the other
9 commenters that came before me, that we agree
10 with many of the comments that were said. And
11 so, I am not going to rehash some of the things
12 that have been said.

13 I want to raise one concern that we
14 have. Others have raised concerns regarding the
15 switch from the 800 series to the 300 series for
16 measuring pressure ulcers, particularly from our
17 perspective on the LTCH care tool. And our
18 concern is really about the way, the inclusion of
19 the unstageable wounds, the way it is calculated
20 in score is that, if you have an unstageable
21 wound, that, therefore, after treatment is
22 revealed to be a stage 3, for example, that the

1 way the measure is currently scored, that would
2 show a worsening of pressure ulcers because the
3 unstageable pressure ulcer now became stage 3.
4 And so it would indicate a new stage 3 wound.
5 And so, we ask that the Committee sort of ask CMS
6 to revise and correct the coding to deal with
7 that issue.

8 Thank you.

9 CO-CHAIR KAHN: Okay. Thank you.

10 Any other comments?

11 (No response.)

12 Okay.

13 MR. TILLY: Great. Thank you.

14 I just want to check quickly, is Deb
15 Saliba on the line? I know we are starting a
16 little bit later than we planned.

17 WORKGROUP CO-CHAIR SALIBA: I'm on the
18 line.

19 Jean-Luc is going to present, I think,
20 for us today.

21 MR. TILLY: That's right, great.

22 Thanks, Deb.

1 So, the MAP PAC/LTC Workgroup reviewed
2 22 measures under consideration for six federal
3 programs, the three measures for the IRF program,
4 the same three measures for the long-term care
5 Hospital Reporting Program, as well as the SNF
6 Quality Reporting Program. No measures for the
7 Skilled Nursing Facility Value-Based Purchasing
8 Program, although we did discuss the existing
9 measure set; five measures for the Home Health
10 Quality Reporting Program. So, those same three
11 for IRF, LTCH, and SNF as well as two others,
12 which I will go into in some detail later. And
13 eight measures for the Hospice Quality Reporting
14 Program.

15 The overall themes for our meeting,
16 the first kind of predominant theme is the IMPACT
17 Act and the effect that that has had on measure
18 development in the PAC/LTC space. You know, by
19 encouraging the alignment of measures across
20 settings, we saw that many of the measures
21 submitted -- I just described many of the
22 measures submitted for this -- were the same

1 across several settings which is by design and
2 which we hope will standardize measurement.

3 But that also means meeting fairly
4 challenging deadlines. And so, in the case of a
5 couple of measures, the measures were not fully
6 developed before coming to the MAP, which led to
7 a revise and resubmit recommendation. But I
8 think the Workgroup strongly agreed that,
9 overall, the measures submitted were making a
10 really positive contribution to the program and
11 were in line with the IMPACT Act recommendations.

12 The MAP Workgroup did highlight,
13 however, that there were many opportunities to
14 address quality improvement, so a continuing
15 opportunity for improvement. And many of these
16 same themes you saw reflected in the Hospital
17 Workgroup just now, but, again, an emphasis on
18 patient-reported outcomes and how key they are to
19 understanding quality. And, of course, the
20 presentation on the PROMIS tool was particularly
21 exciting to the PAC/LTC Workgroup which really
22 was enthused about the opportunity for

1 groundbreaking measurement there.

2 Other measures of importance, you
3 know, particularly to patients, we heard
4 discussion about nutrition measures, care
5 preferences that extend beyond end-of-life care,
6 but care preferences around procedural things
7 such as turning, and finally, measures around
8 medication management.

9 Finally, the Workgroup emphasized
10 shared accountability across the care continuum.
11 So, here where we saw measures of transfer of
12 information at admission and discharge, that
13 means that both facilities and hospitals outside
14 of the PAC/LTC sphere are responsible for making
15 some effort to either improve their health IT
16 capacity or their processes of transfer of
17 information to meet those measures.

18 And then, so we will move into a
19 discussion of consideration for specific
20 programs, starting with the Inpatient Rehab
21 Facility Quality Reporting Program. So, here the
22 specific new opportunities for measurement cited

1 were CAHPS, or their experience-of-care
2 assessment.

3 The measures under consideration:
4 first we have the new or worsened pressure ulcers
5 measure which received a conditional support for
6 rulemaking. That is the measure you heard
7 discussed in the public comments just now.

8 And this recommendation of conditional
9 support for rulemaking is different than the
10 recommendation in the other settings, where it
11 was given a support for rulemaking. Here in the
12 IRF setting, there was, as you heard from
13 HealthSouth, a particular concern about how the
14 measure was being used in the IRF setting and
15 some data that suggested that there were
16 questions around the validity there. So, the
17 condition with the support for rulemaking was
18 that CMS evaluate the impact of the revised
19 specifications specific to IRF patients.

20 Public comments we received were
21 mixed. Some very much supported MAP's
22 recommendation and others concurred with the MAP

1 that there was a need for possible reevaluation,
2 even a return to NQF and the CDP for re-
3 endorsement.

4 CMS submitted a memorandum during the
5 public comment period to address those changes to
6 the measure, and which included some findings
7 from testing that they had done and a specific
8 examination of HealthSouth's data and how that
9 applies to the IRF setting.

10 So, the other two measures under
11 consideration for the IRF QRP were a transfer-of-
12 information measure at admission and at
13 discharge. That is two measures there. They
14 each received refine and resubmit. And the
15 Committee really underlined that it would be
16 important to refine the measure to include
17 transfers between attending clinicians as well as
18 simply between settings. They asked, of course,
19 that testing be completed and it be submitted to
20 NQF for endorsement.

21 And finally, our public comments were
22 generally supportive of MAP's recommendations and

1 added that there are existing regulations that
2 may make this measure somewhat duplicative.

3 So, in the SNF Quality Reporting
4 Program, a lot of the same as in IRF, because,
5 again, the same measures were submitted here in
6 terms of opportunities for improvement. We have
7 had a few other measures to address, the presence
8 of advance directives and measures of nutrition.

9 For the new or worsened pressure
10 ulcers measures, we received support for
11 rulemaking, as I said. But I believe that
12 measure has been pulled for a re-vote as well.
13 In fact, I think every pressure ulcer measure has
14 been pulled for re-vote.

15 And again, the transfer-of-information
16 measures at admission/discharge received many of
17 the same comments, in fact, really the exact
18 same.

19 In the LTCH setting, a little bit
20 different here. So, in addition to the same new
21 opportunities for measurement, nutrition, and
22 CAHPS measure, there were some suggestions around

1 refinement of existing measures already in the
2 program. So there, where there are infection-
3 specific measures that exist already that are
4 addressing a specific infection such as C. diff,
5 replacing that with a kind of general measure of
6 infections, and, also, a reconsideration of the
7 ventilator-associated event measure. There was
8 some suggestion from the Workgroup that possibly
9 that measure was no longer needed.

10 And then, finally, for the SNF program
11 -- and, well, you're familiar with this by now.
12 Pressure ulcers, support for rulemaking, transfer
13 of information at admission/discharge, some of
14 the same comments, transfers between clinicians,
15 between settings.

16 So, finally, in the Home Health
17 Quality Reporting Program, a little bit different
18 there. So, here we had the same measures around
19 pressure ulcers and transfer of admission, but,
20 then, we also had a couple other measures.

21 So, here we had a measure, a
22 functional assessment at admission and discharge

1 together with a care plan. That received a
2 conditional support.

3 And here, the Workgroup really wanted
4 the measure developer to resubmit the measure to
5 NQF for endorsement in new setting. It is
6 actually not endorsed in the home health setting,
7 but, rather, only in the long-term care hospital
8 setting, is my understanding.

9 And then, also, a falls with major
10 injury measure, where the recommendation was
11 basically the same. You know, submit to NQF for
12 endorsement in the setting to which it is being
13 applied.

14 And public comments generally concur
15 with the MAP recommendation, although some
16 suggested expanding the measure to include all
17 falls and not just those with major injury.

18 So, in the Hospice Quality Reporting
19 Program, there we had several new opportunities
20 for measurement. So, medication management at
21 the end of life, especially after death; the
22 provision of bereavement services; patient care

1 preferences beyond end-of-life care, and then,
2 symptom management measures. You know,
3 currently, the Hospice QRP includes several
4 symptom management measures around cancer, and
5 the idea was that we could create other measures
6 that would be related to other diseases, such as
7 dementia or other typically end-of-life
8 conditions.

9 And the idea of the Workgroup there
10 around the existing measure set was to look
11 closely at some of the process measures that were
12 present in that set and to assess their
13 relationship to actual outcome measures and
14 patient satisfaction.

15 Eight measures were submitted for the
16 Hospice Quality Reporting Program, all derived
17 from the CAHPS Hospice Survey. So, getting
18 emotional/spiritual support, getting help for
19 symptoms, getting timely care, the overall rating
20 of the hospice. They all received a support for
21 rulemaking, and public comments here were
22 basically universally supportive. These eight

1 measures actually recently received endorsement
2 in the Palliative and End-of-Life Care Project.

3 And here, I think I will turn it over
4 to Erin to talk about the duals.

5 MS. O'ROURKE: Sure. So, again, the
6 Duals Workgroup convened to provide some cross-
7 cutting input on the PAC/LTC recommendations. In
8 particular, they support measures that capture
9 the degree to which providers and the care they
10 provide is integrated across settings. They
11 encourage continued development of the role that
12 social risk factors play in care delivery as well
13 as the role they play in performance measurement.

14 In particular, for PRO-PMs, some
15 considerations include cultural and language
16 barriers; the person's perspective on whether the
17 measure is meaningful, understandable, and
18 achievable.

19 And some additional gaps the Dual-
20 Eligible Beneficiary Group put forward for
21 consideration include population health and
22 transitions from institutional settings to the

1 community.

2 I think, with that, I can turn it back
3 to Chip for discussion.

4 CO-CHAIR KAHN: First, let me say,
5 just get this right, that before we go over this
6 list, which is the next thing to do, the pulled
7 measures, that Giff added to the pulled MUC16-142
8 and MUC16-327. And to keep things in order,
9 let's do MUC16-142 first, and can you bring that
10 up on the screen, so we know what it is? I
11 didn't memorize all the --

12 MEMBER GIFFORD: What was 3-something?

13 CO-CHAIR KAHN: Well, I was going to
14 start with 142 because the next one is 145, 143.

15 MEMBER GIFFORD: No, I think I just
16 added 142 and 145 to the already-pulled 143 and
17 144.

18 CO-CHAIR KAHN: Oh, I'm sorry, 145 is
19 already --

20 MEMBER GIFFORD: Pulled? That's the
21 home health pressure ulcer one?

22 CO-CHAIR KAHN: Yes, home health

1 patients.

2 MEMBER GIFFORD: I just pulled the
3 four pressure ulcer ones.

4 CO-CHAIR KAHN: Okay.

5 MS. O'ROURKE: Okay. So, to just
6 clarify, there are the four pressure ulcer -- it
7 is essentially the same measure applied across
8 settings.

9 MEMBER GIFFORD: Yes.

10 MS. O'ROURKE: So, let me just get the
11 numbers for everybody, just to help clarify.

12 CO-CHAIR KAHN: Okay.

13 MS. O'ROURKE: So, for home health, it
14 would be MUC --

15 CO-CHAIR KAHN: 145.

16 MS. O'ROURKE: -- 145. For --

17 CO-CHAIR KAHN: Yes, short stay, it is
18 143.

19 MS. O'ROURKE: Yes.

20 CO-CHAIR KAHN: And inpatient rehab,
21 and then, I guess the SNF is 142?

22 MS. O'ROURKE: SNF is 144.

1 CO-CHAIR KAHN: Okay. And then, what
2 is 142?

3 MS. O'ROURKE: Oh, no, SNF is 142 and
4 LTCH --

5 MEMBER GIFFORD: No, SNF is 142 and
6 LTCH was 144.

7 MS. O'ROURKE: Giff was right; I'm
8 wrong.

9 CO-CHAIR KAHN: Okay. And should we
10 discuss these as a package --

11 MEMBER GIFFORD: Yes.

12 CO-CHAIR KAHN: -- since there is
13 commonality between those?

14 MEMBER GIFFORD: Yes.

15 CO-CHAIR KAHN: So, Giff, the floor is
16 yours.

17 MEMBER GIFFORD: And these measures
18 are all exactly the same measure with some minor
19 risk adjustment differences between the setting.
20 Because, recall under the IMPACT Act they have to
21 have standard measures with standard assessment
22 tools.

1 As you heard on the phone, CMS
2 implemented a standard way of measuring pressure
3 ulcers consistent with the NPUAP, which I think
4 most people applauded, which started in all of
5 our settings, IRF LTCH and PAC, just in October
6 of last year.

7 As voiced, there were concerns with
8 how the measure is constructed from that and the
9 fact that this is a new assessment tool, that
10 there is not a good sense on the
11 reliability/validity of the underlying data yet,
12 but, also, how the data is collected, making it a
13 little more difficult to assess change in
14 pressure ulcers over time when someone is
15 admitted with more than one pressure ulcer.

16 And so, again, I find myself in the
17 awkward position of clearly a topic that is of
18 grave importance where there's lots of
19 opportunity in all four settings. And I have
20 heard from all the different settings prior to
21 this meeting that they just don't feel this
22 measure is ready, fully support it, would like to

1 work with CMS on it further.

2 And so, our recommendation would be to
3 move this from the support category down to
4 further develop. The other thing is there are
5 already measures developed and specified last
6 year by CMS to meet the requirements of the
7 IMPACT Act. This was the effort to do more
8 alignment with that, and we just think it is
9 moving faster than we would like to see it. And
10 so, our recommendation would be that.

11 CO-CHAIR KAHN: Good.

12 Are there other comments? Input?
13 Does CMS want to say anything?

14 MS. O'ROURKE: So, I just want to jump
15 in and point to something in your Discussion
16 Guide. I know a lot of the public commenters and
17 Giff was referencing some of the new analyses.
18 So, if you click on the measure under the IRF
19 pressure ulcer under the IRF setting, you can see
20 the comments from HealthSouth, UDSMR, as well as
21 CMS. And at the bottom of the comments from CMS
22 there is a link to a memo that has some

1 supporting analyses.

2 And, Pierre, I wasn't sure if someone
3 from your team wanted to walk through those.

4 DR. YONG: Yes. Thanks, Erin.

5 So, Dr. Alan Levitt or Stace Mandl, do
6 you want to go through the analysis that we
7 provided?

8 DR. LEVITT: Sure. This is Alan
9 Levitt. I'm the Medical Officer in the Division
10 of Chronic and Post-Acute Care.

11 I mean, really, the summary to look
12 at, if you could look at, I guess, the attached
13 item, is really go to page 17, and you can see
14 both our summary, but, then, also, look at the
15 items themselves that are being talked about.

16 What we ended up doing, the reason why
17 we are doing this is really part of our
18 monitoring and evaluation of this measure and all
19 the measures that we do, and was supported by the
20 Technical Expert Panel in the middle of last
21 year.

22 If you look at the 0300 item, it is an

1 item that essentially is counting the number of
2 unhealed pressure ulcers. And so, it is counting
3 it at admission and, then, it is counting it at
4 discharge. So, it is a real-time count by
5 usually the nurse, of the number of pressure
6 ulcers.

7 In addition, on discharge, because it
8 is possible that a patient may heal an ulcer and,
9 then, have another new ulcer, we do also ask
10 whether the count of those unhealed ulcers,
11 whether or not they were present on admission or
12 not. And so, that is how that is done. It is
13 really potentially a real-time count that we do
14 based on the assessment of a patient.

15 The 0800 items, which, then, come
16 later on in the assessment tool, the question on
17 it just asking the number of pressure ulcers that
18 were not present or at a lesser stage on
19 admission. So, it is just asking kind of a
20 number that is asked on the discharged
21 assessment. That is essentially a retrospective
22 kind of assessment. It is just asking, well, how

1 many pressure ulcers were not present or present
2 at a lesser stage?

3 And so, what happened is that the 0300
4 items in the SNF setting, for example, were being
5 used for payment, and the 0800 items were being
6 used for quality. And there was a discrepancy
7 between those numbers. The numbers that were
8 being used for payment tended to be high. And
9 again, you could get paid more, I guess, based on
10 that, it is possible. And then, the 0800 items,
11 the number of ulcers were low. And so, again,
12 that maybe looked favorably, that you had less
13 pressure ulcers when it came to quality, but more
14 pressure ulcers when it came to payment.

15 And so, because of that monitoring and
16 evaluation that we did on those items themselves,
17 as well as other monitoring and evaluation, that
18 is why we have the unstageables that have been
19 added as well, based on that. We did bring it to
20 the TEP, and the TEP supported us moving towards
21 the 0300 items.

22 And so, that was done in the SNF

1 setting over this past year. And so now, the SNF
2 setting is done that way. And what we have
3 actually done here in terms of bringing these
4 measures which are already in our programs back
5 to the MAP was to harmonize this across the
6 settings, similar to like what we really do want
7 to do within the IMPACT Act.

8 And also, really to understand that,
9 look at those M0300 items which count the
10 pressure ulcers. Those are assessment items that
11 can be used longitudinally across settings where
12 you could actually take the counts from one
13 setting to another. And they are very useful
14 items, not just for the measure, but also in
15 terms of the assessment of pressure ulcers.
16 Whereas, the 0800 retrospective item that is used
17 only means something in that setting. It doesn't
18 mean anything from there on.

19 And so, by us going towards an 0300
20 item that can be used across setting and, then,
21 modifying it, we could, hopefully, eliminate the
22 0800 item in terms of any sort of duplication and

1 also get what we would feel to be more accurate
2 results because they could be based on the actual
3 real-time assessment that is being done on the
4 patient both on admission and discharge.

5 And so, we ended up proposing this.
6 And again, the issue that came up within the
7 Workgroup was, as was mentioned in the public
8 comments, that there was a discrepancy when the
9 calculation was being done between 0800 and 0300
10 items. And again, that discrepancy really was
11 representative of why we wanted to do this in the
12 first place, because there was really an
13 underreporting of the ulcers when you are using
14 purely the retrospective item.

15 And what we have showed best, if you
16 go back on the attachment in terms of table 6, if
17 you looked at the stage 2 pressure ulcer line,
18 for example, if you took the difference between
19 the pressure ulcers at stage 2 from discharge to
20 admission, and if they were a greater number,
21 they had to have a new or worsening pressure
22 ulcer. There is no other way they would have

1 that.

2 And so, we were able to identify 526
3 patients that had a greater number. If you
4 looked at those same patients and looked at their
5 0800 items, only 336 of them said they had a new
6 or worsening ulcer. And so, you only got a 64
7 percent hit by having somebody retrospectively go
8 and decide whether or not there was a new or
9 worsening ulcer, which, again, corresponded to
10 the reason why we were doing this in the first
11 place.

12 And I'm not sure if there are any
13 other questions, but that is really why we did it
14 and why we feel you should fully support this
15 measure.

16 DR. GOODRICH: Thank you, Alan.

17 CO-CHAIR KAHN: Kate, yes.

18 DR. GOODRICH: We appreciate it.

19 No, that's it.

20 CO-CHAIR KAHN: Okay, Giff, why don't
21 you --

22 MEMBER GIFFORD: So, a couple of

1 comments on Alan's comments. I don't disagree
2 with anything he said, except we see the same
3 pattern on the SNF side where this is not used in
4 payment at all. So, the fact that he is alluding
5 to the differences have to do with something like
6 payment may be unique to one setting, but the
7 pattern we are seeing is in other settings where
8 it is not tied to payment.

9 Second, I think we applauded the
10 creation of the 300 measures for IMPACT, for all
11 the things that he described. However, the way
12 it is constructed, it makes it a little bit more
13 difficult to measure change during the stay
14 because you can't link it. It is sort of an
15 ecologic analysis. You don't know which measure
16 is tied to change or not. And if there are
17 changes going on, you can actually look like you
18 are having worse or not having worse. And so, it
19 is not fully perfect. So, it is good for
20 clinical care, good for quality improvement, not
21 particularly great for measurement. And how they
22 incorporated the unstageable into the measure

1 calculation also throws the measure off.

2 So, it is not that we object to a
3 measure here, and this is sort of across all the
4 PAC settings. So, it is home health, SNF, IRF,
5 LTCH, all of us had this feeling that the measure
6 just needs more work. It came out with a new
7 scale, a new rating system in October, and they
8 are trying to apply it to a measure. And we
9 haven't gone back and double-checked to see how
10 it has done in some of the preliminary data.
11 And the clinical way suggests that this is not
12 necessarily accurate at individual facility
13 level. It might be accurate at a national level,
14 but at an individual facility level it is not.

15 And so, we would just encourage
16 further development on this measure.

17 CO-CHAIR KAHN: I mean, how do you
18 respond? Or any response?

19 MS. MANDL: This is Stace.

20 CO-CHAIR KAHN: Stace?

21 MS. MANDL: Do you want CMS Central
22 Office to respond or not?

1 CO-CHAIR KAHN: Please.

2 MS. MANDL: Sure. This is Stace
3 Mandl, and I believe we have RTI, our measure
4 development contractor on the line as well that
5 can speak to this. I think those are important
6 points, and I just want to provide some
7 clarification.

8 On the M0300 topic that is sort of
9 being tossed around, it is the assessment of
10 pressure ulcers at the time of admission or on
11 interim assessments or at discharge. And as Alan
12 was describing, it is how many do you have and
13 how many were present on admission, so as to
14 remove attribution. Those M0300 items are used
15 for payment in the run system on the M0300 items
16 for stages 2 through 4.

17 Another thing I am trying to point out
18 is that the M0800 item used in the nursing home
19 version of the measure actually includes even
20 wounds that have healed. So, part of the
21 rationale for moving in this direction was to not
22 include an overcount when using a stay-based

1 measure. So, I just wanted to kind of point to
2 those two topics.

3 Thanks.

4 CO-CHAIR KAHN: Okay. I don't know
5 how to resolve this other than I guess to vote.
6 But, I mean, are there other comments?

7 (No response.)

8 Okay. So, I guess we should vote.

9 Oh, Deb, do you want to add anything
10 to this discussion?

11 WORKGROUP CO-CHAIR SALIBA: I think it
12 has been well-covered. The Committee voted to
13 endorse the measure in three settings. And then,
14 when the IRF measure was brought up, there was
15 some public discussion and concerns where
16 conflicting data was mentioned. And the
17 Committee's intent in doing a conditional support
18 was that somebody take a close look at that data,
19 and CMS generated the memo in response to that
20 request, looking at the data.

21 I think, you know, from the
22 Committee's perspective, there is an expectation

1 that the distribution of the item would change if
2 the item changes, and that part of the reason for
3 changing an item is that you are going to get a
4 change in the distribution of the base frequency
5 responses.

6 So, I think that is why the Committee
7 was comfortable voting for support in the three
8 settings, and was really being respectfully
9 responsive to the public comment in saying, well,
10 let's look at the data that has been raised. So,
11 I think Alan has reviewed the data that was
12 presented by CMS in response to that request.

13 Does anybody have questions that would
14 help them in terms of deciding on this particular
15 measure?

16 CO-CHAIR KAHN: We didn't really
17 generate much in terms of further queries.

18 WORKGROUP CO-CHAIR SALIBA: Okay.

19 CO-CHAIR KAHN: Are there any closing
20 arguments?

21 Okay. Then, I guess we will go
22 through all four and close this out.

1 So, I guess first we will do the SNF.

2 MS. OGUNGBEMI: Yes. We are now
3 voting on application of percent of residents or
4 patients with pressure ulcers that are new or
5 worsened, short stay, MUC16-142.

6 Your options are: 1, support; 2,
7 conditional support; 3, refine and resubmit; 4,
8 do not support.

9 Voting is open. Ready to read the
10 vote?

11 MS. IBARRA: I'm still waiting for
12 remote participants to chat-in their votes. I
13 have not received any yet.

14 CO-CHAIR KAHN: Have you got it?

15 MS. IBARRA: No. Foster, Doris,
16 Steve, Barrett, Brandon, we are waiting. None of
17 your votes have come through.

18 CO-CHAIR KAHN: We're going to give
19 you another 30 seconds.

20 DR. LOTZ: This is Doris. I have sent
21 it twice.

22 MEMBER BROTMAN: Yes, this is Steve.

1 I sent it about a minute ago.

2 CO-CHAIR KAHN: Okay. Thank you,
3 guys.

4 MEMBER HOTHAM: This is Brandon. The
5 same situation.

6 CO-CHAIR KAHN: Okay.

7 MS. IBARRA: All right. Well, I'm
8 going to refresh.

9 MEMBER NOONE: This is Barrett. The
10 same situation.

11 CO-CHAIR KAHN: Okay.

12 MS. IBARRA: All right.

13 CO-CHAIR KAHN: Then, Kim is going to
14 have to fix it on our end.

15 MS. IBARRA: Okay, I'm seeing them
16 now. Okay.

17 CO-CHAIR KAHN: Oh, the votes are in.
18 The votes are in.

19 Okay, are we ready for a tally of the
20 vote, everybody? Have you got all the votes?

21 MS. IBARRA: No. Yes.

22 CO-CHAIR KAHN: Okay. Let's tally the

1 votes.

2 MS. OGUNGBEMI: Results are 59 percent
3 support, 4 percent conditional support, 37
4 percent refine and resubmit, zero percent do not
5 support. We reached the 60-percent threshold in
6 conditional support, and that is for MUC16-142 in
7 the SNF QRP.

8 CO-CHAIR KAHN: Okay, let's go to the
9 next one, whichever is the next one that you
10 want. I guess 143.

11 I think we are going to have to have
12 an Electoral College here.

13 (Laughter.)

14 MEMBER GIFFORD: These are exactly the
15 same measures with the same issues in all the
16 settings. So, I would put on the table as a
17 motion to accept that, unless people want to go
18 back and re-vote, because it is the same measure,
19 the same issues. To have different results on
20 different measures, I don't understand what that
21 means.

22 CO-CHAIR KAHN: Okay, so let me

1 clarify.

2 MEMBER GIFFORD: Internally
3 consistent, not that we seem to require internal
4 consistency, but --

5 (Laughter.)

6 MS. IBARRA: So, if we have the
7 decision as conditional support, we do want to
8 get some clarifications from the Committee on
9 what those conditions are for the conditional
10 support.

11 CO-CHAIR KAHN: To me, this is sort of
12 an awkward situation to have conditional support
13 when you are at 59 percent and 4 percent, because
14 the predominance of the body, not the consensus
15 according to the 60-percent rule, I mean, you're
16 only one -- you know, does anybody want to change
17 their vote? We could have another vote. I mean,
18 because I guess --

19 MEMBER GIFFORD: We didn't do that on
20 other measures.

21 CO-CHAIR KAHN: No, no, I understand.

22 MEMBER GIFFORD: We came up with the

1 system ahead of time.

2 CO-CHAIR KAHN: I understand. I'm
3 not --

4 MEMBER GIFFORD: But the initial
5 support is they can go forward. I think they
6 have got the feedback from everything here.

7 CO-CHAIR KAHN: Okay.

8 MEMBER GIFFORD: We talked about the
9 feedback. We have gotten it written, support. I
10 don't know what else to say, but if you are going
11 to change it and that, then --

12 CO-CHAIR KAHN: Yes, I'm with you.
13 I'm with you.

14 MEMBER GIFFORD: Then, we can go back
15 and re-vote some of the other things that were
16 close.

17 CO-CHAIR KAHN: I shouldn't have
18 brought that up. I should not have mentioned it.

19 (Laughter.)

20 Okay, but I guess there is a
21 suggestion that, since this was the vote on this,
22 that since the other three are parallel issues,

1 that we would have the same vote. And I guess
2 the question is, one, is there a motion? And
3 then, we will see whether there is any objection
4 in the motion to that effect in terms of taking
5 the rest en bloc.

6 So, Giff?

7 MEMBER GIFFORD: I'll make that
8 motion.

9 DR. HUNT: Second.

10 CO-CHAIR KAHN: Okay. Any discussion?
11 Is there anyone who objects?

12 (No response.)

13 Okay. All in favor say aye.

14 (Chorus of ayes.)

15 Anyone object?

16 Okay, so I guess we would -- oh, good
17 -- we would give conditional support, then, for
18 all four of these, with the understanding of the
19 issues that were raised in the discussion.

20 Well, no, we can't do that. I mean,
21 I think Giff was right about that because we were
22 actually at 57 percent, if I remember, on some

1 earlier ones. So, we were at the same -- I mean,
2 the issue arises that we really would have to go
3 back and readjudicate the earlier ones, which I
4 don't think we want to do.

5 DR. ANTONELLI: But I do think we
6 should clarify what the conditions are.

7 MS. O'ROURKE: Could I put a
8 strawperson out, maybe for the Committee's
9 consideration on what the condition might be?

10 CO-CHAIR KAHN: Okay.

11 MS. O'ROURKE: Perhaps the condition
12 could be that CMS work with providers to educate
13 them on the changes to the underlying data
14 elements and the proper coding procedures, as
15 well as with the public to help the people who
16 are using the Compare sites to understand that
17 the instruments have changed and they may see
18 shifts due to some of those. So, some education
19 for both providers and patients around the
20 changes to the measures.

21 MEMBER GIFFORD: And I guess the
22 additional add is looking at how unstageable and

1 people with multiple pressure ulcers might be
2 correctly or incorrectly counted in the measure.

3 CO-CHAIR KAHN: But is that
4 sufficient, Kate?

5 DR. GOODRICH: That is more helpful
6 now.

7 CO-CHAIR KAHN: Yes.

8 But, with your question -- just a
9 moment on it, Giff -- say it again what you said
10 because I don't --

11 MEMBER GIFFORD: The scenario runs in
12 when somebody gets admitted with multiple
13 pressure ulcers, it is harder to figure out what
14 is getting better and changing, the way the
15 coding is there. And the way they have
16 structured the unstageable pressure ulcer in the
17 measure is causing some confusion out there for
18 the calculation.

19 So, what I was asking for is -- I
20 completely agree with what Erin said, that
21 conditional support would be that CMS explores
22 with the measure -- I mean, I think they are

1 moving in the right direction. I think there is
2 general support here. It is just, basically,
3 going back and validating with those conditions,
4 how is the measure working there. And that is an
5 evolution of the measure over time, and
6 conditional support should not hold them up going
7 forward in putting this in rulemaking with what
8 is out there.

9 CO-CHAIR KAHN: So, you can do that?
10 Okay.

11 MR. TILLY: We will make a note of all
12 those comments --

13 CO-CHAIR KAHN: Okay.

14 MR. TILLY: -- as the conditions.

15 CO-CHAIR KAHN: Good.

16 We're moving on to the clinician
17 programs, is that right?

18 MS. O'ROURKE: So, I think if we just
19 want to do our final call for any --

20 CO-CHAIR KAHN: Oh, I'm sorry. So, I
21 need a motion for the en bloc, right, vote on the
22 other measures. And I see a motion from Giff.

1 MEMBER GIFFORD: Motion.

2 MEMBER BRYANT: Second.

3 CO-CHAIR KAHN: And a second over
4 here.

5 And anybody, any discussion of the en
6 bloc?

7 (No response.)

8 All in favor, aye.

9 (Chorus of ayes.)

10 Okay. So, the en bloc is now passed.

11 So, does that, then, finish our --

12 MS. O'ROURKE: Any other cross-cutting
13 conversation?

14 CO-CHAIR KAHN: Any other cross-
15 cutting conversation, suggestions?

16 CO-CHAIR PINCUS: I guess, also, about
17 gaps.

18 MS. O'ROURKE: Yes.

19 CO-CHAIR PINCUS: Gaps.

20 CO-CHAIR KAHN: Any gaps?

21 MEMBER GIFFORD: I would just like to
22 point out the four different PAC settings got

1 through in a third of the time that the hospitals
2 got through.

3 (Laughter.)

4 CO-CHAIR PINCUS: Actually, in terms
5 of gaps --

6 CO-CHAIR KAHN: Yes.

7 CO-CHAIR PINCUS: -- Deb, if you are
8 still on, could you say something maybe about
9 what the Workgroup received as gaps?

10 WORKGROUP CO-CHAIR SALIBA: I think
11 the gaps that were highlighted was the need for
12 increased patient-reported outcome measures, and
13 that was true across all four of the post-acute
14 care settings.

15 The need for preferences to also be
16 accounted for in measurement science better, I
17 think you have probably heard that not only in
18 post-acute care, but in all of the other
19 healthcare settings.

20 One person did bring up nutrition in
21 each one of the settings, as was mentioned in the
22 presentation earlier today.

1 And then, medication reconciliation
2 was highlighted as an important area in which
3 there are significant opportunities for improving
4 care or the lack of appropriate reconciliation
5 could lead to harm. And that had a lot of
6 consensus within the group, that that would be a
7 really important gap to be addressed.

8 And those were the that I think came
9 up across the four settings.

10 CO-CHAIR KAHN: Thank you.

11 Anybody from staff or on the phone?

12 CMS?

13 (No response.)

14 Okay, so we will, then, move on back
15 to Harold and look at the clinician program.

16 All right. I guess we want to take a
17 how many minute break?

18 CO-CHAIR PINCUS: Yes, a 15-minute
19 break.

20 CO-CHAIR KAHN: Okay. So, be back
21 here at 2:35.

22 (Whereupon, the above-entitled matter

1 went off the record at 2:20 p.m. and resumed at
2 2:49 p.m.)

3 CO-CHAIR PINCUS: So, first, we want
4 to hear about public comment on the clinician
5 programs. So, first, is there anybody in the
6 room who wants to make a public comment with
7 regard to the clinician programs?

8 So, anybody on the phone wishing to
9 make a public comment with regard to the
10 clinician programs?

11 OPERATOR: And, once again, to make a
12 public comment, please press star one.

13 And there are no public comments at
14 this time.

15 CO-CHAIR PINCUS: Okay.

16 So, Bruce, Eric, John, do you want to
17 begin to sort of walk us through some of the key
18 issues that you discussed?

19 MR. BERNOT: Sure, yes, I'll take over
20 the slides from here.

21 So, I'm John Bernot, I'm one of the
22 Senior Directors working on the Clinician

1 Workgroup.

2 So, go ahead and go to the -- one
3 more, next slide.

4 What we're going to do is actually on
5 this, even though we've not been going over the
6 actual program summaries, I'm going to spend just
7 a couple of seconds on the programs, mainly the
8 MIPS program, because it had so many significant
9 changes and it's a little bit of a different
10 animal than the other programs with it, being all
11 these different specialties.

12 In addition to that, the clinician
13 self-select subset of the measures themselves, so
14 it brings in some different issues than some of
15 the programs that are all encompassing and every
16 one's required.

17 So quickly, this was established by
18 the MACRA law in 2015 and it was a program that
19 consolidated all of Medicare's existing incentive
20 quality reporting programs for clinicians.

21 In that, there are two different
22 tracks. One of them is the Advanced Alternate

1 Payment Models and one is the MIPS. And the MIPS
2 is the specific one that we're talking about
3 here.

4 Again, they self-select the measures
5 they're going to submit to CMS. And if they
6 participate in the advanced APM model, they are
7 excluded from MIPS.

8 Go ahead, next slide.

9 This does have again, I mentioned,
10 there's four different things that it looks at.
11 It's a quality to cost, advance to care
12 information improvement activities.

13 So specifically there were 18 measures
14 that we reviewed for the MIPS program.

15 MSSP, this does not have the changes.
16 This is more of a compare and contrast. This is
17 looking at the Accountable Care Organizations so
18 more of the common than what we looked at of the
19 other programs for this. We had just one measure
20 for the MSSP program.

21 So I'm going to go over some of the
22 themes that came out of the two-day workgroup --

1 one of them was this move to high-value measures
2 and really just the inclusion of the high-value
3 measures rather than just measures in general,
4 really taking a consideration for burden.

5 They specifically stated that we want
6 to make sure that we're addressing the NQF's aims
7 and priorities.

8 The alignment with other initiatives
9 that may not be at the clinician or ACO level,
10 focus on patient outcomes, we've heard that a lot
11 today and again, sensitivity to the burden.

12 No surprise, more talk about moving
13 towards the outcomes, composites and we also had
14 the promise discussion that the workgroup really
15 found a lot of value in and might be a potential
16 tool to develop more performance-based measures
17 for patient reported outcomes.

18 The next one, again also I'll try to
19 go through this quickly because it's no surprise,
20 based on what we've heard today but attribution
21 was a big discussion.

22 And there's a couple of parts to this.

1 One of them is, are we capturing something that
2 is a team-based measure or a clinician-based
3 measure?

4 Second point, if it is a clinician-
5 based measure, is it something the clinician
6 feels that they're capable of influencing?

7 Timeliness was an interesting issue
8 that we hadn't talked about a lot. I hadn't seen
9 that came up with the timeliness of the outcome.
10 And we'll give a couple examples of that on the
11 next slide.

12 And then this double-edged sword of
13 the accountability that there needs to be
14 consideration for team-based accountability. But
15 at the same point, it also has to be attributed
16 to somebody or some entity. So an appreciation
17 that it can't just follow no one but, it may not
18 be on an individual person that's going to -- you
19 can attribute it.

20 So those were the two themes that we
21 saw. Specific to the MIPS discussions, this is
22 what the committee had talked about.

1 Again we mentioned that the high-value
2 measures but, in the outcomes there was some
3 pretty interesting caveats that came up because
4 of the difference in the program that I
5 highlighted in the MIPS.

6 Some of them are specific to the
7 clinician level. One of them being, is there an
8 adequate sample size? If we're going to look for
9 outcomes, it's one thing at a hospital level but,
10 at a clinician level did they see -- have enough
11 touches to really get up to an adequate sample
12 size?

13 The attribution again, we've talked
14 about that a number of times. Very important to
15 the -- this is the individual clinicians is
16 whether or not that clinician can make an impact
17 on the outcome there.

18 And the last one I thought was
19 interesting was the timeliness discussion that
20 came up. And I believe it was Erica, one of our
21 Chairs who brought up as a breast surgeon, the
22 actual time when you'd be able to realize how

1 good of a job he did is not days to months, it's
2 years and many -- potentially a decade down the
3 road when you're really seeing that.

4 And is that an outcome that can be
5 captured? Probably in this setting, we'd say no
6 but keeping that in mind, the timeliness of when
7 the outcome would be. So that was a good
8 discussion, I thought.

9 Also, continuing the partnership
10 because we have the specialty societies in here.
11 So measures that might be -- we want outcomes
12 but, are they outcomes that are the correct one
13 for a particular specialty? So that's something
14 we encourage this continued partnership between
15 CMS and craft and the specialty societies.

16 The last one was because of those
17 challenges that I just mentioned, when we use
18 process and when there's a need for process
19 measures, what can we do? And the use of maybe
20 considering composite measures or really tying
21 better process to outcomes on the measures. So
22 that was a discussion that came up around that.

1 We can go to the next slide.

2 Some of these are more of the themes
3 that I think we've talked about today so I'll try
4 to be brief.

5 But just addressing the gaps and
6 appropriate use was something that we had a
7 number of discussions about whether or not those
8 were being addressed.

9 Crosscutting measures, this came up
10 because of the specialties or the things that
11 would apply to all clinicians that would be good
12 markers of performance.

13 And lastly, I don't believe I've heard
14 a whole of discussion about this other than Helen
15 did make some comments about measurement science
16 in general, was this issue of topped out measures
17 again with that focus on a clinician level
18 measure that can be self-selected.

19 So when do these get removed? And
20 what's the balancing of these of removing a
21 topped out measure and also having a measure that
22 might be applicable to a specialty?

1 And then are these rates a little
2 different when you're optional? Because it is
3 really the high performers who keep selecting
4 those measures? And so is it really as topped
5 out across physicians as it might be for just
6 that subset who selected it?

7 And then just considering, would this
8 regress if we're not looking at it?

9 So all of these discussions came up in
10 the MIPS program. I think they were good and
11 maybe a little bit different than some of the
12 other programs.

13 For the MSSP, this is pretty much in
14 line with what we've heard. More outcome
15 measures, they would like the care coordination
16 focus to be on these outcome measures, especially
17 with that ACO level thinking.

18 They added specific suggestions,
19 measures of avoidable emergency department use.
20 Since they're really looking at a full spectrum
21 for emergency use to inpatient and even the
22 outpatient.

1 They specifically mentioned the desire
2 for more of the person and family engagement.

3 Also the crosscutting, they mentioned the same
4 thing about the crosscutting measures, something
5 that all clinicians would be represented by and
6 linking the quality and appropriate use.

7 So those are the themes that came up
8 with a little different spin from the two
9 different programs.

10 I'll mention just briefly a few
11 notable -- we had a few notable discussions. I
12 just thought it'd be worth bringing up.

13 This MUC 16-069, the Adult Local
14 Current Smoking Prevalence -- this was actually
15 submitted to both MSSP, this was the one measure
16 for MSSP as well as one of the 18 measures for
17 MIPS.

18 And there was a lot of discussion
19 about this, a lot of good discussion about the
20 need to engage the clinicians in this public
21 health.

22 But there was an encouragement that it

1 needs to be refined due to the attribution level.
2 This was at -- this was proposed at a county
3 level. And the attribution of this is that
4 somebody who can actually make a change on this.
5 And then also trying to look at the accuracy of
6 the data they had.

7 The next measure on here is MUC 16-
8 398. This is appropriate use criteria of
9 electrophysiology. The main reason I wanted to
10 bring this up well, there was two things.

11 One because appropriate use was a big
12 topic that came up several times throughout our
13 discussion. And really wanted to make sure that
14 the appropriate use is tied into guidelines. So
15 that was one of the topics that came up when we
16 discussed this.

17 So that's all on that one, next slide.

18 And, the last one, we had a measure
19 MUC 16-074. This was a measure about the fixed-
20 dose combination of hydralazine and isosorbide
21 dinitrate therapy.

22 This is a specific measure for self-

1 identified black or African-American heart
2 failure patients who are already on a particular
3 therapy. This is one that there was an eMeasure
4 that's been approved for trial use.

5 The workgroup did note that this is a
6 measure that could address the clinical care and
7 potential disparities and heart failure because
8 it would contract the use of a therapy that can
9 reduce morbidity and mortality in this
10 population.

11 The workgroup also raised concerns
12 that it's a measure based on fixed-dose regimen
13 and the ACC/AHA Guideline suggested individual
14 components of the combination therapy could be
15 substituted.

16 So those were the three real big
17 discussions that took a lot of time and were
18 heated discussions in the group.

19 The Dual Eligible comments, I'll just
20 go through those briefly. This is their
21 perspective on the clinician recommendations.
22 That the model of care and the incorporation

1 performance measurements of those models must
2 consider those unique needs and the preferences
3 also of the various subpopulations.

4 And they wanted to provide the
5 feedback or data on a regular basis. So I know
6 that feedback has come up specifically and they
7 actually asked even so far as to go to the data.

8 And for the PRO-PMS, they really
9 wanted these cultural language barriers to be
10 highlighted to the group. So we're thinking
11 about those and the patients' perspective on
12 whether this measure was meaningful and
13 understandable.

14 So with that, we'll go into the
15 measures. I'll turn it back over to you, Harold.

16 CO-CHAIR PINCUS: Any questions here
17 in a general way? And also secondly, I know the
18 Co-Chairs are going weigh in on to elaborate
19 further.

20 WORKGROUP CO-CHAIR BAGLEY: This is
21 Bruce Bagley.

22 I think John did a nice job

1 summarizing the discussion. If anybody has any
2 questions, I'd certainly be glad to attempt to
3 convey the conversation and some of the reasons
4 why we came to these conclusions.

5 CO-CHAIR PINCUS: Well, seeing no
6 hands raised or questions as I understand it,
7 there were two measures that have been pulled for
8 further discussion.

9 One is 16-072, Prescription of HIV
10 Antiretroviral Therapy and 16-073, HIV Medical
11 Visit Frequency.

12 And these were pulled by Amy Mullins.

13 MEMBER MULLINS: Yes, and I'm going to
14 speak to both of those kind of as a group because
15 I pulled them both for the same reason.

16 Both of these measures were included
17 in the Core Quality Measure Collaborative's Core
18 Measure Set for HIV and Hep C.

19 And so I believe they should be
20 included in MIPS with no conditional support or
21 refine and resubmit.

22 I don't know, anyone -- a show of

1 hands if you're not familiar with the Core
2 Quality Measure Collaborative work.

3 Okay so Aparna at AHIP and CMS, the
4 private insurers and, the professional societies
5 got together and said, we have way too many
6 measures measuring way too many things in a whole
7 lot of different ways. We need to come up with
8 some core sets that we all can agree on.

9 And we got around the table and we
10 hashed it out over about two years and came up
11 with core measure sets, one of which was the Hep
12 C HIV measure set.

13 And our work included these two
14 measures that I pulled that had not been
15 supported fully for inclusion into MIPS.

16 So, in the -- this word has been
17 thrown around today and Doug Henley would be so
18 happy in the spirit of parsimony and harmony, we
19 would like to put those on the table for full
20 support for the MIPS program.

21 So I would like for a re-vote. We can
22 do one vote on both measures because they are

1 both of the comments for me are the same.

2 CO-CHAIR PINCUS: John?

3 MEMBER HALL: Amy, could you maybe 30
4 seconds on whether you feel that any of the
5 concerns raised here have already been addressed
6 or what the answers might be to the concerns
7 raised here?

8 MEMBER MULLINS: I feel like we did
9 hash out all of the concerns over the course of
10 two years. Amir, Aparna, Kate, do you recall
11 the specific conclusions that we came to? Is
12 Kate still down there? I can't see.

13 So he asked if our work at the Core
14 Measure Collaborative level addressed any of
15 these specific concerns that the workgroup came
16 up with? I can't recall the exact answers.

17 CO-CHAIR PINCUS: Yes, could you just
18 clarify? So what was the vote? The
19 recommendation from the workgroup? And what were
20 the concerns?

21 MEMBER MULLINS: So in the 073, MUC
22 073 was refine and resubmit and 0972 was

1 conditional support.

2 So -- I must be looking at a
3 discussion group work from two days ago, maybe.
4 Mine says 07 -- oh, I'm looking at 07 -- I'm
5 looking at a different one, sorry.

6 So, but, they both were supported and
7 included in the core measure sets.

8 (OFF MIC COMMENTS)

9 MEMBER MULLINS: So, I pulled 072 and
10 073, so, yes, so that's 072, yes. Yes, so I just
11 have them backwards on my sheet.

12 CO-CHAIR PINCUS: Just could we get
13 just some clarity about what was the
14 recommendation from the workgroup and what were
15 the issues of concern that was expressed in the
16 workgroup? John, do you have it?

17 MEMBER MULLINS: I'm sorry. Oh --

18 MEMBER QASEEM: So, I can -- well,
19 what I remember, just to chime in over here what
20 Amy's saying and I'm going to take one by one,
21 guys. There's so many numbers over here, I'm
22 getting confused. So, I've been confused all

1 day.

2 So 16-072, that's about the
3 Antiretroviral Therapy, is that the correct one?
4 I do remember the discussion we had concerning
5 the new guidelines that everyone should be
6 getting the treatment if they follow the current
7 guideline recommendations. That's the bottom
8 line summary, if I have to summarize it.

9 So I do think it addresses all the
10 workgroup concerns. So I'm not really sure why
11 this was actually -- why it's resubmit?

12 CO-CHAIR PINCUS: What were the
13 workgroup concerns? That's the question.

14 MR. BERNOT: Yes, I'll go through them
15 one by one.

16 So there was different concerns on the
17 two. The first of all --

18 MEMBER QASEEM: So just one by one, do
19 you mind just taking one by one?

20 MR. BERNOT: I'm going to do one by
21 one, correct.

22 MEMBER QASEEM: Perfect.

1 MR. BERNOT: Yes, so I'm going to
2 start with 072.

3 There was two issues on this. The
4 first one so to clarify, this is the eMeasure
5 version of the existing claims-based measure.
6 Both of these are eMeasures.

7 So the concerns were twofold on 072.
8 The first one was whether this supports
9 alignment. And in the final rule that came out,
10 the corresponding non-eMeasure, the claims-based
11 measure was pulled, the corresponding 072.

12 So it did not support alignment
13 anymore. That was the first part of the
14 discussion.

15 The second one was that as it's an
16 eMeasure, it had not been fully tested as an
17 eMeasure yet. And so it was to wait until the
18 eMeasure testing had been complete. So that's
19 072.

20 CO-CHAIR PINCUS: Could somebody
21 clarify what's the status of the eMeasure
22 endorsement process?

1 MR. BERNOT: So that is it's in the
2 process right now. Oh, I'm sorry.

3 MS. MARINELARENA: Hi, Melissa
4 Marinelarena again.

5 So I'm working on the infectious
6 disease project that these measures have been
7 submitted to. We're in the process of doing the
8 preliminary analysis. Our in-person meeting is
9 March 14th, I believe, a one-day meeting. So,
10 all of the eMeasures will be -- that are new to
11 us will be evaluated then with recommendations,
12 including the original paper case measures.

13 MEMBER QASEEM: So Harold, can I ask
14 a clarification question? All the measures that
15 are eMeasures that are reviewed by MAP, aren't
16 they always tested before they come for our
17 internal for approval? So why is that an issue?
18 I mean, that's why, first, this is a two part
19 question.

20 The first is are all eMeasure tested?
21 And, if they're not, then why would this be an
22 issue with this specific eMeasure? Why do we

1 have to wait?

2 CO-CHAIR PINCUS: We don't have to
3 wait. We can make a -- we can make whatever
4 recommendation we want.

5 MEMBER QASEEM: I'm talking about the
6 workgroup recommendation. They used as a logic
7 that why did it even come up? What was the --

8 CO-CHAIR PINCUS: But you know, but
9 eMeasures do have to go through the regular
10 endorsement process. There's a sort of separate
11 -- there's kind separate -- a track for it, but
12 they do have to go through the endorsement
13 process to get endorsed.

14 MEMBER MULLINS: Point of clarity.
15 I'm sorry. The numbers are confusing and I was
16 confused.

17 So, the one that we -- that I should
18 have pulled, 073 should have pulled. I would
19 retract my pull of 072 and replace it with 075.
20 That is the one that I should have pulled.

21 So 073 and 075, I retract 072. 072 is
22 not in the core set, 075 is the core set, the HIV

1 viral suppression.

2 MS. MARINELARENA: So the status is
3 the same for that one, the original measure has
4 been submitted and I believe for that one,
5 there's the -- this is the eMeasure and that has
6 also been submitted.

7 MEMBER MULLINS: So, my comments are
8 the same?

9 MEMBER HIGGINS: Sorry, so, was this
10 the recommendation on just the eMeasure part of
11 it or the measure itself?

12 MS. MARINELARENA: This is the
13 eMeasure that you have before you. So only the
14 eMeasure version of the paper-based measure was
15 submitted to the program because the other ones
16 are the original measures, the paper measures,
17 are already in the program except for the one
18 that final rule has removed it from MIPS.

19 But the eMeasures and from an NQF
20 standpoint, we review eMeasures based on paper-
21 based measures separately. So we consider them
22 two separate measures. So you're only looking at

1 the eMeasures right now.

2 They're already endorsed, yes.

3 They're in the core set and already -- yes, in
4 different programs. One is being removed from
5 MIPS, as John stated.

6 CO-CHAIR PINCUS: Now let's -- let's
7 just get clear. So we have the -- so what
8 you're polling is the 16-073 and 16-075, okay?
9 And my understanding that for the 075, that is an
10 eMeasure that is in the queue for evaluation for
11 endorsement in March.

12 MS. O'ROURKE: 075, isn't that NQF
13 2082 paper and it's the claims measure?

14 CO-CHAIR PINCUS: Well is it the same
15 or is it the eMeasure version? Again, just
16 trying to get clarity.

17 MR. TILLY: So what's in here -- so,
18 let's just be really specific now.

19 16-075, which is the HIV Viral
20 Suppression measure, as far as the measure
21 specifications that are included here, we have
22 data source includes stated by HHS, the

1 administrative claims data or administrative
2 clinical data claims, paper records and record
3 review. That's what I'm -- that's -- and it's
4 NQF's 2082.

5 CO-CHAIR PINCUS: So --

6 MR. AMIN: John, is that correct? I
7 just want to be clear because this is not -- now,
8 we're talking about a new measure, just want to
9 be specific.

10 CO-CHAIR PINCUS: Well, so, let me be
11 clear. So this is not an eMeasure and it is not
12 an already endorsed measure?

13 (Off-microphone comments.)

14 CO-CHAIR PINCUS: Okay, so, yes, so,
15 I'm trying to get clear about this.

16 WORKGROUP CO-CHAIR BAGLEY: Harold,
17 this is Bruce Bagley.

18 If I remember correctly, I don't think
19 the committee had any problem with either one of
20 these measures as a measure. The real problem is
21 that they haven't been properly tested and
22 evaluated in the real life situation.

1 So I think that's really the only
2 hurdle.

3 PARTICIPATE: Their issue that was in
4 the report was whether a gap existed.

5 CO-CHAIR PINCUS: Okay. But let's --
6 before we start getting comments, I just want to
7 get clarity about what it is -- what's the issue,
8 okay?

9 So the issue for -- so let's start
10 with I guess, 16-075. So the issue here is that
11 that is -- is that or is that not an already
12 endorsed measure?

13 MEMBER BAKER: John, do you mind just
14 walking through the conditions that are --

15 CO-CHAIR PINCUS: So wait, let's get
16 clear. Is it or is it not an endorsed measure?

17 (Off-microphone comments.)

18 CO-CHAIR PINCUS: Okay, okay, so, it's
19 an endorsed measure. And let's not -- and, has
20 been proposed by CMS is the use of that endorsed
21 measure, Kate?

22 (Off-microphone comments.)

1 CO-CHAIR PINCUS: Yes, that -- what
2 you're proposing in the MUC is the use of that
3 already endorsed measure? Oh, the eMeasure?

4 DR. GOODRICH: We already have the
5 non-eMeasure form of these measures in our
6 programs. This was to put the eMeasure form,
7 which is in the process of being tested and so
8 forth by HRSA so that they could be included in
9 the program as well.

10 CO-CHAIR PINCUS: Okay. So, what
11 you're proposing is the eMeasure version --

12 DR. GOODRICH: Correct.

13 CO-CHAIR PINCUS: -- to be included.
14 It's not yet endorsed, but it's in the queue?

15 DR. GOODRICH: It's eMeasure form is
16 not yet endorsed, right?

17 (Off-microphone comments.)

18 DR. GOODRICH: I'm pretty sure, that
19 is -- okay, yes. It's coming to you guys soon.

20 CO-CHAIR PINCUS: Okay.

21 DR. GOODRICH: Yes.

22 CO-CHAIR PINCUS: So, we're clear

1 about the current status of it. So what were the
2 issues that were raised?

3 MR. BERNOT: Okay so I can go through
4 --

5 CO-CHAIR PINCUS: And was it
6 conditionally supported?

7 (Off-microphone comments.)

8 MR. BERNOT: So I'll go through those.
9 There's two different measures. So 07 --

10 CO-CHAIR PINCUS: Let's just start
11 with the -- let's just do 075.

12 MR. BERNOT: 075, okay. 075 is
13 conditionally supported. And the issues were
14 even though the same issues came up, the reason
15 the committee and Bruce or Erica can weigh in on
16 this, the reason the committee went with
17 conditional support on this was because of the
18 fact that it was an outcome measure and they
19 wanted to have -- the outcome was one of the
20 issues that came up.

21 It was the same testing issues though.
22 It still has not been through and the condition

1 was that it passes the -- or completes the
2 eMeasure part of the endorsement process. So
3 that was 075.

4 CO-CHAIR PINCUS: Okay. So let's
5 discuss that first. So all right, do people want
6 to discuss that 075?

7 Carl?

8 MEMBER SIRIO: I mean my comments will
9 be relatively simple. One is, it gets me a
10 little uncomfortable when we have a group this
11 size trying to figure out what we're even talking
12 about. That leads to a potentially disservice to
13 the work that's been done in terms of the clarity
14 of the question, to your point.

15 The second thing is, I think that the
16 testing issue is a real one insofar as -- I mean
17 that's one of the principles that we have really
18 upheld over time which is, is that the wisdom of
19 a process, at least with true testing in a field
20 where the implications are real.

21 So the bottom line is, I would submit,
22 that the workgroup did a lot of legwork on this

1 with clarity, I know we support the workgroup for
2 this and the second measure.

3 CO-CHAIR PINCUS: Other comments?
4 Rhonda?

5 MEMBER ANDERSON: I think we have seen
6 this question from a very large number of
7 workgroups when it's going for e-testing that
8 they want to be certain that the testing is
9 completed.

10 A question that I have is, if we have
11 any data on those that have been already endorsed
12 on paper and now have gone for e-testing, is
13 there a correlation or a percentage that with the
14 e-test issue that they actually are -- they have
15 issues or problems?

16 I'm not quite sure what the results
17 have been when they've gone for e-testing. So I
18 just wondered if anybody has that information?

19 DR. BURSTIN: I don't think we have
20 any --

21 MS. MARINELARENA: No, we don't. So
22 that will be a discussion that the standing

1 committee has in March.

2 Now just to make things a little more
3 confusing, we consider these legacy measures, the
4 eMeasures. Right? Because they're based on
5 existing paper-based measures that are in a
6 federal program.

7 So our testing requirements are a
8 little bit different. We will not have
9 performance. They're not in use yet, of course.
10 We don't have any performance rates for them.

11 I know that HRSA is in the process of
12 testing them. We will -- we accept only -- we
13 accept, at a minimal, Bonnie testing or using
14 synthetic patients. So, I believe that's what
15 we're going to be looking at. We haven't
16 finished looking at our preliminary analysis yet.

17 For a legacy measure, that is the
18 minimum that we require is Bonnie testing. This
19 is the conversation that standing committees have
20 every time, if you care to join us about the
21 correlation between a paper-based measure and an
22 eMeasure. But that discussion I'm sure, will be

1 had in March. But we don't have that information
2 right now.

3 CO-CHAIR PINCUS: Aparna?

4 MEMBER HIGGINS: So do we have a sense
5 for when HRSA might finish their testing or do --

6 DR. BURSTIN: Well it's being -- I
7 mean, it's being submitted to us for review in
8 March. So this is eminent.

9 MEMBER HIGGINS: Oh, okay.

10 DR. BURSTIN: And also you know --
11 again, David can certainly speak to this, but
12 laboratory data is readily available on a
13 eMeasure. So I can't imagine it's a huge lift
14 compared to some other potential eMeasures --
15 with actually not large requirements because it's
16 a legacy eMeasure.

17 Now new de novo eMeasures have a much
18 higher lift than legacy measures.

19 MEMBER HIGGINS: Okay. Well, I think
20 I just want to -- you know echo what Amy said
21 about alignment with the Core Measures
22 Collaborative. And you know -- the importance of

1 making sure that you know -- public and private
2 programs, we have the same set of measures.

3 So I think there was a question
4 earlier about gaps in performance, I can't
5 remember who raised it I mean -- we had -- and
6 Amy can correct me and Kate as far as these
7 discussion too, we had some of those discussions
8 in the HIV Hep C Workgroup when we were going
9 through the Core Measures Collaborative.

10 We actually had physician
11 representatives from both HIVMA as well as the
12 Infectious Disease Society. And, these were
13 practicing physicians as well and they talked
14 about how they do see variations in care and
15 practice and they had cited some studies which I
16 don't remember right now, which is one of the
17 reasons why we had included these measures in our
18 core set.

19 So, I wanted to share that as well.

20 CO-CHAIR PINCUS: So Amy, are you
21 still proposing that we re-vote on this?

22 MEMBER MULLINS: If this is a

1 conditional support and the condition being that
2 it passes the eMeasure specs, then I am okay with
3 that on 075.

4 CO-CHAIR PINCUS: Okay. Sounds like
5 that's the way it is.

6 MEMBER MULLINS: Okay.

7 CO-CHAIR PINCUS: Okay, Bruce?

8 MEMBER HALL: And I just want to
9 confirm them because the workgroup did ask
10 whether performance gaps continue to exist. So
11 Aparna has weighed in on that and I'm wondering,
12 does the existing paper legacy measure also weigh
13 in, that there are still gaps?

14 MS. MARINELARENA: So for the
15 maintenance measure which is the paper-based
16 measure, we do require performance over time.
17 They have submitted that information to us.
18 We're in the process of doing the initial
19 analysis and then giving it to the committee.
20 The committee will talk about it. But without
21 looking at all of them, there probably is a gap.

22 And then we also asked for, once a

1 measure is topped out often, we'll ask -- we look
2 at the -- for you know, gender, race, is there
3 different gaps looking at that? So they've
4 provided a lot of information, we're in the
5 process of analyzing it.

6 CO-CHAIR PINCUS: David?

7 MEMBER BAKER: I think that last point
8 was really important that, for determining
9 whether a gap exists, it's the old chart-based
10 measures. Because if we're seeing a gap on the
11 eMeasures, that's a pseudo-gap. That's a problem
12 with the eMeasures.

13 And that's what we've seen with some
14 of the measures that have been submitted on a
15 pilot basis to the Joint Commission. You know --
16 organizations that were at 99 percent, 99
17 percent, 99 percent and then, all of a sudden
18 they're well less than 95 percent on the
19 eMeasures.

20 CO-CHAIR PINCUS: So sounds like we
21 can move on to consider actually 16-073.

22 MR. BERNOT: Sure. I can give the

1 brief introduction.

2 So 073, this is the same situation,
3 the eMeasure of an existing measure. This was
4 given a different assignment though. This one
5 was given refine and resubmit, not the
6 conditional support that 075 had.

7 So even though it's in the same
8 situation and again, I'll ask Bruce and/or Eric
9 if they'd like to contribute but, my
10 understanding of the discussion was that they
11 felt that the outcome measure, one -- that they
12 wanted to get the outcome measure moving. They
13 wanted to take more time on the process measure.
14 And that was the difference.

15 Otherwise, it's in the same exact
16 stage of testing, same time we'll have the
17 testing data back that Melissa already mentioned.

18 CO-CHAIR PINCUS: So what exactly was
19 the problem with it as a process measure that
20 there was some inadequacy of the data in support
21 of it?

22 MR. BERNOT: No, there's no difference

1 in the adequacy of the data between the two.
2 That's just my recollection of the discussion.
3 But again, I'd rather if Bruce or Eric wants to
4 say anything to make sure that you recall this
5 the same way that I do.

6 WORKGROUP CO-CHAIR BAGLEY: Yes, this
7 is Bruce.

8 I think the main thing was that if
9 you're successful on 075, it's not as important
10 whether they went once to the doctor or 20 times
11 to the doctor. If they have viral load
12 suppression, they had to go to the doctor to get
13 that done.

14 WORKGROUP CO-CHAIR WHITACRE: This is
15 Eric.

16 And I do recall that that was the
17 emphasis of the discussion. I also don't
18 remember, and I may just have forgotten the issue
19 about the consensus core set.

20 As I recall, that didn't come up
21 because we do want to be sensitive to alignment
22 and other measurement programs. And I just don't

1 remember if that was mentioned.

2 MR. BERNOT: Eric, just to clarify,
3 that was just for 072 and she withdrew that one,
4 the alignment issue. So we're okay on that.

5 WORKGROUP CO-CHAIR WHITACRE: Oh, I
6 see, okay, okay.

7 MS. MARINELARENA: Sorry, this is
8 Melissa again.

9 And another clarifying, CDP process is
10 we review the legacy measures first. If it fails
11 on any of the must-pass criteria such as
12 evidence, which could be -- you know the case
13 here or gap, then the legacy or the eMeasure
14 version would not pass as well.

15 MEMBER MULLINS: Can I move that we
16 vote on this? And I would like to submit that
17 this get conditional support much like 075?

18 CO-CHAIR PINCUS: Chip?

19 CO-CHAIR KAHN: This whole discussion
20 has gotten so much in the weeds, my mind has
21 trouble getting in there.

22 But I think it really is important

1 here that we just keep in mind two things. You
2 know -- one thing is, I guess, does it
3 technically work?

4 And two, beyond it technically
5 working, which I guess the Bonnie thing
6 determines whether if it fits the logic, does it
7 work in such a way that isn't a problem
8 considering how EHRs work?

9 And I don't know -- I don't have a
10 complete sense that the second is completely
11 confirmed in these cases, even if the first is.

12 On the other hand, you know I'll go
13 with the flow, but I think we have to be very
14 careful when we're converting or moving from
15 measures that are accepted and used in one area,
16 you know, into EHRs because it -- the transfer,
17 even if all the work is done on the very
18 technical side doesn't necessarily carry.

19 So I think we have to be really
20 careful here. But that's all I have to say. I
21 don't think there's anything else to add.

22 CO-CHAIR PINCUS: Yes so I think for

1 this issue, the question is -- as I see it is,
2 you know, is it, you know -- if the other
3 measures or the other viral load measure actually
4 passes you know, gets endorsement, is this really
5 necessary?

6 MEMBER MULLINS: Yes.

7 CO-CHAIR PINCUS: Yes, that's the
8 issue.

9 MEMBER MULLINS: Yes, because it's
10 core set.

11 DR. BURSTIN: Right, but I think MAPS
12 specifically talked about it in the context of,
13 if you have an outcome measure, do you still need
14 the associated process measure? And that came up
15 multiple times during the earlier MAP work with
16 their discussions as a MACRA initiative.

17 CO-CHAIR PINCUS: So let's let Amir go
18 and then you, Kate, in case there's a response
19 you have to make to that.

20 MEMBER QASEEM: So this measure has
21 got problems beyond this. This is not the
22 current standard anymore. I don't know if you

1 guys noticed or not.

2 The two CD4 counts is not normal with
3 the current standard. So I think we need to go
4 back and look at the basic evidence behind it and
5 actually look at the newer --

6 CO-CHAIR PINCUS: Which measure are
7 you referring to?

8 MEMBER QASEEM: It's not 16-073?

9 CO-CHAIR PINCUS: No. Yes, that's
10 visit frequency.

11 MEMBER QASEEM: Okay, hold on, let me
12 just --

13 WORKGROUP CO-CHAIR BAGLEY: It is
14 actually viral load and not CD4 count.

15 CO-CHAIR PINCUS: Yes, right, and
16 that's what we're discussing.

17 MEMBER QASEEM: So that's what I'm
18 talking about that you're not supposed to come
19 and get the CD4 count on every visit. You're
20 supposed to actually follow up with a consistent
21 viral load suppression over the forms or any
22 other virtual visits or something like that.

1 This is actually not evidence-based
2 measure any more. So it's beyond that discussion
3 we are having right now.

4 DR. GOODRICH: But I think that's a
5 discussion for the NQF Endorsement Committee, for
6 one. I mean -- I'm not disagreeing with you on
7 that, I don't know the evidence at the tip of my
8 fingers, but I think that that's --

9 MEMBER QASEEM: So if we approve this
10 measure, then it's going to get implemented,
11 right? So, we have to --

12 DR. GOODRICH: Well I mean, we have a
13 condition for NQF endorsement and this one where
14 it would be very critical to go because they're
15 eMeasures to go through the testing, which is
16 what we're waiting on primarily I think before it
17 goes through endorsement.

18 The other comment I wanted to make on
19 this one that I recall from the conversation in
20 the Core Measures Collaborative, but Aparna,
21 correct me if I'm wrong, because this came --
22 this issue came up about, if you've got the

1 outcome measure, why do you need this one?

2 I think the points that were made by
3 people around the table during that discussion
4 was, for the viral load suppression measure, in
5 your denominator, you have to have people that
6 you're seeing and drawing blood on.

7 And there's definitely a quality
8 problem or a quality gap within the HIV community
9 and I think a lot of folks felt like this was
10 particularly the case in FQHCs and other types of
11 clinics that serve you know, low income
12 vulnerable populations that just getting people
13 in to see clinicians to even get tested was just
14 a major first hurdle.

15 And so, because there was a gap in
16 that measure, as was described to us at the time,
17 they felt like that having this measure was still
18 needed.

19 Now I don't want to quibble with you
20 over the evidence, you may well be right in that
21 maybe that we shouldn't go forward with this
22 measure. But I think we'd need more review of

1 that to understand.

2 MEMBER QASEEM: So what I was
3 suggesting was we can keep it as refine and
4 resubmit and let the group address this issue
5 because I don't think we will be able to resolve
6 it over here.

7 DR. BURSTIN: Although that's what we
8 do conditional support for. If we know this is a
9 measure that's coming forward, it could be
10 conditional. I think that's the point.

11 CO-CHAIR PINCUS: Aparna?

12 MEMBER HIGGINS: So to -- I'd echo
13 with what Kate said and that's exactly the
14 discussion our HIV Hep C Workgroup had. And
15 again, it was a lot of them were clinicians who
16 you know, specialists who were treating patients
17 who had seen this and saw this as a problem,
18 which is why we included both measures in our,
19 you know, in our core set.

20 So I would agree with Amy that you
21 know, given that the other measure was
22 conditional support and this is going through

1 ECQM testing, we should consider this in the same
2 way.

3 CO-CHAIR PINCUS: So you're proposing
4 that we pull it and we re-vote. Now if we're
5 voting for conditional support, we're talking
6 about it going -- it is up for review, correct?
7 As an eMeasure or as a paper measure? Both? As
8 both?

9 MS. MARINELARENA: But the one before
10 you right now is the eMeasure for now.

11 CO-CHAIR PINCUS: Right. But it's
12 coming up for review in March as well. So why
13 don't we vote with the understanding that that's
14 the condition, if we vote for conditional
15 support?

16 MS. OGUNGBEMI: All right, voting is
17 open. We are voting on MUC 16-073, HIV Medical
18 Visit Frequency in the MIPS Program.

19 Your options are one, support, two,
20 conditional support, three, refine and resubmit,
21 four, do not support.

22 Voting is open.

1 MEMBER GIFFORD: I'm abstaining from
2 voting for a conflict of interest.

3 MS. IBARRA: Brandon, Dora, Eric,
4 Foster and Steve, we received your votes, thank
5 you.

6 MS. OGUNGBEMI: Results are 4 percent
7 support, 65 percent conditional support, 26
8 percent refine and resubmit and 4 percent, do not
9 support.

10 Our 60 percent threshold is met and
11 conditional support.

12 CO-CHAIR PINCUS: Any further
13 discussion about any of the measures on the -- in
14 the clinician group?

15 MEMBER QASEEM: The couple of
16 measures, if I can just hear some of the
17 comments, one is the 16-398, the Cardiac
18 Electrophysiology. I think it's refine and
19 resubmit and I just wonder, I wasn't really
20 clear, why is that refine and resubmit?

21 I think it seemed like, at least to
22 me, it's a great measure. There's a lot of

1 inappropriate use. It's incredibly expensive.
2 It's evidence-based based on the current
3 guidelines by ACC and AHJ.

4 CO-CHAIR PINCUS: Could you repeat
5 what measure that was?

6 MEMBER QASEEM: It is 16-398.

7 DR. BURSTIN: No testing data has been
8 done yet, yes.

9 MEMBER QASEEM: The second one I
10 wanted to ask is just, give me one second, let me
11 get the right number here, guys. This is -- it's
12 16-287. It is the, hold on, I'm scrolling down,
13 it's the bone density one.

14 So that again, is it the duration?
15 Because again it's -- because it seems like it
16 would improve clinical outcomes based on the
17 guidelines as well. It's evidence-based. It's
18 here, I read as a good measure.

19 MR. BERNOT: There was -- so there are
20 two issues on that, the data was the big one.

21 MEMBER QASEEM: It's the same issue as
22 --

1 MR. BERNOT: The second one was the
2 populations, that whether inclusion or exclusion
3 of populations were adequate.

4 MEMBER QASEEM: Okay. Sorry, and my
5 list is long. Sorry guys, but we have until 5:00
6 to discussion clinical measures right, clinician
7 measures?

8 16-069, the smoking one -- I was
9 surprised that it didn't go through. Can you
10 just tell me what happened?

11 MR. BERNOT: Yes, just the -- this was
12 the attribution issue, plus testing data. This
13 was the county level attribution that whether an
14 individual clinician or, even in the case, so
15 that was for the MIPS side, could influence that.

16 Or whether the ACO and the MSSP could
17 effectively be held accountable for that measure.

18 MEMBER QASEEM: Okay. But it is a
19 MIPS measure though, right?

20 That's it.

21 CO-CHAIR PINCUS: Okay. Now we do
22 have one public commenter that was unable to get

1 through earlier. And so can we hear from that
2 public comment?

3 OPERATOR: Okay, and the comment comes
4 from Soeren Mattke.

5 DR. MATTKE: Hi, can you --

6 CO-CHAIR PINCUS: Hi, Soeren, it's
7 Harold Pincus.

8 DR. MATTKE: Hi.

9 CO-CHAIR PINCUS: Can you --

10 DR. MATTKE: Hi, Harold.

11 Yes, Soeren Mattke, SRM. We have the
12 developers of 16-151 which received conditional
13 support by the workgroup and the conditional
14 support was pending the clarification of one
15 question. I wanted to do that.

16 The measure which is NQF endorsed
17 looks at whether patients receive risk assessment
18 for febrile neutropenia prior to assumption of
19 chemotherapy.

20 And the question that the workgroup
21 had was whether a protocol-based risk assessment
22 system would meet our criteria? And our answer

1 is yes, if that system gives appropriate
2 consideration to both patient level and regime
3 level risk factors.

4 The rationale is that current
5 guidelines recommend use of CSF prophylaxis to
6 avoid febrile neutropenia if the expected risk of
7 febrile neutropenia is greater than 20 percent.

8 That risk depends, on the one hand, on
9 the inherent toxicity of the chemotherapy regime
10 but also on patient risk factors like age, prior
11 treatment and, comorbidity.

12 So you're going to have regimes where
13 you have an inherent toxicity risk always greater
14 than 20 percent just because the drugs are that
15 toxic. But there are also regimes for which the
16 risk will be above 20 percent only if you are
17 talking about higher risk patients like elderly
18 or frail patients.

19 So our answer is, if a protocol system
20 is able to incorporate both the regimen level and
21 the patient level factors, it is perfectly
22 compliant with how we specified the measure.

1 We want to make one other
2 clarification. The workgroup correctly pointed
3 out that the measure will make it more likely
4 that patients with higher risk receive beneficial
5 CSF prophylaxis.

6 But we wanted to emphasize that the
7 measure will also make it less likely that lower
8 risk patients receive an extensive treatment with
9 potential side effects and potentially low value.

10 And for those reasons, we would
11 request that you reconsider and re-vote on the
12 measure to give it full level unconditional
13 support.

14 Thank you.

15 CO-CHAIR PINCUS: Thank you, Soeren.

16 Is there comment, discussion from the
17 task force or from the coordinating committee?

18 Is there a move to make any change?

19 Okay. Any other comments on any other
20 issues from the task force, from the coordinating
21 -- yes, I'm going back to my Medicaid task force
22 role.

1 Okay, well, so we pretty much finished
2 then, the agenda for today.

3 DR. BURSTIN: We have the consent --

4 CO-CHAIR PINCUS: Oh, yes, the consent
5 calendar, right.

6 So, we'll accept people want to --
7 anybody want to nominate the acceptance of the
8 consent calendar?

9 MEMBER SAKALA: So moved.

10 CO-CHAIR PINCUS: Okay. All in favor?

11 (Chorus of ayes.)

12 CO-CHAIR PINCUS: Opposed?

13 (No response)

14 CO-CHAIR PINCUS: Okay so we finished
15 our agenda for today. So Erin, do you wanted to
16 discuss what -- how things are going to go
17 tomorrow?

18 MS. O'ROURKE: Sure. So for tomorrow,
19 we are actually going to focus more on some
20 crosscutting issues that arose from the
21 workgroup's deliberations.

22 First, we're going to present some of

1 the findings of NQF's recent attribution expert
2 panel. As John was noting in his presentation,
3 we heard a lot of concerns about how MAP should
4 be handling attribution issues. And in
5 particular, who has the locus of control for a
6 measure and a patient's outcome.

7 So we wanted to highlight some of the
8 findings of that committee to perhaps allow the
9 coordinating committee to give some more guidance
10 to the workgroup on concerns about attribution.

11 We also will have an update on the
12 Medicaid Task Forces. In particular, we're doing
13 some work to improve that process that we need
14 approval from the coordinating committee.

15 In particular, John is going to show
16 you a preliminary analysis algorithm that the
17 task forces would be using, similar to what the
18 workgroups used for the pre-rule making
19 recommendations.

20 We want to ensure that MAP's doing all
21 of its work as consistently as possible.

22 We will also have presenters from ASPE

1 here to share with you some of the findings from
2 the Impact Act study.

3 I will also be giving an update on
4 NQF's trial period for risk adjustment for SDS
5 factors. And we'll be looking for discussion and
6 any thoughts the coordinating committee might
7 have on a potential path forward on that issue.

8 We know we are unlikely to resolve
9 such a topic but, did want to keep you abreast of
10 developments in the field and potential
11 implications for MAPs work.

12 And then finally, in the spirit of
13 process improvement, we'll be having a session to
14 get feedback from the committee on what worked
15 and what didn't and, some areas where we'd like
16 guidance from the coordinating committee to
17 improve the process for next year's approval
18 making work just to get you think about that.

19 In particular, we welcome some
20 comments on how we can better clarify the
21 distinctions between the decision categories.
22 We'd also welcome any thoughts you have on how we

1 could better do the review of the measures that
2 are currently in the program set in particular,
3 what's the most useful information that MAP
4 members need to make recommendations on the
5 measures that are currently in the sets.

6 And then finally, we'll be sharing
7 with you some information on the feedback loop
8 pilot that we tested with the post-acute care,
9 long-term care workgroup this past fall as a way
10 to keep MAP up to date on some of the
11 developments that have happened to the measures
12 since MAP has made their recommendations as a way
13 to show that we are getting progress on some of
14 the refines and resubmits, if you will.

15 So we want to hopefully roll that out
16 across the workgroups. So we'd welcome input
17 from the coordinating committee members on how we
18 can do that most effectively.

19 So that's all for tomorrow but did
20 want to just put some of those issues in your
21 minds for mulling over tonight.

22 Helen, anything else?

1 CO-CHAIR PINCUS: So you have a little
2 bit of extra time. And want to thank NQF staff,
3 thank the committee, thank my Co-Chair Chip and
4 also the workgroup Chairs, as well.

5 We will reconvene tomorrow morning at
6 breakfast at 8:30.

7 (Whereupon, the above-entitled matter
8 went off the record at 3:40 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Coordinating Committee Meeting

Before: National Quality Forum

Date: 01-24-17

Place: Washington, DC

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
true and accurate record of the proceedings.



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NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE MEETING

+ + + + +

WEDNESDAY,
JANUARY 25, 2017

+ + + + +

The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, NW, Washington, DC, at 9:00 a.m., Charles Kahn and Harold Pincus, Co-Chairs, presiding.

PRESENT:

CHARLES KAHN III, MPH, Co-Chair
HAROLD PINCUS, MD, Co-Chair
RHONDA ANDERSON, RN, DNSc, FAAN, American
Hospital Association
DAVID BAKER, MD, MPH, FACP, The Joint Commission
MARY BARTON, MD, National Committee for Quality
Assurance
JOHN BOTT, MSSW, MBA, Consumers Union
MARY BETH BRESCH WHITE, American Nurses
Association
STEVE BROTMAN, MD, JD, AdvaMed*
JENNIFER BRYANT, MBA, Pharmaceutical Research and
Manufacturers of America (PhRMA)
CAROLE FLAMM, MD, MPH, Blue Cross Blue Shield
Association
FOSTER GESTEN, MD, FACP, National Association of
Medicaid Directors*

BRUCE HALL, MD, PhD, MBA, FACS, American College
 of Surgeons
 APARNA HIGGINS, MA, America's Health Insurance
 Plans
 BRANDON HOTHAM, MPH, Maine Health Management
 Coalition*
 WILLIAM KRAMER, MBA, Pacific Business Group on
 Health
 SAMUEL LIN, MD, PhD, MBA, MPA, MS, AMGA
 AMY MULLINS, MD, FAAFP, American Academy of
 Family Physicians
 R. BARRETT NOONE, MD, FACS, American Board of
 Medical Specialties*
 SHAUN O'BRIEN, JD, AFL-CIO
 AMIR QASEEM, MD, PhD, MHA, American College of
 Physicians
 CHRIS QUERAM, MS, Network for Regional Healthcare
 Management
 ARI ROBICSEK, MD, Providence Health and Services
 KORYN RUBIN, American Medical Association (for
 Carl Sirio)
 CAROL SAKALA, PhD, MSPH, National Partnership for
 Women & Families
 MARISSA SCHLAIFER, RPh, MS, Academy of Managed
 Care Pharmacy
 STEVEN WOJCIK, MA, National Business Group on
 Health*

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, MS
 DORIS LOTZ, MD, MPH*

FEDERAL GOVERNMENT LIAISONS PRESENT:

DAVID HUNT, MD, FACS, Office of the National
 Coordinator for Health Information
 Technology (ONC)
 NANCY WILSON, MD, MPH, Agency for Healthcare
 Research and Quality (AHRQ)

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ELISA MUNTHALI, Vice President, Quality
Measurement
MARCIA WILSON, Senior Vice President, Quality
Management
TAROON AMIN, NQF Consultant
KIM IBARRA, Project Manager
YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst
ERIN O'ROURKE, Senior Director
DEBJANI MUKHERJEE, Senior Director

ALSO PRESENT:

NANCY DE LEW, ASPE/HHS*
KATE GOODRICH, MD, CMS
RENEE FOX, MD, CMS*
KAREN JOYNT, MD, MPH, ASPE/HHS*
ROBIN YABROFF, ASPE/HHS*
PIERRE YONG, MD, CMS
RACHEL ZUCKERMAN, ASPE/HHS*

* present via telephone

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P-R-O-C-E-E-D-I-N-G-S

9:09 a.m.

CO-CHAIR KHAN: So I think we have the same crew. I think Gif had some family issue or something, had to leave. But pretty much the same crew as yesterday. It's really great having entertainment.

I thank the NQF staff for providing that. I feel like when I was be in high school, I grew up in New Orleans and we would out in August doing football practice, and you know it was like 95 degrees. But, you know, in terms of the real heat it was probably 120.

The coaches would yell and scream that this was fun in the sun. People paid thousands of dollars for this, and we were getting it for free. So since all of you are paying so much to come today, are being paid so much to come today, either way you look at it, we've given you free entertainment up here.

So I hope everybody got their before pictures and we'll see what happens in terms of

1 when the -- we can take a break when the banner
2 comes down and everybody can go take their after
3 pictures.

4 So moving on, I think in terms of
5 yesterday, I guess what is there to say but we
6 accomplished most of the major areas, and went
7 through a number of measures and had votes, and I
8 think successfully completed a good bit of our
9 task. I don't know what -- do you want to add
10 anything?

11 CO-CHAIR PINCUS: No, I think we did
12 a great job yesterday. I think we've gone
13 through everything, had a complete discussion. I
14 think the discussion we had yesterday will inform
15 some of the discussion planned for today, in
16 terms of thinking about some of issues around
17 attribution.

18 We're going to get an update about
19 some of the Medicaid processes which are being
20 conformed to be more closely with how we've been
21 operating in terms of the Coordinating Committee,
22 and we're also going to hear about some of the

1 issues around various risk-adjustment scenarios.

2 CO-CHAIR KHAN: So just without
3 further ado, why don't we, I guess Harold will
4 facilitate this, but we go to Erin and Helen now
5 for the Pre-Rulemaking Cross-Cutting Issues colon
6 Attribution.

7 MR. AMIN: Great, Chip. Erin and I
8 will take the lead on the attribution discussion,
9 and I encourage Helen to jump in as we go
10 forward.

11 So one of the interesting things with
12 this attribution work is that, you know, as we
13 had our conversation yesterday around the
14 consensus-development process, and some of the
15 learnings that we've had with the measure
16 selection process here with the MAP, many of
17 these measurement science, basic science issues
18 that emerged through our conversations, and many
19 times our committees don't really have enough
20 time to really dig deep into them.

21 We identify them both through the
22 measure evaluation process and also through the

1 very thoughtful comments of our members and
2 stakeholders through our commenting process. The
3 discussion around attribution has been one that's
4 sort of plagued us for several years and, you
5 know, there are many of you in the room who have
6 had the opportunity to be part of these
7 conversations in many different forums.

8 You know, a few that come to mind,
9 Bruce your work with the Readmissions Committee,
10 Amir, all your work with the, you know, the
11 clinician measures and as we think about, you
12 know, how do we think about shared accountability
13 and at the same time be able to have clinician-
14 level measures that are meaningful.

15 Actually in a lot of ways, Carol, your
16 work with the linking cost and quality work that
17 you led several years ago sort of at the same
18 time led to some of these initial discussions
19 around how do we think strategically about the
20 question, the measurement science question of
21 attribution.

22 And so we embarked on a project over

1 the last year to at least start to really
2 identify, from the guidance of the NQF Board,
3 around a path forward for some of the measurement
4 science issues with attribution. So the purpose
5 of this morning's conversation is to give you a
6 summary of some of our discussions, which are in
7 some ways very preliminary.

8 We've identified that there's, you
9 know, at a very high level that, you know,
10 there's a tremendous amount of variation in terms
11 of attribution models that exist, as Erin will
12 talk through in some of the environmental scan
13 undertaken by Andy Ryan's group at the University
14 of Michigan, who helped support this work.

15 Essentially, we agreed that a good
16 path forward would be to identify guiding
17 principles about the evaluation and selection of
18 attribution models, and then develop a selection
19 guide to help users, both public and private
20 users of measures, to identify best practices for
21 attribution as place to start from.

22 And again, those of you who are

1 measure developers in the room who have been
2 thinking about this quite a bit and have
3 struggled with attribution models as you're
4 developing your measures, we would certainly
5 welcome your thoughts and feedback as we discuss
6 the work here.

7 So you know again, some of the other
8 inputs. Legislation such as the IMPACT Act and
9 MACRA continue to focus on developing and pushing
10 forward value-based purchasing programs by
11 realigning incentives, and again, the question
12 here as we think about shared accountability in
13 an environment of pay-for-performance models,
14 there needs to be a decision made around how and
15 who to hold accountable for the results of
16 quality and efficiency measures to ultimately
17 judge performance.

18 Increasingly as we are looking toward
19 measuring outcomes, this question of attribution
20 becomes even more important. When we think about
21 the question of attribution, it really is the
22 methodology used to assign patients and their

1 quality outcomes to patients or clinicians, and
2 helping to identify the patient relationships
3 that we're trying to measure.

4 And as we again move the system away
5 from fee for service to alternative payment
6 models, the question about how we attribute
7 performance again becomes increasingly important.

8 So this project scope was taking into
9 account these trends, just moving to the next
10 slide please, was taking into some of these --
11 taking into account some of these trends, and our
12 overarching goal which has come up through the
13 MAP process over this last several years, and is
14 one of our guiding principles around shared
15 accountability.

16 We've brought together a
17 multistakeholder group to really be able to
18 advance the measurement science of this area,
19 first by identifying the key challenges in
20 attribution that have been identified in the
21 field, but also have been identified through all
22 of our work. Again, the MAP selection process

1 and the CDP, develop a set of guiding principles,
2 identify elements of an attribution model.

3 Again this -- I have to say this was
4 one of the elements that I thought was one of the
5 key components that I was really surprised by is
6 that we look forward into what we describe as an
7 attribution model, there is a lot of variation in
8 terms of what's even included in an attribution
9 model.

10 So it's really setting a foundation of
11 what are the key elements of what we -- when we
12 describe an attribution model, what are the key
13 elements, exploring some strengths and weaknesses
14 as you're developing tradeoffs, and then
15 identifying some recommendations for developing,
16 selecting and implementing attribution models.

17 So Erin will talk us through some of
18 the project, you know, activities in more detail.

19 CO-CHAIR PINCUS: Taroon, one quick
20 question. When you say model, what do you mean
21 by a model?

22 MR. AMIN: I think that's inherently

1 what we were trying to define when we talk about
2 the elements, and I think we'll get into that in
3 a moment. Again, we struggled -- actually we
4 struggled with that particular question quite a
5 bit through this project.

6 MS. O'ROURKE: Thanks, Taroon. So on
7 this side, you can see who served on the
8 committee. I won't read all the names,
9 obviously, but just to give you an idea that it
10 was a multistakeholder committee that included
11 clinicians, providers.

12 We tried to get providers from across
13 the care continuum, in addition to public and
14 private sector payers, purchasers, a consumer
15 representative.

16 It was chaired by Ateev Mehrota from
17 Harvard and Carol Raphael, a former member of the
18 MAP Coordinating Committee. So we did want to
19 make sure someone could share some of the measure
20 selection challenges the MAP has faced over the
21 years and bring forward some of the discussions
22 you've had about attribution.

1 So as Taroon was saying, we started
2 this project by commissioning an environmental
3 scan from Andy Ryan and his team at the
4 University of Michigan, to see what they could
5 find in the literature about what's currently
6 being used as far as attribution models go. They
7 found about 163 models that are either in use or
8 proposed for use.

9 The vast majority actually were not in
10 use. Only 70 percent were currently in use. Of
11 what they found, 89 percent used retrospective
12 attribution, and 77 percent attributed to a
13 single provider, generally a physician. As
14 Taroon was saying, we really struggled on how you
15 even define an attribution model.

16 Some of the elements that they used to
17 categorize a model were the stage of the program,
18 the type of provider that results were attributed
19 to, the timing of the attribution calculation,
20 clinical circumstances, the payer or programmatic
21 circumstances.

22 If the attribution was exclusive to

1 one provider or clinician or was shared among
2 multiple, which measures they used to determine
3 who would be responsible, as well as the minimum
4 requirement to make attribution and the period of
5 time for which a provider is responsible for a
6 given patient.

7 MR. AMIN: Erin, before you move on
8 from this slide, going back to Harold's question,
9 I think what we tried to actually put forward
10 here on the left side of this slide was that if
11 you think about the specifications of a measure,
12 of a performance measure that's submitted to NQF,
13 we were sort of thinking about what's on the left
14 side of the slide as the specifications of an
15 attribution model.

16 Again, we understand, and Erin will
17 get into this, there was no best practice. But
18 these are the elements that we would want to
19 evaluate as you're looking at -- or, yes,
20 evaluate as you're looking at an attribution
21 model.

22 MS. O'ROURKE: Next one. So some of

1 the key findings that we wanted to highlight for
2 you from the Commission paper, as Taroon was
3 saying, one of the author's main conclusions was
4 that best practices for attribution have really
5 not yet been determined.

6 They found that the existing models
7 have been largely built off of what was
8 previously used, without a lot of consideration
9 of the different tradeoffs and the development of
10 attribution models that need to be explored and
11 made transparent to all the stakeholders.

12 They found there's really no standard
13 definition for an attribution model, and this
14 lack of standardization really limits the ability
15 to objectively evaluate the models and compare
16 them to each other, to eventually get to that
17 evidence base that would allow us to make
18 determinations of best practices.

19 So some challenges that the Committee
20 wanted to start to tackle in this work. First,
21 greater standardization is needed among the
22 models so that we can start to make these

1 comparisons and allow best practices to emerge.
2 They found there's little consistency across
3 models, but there's actually quite a bit of
4 evidence that changing the rules of attribution
5 can dramatically alter the results on how a
6 clinician or provider might look on the results
7 of a program or a measure.

8 This lack of transparency on how
9 results are attributed really means there's no
10 way to appeal the results of an attribution model
11 that could wrongly assign responsibility to a
12 particular clinician or provider.

13 Next slide. So to start to address
14 these challenges, the Committee came up with a
15 number of different products in this work, if you
16 will. They developed a set of guiding
17 principles.

18 They made a number of recommendations
19 about attribution models going forward, and they
20 created a tool for calling the attribution
21 selection model guide that Taroon will get into
22 in greater detail.

1 These products allow for greater
2 standardization, transparency and stakeholder
3 buy-in. The Committee was aiming that, in the
4 future, this would allow for the evaluation of
5 attribution models and to start to lay the
6 groundwork so that we can develop the necessary
7 evidence base to determine what the best
8 practices may be.

9 MR. AMIN: So as we get into the
10 guiding principles, before we get any further,
11 Helen, is there any other sort of introductory
12 sort of comments about the group's work here and
13 sort of the importance or the background that you
14 want to get into before we go --

15 DR. BURSTIN: Just to highlight two
16 things I think we'll do here shortly, which is
17 really surprising there is no gold -- there is no
18 gold standards, which is why we thought having an
19 approach that everyone could use consistently was
20 really important.

21 And secondly, just there's also a lack
22 of transparency in the way the attribution models

1 are discussed, thought about and then shared with
2 those who would be measured. There's a real
3 opportunity here to just be very transparent, and
4 try to have a consistent approach. But a lot
5 more to do in this phase, for sure. I think this
6 is really just a way for us to begin working in
7 this space.

8 MEMBER ROBICSEK: Quick question and
9 maybe this will become clear as we describe this
10 more. But in a world where there's no gold
11 standard, against what sort of reality do you
12 validate these models against?

13 MR. AMIN: So I think, let's try it --
14 let me try to get to that through this work,
15 through the discussion here, because I think the
16 use and intent is really what we are comparing
17 the components of an attribution model against.
18 But again, let's try to get to that and if we
19 don't hit the mark, this is where we're
20 interested in the feedback from the group.

21 MEMBER QASEEM: You guys also had that
22 evidence review done by the Michigan people.

1 MR. AMIN: Absolutely.

2 MEMBER QASEEM: Did you find anything
3 even in terms of evidence, because you're talking
4 about the, you know, attribution model evidence
5 base. It goes back to what Erin was saying. I'm
6 not sure that there is much there.

7 MR. AMIN: Well, yes. I mean actually
8 what Erin just described at the beginning of this
9 around the, you know, the review of all the
10 attribution models, that was from the evidence
11 review from the University of Michigan, and
12 that's what the Committee used as their starting
13 point.

14 MS. O'ROURKE: And to your point, I
15 think that's what Andy and the other authors were
16 really trying to highlight, is people just
17 developed their models based on what's been
18 previously done, without any objective evidence
19 of if it's working or if it's really attributing
20 correctly.

21 DR. BURSTIN: And as far as evidence,
22 it's evidence -- there also very little testing

1 of the different models to see their impact. So
2 that's our key issue too.

3 CO-CHAIR PINCUS: I think there's
4 somebody on the phone who has a question.

5 MEMBER BAKER: I am still struggling
6 with this, because I would think you would want
7 to be able -- the gold standard would be if you
8 actually looked at the clinical situation, and
9 said yes, this person was truly responsible for
10 the care. That would be the gold standard.
11 That's incredibly hard to do.

12 (Off mic comment.)

13 MEMBER BAKER: That's a good question.
14 I think, you know, you'd have to. It's the
15 question of who's responsible. Is this the
16 primary care physician, for example, who refers
17 to a specialist, and then the specialist carries
18 out a variety of things, or the primary care
19 physician still had some involvement in that?

20 But what about the situation which is
21 very common, where patients can go to a
22 specialist, right, and the results are coming

1 back to the primary care physician and the
2 specialist already did a whole bunch of the
3 expensive wacky things, right, and some of which
4 I need to follow up on.

5 This happens all the time in the
6 emergency department. Somebody comes in, gets a
7 CT scan. They have multiple incidental findings
8 and the recommendation from Radiology are follow-
9 up CT scan every six months for two years, that
10 these endocrine tracks, and I've just spent
11 \$10,000 on something that was really the original
12 test was not appropriate.

13 So that's the type of thing. It's
14 just really hard to get into, you know, who is
15 really -- especially I'm thinking about cost.
16 Who's really the drivers in that?

17 DR. BURSTIN: I think we'll come to
18 that.

19 (Off mic comment.)

20 CO-CHAIR PINCUS: But I do think it's
21 a very complex question that seems, because in
22 some -- and it depends on a number of things.

1 Number one is that in some cases, you know, it's
2 like a projective test. You know, you talk to a
3 group of people that are involved with the
4 patient and you are not necessarily going to get
5 a unanimous opinion about who's responsible for
6 what.

7 DR. BURSTIN: I think that's why
8 you'll see what we've laid out as a series of
9 questions that should be part of a dialogue to
10 begin getting to that. Jack Resnick, who's on
11 the Committee, who's a dermatologist from UCSF,
12 gave an excellent example of how he treats a lot
13 of psoriasis as UCSF.

14 He tends to see those patients fairly
15 frequently because they come in for treatments.
16 So depending on the attribution model, at times
17 he is labeled as the one who's the person's
18 principal physician because he seems them most,
19 and all the costs of their associated CHF,
20 pulmonary disease, anything goes to him. But he
21 truly has no actual role in controlling or
22 thinking about any of that.

1 So I think when you see the principles
2 and the recommendations, let's come back and see
3 if we've answered some of these. Go ahead.

4 CO-CHAIR KHAN: I'd like to propose on
5 other thing as we get into the next discussion,
6 which is here we're talking about specific sort
7 of measures regarding a particular care. Let's
8 look at readmissions.

9 What some of the global measures or
10 the cost efficiency measure that's so, to me
11 horrendous inside of value-based purchasing, it
12 just assumes over a 38 period, or is it 30 days,
13 whatever the period is, that the hospital, which
14 is going to be judged, is somehow in control of
15 those costs.

16 Now if there's a readmission, maybe
17 there was a hack and it's the hospital's fault.
18 But you know, in terms of who really is the
19 decision-maker, well you know in a voluntary
20 medical staff, heavens knows who's the decision-
21 maker.

22 MR. AMIN: Right.

1 CO-CHAIR KHAN: So the trouble is it's
2 with the global issues as well as --

3 DR. BURSTIN: Absolutely.

4 CO-CHAIR KHAN: On the global
5 measures, as well as the ones that are --

6 DR. BURSTIN: Correct, and we actually
7 used that measure as a case study, Chip, in the
8 report, to work through the decision guide.

9 CO-CHAIR PINCUS: And I just want to
10 say, I don't think it's more complicated when you
11 add in the population-based measures that have
12 been --

13 DR. BURSTIN: Oh yes. We have another
14 case on that one too.

15 CO-CHAIR PINCUS: Okay, good.

16 MR. AMIN: So I think as we just sort
17 of wanted to set the foundation, I think as we
18 talk about this, there's a tremendous amount of
19 complexity that I think we've just started to
20 unpack here. But I think what the Committee
21 wanted to do was to at least set some baseline
22 sort of parameters, if you will, so guiding

1 principles, first to acknowledge the complexity
2 and the multidimensional.

3 They were very particular about the
4 language here, which is why I typically don't
5 like to actually read the actual language. But
6 they were very particular about the language, and
7 I want to make sure that we're all on the same
8 page or I'm not mischaracterizing it.

9 The multidimensional challenges with
10 implementing attribution models, as they can
11 change depending on their purpose and the data
12 available. They should be grounded in the
13 National Quality Strategy, as attribution can
14 play a critical role in advancing these goals.
15 And again, this is where, you know, we talk about
16 the importance of measures, measures alignment
17 and measure selection.

18 But attribution, which can refer to
19 both the attribution of patients for
20 accountability purposes and the attribution of
21 results of a performance measure are both equally
22 as important.

1 They also highlighted the absence of
2 a gold standard for designing or selecting an
3 attribution model, and must understand -- you
4 must understand the use and the goals of each use
5 case, and then the key criteria for selecting
6 attribution are the actionability of the
7 accuracy, fairness and transparency.

8 So as we go to the principles on the
9 next slide, the attribution model should fairly
10 and accurately assign accountability.

11 Attribution models are an essential part of
12 measure development, implementation, policy and
13 program design. Consider choices among available
14 data are fundamental in the design of an
15 attribution model.

16 Attribution models are not stagnant,
17 and they should be reviewed and updated
18 regularly, particularly as data, enhanced data
19 assets become available. Attribution models
20 should be transparent and consistently applied,
21 and attribution models should align with the
22 stated goals and the purpose of the program.

1 Again, this is where some of the work as it
2 relates to MAP comes in.

3 So the second component here of what
4 the Committee wanted to develop is this
5 attribution model selection guide, and the
6 current state here is that there's a tension for
7 the desire for clarity around an attribution
8 model's fit for purpose and the state of the
9 science related to attribution model.

10 There is a desire, and this is a lot
11 of what we heard through the NQF endorsement
12 process and a lot of what we heard from the
13 Board, to clarify which attribution models should
14 be used in a given circumstance, you know. When
15 should we hold certain -- some actors accountable
16 in certain situations.

17 But there is not enough evidence to
18 support the development of such rules at this
19 time. So the goals of the attribution model were
20 really to aid measure developers, measure
21 evaluation committees and program implementers on
22 the necessary elements of an attribution model

1 that should be specified a priori, and represent
2 the minimum number of elements that should be
3 shared with those being held accountable.

4 So on the next slide, I know this is
5 really small to read, but I want to just sort of
6 point out on the next slide. So on the left
7 side, these are the elements, and I'll walk
8 through, you know, what the Committee was
9 actually recommending as you think about
10 attribution models.

11 So on the left side I'll walk through
12 what is the context and goal of the
13 accountability program, and Ari, to your point
14 earlier, you know, I think this was a key part of
15 the discussion around what are you measuring
16 against. The second component is how do the
17 measures relate to the context in which they're
18 being used, which is a lot of the conversation we
19 have in the MAP.

20 You know, as we think about new
21 measures coming in, what are the current measures
22 in the set, what are the goals of the program,

1 which units will be affected by the attribution
2 model, and then how is the attribution performed.
3 And then so as we go through each box here, the
4 context and goal of the accountability program is
5 really what are the desired outcomes and goals of
6 the program.

7 Is the attribution model evidence-
8 based? Is the model aspirational? Are we trying
9 to incentivize certain delivery system behaviors
10 through the attribution model? What is the
11 accountability mechanism of the program? Is it,
12 you know, is it a pay-for-performance program?
13 Is it, you know, is there dollars assigned, you
14 know? How is the program designed with a strict
15 cutoff in the readmissions example, and which
16 entities will participate and act under the
17 accountability program?

18 The second component, how do the
19 measures relate to the context in which they're
20 being used? What are the -- this sort of gets
21 into some of the measure specification
22 challenges.

1 What are the inclusion/exclusion
2 criteria, and does the model attribute enough
3 patients to draw fair conclusions, and this is
4 getting toward the scientific acceptability sort
5 of components.

6 Which units will be affected? To
7 which units are eligible for the attribution
8 model? To what degree can the accountable unit
9 influence the outcomes, and I think, Chip, to
10 your point on the readmission discussion, that
11 was a key part of the discussion, you know.
12 What's the level of influence, and that's a
13 little bit of a tradeoff to the aspirational
14 question earlier.

15 Do the units have sufficient sample
16 size to meaningfully aggregate, and are multiple
17 units to which -- are there multiple units to
18 which the attribution model will be applied,
19 getting to the shared accountability discussion.
20 Then the last component is how will the
21 attribution be performed, and this sort of is the
22 nuts and bolts, the data that's being used. Do

1 the parties have access to the data? What are
2 the qualifying events for attribution? What are
3 the details of the algorithm used to assign
4 accountability?

5 Were there multiple methodologies
6 considered, and that should be made transparent
7 in why and how certain models were selected, and
8 then the timing of the attribution computation.
9 So I'll turn it over to Erin to walk us through
10 the final recommendations of the Committee.

11 CO-CHAIR PINCUS: Taroan, can I just
12 go through the question about, I guess in some
13 ways, the model that you described in terms of,
14 you know, selecting. If we go back, can you go
15 back one slide?

16 Yes, if you go back one slide. So is
17 this design to be applied, sort of thinking about
18 it from different levels of abstraction? Is it
19 designed to be applied at a program level or at a
20 measure level? So we talked about that. In some
21 ways, it's kind of the intersection of both, you
22 know. We talked about, you know, as we think

1 about selecting measures into programs, but then
2 also individual measures also include attribution
3 models in terms of how you're designing the
4 attribution model within the measure itself. So
5 we've talked about it at both levels.

6 CO-CHAIR PINCUS: I can imagine a
7 program that is designed to, you know, like a
8 quality program that is designed to hold
9 hospitals accountable, and you could look at
10 whether or not the assumptions about that program
11 are correct. But then you also have to look at
12 each measure, to see whether each measure is
13 actually appropriate for holding hospitals
14 accountable.

15 MR. AMIN: In the structure, in the
16 structure in which the program is designed,
17 absolutely. Helen, did you have anything else?

18 CO-CHAIR KHAN: And then that gets to
19 be almost multidimensional chess if you have
20 composite measures, because then you have the
21 question of does each measure know? Is the
22 gestalt really what people assume it is, since

1 simply by smashing a bunch of measures together?

2 (Simultaneous speaking.)

3 CO-CHAIR PINCUS: You can look at, you
4 know, measure data elements to the extent to
5 which the source of those data elements actually,
6 you know, can be attributable.

7 DR. BURSTIN: And part of the reason
8 for this work is the lack of consistency in this
9 space, and feeling like sometimes measures bake
10 in the attribution model. Sometimes it's only
11 part of the programmatic approach. Sometimes
12 it's baked into legislation as you know well,
13 Jim. I mean there's all different ways to do
14 this.

15 I think the key thing was to try to
16 add some consistency. We think the questions
17 will be very useful in terms of developers
18 developing measures, groups like this looking at
19 measures in the context of programs. But also
20 very much so even outside the context of the
21 federal government, you know.

22 We know a lot of these discussions

1 happen on the ground as well between health
2 systems and payers. So having again a consistent
3 way to have that dialogue is really our goal.

4 CO-CHAIR PINCUS: But I think this is
5 very useful, because it sort of enforces for any
6 program or measure, it forces the developer or
7 the person developing the program to be -- to
8 actually lay out in a purposeful way and a formal
9 way of here's what we're thinking in terms of
10 attribution.

11 MR. AMIN: Yes.

12 CO-CHAIR PINCUS: And here's how we're
13 making that attribution.

14 MR. AMIN: The only other comment I
15 would make on your question, Harold, is that in
16 some ways we've walked into the challenge of
17 attribution both here in the MAP and then also in
18 the CDP process at the measure level, because all
19 of this is not really always transparent.

20 And so we've tripped on this question
21 a number of times because all -- well again, it's
22 not transparent. So we're hoping that this level

1 of structure will be able -- we will then now be
2 able to think about how it fits within our two
3 different processes, and add to this contextual
4 question.

5 So Erin, can you just walk us through
6 the remaining part, and I think there's some more
7 questions on the phone.

8 MS. O'ROURKE: Yes, absolutely. So
9 building on these, the principles and the
10 attribution model selection guide, the Committee
11 made a series of recommendations that they
12 intended would apply broadly for the development,
13 selection and implementation of attribution
14 models in the context of public and private
15 sector accountability programs.

16 They attempted to recognize the
17 current state of the science and consider what we
18 can achieve right now, as well as what would be
19 the ideal state they'd like to see in the future
20 as far as attribution goes. The recommendations
21 really stressed the importance of aspirational
22 yet actionable recommendations to drive the field

1 forward.

2 Next slide. So their first
3 recommendation, fairly self-evident -- to use the
4 attribution selection model guide and to evaluate
5 the factors to consider in the choice of an
6 attribution model. Here, they really stress
7 there's no gold standard. Different approaches
8 may be more appropriate, depending on the
9 situation.

10 Model choice should be dictated by the
11 context in which it is used and supported by
12 evidence and measure developers and program
13 implementers should be transparent about the
14 potential tradeoffs between the accountability
15 mechanism, the opportunity for improvement, the
16 sphere of influence of the accountable entity
17 over the outcome being measured, as well as the
18 scientific properties of the measure being
19 considered for use.

20 The Committee noted that attribution
21 models should be tested. In particular,
22 attribution models of quality initiative programs

1 must be subject to some degree of testing for the
2 goodness of fit, scientific rigor and unintended
3 consequences. The degree of testing may vary
4 based on the stakes of the program, and
5 attribution models would be improved by rigorous
6 scientific testing, and making the results of
7 this testing public.

8 In particular, the Committee
9 recommended when used in mandatory accountability
10 programs, models should be subject to testing
11 that demonstrates adequate sample size,
12 appropriate outlier exclusion and/or risk
13 adjustment to fairly compare the performance of
14 attributed entities, and sufficiently accurately
15 data sources to support the model.

16 Next slide. The Committee recommended
17 that attribution models should be subject to
18 multistakeholder review, and here they really
19 highlighted the lack of current evidence and the
20 lack of a gold standard, so that a stakeholder
21 perspective could really influence what is the
22 best approach and maybe, you know, which approach

1 is best maybe in the eye of the beholder.

2 So recommended that attribution
3 models, selection and implementation in the
4 public and private sectors should use a
5 multistakeholder review to determine which
6 attribution model may best serve their purpose.
7 Attribution models should attribute care to
8 entities that can influence care in outcomes.

9 The Committee recognized that
10 currently, attribution models may unfairly assign
11 results to entities that have little control
12 over, influence over the patient outcome. Helen
13 used the example of a dermatologist being held
14 responsible for CHF.

15 For a model to be fair and meaningful,
16 an accountable entity must be able to influence
17 the outcomes for which it's being held
18 accountable, either directly or through
19 collaboration with others. The Committee did
20 want to highlight the need to get to shared
21 accountability and attribution as a way to move
22 us forward.

1 As care is increasingly delivered by
2 teams and facilities become more integrated,
3 models should reflect that what accountable
4 entities are able to influence rather than
5 directly control.

6 Then finally, attribution models used
7 in mandatory public reporting or payment programs
8 should meet minimum criteria. In particular,
9 they should use transparent, clearly articulated,
10 reproducible methods of attribution. They should
11 identify accountable entities that are able to
12 meaningfully influence the measured outcomes.
13 They should utilize adequate sample sizes,
14 outlier exclusion and/or risk adjustment.

15 They should undergo sufficient
16 testing, they should demonstrate accurate enough
17 data sources to support the model, and be
18 implemented with adjudication processes that are
19 open to the public and allow for a timely and
20 meaningful appeal by the measured entities.

21 MR. AMIN: Erin, before you move on
22 from that, I just want to underscore that third

1 to last bullet, undergo sufficient testing at the
2 level of accountability being measured, which is
3 again something that we've struggled with at
4 times with measures. For the goal of aligning
5 measures across different programs at different
6 levels of analysis, we want to make sure that
7 they've been tested at the level of analysis that
8 they're being implemented at.

9 MS. O'ROURKE: I think with that we'd
10 like to open up for questions or discussion by
11 the Committee.

12 CO-CHAIR PINCUS: So we have Chip, we
13 have Doris on the phone. We have Marissa, we
14 have Rich, we have Rhonda and we have Andy and we
15 have John. Aparna, is your -- is your thing up
16 too?

17 MEMBER HIGGINS: Yes.

18 CO-CHAIR PINCUS: Okay. So Chip and
19 then Doris.

20 CO-CHAIR KHAN: So what strikes me
21 about the development here is that we seem to be
22 at sea a lot over whether measures, when they go

1 through the endorsement process or they go
2 through our process, are really fit for a certain
3 purpose. With the discussion this morning, it
4 seems to me provides is at least one really
5 important criteria that I'm sure is generally
6 considered but not necessarily specifically
7 considered with the depth that you have now sort
8 of developed, and it seems to me that an
9 attribution is like one of the --

10 I mean is like a key in terms of
11 whether -- it may be a great measure, but what's
12 the purpose? I mean does it fit a purpose and
13 depending on how it fits in terms of this
14 attribution, it could be a determining factor.
15 So I guess my question is, and maybe this is a
16 question for the end, is where do we go from here
17 because what you've developed is something that I
18 think ought to affect the endorsement process and
19 begin to allow the endorsement process to have
20 various levels of approval based on a perception
21 of, you know, what it's fit to do.

22 Because if something is sort of

1 loosey-goosey on meeting your standards in terms
2 of where the root is of that attribution, then do
3 we really want that measure being used for pay
4 for performance, I mean just in the most simple
5 assessments? So where do we go with this?

6 DR. BURSTIN: Right, and we'll be
7 happy to come back to this at the end. Obviously
8 we very much welcome your thoughts about next
9 steps. So we've been proposing some potential
10 next steps, one of which is to review and revise
11 what we already do on the CDP and MAP side, to
12 consider how this fits in. So we recognize
13 that's an issue.

14 There are also a lot of unresolved
15 issues here, so I think there's more work to be
16 done. I feel like we've scratched the surface of
17 a really big issue. Somebody recently referred
18 to attribution to me as the soft underbelly of
19 value-based purchasing. Like we've got to figure
20 out how we all agree on this to really move
21 forward, particularly to move towards population-
22 based measurement and all the rest of it.

1 So great questions. Just keep them
2 coming. We'd love to --

3 CO-CHAIR PINCUS: Doris on the phone.

4 DR. LOTZ: I think this is fabulous
5 work. I agree, Helen. I think this is the soft
6 belly of, you know, value-based purchasing.

7 What I'm not hearing in the discussion
8 yet is, inasmuch as the Committee work, the work
9 today has talked about differences between who
10 might actually be the provider of the service or
11 have ability to implement a measure, being
12 somewhat different than accountability, I'm not
13 clearly hearing in the discussion around the
14 slides how there might be some way of reconciling
15 different attribution measures, strategies
16 rather, or having some sort of a hierarchy.

17 From the position of a payer, you
18 know, I think that the payer desire is -- and
19 those of you who again I apologize for not being
20 able to be in the room -- but I have
21 accountability for the Medicaid program in New
22 Hampshire as well. And, you know, the interest

1 is in paying at a fairly high level and then
2 letting some of the individual decisions around
3 service utilization or priorities or integration
4 occur at a smaller unit of analysis, either a
5 provider group or a geographic level.

6 So if you have different attributions
7 for different measures, how do you potentially
8 reconcile them into some more cohesive payment
9 strategy?

10 DR. BURSTIN: Doris, I think it's a
11 great question, one we'd love to have more
12 discussion on. Certainly, I think as we think
13 about potentially attribution being at a higher
14 level, and allowing more of that internal
15 attribution to be ferreted out, that's fine. I
16 do still think these questions are even useful
17 internally then, as part of that discussion, even
18 if it doesn't influence the topic.

19 DR. LOTZ: Yes, agreed. Thanks.

20 CO-CHAIR PINCUS: Amir, then Marissa.

21 MEMBER QASEEM: Just to follow up I
22 think what Chip just said, and I just wanted to

1 go back to Helen. I mean to a certain degree,
2 when we're reviewing the measures at NQF level,
3 we do look at attribution.

4 I mean it's a little bit buried in
5 there, but the measures that do come forward do
6 have a very clear attribution there.

7 I think the problem that happens is
8 that we don't have any of the CMS colleagues
9 right now here. I would love to get their
10 feedback. They're somewhere, okay.

11 DR. BURSTIN: They gave a lot of
12 feedback to this. So this not, you know, this is
13 work we did --

14 MEMBER QASEEM: No, no, no. My point
15 is what we endorse the measures for, we do have
16 it in minds what level we're endorsing the
17 measures, and then these measures end up getting
18 implemented.

19 That's where I don't think it's
20 they're being taken into account the attribution
21 part, right. Have you had that sort of
22 discussion with CMS or any of the folks, what

1 happens with attribution?

2 So even when we're reviewing it at
3 ACP, we come to you guys and we say well, this
4 attribution is perfectly fine at this level. But
5 then the measure ends up getting in an expanded
6 role, and you don't never hear about the
7 attribution part. So you have had any
8 conversations or --

9 DR. BURSTIN: Absolutely, and in fact
10 one of the specific recommendations, and I forget
11 where it was, specifically said at the level at
12 which it will be used is that this really needs
13 to be discussed. So we've been having some
14 ongoing discussions with CMS, for example, about
15 the use of the readmission measure and the
16 physician program, and are working with CMS to
17 try to get some of the testing done at that
18 level.

19 But you're right. I mean -- you know,
20 at least on the endorsement side we clearly
21 require that. Testing is required at the level
22 at which the measure will be used, and I think we

1 need to understand how that relates to the
2 attribution when it's not as clear.

3 MEMBER QASEEM: And just to wrap up on
4 it, I think you guys did a very good job with
5 this attribution paper. I really, really enjoyed
6 it and I think you have pretty much taken into
7 account some of the major principles. But it's
8 still very high level. I think it's a lot how
9 it's going to get operationalized.

10 I think it will be still be good that
11 if you very clearly state in there that the
12 clinician or whoever is being measured, they
13 should have some sort of influence on the process
14 or the outcome that's being measured. I still
15 feel like after reading that report it's really
16 buried in there. It does not come out as clearly
17 in some of the principles, but thanks.

18 CO-CHAIR PINCUS: Marissa.

19 MEMBER SCHLAIFER: First just thank
20 you for starting this work. It's definitely
21 something very important and some of my comments
22 are from participating in the American

1 Pharmacists Association Policy Committee meeting,
2 where we were talking about the pharmacists' role
3 in value-based purchasing, and spent some time
4 talking about attribution.

5 Not trying to like solve anything, but
6 talking about it as an issue. I think one of the
7 things to -- that I'm sure you thought about,
8 that I should point out, as David talked about,
9 he talked about, you know, when you see
10 physicians and specialists, with primary care
11 physicians and specialists, there's some kind of
12 handoff potentially.

13 Those times where there's truly shared
14 responsibility with no -- with several providers
15 that may not even know that the other exists, and
16 specifically as we get into more and more
17 medication of care and medication management type
18 measures, obviously the physician or NP or PA has
19 a very important role.

20 At the same time, a pharmacist is
21 doing their role in making sure that the patients
22 are taking medications appropriately in maybe the

1 medication adherence space. It may be in
2 identifying gaps in therapy and notifying the
3 prescriber about those gaps in therapy.

4 It also may be in those potentially
5 bad handoff situations, as a patient goes from
6 hospital back to outpatient and there's a
7 pharmacist that identifies, you know, the
8 medication misadventures that often happen there.
9 So I think as you go through your work and I
10 don't have any answers, it's more questions, you
11 know, thinking about when there's definitely
12 shared attribution or there needs to be shared
13 attribution, and this is something especially I'm
14 sure to many of the allied health professions,
15 you know, it's important.

16 Right now it's pharmacies talking.
17 Pharmacists aren't providers under Medicare Part
18 D today but hope to be in the not-too-distant-
19 future. But also as pharmacists are contracting
20 with ACOs and with physician groups, when we look
21 at improvement in ACO measures and MSSP measures
22 or MACRA measures for physicians, PAs and nurse

1 practitioners.

2 While pharmacists may not be getting
3 paid by Medicare, they're looking at how they can
4 identify to those medical groups that they have
5 had a role. So I think this is something that's
6 very important to the pharmacy profession and I'm
7 sure others also. Is there any chance we can get
8 these slides? That would be nice. They are in
9 there? Okay. If they are, okay.

10 CO-CHAIR PINCUS: Rich.

11 DR. ANTONELLI: I also want to
12 acknowledge and thank you guys for setting this
13 work on this path. I usually restrict my
14 comments to strategic framing, but I'm actually
15 going to get into the grassroots with this. So
16 to the degree, the couple of comments that I'd
17 make, one is the attribution model versus a
18 process.

19 For those of us, and right now in the
20 name of Romneycare in Massachusetts, we are going
21 forward with serious ACO development.
22 Conversations of attribution are happening

1 literally in real time. I don't know that that's
2 something that has really any relevance for this
3 body, in terms of being prescriptive about what
4 needs to happen, because we still have to develop
5 what the evidence is in that space.

6 So what I want to call out to people
7 is, and I think the example that we raised about
8 the readmissions work, right. Here's the
9 measure. If we had spent a lot of time in this
10 room and in the MAP thinking about attribution, I
11 don't think we would have made as much progress
12 as we did.

13 So the way I would think about an
14 approach, maybe not the singular approach to
15 attribution but an approach to attribution is
16 thinking about attribution at the tactical level.
17 This is going to have significant implications,
18 and I think, Marissa, you raised an issue that
19 we're thinking about a lot in pharmacy, is still
20 at the level of implementing a model of care.

21 So for example, pharmacy is relatively
22 easy because it's still in the medical silo.

1 We're starting to get into some serious work on
2 the Massachusetts and several other states that
3 I'm providing some support for in integration,
4 around social determinants and community so-
5 called CPs or community partners, long-term and
6 social, LTSS subpopulations.

7 I think for the MAP to actually think
8 about measures and attaching attribution
9 methodologies or worse, an attribution model,
10 would slow the process down. So I just want to
11 call that out. I think this is great. This will
12 inform our work at a tactical level.

13 But the same thing that works for SDOH
14 intervention in Roxbury, Massachusetts may not be
15 how it's going to play out in Indianapolis. And
16 so -- and then the last thing I'd like to react
17 to is the notion of the measure developers being
18 mindful of attribution. To the degree that
19 that's desirable, that's okay. But frankly,
20 especially thinking about being responsive to the
21 Vital Signs report of the NAS/IOM, where we're
22 actually talking about things beyond singular

1 medical resources.

2 I would like to have the ability to
3 think about attribution across a community. So
4 please, please let's not make attribution a
5 component of endorsement, if we're trying to get
6 to some of those holistic community-based
7 population health measures. Not at all saying we
8 shouldn't discuss it, but I for one would not
9 care about, you know, endorsing if we haven't
10 worked out the attribution methodology de novo.

11 DR. BURSTIN: One quick response. I
12 think the Committee intentionally said the model
13 can be labeled as aspirational, and then the
14 discussion can proceed.

15 But at least it's labeled as such,
16 recognizing that some of this may not be within
17 the current purview but there's a recognition
18 that's where people want a signal to go, and then
19 you would logically think through the next set of
20 steps, perhaps with a slightly different eye,
21 knowing it's aspirational. We intentionally put
22 that in there.

1 DR. ANTONELLI: Yes, and thank you for
2 that. I think the optics. So I'm very mindful
3 of what comes out of this Committee, and the NQF
4 in general often gets -- I'll even use a somewhat
5 provocative term on purpose -- over-interpreted
6 in the street. Well Rich, why would we want to
7 use that measure out here in the XYZ Medicaid
8 program? It's not NQF-endorsed.

9 So I think if NQF and the MAP in
10 particular could manage the optics of
11 conversations around attribution because they are
12 aspirational, hugely important by the way. But I
13 do think some of these measures that get into
14 LTSS and get into population health and social
15 determinants, there is no a priori way, there's
16 no -- there's no best model for that yet.

17 So Helen, I think if we can capture
18 the spirit of what you just said and have that be
19 attached to discussions around attribution, that
20 would actually be very helpful.

21 CO-CHAIR KHAN: To respond, I think
22 you really need to discriminate between your

1 measures, because when you're shooting with real
2 bullets on a CMS basically fee-for-service
3 measure, or set of measures, and I would argue
4 value-based purchasing is a fee-for-service
5 aspect of Medicare for hospitals, I don't think -
6 - I think this really is an essential component
7 to whether or not we go, you know, of any kind of
8 design of the set of measures.

9 I agree. You don't want to hold up
10 necessarily looking at a global situation, but
11 everything isn't a global situation. So I think
12 that's why I really think in the endorsement
13 process, you may want to discriminate as to the
14 -- and this goes back to fit for purpose -- what
15 is the purpose of the measure?

16 If it's a population-based measure, it
17 may have a different purpose and attribution may
18 be dealt with at a different level than it would
19 if we're talking about measures that are going to
20 be used in either a real, either a fee-for-
21 service environment or even, I would argue,
22 you've got to be a little bit careful about your,

1 you know, beautiful ACOs on the hill environment,
2 because not all that's population.

3 A lot of that is simply, you know,
4 moving a fee-for-service measure into a different
5 environment and it's basically the same thing,
6 and you've got to make sure that it's fair.
7 Because at the end of the day, it's three things:
8 transparency, accountability and improvement. If
9 it really can't be used for improvement, then so
10 what to transparency and accountability?

11 CO-CHAIR PINCUS: Rhonda.

12 MEMBER ANDERSON: I would underscore
13 what Chip has said. I think there is a balance
14 there between what Rich and Chip have said. So I
15 hope that we consider both, because I was going
16 to comment on the endorsement piece. So Chip,
17 thank you for that.

18 But the question, other question that
19 I had for Helen is you alluded to the fact that
20 to do a little testing with one of the measures.
21 I was wondering if any additional testing really
22 has been done, based on the principles and if

1 that you could share that with us?

2 DR. BURSTIN: Yes. I mean again, I
3 think what Andy Ryan was able to find with his
4 colleagues was this, there's actually very little
5 testing done of attribution models per se. I
6 think we've been trying to make sure that as
7 measures are in use perhaps at different levels
8 that are originally intended. Sometimes the MAP
9 has referred to it as off label measure use.

10 We want to make sure there is in fact
11 the ability to make sure it's tested at every
12 level it's used for scorecard purposes.

13 MEMBER ANDERSON: And as we, and I
14 really want to commend you, because this is such
15 a difficult area. But it's so important.
16 Somebody used the underbelly; I use the elephant
17 in the room concept.

18 But the question I guess then I have
19 is as you bring this forward, and it maybe goes
20 to the next steps, will you select a few measures
21 and if I look at what our conversation was
22 yesterday, we had the opioid discussion; we had

1 the alcohol and substance abuse discussion, and
2 there were a lot of questions about attribution,
3 et cetera.

4 Will you take a couple of those and
5 try to do some of our own testing, so that we get
6 some of that information back to us about the use
7 of the principles and how this -- how you at NQF
8 have found those principles to be usable and
9 maybe some changes even to them?

10 CO-CHAIR PINCUS: Aparna.

11 MEMBER HIGGINS: I'm actually going to
12 -- she put up her card before me. I don't know
13 if you noticed, but I'd have Amy go first.

14 CO-CHAIR PINCUS: Okay.

15 MEMBER HIGGINS: She had her card up
16 before I did.

17 MEMBER MULLINS: So thank you for the
18 work here. Thanks, Aparna, for that. One of the
19 things primary care physicians get frustrated
20 with is the duplicity and all the measures they
21 have to report on, and likewise all of the
22 attribution methodologies that come with all the

1 programs they participate in.

2 So, much like we have core measure
3 sets, I think that there is something to be said
4 for maybe some core methodology around
5 attribution. So I'm hoping that this is where
6 this work is going.

7 I think that one of the things, the
8 conversation from me is getting a little
9 confusing, because I don't think we attribute --
10 we don't need to attribute measures. I think we
11 need to attribute patients and people.

12 So when I think of attribution, I
13 attribute patients to physicians and providers.
14 I don't attribute measures to programs. So for
15 me, it's kind of -- the conversation kind of took
16 a turn, because attribution is for patients.
17 It's not for measures. So for me, that's kind of
18 weird how we were speaking about it.

19 Perhaps attribution is for measures.
20 I don't know. But for me as a provider,
21 attribution is for patients to providers. I
22 don't know when the discussion, when the

1 Committee was having the discussion if they
2 considered all the methodology that was written
3 into the final rule with comment for MACRA around
4 provider codes, patient codes that where
5 providers can -- is everyone in the room familiar
6 with this? Am I just being redundant?

7 Providers can assign a code to their
8 patient to describe the relationship that they
9 have with them, to prevent the confusion around
10 how much responsibility they have in order to get
11 the cost correct. So if that was taken into
12 account, I'd like to hear a little about that.

13 DR. BURSTIN: I'll answer the second
14 part first. It was literally coming out as the
15 Committee was meeting. So there was nothing to
16 reflect on. I think it was out for comment I
17 think at the time. So I think the Committee
18 recognized that was something to keep an eye on
19 as something potential.

20 In fact, there have been other things
21 written as well, and in fact with Healthcare
22 Learning and Action Network, sort of more look

1 towards a patient-based attribution model. We
2 looked at all of those different models. Again,
3 not having a gold standard is one of the
4 difficult things.

5 But in terms of your first point, it
6 is very much -- you can go back to the definition
7 of attribution. It is all about assigning
8 patients. It is not about measures. But the
9 idea is the way measures are used and the concept
10 of value-based purchasing is you are essentially
11 assigning patient results to providers.

12 So that's what we were thinking. But
13 actually one of the key things that came out, and
14 we just did our member webinar last week and
15 Carol said this really eloquently is at the end
16 of the day, the most important thing here is that
17 the patient is true north. We want to do nothing
18 that hurts the patient by having everybody go
19 it's their responsibility, it's their
20 responsibility and nobody takes responsibility.

21 So that is truly the true north, is
22 making sure everybody is really making sure

1 somebody's accountable at the end of the day, but
2 also trying to do it in a way that there is at
3 least an assessment of fairness.

4 MEMBER MULLINS: Yes and I would just
5 -- and I totally agree with that. I would just
6 caution against trying to bake methodologies or
7 attribution methodologies into measures, because
8 then you would have different methodologies in
9 different measures, and then you have a mess when
10 you try to report different measures with
11 different methodologies built into them, because
12 reporting is already a burden enough, and if you
13 have to report using different methodologies for
14 attribution, then I can see this becoming a mess,
15 even bigger than it already is.

16 CO-CHAIR PINCUS: Aparna.

17 MEMBER HIGGINS: So I just want to
18 build on some points that Amy and Rich and Amir
19 have made. So I want to apologize for being
20 late. I got stuck with the whole drama outside
21 the window with the traffic, and I know I missed
22 a lot of the conversation earlier. So if I'm

1 saying something somebody already discussed, I
2 apologize for that.

3 So I want to build on what Amy said.
4 I think in my mind too, I always think of
5 attribution of a patient not a measure. I
6 understand and I feel like maybe there's sort of
7 two concepts here that we're trying to address.
8 One is who's accountable for the patient, which
9 is the attribution piece, and more and more the
10 field is moving towards using patient attestation
11 as the gold standard for that.

12 So you no longer use, relying purely
13 on claims-based. So I think at some point, a
14 patient's going to say yes, so and so is my
15 physician and you don't have to be here talking
16 about attribution.

17 I think so -- and then the other
18 concept to me, at least as we've been discussing,
19 and Rich I heard you sort of bring it up, is the
20 fit for purpose, which is, is it, you know, is it
21 useful for QI, it is useful for public reporting,
22 it is useful for payment.

1 To me, attribution is patient-level
2 accountability and fit for purpose is is the
3 measure useful for payment? Is the measure
4 appropriate for, you know, public reporting,
5 which in my mind are sort of two different
6 things. Also I think, you know, would agree with
7 both Rich and Amy that, you know, I don't think
8 it's a good idea that attribution be part of the
9 measure endorsement process that you want to have
10 the measure be evaluated for.

11 It's already being evaluated for a
12 number of scientific criteria, including as Amir
13 mentioned, you know, sort of the level of
14 analysis, which tells you what the appropriate
15 setting is.

16 One of -- a couple of other things I
17 want to bring up. I know Amy brought up the
18 MACRA. The LAN has obviously done a lot of work
19 on attribution, so I don't know where the
20 Committee, you know, what kind of input they had
21 or review they did of the LAN papers.

22 You know, they've put out a model for

1 attribution which I think, you know, kind of got
2 broad input. They went through a public comment
3 period. As part of that, they had actually
4 talked to people who had tested various
5 attribution models empirically, and had included
6 some of that data work in their paper.

7 You know, so okay. So there is quite
8 a bit of empirical testing that's ongoing, in
9 terms of trying to figure out what the optimal
10 methods are. So I just want to make sure we're
11 not reinventing the wheel. I think that was sort
12 of my set of comments.

13 CO-CHAIR PINCUS: John.

14 MEMBER BOTT: Yes. I actually
15 submitted comments on the draft report when it
16 was out, so if you can bear with me, I'll just
17 read what my general comments were on that, and
18 then I will probably tack on one comment. But an
19 excerpt from one of my general comments on the
20 draft report, which are still germane to the
21 final report in having read it, is a large
22 portion of the report is dedicated to relaying

1 the attribution model selection guide.

2 This guide is followed by several
3 recommendation, where the first suggests using
4 the guide to evaluate attribution models.
5 However, the guide is less of set of evaluation
6 criteria and more of a set, a list of nice to
7 know facts about a methodology.

8 These facts solicited about a given
9 methodology do not add value, to truly evaluate a
10 given attribution methodology. Of the questions
11 posed in the guide, I would estimate that less
12 than half would be of utility in the evaluation
13 of an attribution model. So I'd recommend that
14 if indeed we want the guide to serve in an
15 evaluation capacity tool to revisit and refocus
16 the questions comprising the selection guide.

17 Just one thought on that to try to be
18 helpful. I really liked a couple of the past NQF
19 reports where they -- where it was posed here's
20 the NQF-given criteria, and here's how the
21 composite measures and PROMs fit within those
22 evaluation criteria. So I liked when criteria

1 were discussed in relation to the NQF criteria.
2 That might be helpful here.

3 And just one other thought is about a
4 year ago, CMS had a measure and NQF endorsement
5 process and it largely was voted down if you sit
6 there and read like I do, the steering
7 committee's rationale, and it was largely shot
8 down because of the attribution methodology.

9 You know, we all know this is a very
10 contentious area, and I thought the criticisms
11 were rather soft and not well-founded. So if I
12 were to put myself in CMS' shoes, to say oh
13 great, here's some guidance coming out, this
14 really -- if I was CMS and I'm not speaking on
15 behalf of CMS, I don't really see this as going
16 nearly far enough as helping a measure steward,
17 measure developer in guiding them on what's
18 acceptable and what's the parameters for
19 evaluation principles.

20 So while maybe this is a nice start,
21 a nice part one and addresses a number of issues
22 about attribution, I guess I would encourage, as

1 Amir hinted at, some more specificity and perhaps
2 a part two report. Thanks.

3 CO-CHAIR PINCUS: Thank you. So Carl,
4 then Jennie, then David, and then I have a
5 comment.

6 MEMBER QUERAM: Just a quick one,
7 since much of what I was going to say has been
8 said. But I want to pick up on just the Amir-
9 David-Chip kind of thread, when compared to some
10 of the threads on attribution that have said,
11 well, maybe not so much.

12 Alan, to the point, if we were to look
13 forward, given the comments you made about
14 aspiration, what do you anticipate we would see
15 in this conversation a year from now when we look
16 at next year's measures, as some practical,
17 tangible changes to the process that we would
18 actually feel and see?

19 DR. BURSTIN: That's a super question,
20 Carl. I don't know that we know that yet. I
21 think part of what we'd like to think through
22 with you today is at least part of the question.

1 So that I agree: they didn't go far enough. They
2 weren't specific enough, and frankly, as you
3 guessed, there's not enough out there on which to
4 base additional principles or recommendations, to
5 be perfectly frank at this point.

6 I think the question would be, does
7 some of that get baked into at least the
8 discussions that we have here about measures? Do
9 we at least perhaps, as part of our preliminary
10 evaluation of measures, go through some of the
11 elements of the guide to answer some of those
12 questions to again try to have a more -- have a
13 discussion that's perhaps more informed?

14 Again, not the intent to say more
15 measures go down; really, the intent is to say,
16 to have a very transparent discussion, and then
17 the Committee should make a decision based on
18 having that information on hand. But we'd
19 welcome your thoughts on that as we finish this
20 discussion.

21 CO-CHAIR PINCUS: Jenny.

22 MEMBER BRYANT: Thanks. This has been

1 a fascinating conversation for me. It's my first
2 meeting, so I'm now exposed to the -- how far we
3 have to go in the science related to attribution.
4 One thing that -- I mean many of the things I was
5 going to say have been said.

6 But one thing that occurs to me as we
7 think about sort of next steps in the work would
8 be that if you go -- if you think back to the
9 principles that you articulated in selecting
10 attribution models, they're very -- my sense
11 based on the conversation is there can be very
12 challenging -- it's challenging to meet, right.

13 So most folks who are developing an
14 attribution model won't be able to meet all of
15 those principles. So they're by themselves
16 really aspirational, and it struck me that it
17 could be useful to begin to articulate where the
18 risks are higher and lower of being successful.

19 So you know, it's sort of -- I think
20 it builds on and gets related to some of John's
21 points of something about it being more tactical
22 thinking about this, and taking it down to the

1 next level so that folks who are developing
2 attribution models in some ways could have a set
3 of -- a set of, I don't want to say criteria, but
4 it's almost like warning signals.

5 If you're dealing with a measurement
6 problem that has these characteristics, you're
7 much more likely to not be able to satisfy these
8 principles. So beginning to parse the principles
9 and the challenges a little bit more finely,
10 because I think talking about it at the 100,000-
11 foot level does a disservice to the level of
12 thinking that you have actually already done.

13 So you're going to find very different
14 challenges when you're talking about attribution
15 for clinician models than when you're talking
16 about attribution of outcomes in the hospital
17 setting, and it will be worth talking about the
18 specific pitfalls, since I think that's where we
19 are, is realistically we're going to be doing a
20 lot of work on attribution, and we need to do it
21 better.

22 So I think setting sort of some

1 incremental goals about how to improve
2 attribution models which are clearly imperfect
3 and not well-tested at the moment would be a
4 place to start.

5 I was, say, also really struck by the
6 conversation about how this relates to fit for
7 purpose, and it does seem that there's an
8 inherent tension here with the notion of
9 fostering shared accountability across the system
10 and moving to team-based care, and a desire to
11 drive toward pinpoint attribution. And maybe was
12 just worth acknowledging that the biggest
13 challenges we have in the system are around hand-
14 offs, where attribution is going to be really
15 contentious.

16 So I think that gets to why it might
17 be important to continue to, in the endorsement
18 process, identify places where measures are
19 critical to develop but almost unattributable,
20 and not then decide that they're not -- that that
21 means that they're not important measures, but
22 that it might mean that we have IT challenges,

1 infrastructure challenges that need to be focused
2 on as a way of making progress on those measures.

3 You know, I think there is a -- there
4 is a rush to using every measure for payment that
5 does a disservice to the development of the
6 measures. I think it's important in the
7 endorsement process. I think maybe this is part
8 of what Rich was saying, like to not assume that
9 they only have one purpose.

10 CO-CHAIR PINCUS: David.

11 MEMBER BAKER: So I think that you
12 don't want it to be rigid, but I do think this
13 should be part of the endorsement process, at
14 least to have the measure developers give some
15 idea of what their intent is, and I'll give a
16 couple of really concrete examples.

17 One really simple one are diabetes
18 measures. When we were doing the group physician
19 reporting option, if you looked at our
20 endocrinology practice at Northwestern in general
21 medicine we did really well. But we had all
22 these people with diabetes who are coming in to

1 see dermatologists, orthopedic surgeons, and you
2 said, well everybody with diabetes who touched
3 the system, we weren't doing well at all, right.

4 And for the developers to say, you
5 know, there has to be some way of identifying
6 those physicians who are truly responsible for
7 caring for that patient's diabetes, that would
8 help us tremendously. Another example is for
9 some of these measures that were designed for
10 hospitals, to apply those to an individual
11 hospital was well. Most patients who are cared
12 for by hospitals are cared for at least two,
13 sometimes by three, and sometimes with input by
14 the primary care physician.

15 So you know, it's really problematic
16 to apply some of those things to an individual
17 physician. So just for developers to give some
18 statement of their philosophy, not necessarily a
19 detailed model and not something that's
20 prescriptive and says, you know, it can't be used
21 in these other settings. But just to at least
22 begin that conversation, I think, would be

1 helpful.

2 CO-CHAIR PINCUS: I had a couple of
3 comments that I wanted to make, actually three.
4 So one is, you know, we've been thinking about
5 attribution as a binary concept, but it's not.
6 It's really in many ways proportional, and I
7 think it gets to some of the points, David you
8 made and Jennie made, in terms of the
9 determination of that proportionality is very,
10 very difficult and may not be even possible in
11 many cases.

12 So that's one issue to think about in
13 terms of how to do that. I mean the typical
14 example I think about is in terms of shared
15 accountability. If I have a patient with
16 schizophrenia and diabetes, at some level I'm
17 responsible for both the schizophrenia and
18 diabetes, and I should be thinking about the fact
19 that there's this comorbidity. And while I'm
20 primarily focused on treating the schizophrenia,
21 if I see that the patient's gaining weight
22 because of the medication I'm using, I need to

1 think about what kind of intervention.

2 I need to certainly communicate with
3 their primary care physician or their
4 diabetologist. So that that's a -- so how to
5 think about that is complicated.

6 Number two is, when the report talks
7 about testing, I'm trying to think about what do
8 we mean by testing. How does one determine the
9 validity of an attribution model? What would be
10 the methodology for doing that? Would you
11 convene all the providers and say, you know, well
12 what do you think is your responsibility?

13 You know, how would you actually test
14 the validity of the assumptions in a formal way?
15 I think some work, further work on what are some
16 of the research methodologies for assessing the
17 assumptions about attribution would be sort of a
18 worthwhile endeavor.

19 Then third, I think that -- so I'm
20 sort of in between in terms of whether you would
21 include attribution as a criterion or not. I
22 think it would vary by the kind of measure or

1 program you're looking at. I think, for example,
2 for a structural measure, there obviously is
3 accountability that is quite clear, and for many
4 process measures, that would be the case.

5 For outcome measures, it's much more
6 complicated certainly. So those are the kind of
7 things in terms of how -- you know, so that it
8 would -- but certainly I agree with David and I
9 think Jennie that there should certainly be a
10 discussion about assumptions being made about
11 accountability, both in terms of the endorsement
12 process and also in terms of the MAP process in
13 that way.

14 DR. BURSTIN: And just quickly this
15 time, we have a list, a running list of the
16 issues we've not -- we weren't able to really
17 resolve as part of that, and certainly this
18 question of what is attribution model testing?
19 What are the methods? How would you interpret
20 the results?

21 The data issues, we didn't talk a lot
22 about that today, but it was a big cornerstone of

1 the discussion of the Attribution Committee. If
2 you're looking at claims versus paper records
3 versus patient attestation versus physician or
4 other clinician attestation, how does that all
5 come together? What's the integrity of the data
6 source? This whole issue of team approaches, and
7 Marissa raised this earlier, is something we've
8 not really -- particularly around non-physicians
9 came up a lot.

10 And then the attribution challenges in
11 special settings and special populations.
12 Patients with multiple chronic conditions are a
13 whole lot harder than a patient who primarily
14 sees one specialist for their one given disease.
15 Then one of the things we did include, there was
16 something about an ability to have adjudication
17 or feedback, and how that even gets
18 operationalized.

19 Again, many of the things we think we
20 just didn't get to but I think are important
21 questions.

22 CO-CHAIR PINCUS: Bruce, Amir and

1 Nancy and Rhonda.

2 MEMBER HALL: Thank you. I'll build
3 on a couple of comments. Harold, I think
4 ultimately the way we judge whether the
5 attribution works is whether the feedback of
6 information improved care, and we rarely ever
7 reach that point with any measure anymore.

8 Having read this document a couple of
9 weeks ago, I think it's a fantastic opening
10 gambit. I agree with John and others that
11 there's much more than we need to dive into, but
12 it's a great opening gambit. I would just argue,
13 and I'll sort of go even farther and harder than
14 David did a minute ago.

15 I would argue that attribution has to
16 be explicitly concretely specified in a measure.
17 You don't have a measure if you haven't
18 attributed. In the document itself, we talk
19 about some related principles that are not all
20 exactly attribution. The document talks a little
21 bit about eligibility of data for a measure. Are
22 these data points eligible to be in this measure?

1 And those data points may represent people or
2 other pieces of information.

3 And then are these providers eligible
4 for this measure, and those are sort of issues of
5 accrual into the measure. Then inside of the
6 measure, you decide how you attribute cases or
7 information to the units you're evaluating,
8 whether those units are individual providers,
9 groups of providers, institutions or whatever
10 they might be.

11 And then once you've done that, you
12 have to return to the issue of fit for purpose,
13 which several people have raised. But I would
14 argue you cannot discuss and contemplate fit for
15 purpose until you have a measure, and you don't
16 have a measure until you've attributed the
17 information internally in the measure and done
18 the modeling.

19 I think the real challenges, one of
20 the biggest challenges will be how, at what level
21 of testing do we require a measure to be
22 evaluated in the measure development process?

1 Because you can have very different measures,
2 very different performance if you simply
3 attribute the results of your calculations to an
4 individual versus to a group.

5 I would argue that each of those
6 levels has to be separately contemplated and
7 tested, evaluated, approved, whatever. The
8 history of what we've done here at the NQF,
9 having contributed to these processes myself for
10 15 years or more as well, was that at first, we
11 used to say we refuse to talk about that. That's
12 an implementation issue. That's not in our
13 scope.

14 Then we evolved towards saying we'll
15 specify measures at different levels. The
16 individual provider, the institution, the system.
17 So that was an advance forward.

18 I think where we're heading now is to
19 say we're realizing that the measurement science
20 argues that until you've clearly said how you're
21 going to accrue, attribute and then use, you
22 can't do the evaluation of that measure in its

1 complete, in its completeness so to speak. So
2 thank you.

3 CO-CHAIR PINCUS: Thanks. Amir,
4 Nancy.

5 MEMBER QASEEM: So I'm just going to
6 come back to what's already been said, and I
7 think Chip started this discussion. He hit the
8 nail on the head in terms of these measures are a
9 high stakes game at this point right, and this
10 report is very good. You guys did a great job.
11 But I still think this report is not even at
12 10,000-foot level. This is like at hundreds of
13 thousand foot level, because the practical
14 applicability, there's -- I have some concerns
15 about it.

16 And then -- and Chip again is
17 absolutely right. The transparency, you have
18 that as a principle. It's not going to really
19 matter if you cannot really apply some of these
20 principles, and I'll give you an example of that.

21 You have a principle in there,
22 considered choices among available data are

1 fundamental in the design of attribution model.
2 After I heard Helen talk about the discussions
3 about the current limitations of the data and the
4 availability of the data, that kept on coming up
5 in the work core measure set confidence as well.
6 All the time, right?

7 But there was -- seems like there was
8 very rich discussion during that meeting, Helen,
9 but if you read that principle and underneath the
10 text underneath the principle, it does not even
11 mention the issues with the data availability and
12 the limitations of the data, and that concerns
13 me.

14 Now I'm coming to a point of, yes, I
15 really like the report. But again, that's why I
16 said 100,000-foot level or feet level. I think
17 again, you need to remember it is a high stakes
18 game. Look, I mean CMS is using them for
19 reimbursement and all that purpose, something
20 what Bruce has just mentioned I think. We need
21 to start keeping that in mind, and I think we
22 need to really look into this report, now that --

1 is it -- how can it practically applied.

2 The first step is going to be make
3 attribution part of the endorsement process
4 before we can even go beyond that. And then go
5 from there.

6 CO-CHAIR PINCUS: Nancy and then
7 David.

8 DR. WILSON: Well, I'll be quick. I
9 want to weigh in on agreeing with Rich and Aparna
10 and Amy that I see attribution as a person-
11 centered function. And I remember ten years ago,
12 Mark McClellan, remember Mark McClellan, saying I
13 just want to know who the team is that's taking
14 care of the person. I don't care how they
15 distribute the money that we're going to give
16 them.

17 I mean, and I hope he doesn't mind me,
18 because I am paraphrasing a little. But it was
19 basically, who's caring for the person? Who's
20 caring for the community? Who's caring for ---
21 you know, I tend to think of it as ZIP codes and
22 counties and things like that for the social

1 services, et cetera.

2 Being very person-centered and that
3 gets you into a provider attribution model for
4 payment. But I think that really focusing on
5 people, the person and the patient as opposed to
6 even providers is where we need to -- is the gold
7 star. I think that part of what Mark was saying
8 and I agree with is that it is tactical to figure
9 that out.

10 I thought it was great to see the
11 principles and what are kind of the things that
12 should be in an attribution model. If I were
13 trying to -- if I were sitting in a seat trying
14 to create one for whatever the entity is that I'm
15 trying to create it for, I'd run through that,
16 because it would be -- I never remember
17 everything that I should think of, and here's
18 this astute body that came up with all these
19 things.

20 So I see this being very useful, but
21 translating and operationalizing it I think has
22 to be at a very tactical level, depending on what

1 you're talking, who you're talking about.

2 Thanks.

3 CO-CHAIR PINCUS: David. Rhonda, did
4 you put yours down? Okay. Okay, David.

5 MEMBER BAKER: So Bruce and Amir
6 talked about that this should be part of the
7 endorsement, and I'd just like to hear what that
8 means. I think testing actually the attribution
9 model is just a step way too far, particularly
10 like you were talking about. I mean, we don't
11 even know how to do that accurately or what the
12 best practice is.

13 So what do people mean when they talk
14 about that, as opposed to again, saying that you
15 should be -- it's interesting. You think about
16 the testing, and when organizations do testing of
17 their measures, they're making assumptions about
18 the attribution, just by who is in that
19 population.

20 So I think for them to make a
21 statement of the philosophy and explain why they
22 chose the test population is one thing. But I

1 just wanted to hear from the two of you whether
2 you really think there should be any testing of
3 the accuracy of the attribution, because I think
4 that will be very difficult.

5 MEMBER HALL: Well I support what you
6 just said. I think in almost all cases when
7 we're sitting at the measure development level
8 and we're evaluating a measure, you're actually
9 evaluating -- whatever the testing's been done,
10 it's been done at some level by those developers.
11 I think most developers develop a measure
12 thinking it will be applied at one level or the
13 other. It's true, some measures come through and
14 they might say this could be applied at
15 physician- or system-level.

16 But I think almost all the information
17 that I've seen over the years that will come in
18 on a measure will represent testing at some
19 level, and that's why I said until you've
20 attributed, until you've accrued, attributed, and
21 sort of stated what your intended purpose is, you
22 don't have a measure to evaluate.

1 Maybe the intended purpose is the one
2 that is the softest, because people might feel if
3 they get through all those preliminary steps,
4 then that they're then approved to use it for
5 different purposes. I would argue against that.
6 And I would say that usually when we're doing
7 measure development evaluation, we are looking at
8 results that a developer has done at a particular
9 level.

10 So they have attributed it at a
11 particular level, at a particular unit of
12 performance, individual, group, system, you name
13 it, and that's usually what we're contemplating.
14 That's probably -- that should be the extent of
15 the approval, unless they've truly submitted,
16 here's how this measure performs on individuals,
17 where the reliability will be an entirely
18 different picture than it is for groups.

19 So I think your question reaffirms my
20 feeling, which is, you don't have a measure until
21 you've specified those things, and usually when
22 we're evaluating a measure, those things have

1 either been implicitly or explicitly specified.

2 I would argue that's the level the approval

3 should sit at.

4 MEMBER QASEEM: Just to add to that,

5 what I'm trying to get to, David, you already

6 nailed. I'm trying to avoid the off-label use of

7 the measure that's happening a lot, and I think

8 we need to start acknowledging there is a

9 fundamental problem with the current measures.

10 We all know that.

11 I think this seems like we're

12 oversimplifying the process and how they're

13 getting used and becoming a high stakes game.

14 We're all aware of it, but I think we need to be

15 aware of it and start investing resources to

16 understand how we can improve the whole

17 performance measures process. The point is to

18 improve the quality of our patient. You keep on

19 hearing, Amy mentioned patients. We're all

20 providers over here.

21 If that's not happening, what's the

22 point? I mean are we just -- it starts feeling

1 like it's checkbox. And I know CMS is
2 struggling, and they have to meet certain
3 requirements and all the law and all that. But
4 you don't want to make it, again, a checkbox,
5 just we implemented the measures.

6 We need to be fundamentally behind to
7 improve the quality of our patient care. If
8 that's not happening, we need to start looking at
9 it. I think, sometimes I feel like when I sit at
10 these meetings, it seems so oversimplified that
11 these measures are going to go, and we endorse
12 them, and now certainly patient care is going to
13 change.

14 We endorsed a lot of measures
15 yesterday. Do you really guys believe that some
16 of those measures are going to improve the
17 quality of care? I'm not sure. I can actually
18 list some of the measures, and without going
19 back, and I know you guys are going hate me if I
20 start extracting the measures again. But that's
21 essentially the point.

22 I think I absolutely agree with Bruce,

1 and I think we need to start investing resources
2 to learn a little bit more.

3 DR. BURSTIN: Sometimes there's also,
4 it's interesting. Somebody said sort of implicit
5 versus explicit attribution. So we oftentimes
6 hear from committees when they look at health
7 plan-level measures, for example, and I'm sorry
8 Mary left the room, that we keep reminding them
9 it's only at the health plan-level of analysis.

10 We frequently hear, particularly from
11 the providers at the table is, well, you say
12 that, but then the health plan sends those
13 results to me at my level and expects me to
14 respond. But again, we've not looked at the
15 measure at that level. So I think the explicit
16 versus the implicit is something we want to make
17 sure we understand, too.

18 MEMBER BAKER: For those physicians,
19 if something's in the measure set that shouldn't
20 be applied at the physician level, right?
21 Because they may go ahead, the organizations may
22 go ahead and do it anyway, but at least, you

1 know, you could come, and physicians could say
2 this isn't supposed to be applied at my level.

3 CO-CHAIR PINCUS: It sounds like, in
4 terms of this issue of a criterion for
5 endorsement that there's pretty much a consensus
6 about it should certainly be discussed and
7 detailed. Whether it should be a checkbox or not
8 is a whole other issue. But it certainly
9 requires some degree of intense discussion.
10 Aparna.

11 MEMBER HIGGINS: I don't feel like
12 we're -- there's different set of -- so there's
13 the measures and then what I think of as the
14 measurement methodology. And so part of that is
15 the attribution, the small numbers issues, all of
16 the things that we were all familiar with.

17 I feel like some of the comments that
18 have been made here fall in this sort of -- some
19 of it is small numbers issues, because I know the
20 concept of reliability was brought up, and I
21 think that's important to address if we're going
22 to use a measure for a particular purpose.

1 I feel like a lot of what we talked
2 about is fit for purpose, and how do you move
3 measures and identify measures that are good for
4 particular kinds of purpose, and not so much
5 attribution, because that's still, as Nancy said,
6 it's the patient, and who does this patient
7 belong to.

8 I think the challenge of putting it in
9 the endorsement process also is that, to Amy's
10 point, it's not just different methods from
11 different developers, but could be slightly
12 methods depending on what payment model you're
13 talking about. So now you're talking about a
14 measure that could be applied in a specialty
15 setting; it could be applied in a population
16 setting. And then you've kind of, sort of even
17 multiplied that complexity even further.

18 I just worry that we're going to get
19 away from evaluating measures for their
20 scientific properties, and then also looking at
21 sort of what's the appropriate level of analysis,
22 which is part of the current endorsement process.

1 CO-CHAIR PINCUS: So Helen, Taroon,
2 Erin. Do you want to sort of summarize your own
3 thoughts at this point?

4 MR. AMIN: So this was a very, very
5 rich discussion. We really appreciate all the
6 thoughts related to this conversation. As a
7 recap, we embarked on the work of the attribution
8 effort because of our experience, both in the
9 measure endorsement process -- and I think Bruce
10 characterized a lot of the challenges that we
11 have in that sort of structure very well -- and
12 also within the MAP process.

13 So this effort was to be a first step,
14 to understand the state of the science first, and
15 then second to characterize what the elements are
16 that we may want to consider. I think the
17 conversation we had today was very rich in terms
18 of providing input about how the endorsement may
19 consider the elements of an attribution model,
20 and then how we might consider this going forward
21 in the MAP process.

22 I think we're going to still have to

1 take this back and try to figure it out.

2 Operationally, I think we heard this very loud
3 and clear in terms of making this tactical in
4 terms of what are the expectations of both of
5 these processes. I think we quite frankly
6 haven't yet done that work, and I think that's
7 clearly the next step.

8 There's also been this underlying
9 conversation around what are some of these
10 scientific components around testing? What does
11 that mean in the context of attribution? And
12 again, that's partially what we're going to have
13 to go back and think about in the next phase of
14 work for these activities if we're really going
15 to be including them in the next phase of
16 evaluation.

17 Helen, are there any other sort of
18 high level takeaways that you have? I mean
19 obviously there's a lot of rich discussion here,
20 and we'll make to represent it in the discussion
21 and as we think about our next steps. Also, if
22 there's any thoughts from CMS in particular, we

1 welcome those as we close up the discussion.

2 DR. BURSTIN: Just a great discussion.
3 It gave us lots to think about. I think we'll be
4 kind of bringing back a lot of these issues to
5 our CSAC and other groups as we think through
6 next steps.

7 MEMBER QASEEM: Can I ask a
8 clarification question? So right now the testing
9 is happening at a certain level right?

10 MR. AMIN: Yes.

11 MEMBER QASEEM: So maybe I'm not
12 really get it. Going back to what Bruce said,
13 wouldn't that be a low-hanging fruit to implement
14 what Chip just said? So if the testing is
15 happening at a clinician level, or whatever level
16 it's happening, that it becomes a requirement?
17 What's there to discuss for this one? I mean why
18 can't we just really quickly move on this?

19 MR. AMIN: Well, so there were some
20 discussions around testing different attribution
21 models, and the criteria of what we would be
22 looking at there, I think, is still not

1 completely clear. The second, and I don't mean
2 to speak for Bruce, but I think where we're not
3 going all the way to the level of testing the
4 reliability and validity sort of cut-offs that
5 are included in the context of the program that
6 it's being used.

7 And that's sort of hinted at in some
8 of these components that have been laid out here,
9 which is, a lot of it is the measure evaluation
10 context of the program. That's a step that we
11 haven't taken yet. It's not that it's difficult
12 to do. It's just whether it's the, you know, the
13 next step that we should take.

14 MEMBER QASEEM: So what I'm asking, I
15 mean that's going to take a while to do all that,
16 and since we have -- we have a little bit of a
17 simplified performance measure evaluation process
18 right now in place in the country anyways. What
19 I'm asking is if a measure is being endorsed at a
20 certain level right now, and I know NQF already
21 does that, why can't we move that little bit
22 forward, that that's going to become one of the

1 criteria?

2 At this point, more knowledge that if
3 the measure has been tested at this level, this
4 is what is being endorsed right now. It's buried
5 in the text when you're endorsing the measure.
6 But what I'm saying is that because one of the
7 criteria that this is all we're endorsing it for.

8 MR. AMIN: So technically that is the
9 way the current endorsement works.

10 MEMBER QASEEM: But it's buried.

11 MR. AMIN: Yes. I mean we definitely

12 --

13 MEMBER QASEEM: It's buried. It is
14 there. What I'm asking is to make it your
15 criterion.

16 MR. AMIN: Yes, and make this whole
17 off-label use, meaning if it's used at different
18 levels, more transparent and clear. There's
19 obviously what we could do that. And you're
20 right. It is straightforward. It's not what the
21 testing supports. So we could certainly bring
22 that back.

1 DR. ANTONELLI: I promise this will be
2 30 seconds. In terms of language, so I know at
3 the IOM or NAS, whatever we're calling it now,
4 earlier this month, they were talking about child
5 health measures. In fact, some of those measures
6 are actually readiness for kindergarten, high
7 school graduation, so really community measures.

8 So to the degree that you bake into
9 your discussions use of the term patient versus
10 person, I would really appreciate it.

11 CO-CHAIR PINCUS: Okay.

12 DR. ANTONELLI: Because when I think
13 about population health, you're a person who
14 happens to become a patient. I recognize that in
15 this group, because we're thinking about CMS all
16 the time, your ticket to the dance is that you're
17 a patient. I actually am excited about this
18 attribution discussion, because of the potential
19 bridge it builds into the world of true
20 advancement of health.

21 So could you bake in some components
22 of your language going forward around person, not

1 just patient.

2 CO-CHAIR PINCUS: Yes, yes. We
3 realize that we did not leave room for public
4 comments on this, so just at this point, let's
5 open it up. Are there any comments from the
6 public participants in the room?

7 (No audible response.)

8 CO-CHAIR PINCUS: Any comments from
9 public participants on the phone?

10 OPERATOR: At this time if you'd like
11 to make a comment, please press star then the
12 number one.

13 (No audible response.)

14 OPERATOR: There are no public
15 comments at this time.

16 CO-CHAIR PINCUS: So why don't we take
17 a break now and reconvene at 5 to 11:00.

18 (Whereupon, the above-entitled matter
19 went off the record at 10:39 a.m. and resumed at
20 11:04 a.m.)

21 MS. O'ROURKE: While we reconvene, I
22 did want to just kind of jump in for a few

1 minutes for some of our newer MAP members, who
2 actually may not be familiar with the work of the
3 MAP task forces, and to give some background that
4 MAP does have responsibilities outside of the
5 pre-rulemaking rule.

6 So obviously the pre-rulemaking work
7 that we've done over the past two days
8 constitutes one of MAP's largest charges, but if
9 you recall from the org structure that we show
10 during the orientation, we do also have the
11 ability to convene time-limited task forces to
12 tackle particular challenges or to do work
13 outside of the scope of pre-rulemaking.

14 So historically, we've looked at a
15 wide range of topics. We've provided some input
16 on the health insurance exchange's quality rating
17 when that was getting set up. We also created
18 families of measures around the different NQF
19 priorities, and one of the more enduring task
20 forces has been the work of the Adult and Child
21 Medicaid Task Forces, to provide input on the
22 core sets of measures used by the states.

1 So what we're hoping to do today is to
2 shift the focus of the Coordinating Committee for
3 a bit to the process that the Medicaid Task
4 Force, forces I should say, have been using to
5 make those recommendations, and to help us
6 continually improve them and perhaps bring the
7 more in line to the way that MAP makes its pre-
8 rulemaking recommendation, so that CMS and others
9 can see a consistent process and product from MAP
10 and to know that all the recommendations are made
11 equally rigorously. So, I think, Taroon, if you
12 have anything to add or --

13 MR. AMIN: No, just to say that this
14 next conversation obviously builds on the
15 conversation we had in September, related to the
16 preliminary analysis algorithm. So you'll find
17 the goal here is to create more alignment in the
18 approach that's being used across the work
19 groups. So that is the purpose of today's
20 discussion.

21 CO-CHAIR PINCUS: And actually let me
22 just say a word. In some ways and I may be

1 wrong, but in some ways the first meeting of the
2 group that reviewed the Medicaid measures
3 actually predated the MAP process. In that way,
4 it became kind of the model for how MAP operated.

5 I was there at that meeting and
6 participated in it, and it was really sort of an
7 interesting process to see how one does that,
8 that came out of the CHIPRA rules, and so it's
9 kind of come full circle now to now sort of get
10 more joined up with the MAP process. So Debjani.

11 MS. MUKHERJEE: Thank you. So I would
12 like to thank Harold and everybody, and
13 especially the MAP Coordinating Committee for
14 this opportunity to present some of the MAP
15 Medicaid process refinements here today, and what
16 I'll do first is provide a background, and my
17 name is Debjani. I'm the Senior Director for the
18 Medicaid Adult and Child Core Set, and I'd like
19 to acknowledge our chairs here today.

20 Harold is the chair for our Medicaid
21 Adult Task Force, and which is -- Rich Antonelli
22 is the chair for our Child, and he's our new

1 incoming chair, replacing Foster Gesten. So with
2 that, what I'd like to do is, the first couple of
3 slides will be foundational, providing some
4 background on the core sets and sort of the task
5 force charge and sort of the goal of the core
6 sets.

7 Hopefully, that will set some context
8 for the ensuring discussion about the preliminary
9 analysis. So the Adult Core Set came out of the
10 Affordable Care Act, and sort of that was the
11 genesis of creating an initial Adult Core Set,
12 and since then it has been updated annually with
13 recent iterations reflecting the input from MAP.

14 Similarly, the Children's Health
15 Insurance Program Reauthorization Act of 2009
16 provided for the identification of a core set for
17 children enrolled in Medicaid and CHP. And the
18 CMS and AHRQ, Agency for Health Care Research and
19 Quality, jointly came together with a group of
20 experts and created the initial core set in 2009,
21 and just a point about this core set.

22 The measures cover children ages 0 to

1 18, as well as pregnant women to get pre- and
2 post-natal care needs. So the core sets must be
3 updated annually, and the way this happens is the
4 Medicaid Task Forces come together. They discuss
5 potential recommendations for addition, as well
6 as measures for removal from the core set.

7 These recommendations are sort of
8 blessed by this MAP Coordinating Committee in
9 August. Then they are sent forth to CMS HHS,
10 where they get feedback from their various
11 internal/external stakeholders, and the final
12 annual updates for that year to both the core
13 sets are published in December.

14 So what is the core set's
15 charge/purpose? The purpose is to get states'
16 experiences in implementing and reporting on the
17 core set measures, and in a way, that functions
18 as a feedback loop and gives us experiential data
19 regarding sort of the feasibility and sort of the
20 difficulties with respect to implementing.

21 The core set purpose is also to sort
22 of gather concrete recommendations for

1 strengthening and sort of addressing measure
2 gaps, potential measures that should be
3 considered, as well as measures that are
4 ineffective and should be removed.

5 Together, the input provided helped
6 CMS formulate strategic sort of direction and
7 sort of policies with respect to Medicaid.

8 So as mentioned before, the task
9 forces are time-limited bodies, and it's an
10 interesting point, because the Medicaid task
11 forces have been around for a couple of years,
12 and what they -- what the goal of the task force
13 is is to come together, provide guidance on a
14 very specific topic, and then they get disbanded.

15 Just because of their annual updates,
16 the Medicaid task forces have been around for a
17 while, and one of the caveats is that the task
18 force membership is drawn, has to be drawn from
19 the current MAP work groups, as well as the
20 Coordinating Committee. This is also another
21 reason why that the Medicaid work happens off-
22 cycle, so that we can let the MAP pre-rule work

1 be completed before we start tapping the same
2 individuals for the Medicaid work.

3 So the core set data or sort
4 of reports on measures from the core set are used
5 to create a snapshot of quality across Medicaid
6 and CHP. The data is provided annually in the
7 Health Quality Report. There are two reports,
8 one for child, one for adult. There's also a
9 chart pack that has state-specific data and other
10 analyses, and altogether all of this, again, is
11 used to inform policy and program decisions.

12 Again, a quick recap of the task
13 force's charge. Review states' experiences in
14 reporting measures to date; refine; identify
15 measure gaps, and sort of, usually it's growing
16 the measure gap on a yearly basis; recommend
17 potential measures for addition to the set; as
18 well as recommend measures for removal based on
19 loss of endorsement and/or ineffectiveness within
20 the program.

21 This provides you with a quick time
22 line. The Medicaid work again is off-cycle. It

1 starts in March with a web meeting. Then the in-
2 person meeting always happens in May, late May.
3 Report development happens June through August.
4 Mid- to late August is when all the
5 recommendations as well as comments are brought
6 forth to the MAP Coordinating Committee for
7 review and approval.

8 The final reports are completed by
9 August 31st on a yearly basis, and then the core
10 set updates are provided usually by December of
11 that year.

12 So the project evolution. The whole
13 point of sort of undertaking this process
14 improvement is to sort of align with the
15 expansion of Medicaid and sort of the impact in
16 importance of Medicaid and health care,
17 standardize the work flow, as well as the
18 assessment of measures and recommendations across
19 project tiers, as well as systematically review
20 measures.

21 The current processes of document
22 review considers the gaps within the Medicaid

1 population and sort of the needs of the
2 population, as well as being guided by the
3 measure selection criteria. What is being
4 recommended and sort of put forth for discussion
5 today is the introduction of a standardized way
6 of discussing potential measure recommendations
7 based on a Medicaid-specific algorithm and
8 preliminary analysis.

9 And just to note that what staff has
10 done is take the MAP pre-rulemaking algorithm and
11 preliminary analysis and has adapted it for
12 Medicaid on core sets. Hence, the edits are not
13 drastic. It's more sort of a clarification of
14 what Medicaid needs might be and how they might
15 be different from MAP pre-rulemaking Medicare
16 needs.

17 So in the next couple of slides, what
18 I want to do is quickly talk about some of the
19 Medicaid decision criteria before I go into the
20 actual edits of the algorithm, and the
21 preliminary analysis tool with the edits has been
22 distributed. It's a draft copy. So everybody

1 should have a copy of it at your table right now.

2 So the decision criteria starts with
3 support, and support criteria basically addresses
4 a previously identified measure gap, measures
5 that are ready for immediate use and promotes
6 alignment across programs and settings. The
7 other decision criteria is conditional support,
8 and that's for measures that are pending
9 endorsement from NQF, pending change by the
10 measure steward, pending CMS confirmation of
11 feasibility of implementation reporting, and
12 other such considerations, practical
13 considerations.

14 And finally, the do not support
15 criteria are for measures and/or measure focus
16 that are inappropriate are a bad fit for use for
17 the Medicaid core sets. There's a duplication of
18 efforts, resource constraints, which is a big
19 issue, and Medicaid agencies at the state level
20 will need to tweak and/or vary the level of
21 analysis to increase measure adoption and
22 implementation.

1 So with that, the next couple of
2 slides talk about where changes have been
3 introduced to the MAP pre-rulemaking preliminary
4 analysis tool. So for the first couple of
5 assessments, all we have done is add high impact
6 area with a focus on the Medicaid population. So
7 that's more of a clarification. And then the
8 major adaptations or deletions are, if you want
9 to follow along in the paper copy that's been
10 handed out for Assessment Number 5.

11 The Assessment Number 5 for pre-
12 rulemaking says the measure can be feasibly
13 implemented. For Medicaid, it has been changed
14 to operational feasibility because we want to
15 make sure that it's implementable. From reports,
16 sorry, the pre-rulemaking says reporting
17 feasibility. The Medicaid one says operational,
18 because we want to make sure that it can be
19 implemented and operationalized before we get to
20 sort of the reporting aspect.

21 And then the final one is number
22 seven, which for the pre-rulemaking is sort of

1 asking for end user feedback on measures that are
2 already implemented in other programs, and that
3 has been deleted for the Medicaid.

4 That's one of the questions I have for
5 the MAP today: should this assessment still be
6 done? Because the Medicaid program is unique in
7 having the data of how feasible -- or sort of
8 user feedback from PQS and some other program, I
9 don't know if that's going to be very helpful for
10 the Medicaid-specific core set.

11 But if this group feels like it should
12 be put back, all we'll do is just add it back.
13 With that, those were the only two sort of big
14 edits done. I want to open it up to say what
15 other factors or considerations should be added
16 to this Medicaid-specific preliminary analysis?
17 Any additional edits? Any additional comments?
18 Sort of your thoughts on sort of adapting
19 something that's for pre-rulemaking to something
20 that's for Medicaid.

21 I just want to keep this to this part
22 brief so that we can have time for discussion.

1 Harold.

2 CO-CHAIR PINCUS: So any comments, any
3 thoughts? I know, you know, Rich, you are coming
4 into the process. You've been involved in the
5 process, but coming in as chair, and Carol's been
6 very involved as well. And others have been
7 involved in the Medicaid Task Forces.

8 So maybe we could -- people would have
9 some thoughts in terms of some of these changes.
10 Important points about, just to reemphasize, is
11 that it's interesting in that this is a voluntary
12 program, and so that states have the option of
13 participating in it or not participating in it.
14 States also have the option of choosing which
15 measures they want to implement.

16 So there's a balance in terms of
17 thinking about both what are individual state
18 needs? What are the needs across the Medicaid
19 program? What capacity states, individual
20 states, have in terms of the implementation of
21 these programs. And also there's a real
22 opportunity to have very good interactions

1 between people involved in running state Medicaid
2 programs, as well as other stakeholders in
3 getting some of the back and forth about how they
4 -- the difficulties and barriers they have in
5 implementing some of the measures, but also in
6 terms of how they're using the measures within
7 their states to improve care.

8 So it really provides an interesting
9 sort of laboratory of what actually goes on in
10 other areas of other programs that MAP oversees.
11 So comments. Rich, did you want to say
12 something?

13 DR. ANTONELLI: I have a couple of
14 comments, but I'm going to anticipate a question.
15 Debjani, could you say a little bit more about
16 the rationale for deleting number 7?

17 MS. MUKHERJEE: Sure. So I think from
18 sort of the staff perspective, we wanted it to be
19 as Medicaid-focused as possible and sort of
20 really attuned to the specifics of needs of the
21 Medicaid population. And from our point of view,
22 we didn't know if looking at other federal

1 programs that have already implemented the
2 measure, whether that sort of information is
3 translatable to the Medicaid population.

4 So if it worked in some sort of pay-
5 for-performance, is it going to sort of translate
6 easily to sort of the Medicaid population? And
7 Medicaid is voluntary. Also, a lot of the issues
8 we hear in Medicaid as resource constraints are
9 political, sort of, will-related issues. I don't
10 know if that, especially the political will
11 issue, is going to be captured in sort of the
12 states' experience in reporting.

13 And that's why I said staff is open to
14 putting it back in if the MAP Coordinating
15 Committee thinks that it is something we should
16 at least hear from and consider, even if it's not
17 directly relatable or translatable.

18 DR. ANTONELLI: So thank you, and I
19 don't know whether Foster is listening in today,
20 but I have huge shoes to fill. But I'm honored
21 to be asked to be able to do this, and I'll make
22 a couple of comments. I'll keep them brief. So

1 first of all, I think in general, the document,
2 the tool that you've shared with us for comments,
3 I think aligns very nicely with being able to
4 look at some of the core principles around
5 validity and parsimony harmonization, usability,
6 and feasibility.

7 Last year what we did is we had, for
8 the child and the adults, actually there was like
9 a three day meeting with overlap between the
10 child and the adult for two of those three days.
11 So I really liked that, and one of my core
12 principles with respect to care coordination and
13 integration measures is to try really hard to
14 promote a single approach to integration that is
15 not age-specific.

16 So I really like this approach, and I
17 like the criteria. This will be especially
18 important as we try to identify and then promote
19 measures to fill gaps in the area around
20 behavioral health assessment and integration as
21 an example. So I really appreciate the ability
22 to have the child and the adult task forces to

1 co-convene, and to look at experience.

2 The other piece though that I found
3 valuable last year, and I wanted to bring up with
4 our CMS colleagues in the room, we have
5 qualitative experience from selected states that
6 will come in to talk a bit about their measures.
7 I want to make sure that that continues. That's
8 very helpful.

9 It also would be really helpful for us
10 to be able to see some data from the states that
11 actually are using some of these measures. What
12 I'm particularly mindful of is, because a state
13 isn't using a measure, if I don't have any more
14 information than that, I don't know is that was
15 because of lack of resources, lack of political
16 will, or whether in fact it speaks to the
17 usability, feasibility, or applicability of the
18 measure.

19 So I think if CMS could consider
20 getting some data to the task forces when we have
21 that component of measure review, that would make
22 our -- that would inform our deliberations that

1 much more. Then I think it would be -- I'm also
2 keen to hear a little bit about Item 7. Full
3 disclosure, this is the first time that Harold,
4 Debjani and I are talking about this.

5 But I am mindful, being a provider
6 myself. There may be measures that I have
7 experience with that aren't necessarily in the
8 Medicaid space yet. So while I agree with the
9 need to have relevance and comparability, we may
10 want to have some criteria by which we will
11 either rule in or rule out the content, if you
12 will, for Element 7, or make sure that those
13 comparability criteria fold into another element.
14 Those are my, those are my comments.

15 CO-CHAIR PINCUS: Carol?

16 MEMBER SAKALA: Yes. So I've been
17 through this process for three rounds and heading
18 toward a fourth. I'd like to second what Rich
19 says I think about the structure, which I think
20 is really valuable and rich to have the task
21 force members, NQF staff, people from CMS. Very
22 rich presentations, feedback from the states,

1 which do give some of the feedback about measure
2 use issues in the context of Medicaid.

3 And also, having a day of overlap
4 where the child and adult groups meet together.
5 So I think it's really fundamentally a very
6 excellent process, and I support the effort for
7 continued alignment with the overall, the MAP
8 process. I just wanted to follow up. Leah made
9 a comment yesterday that I think might have
10 seemed a little strange. She mentioned maternity
11 and cesarean in the context of a conversation
12 which is framed around Medicare.

13 Last year we had the VBAC measure, but
14 it wasn't an all-payer measure. So I just wanted
15 to share a little bit of -- like be sure that
16 everyone's aware of what I would call an
17 imbalance right now, because the Medicaid is
18 really, there are facility measures, clinician
19 health plan, but they're aggregated to the state
20 level.

21 So the potential for improvement is
22 very different from the Medicare measure. So I

1 just wanted to be sure that everyone understands
2 that, and as Harold said, it's voluntary, and it
3 is at the state level. And it's also
4 confidential, so that we don't even get the state
5 performance results there. And the three aims
6 are that over time, more states should be
7 collecting -- more states should be involved.

8 States should collect an increasing
9 number of measures, and states should use them
10 for quality improvement. But that is very
11 different from the various federal programs that
12 we've been talking about, and there were some
13 public comments this time around directed to the
14 hospital draft report, saying that on the model
15 of the elective delivery measure, that is an all-
16 payer measure that is in the inpatient quality
17 reporting program and in Hospital Compare.

18 Maybe it's time to think about how we
19 might fix this imbalance between the two
20 programs. So in the context of discussing
21 Medicaid, I just wanted to rise that, because
22 conditions that apply to younger populations,

1 pediatric, maternity, other things, really are
2 pretty left out of the federal programs.

3 CO-CHAIR PINCUS: Marissa.

4 MEMBER SCHLAIFER: So some of my
5 comments very much mirror Rich's comments and
6 Carol's comments. I'm only -- I've been through
7 just two years going on Year 3, and one thing I
8 just want to reiterate, the importance of having
9 the Medicare/Medicaid program directors, state
10 directors here to share information.

11 There's some of us on the Committee
12 who have strong managed Medicaid background and
13 not fee-for-service Medicaid background, and I
14 think explaining the feasibility of why things
15 can't be collected. I think I learned so much
16 over the last two years about why measures that
17 made sense to me don't really make sense, or make
18 sense in the managed Medicaid world and don't
19 make sense in the fee for service Medicaid world.

20 So I just would encourage that, and
21 that's originally what I thought this question
22 was, and now I'm understanding I guess that it's

1 more people that are non-Medicaid. I just wanted
2 to say that.

3 One question, and I don't expect it to
4 be answered here, but I think that came up
5 briefly at the end and Kate, I don't know that
6 this is something that CMS has gotten to yet.
7 But one of the interests that I know on the
8 management Medicaid plans have is with the new
9 managed Medicaid quality measures that will be
10 rolling out in I think 2021, and we are still
11 pretty far away, I think trying to --

12 One of the questions that was asked at
13 this past go-round of the meetings was whether a
14 MAP or MAP-type entity would have input on those
15 managed Medicaid measures, and whether those
16 managed Medicaid measures could be -- we would be
17 assured that they would mirror the state Medicaid
18 measures.

19 So I think that's just something that
20 hopefully we can talk about a little more at the
21 upcoming this year's meetings, and maybe CMS will
22 have had time to think about that by then.

1 CO-CHAIR PINCUS: Other comments? I
2 just have a few. Oh, Doris.

3 DR. LOTZ: Yes, thanks. A couple of
4 general comments. I wouldn't want too much
5 departure from the MAP process, you know,
6 inasmuch as the MAP process we've just discussed,
7 you know, evolves the contribution about
8 attribution. Other conversations we've had over
9 the last day and a half, applying those to any
10 approach taken for Medicaid to me would be, you
11 know, should be done.

12 I think there are some unique aspects
13 of the Medicaid population, you know, the
14 population, some of the services maybe. But as
15 far as measurement is concerned, I would strongly
16 encourage just keeping the same approach, the
17 same standards, maybe with a few additional
18 standards, but without substitution.

19 You know, the past physiology is the
20 same. We're moving more and more towards
21 integrated payer models, where Medicaid is most
22 effectively affecting changes to population when

1 thinks its service delivery across payers, and
2 not as some sort of unique payer. So you know,
3 the ACO models, some of the models that came out
4 of SIM, these are looking for Medicaid to partner
5 with the commercial sector and with Medicare.

6 If we create too different a set of
7 standards for measurement, we're going to have a
8 hard time, you know, introducing payment models
9 and some assessment of value and change. That
10 said, I do think we need to think about some
11 unique needs of the populations. But I see that
12 almost as, you know, secondary to creating the
13 gold standard in a measure so to speak, that I
14 kind of like to think of coming out of this
15 process.

16 I think absolutely feedback on
17 measures, though, is good. So I'm not, I'm not
18 clear, and I don't have the full document. I
19 only have the slides that were distributed. But
20 number seven it says regarding feedback, delete
21 number seven regarding feedback.

22 I would speak against that. I've had

1 a chance to talk to the Medicare MAP group a
2 couple of times in my capacity as CMO for
3 Medicaid, and pointing things out that, you know,
4 we have a good portion of our population going to
5 places called Institutes for Mental Disease,
6 which are the state psychiatric facilities or
7 otherwise, you know, psych facilities that are
8 dedicated primarily to the public sector.

9 Historically, these were taken out of
10 the payer mix so Medicaid didn't pay for them.
11 They were primarily funded through other state
12 reimbursements. But as we've kind of evolved our
13 Medicaid practices, we look at, you know, the
14 measures that deal with discharges from mental
15 health facilities, certain follow-up criteria, et
16 cetera, as definitely applying to the IMDs or the
17 Institutes of Mental Disease.

18 So this is a variation in Medicaid
19 that I think enhances the use of the measure, and
20 that the MAP process ought to be familiar with.
21 But it certainly doesn't require a different
22 approach to creating that measure, and certainly

1 not a different measure.

2 So I would speak against deleting the
3 feedback, and I'm also similarly befuddled about
4 why separating operational feasibility from
5 reporting feasibility. As been said before it's
6 voluntary, so where there's politics, where there
7 might be resource constraints, that's on the
8 states to sort through.

9 To take them somehow formally out of
10 the discussion, it seems prematurely to take them
11 out of there because politics and resources
12 change, and you know, I would rather see for
13 Medicaid a robust set of measure sets. It allows
14 us to capture local opportunities and capture
15 integration where we can, rather than to have
16 them sort of presorted before the measure set is
17 complete.

18 So I know that was a lot, but 15 years
19 I've been working with the Medicaid program
20 primarily with quality improvement and
21 specifically with measures. I would rather at a
22 philosophic level have the measure set reflect,

1 you know, the general delivery of medicine, as I
2 said, the pathophysiology that we're trying to
3 address, rather than have it be some sort of
4 separate set of criteria that leads to Medicaid
5 measures. I'll go back on mute now.

6 CO-CHAIR PINCUS: Thanks, Doris. I
7 had a -- oh, Aparna.

8 MEMBER HIGGINS: Sorry, I had a quick
9 question. On the operational feasibility aspect,
10 are there -- I know when we do our MAP selection
11 criteria, we have subcriteria. So is that
12 something? That's actually a question? So do we
13 have subcriteria in terms of how the Committee
14 looks at operational feasibility? So I mean kind
15 of looking at it --

16 CO-CHAIR PINCUS: And maybe explain
17 the difference between operational feasibility
18 and implementation and reporting.

19 MEMBER HIGGINS: Reporting, yes.

20 CO-CHAIR PINCUS: What are the --
21 because it seems like a fuzzy mentality there.

22 MEMBER HIGGINS: And then I have a

1 comment after that, after I get an answer to my
2 question. So go ahead.

3 MS. MUKHERJEE: So the way we were
4 looking at it is can it be adopted as specified
5 without additional resources being needed at the
6 state level, and if additional resources are
7 needed, does the state have access to that? Also
8 we're looking at the implementation. Is it at
9 the state level, at the plan level and sort of
10 what is the feasibility of doing that?

11 But again, all of this is up here
12 today for sort of input, refinement. So if
13 anybody has other thoughts, other subcriterias
14 that should go other than sort of the level of
15 analysis, operationalizing at the level of
16 analysis, and sort of the resources of adopting
17 it as specified, I think we're open to any and
18 all suggestions at this point.

19 MEMBER HIGGINS: Because one thing I
20 would -- I mean this probably came up in
21 discussion is the availability of data, right,
22 for calculating all the measures. Depending upon

1 how the state defines the benefit, you know, some
2 states carve in behavioral health, some don't.
3 You know, it's just going to vary in terms of
4 what states are going to be able to do.

5 So you probably want to make that
6 explicit. I think I'll say the same thing as
7 what Doris said for seven. I think it's still
8 useful to get feedback from current measure
9 users, because if say implementing the measure in
10 the commercial population they run into some
11 challenges, I think it would be good for the
12 committee to understand those.

13 People might say oh yes we have the
14 same problem because we don't have X, Y or Z. So
15 I think there's value in that. And then just to,
16 you know, sort of comment on what Marissa said
17 about Medicaid managed care, and looking at what
18 the states are doing, you know, I mean there's
19 variations on a theme.

20 I mean I think we're all familiar with
21 the buying value project. We looked at use of
22 measures at the state level and there were, you

1 know, over 1,000 measures and variations on those
2 as well. I think, and again it's also driven by
3 the benefits and what the states decide to do.
4 So that's -- I mean it's a huge challenge and I
5 just say more power to the committee so --

6 CO-CHAIR PINCUS: So just a couple of
7 comments. One is with regard to the two issues
8 about the changes, it seems to me that, you know,
9 one of the sort of real things I like about the
10 program is the fact that it is voluntary, and it
11 allows, you know, more flexibility in a sense in
12 terms of how one applies this.

13 There's always going to be a balance
14 between having the flexibility versus having
15 standardization, you know. While, you know, at
16 some level the goal is to have every state report
17 on every measure, there's also an understanding
18 that every state's going to be very different,
19 and if you look at where the Medicaid program is
20 heading, there's going to be even more
21 variability.

22 So that, you know, during this period,

1 especially when there's going to be this
2 transition, I think having flexibility may be
3 important. So that different states applying
4 different models having different capacities can
5 get their feet wet in reporting in some way. At
6 some levels, we want to encourage people to come
7 in, states to come into this.

8 And they may -- with the understanding
9 that they may not be able to report on every
10 measure, but still to participate and to begin to
11 be able to sort of evolve over time, particularly
12 from the point of view of what they find useful
13 in participating in this.

14 Because one can think of feasibility
15 from a number of different perspectives,
16 feasibility in terms of reporting, actually
17 collecting the data. But also feasibility of the
18 ways in which they might use the data. They have
19 different capacities to do that.

20 So I would, you know, be more general
21 in terms of thinking about, in terms of
22 Assessment 5 to say that that's something that

1 should be explored, but it should be, you know,
2 with not, you know, we shouldn't set the lowest
3 possible capacity to do that as the standard,
4 that we should have some, you know, allow some
5 flexibility.

6 With regard to Item 7, you know, I
7 think that it's always useful to have this kind
8 of information. I don't see a reason to exclude
9 this kind of information. So you know again,
10 it's input and it's useful and I think, you know,
11 members of the task force think about these
12 things anyway, because they may have been exposed
13 to the use of these measures, you know, in other
14 ways.

15 So we should probably be explicit
16 that, you know, we welcome this kind of
17 additional information. But I think, you know,
18 as I said before, given the current political
19 issues going on around Medicaid, this is going to
20 become, you know, increasingly important as a
21 program. I think we also want to sort of
22 generate as much interest as possible from the

1 states themselves, in understanding as they move
2 towards these more, you know, potentially more
3 flexible and potentially more innovative
4 arrangements, how they can sort of understand
5 where they are in relationship to other states
6 and how they, you know, can use this kind of
7 program to improve what they're doing and learn
8 from the experiments that are going on.

9 MS. O'ROURKE: Could I jump in with a
10 perhaps suggestion of a path forward? So it
11 sounds like from Doris' comments and Aparna's,
12 perhaps maybe we want to adopt the same seven
13 assessments for both pre-rulemaking and the
14 Medicaid work, and then allow for the necessary
15 customization in the definition of those
16 assessments, so that now we'll have a consistent
17 preliminary analysis algorithm across the board
18 when you look at the overarching assessments that
19 every measure will be subject to.

20 And then versus pre-rulemaking versus
21 the Medicaid at work, there will be the need for
22 the customization. Again, just to highlight why

1 we're bringing this to you, is we want the
2 Coordinating Committee to feel comfortable with
3 the process, that the task forces will now go use
4 to make their initial recommendations to you,
5 because we'll be bringing the findings of the
6 task force to you at your August web meeting, to
7 finalize. Similarly to the charge of the
8 Coordinating Committee to finalize the pre-
9 rulemaking recommendations.

10 So again like we discussed in
11 September, the process for pre-rulemaking, we
12 want you all to feel comfortable with the process
13 the task forces are about to embark on for their
14 work. So we would perhaps put that suggestion
15 out for the Committee's consideration as a
16 potential path forward.

17 CO-CHAIR PINCUS: I think that makes
18 a lot of sense. Rich.

19 DR. ANTONELLI: Yes. I don't know
20 whether our CMS colleagues didn't respond to the
21 Medicaid MCO, or whether you were just being
22 polite. So I would absolutely respect you not to

1 feel comfortable, but I'd love to hear what you
2 would say about, you know, what would the lines
3 of sight be between this work and the Medicaid
4 MCO measure sets.

5 DR. GOODRICH: I think we need our
6 Medicaid colleagues to answer that question up
7 here. We need our Medicaid colleagues to answer
8 that question. Peter and I work on the fee for
9 Medicaid service side. I don't know if there's
10 anybody on the phone.

11 MS. O'ROURKE: Oh okay, okay.

12 DR. GOODRICH: So if we have somebody
13 from CMS on the phone who can answer that.

14 MS. MUKHERJEE: Renee, are you on the
15 phone? Gigi, Renee?

16 DR. FOX: Debjani, can you hear me?

17 MS. MUKHERJEE: Yes, we can hear you.
18 Do you hear the question? Do you want to take
19 sort of an --

20 DR. FOX: So I'm going to -- I'm not
21 the managed care rule guru, and I'm going to
22 defer the question. I think we would be happy to

1 discuss it in the -- maybe we can add that to the
2 agenda for the MAP meeting in March.

3 CO-CHAIR PINCUS: That makes sense.
4 I mean it's certainly something that we want to
5 discuss and --

6 DR. FOX: Great. We'll make sure that
7 --

8 CO-CHAIR PINCUS: And we can prepare
9 for that.

10 DR. FOX: Yes. Thank you.

11 (Off mic comments.)

12 CO-CHAIR PINCUS: Other comments,
13 other questions? Any other comments from the CMS
14 Medicaid participants?

15 (No audible response.)

16 CO-CHAIR PINCUS: Okay. So why don't
17 we move on to the next section. Is there any
18 other -- that's good. Let's move on. Let's move
19 on to the next section. So there's an
20 opportunity for public comment on this Medicaid
21 presentation. Okay. Are there any comments on
22 the sort of Medicaid task forces discussion that

1 we just had from the public in the room?

2 (No audible response.)

3 CO-CHAIR PINCUS: What about the
4 public on the phone?

5 OPERATOR: If you want to make a
6 comment, please press star then the number one.

7 (No audible response.)

8 OPERATOR: There are no public
9 comments at this time.

10 CO-CHAIR PINCUS: Okay, thanks. So
11 Chip, I think we're going to move on to
12 discussions about process improvement of the work
13 that we've been doing over these two days.

14 (Pause.)

15 MS. O'ROURKE: Sure. So we can -- the
16 presenters from ASPE can be available at one
17 o'clock.

18 CO-CHAIR KHAN: Okay. Well then let's
19 barrel through. So I'll turn to Kim to present
20 this process.

21 MS. O'ROURKE: Thank you. Do you want
22 to at this -- sure. So again, this is something

1 we've done with the Coordinating Committee every
2 year. We want to hear your feedback on what
3 worked about the pre-rulemaking process, both
4 what the process, the work groups used to make
5 their recommendations, as well as the process for
6 the Coordinating Committee's meeting.

7 So Kim's going to be taking you
8 through an exercise there. She's also going to
9 be highlighting a few areas where we'd really
10 love your feedback on some potential ways to do
11 this a little better next year. In particular,
12 we're looking for feedback on the decision
13 categories. If you need to further clarify the
14 differences between the refine and resubmit and
15 the conditional support, and if the Committee
16 thought that having these four categories worked
17 for this year.

18 We also want any input you might have
19 on building out the process to look at the
20 measure that are currently finalized for the set,
21 any ideas about data we could bring into the
22 Committee for their consideration, potential

1 sources for that data.

2 Kim's also going to give you a
3 refresher on the feedback loop that we've piloted
4 with the PAC/LTC group and some suggestions from
5 the Coordinating Committee would be most welcome
6 as we roll that out across all the MAP work
7 groups.

8 DR. GOODRICH: Thanks, Erin. So we'll
9 do a warm-up process improvement exercise. It's
10 the round robin plus delta. This is something
11 that the Clinician Work Group used. Yes, the
12 Clinician Work Group used in their December
13 meeting. So what we'd like to do is to go around
14 the room and have each Committee member talk
15 about something that worked really well over
16 these last two days, and what could be improved.

17 NQF staff will be taking notes and
18 we'll use this to help inform the process that
19 happens next year.

20 MEMBER BAKER: I thought the decision
21 categories worked well. I particularly liked --
22 for the conditional support, I thought all of the

1 groups did a good job at saying what were the
2 conditions that needed to be met. I thought that
3 was really helpful.

4 In terms of what could be improved, I
5 think just to be able to come up to that higher
6 level and be able to understand the existing
7 measure set and what niche does this fill. I
8 think we need to get more information on that, a
9 couple of very concrete things. We talked about
10 some of the measures for end stage renal disease
11 and how --

12 It wasn't apparent from the materials
13 that they were -- you had a dig a little bit to
14 see that they were addressing specific problems
15 in some of the existing measures, and the same
16 with one of the other ones, where you were
17 shifting, essentially replacing ECQMs, chart-
18 based measures with new ECQMs. So just to be
19 able to give that higher level view I think would
20 be helpful.

21 DR. GOODRICH: So I think the prep
22 materials and having this online, which we've had

1 now for a couple of years for me works very well.
2 I felt like there was a button missing this year
3 that allowed you to get back to the top really
4 easily. So a tiny little thing, but I just
5 thought I'd say that. I looked for it a couple
6 of times. I remember it being there before.

7 The one thing that for me was a
8 little, I don't know if it came out in previous
9 years or not, but was the process by which when
10 you had multiple votes in multiple categories,
11 that it would roll down to the, you know, to get
12 to the 60 percent. Sometimes we saw a couple of
13 examples of this yesterday.

14 That was just awkward, because you
15 ended up having most in one category, but you did
16 have a couple of like in refine and resubmit sort
17 of roll down to refine and resubmit, which didn't
18 always make sense for the measure if it was fully
19 endorsed, fully specified.

20 So I would just think through that a
21 little bit for next year. So that's one area I
22 would point out. I feel like we struggle with

1 this every year, like what does consensus mean,
2 you know. Should it just be a simple majority?
3 Now we've come to the 60 percent, and I know why
4 we got where we did each time. It continues to
5 be a struggle. I do not have a suggestion. I'm
6 sorry.

7 DR. YONG: So along with Erin and
8 Helen having sat here now for eight days of MAP
9 meetings, over the course of the past two months.
10 Just from my own observations, I think -- I think
11 the -- at the work group level and at the
12 Coordinating Committee level, I think what has
13 worked really well is both having a chance to dig
14 into the measures on the MUC list.

15 But then also having these cross-
16 cutting conversations even at the work group
17 level, I think they -- we've heard a lot of
18 comment, feedback that that worked. The members
19 really appreciated that opportunity to think
20 about sort of broader cross-cutting issues.

21 I also agree with Kate. I think the
22 prep materials have been really helpful too, and

1 so I really appreciate the work the staff has
2 done just to get those done and out to the
3 Committee.

4 MEMBER ROBICSEK: On the plus side, I
5 felt like the chairs did a very good job of
6 stimulating conversation, helping it move, making
7 everybody wanting to comment and feel comfortable
8 doing so. I also thought the materials that were
9 prepared were very thorough. On the delta side,
10 I did feel like the kind of relative proportion
11 of discussion about procedural things and
12 discussion about the kind of material that we're
13 talking about was maybe not as favorable as it
14 could have been.

15 There was also I felt like, at least
16 for me maybe, because I'm new, ambiguity about
17 what was the what that was in scope for us to be
18 talking about? What would be excessively
19 duplicating work that was already done by the
20 work groups, and what's discussion that should
21 happen here?

22 So kind of what level? Should we stay

1 at that 100,000 foot level? Should we get down
2 into the details that again, at least as a -- for
3 a newbie wasn't totally clear.

4 And then I just want to reemphasize
5 David's point about it would be helpful to see
6 what the existing measure set is, so that we can
7 know where this fits in.

8 MEMBER FLAMM: So I would just, I
9 guess, pile on on the positive side about the
10 materials. A lot of information, very easily
11 accessible. So I think that worked well from my
12 perspective as well. On the opportunity to
13 improve piece, perhaps and others have mentioned
14 this, that is getting clearer around the category
15 purposes and definitions for conditional versus
16 refine and resubmit.

17 I know we kind of touched on that, and
18 I noticed when we were reviewing the MAP Medicaid
19 Task Force, they only had the conditional
20 category. As we're looking to kind of align
21 these processes, maybe there is another
22 opportunity to really clarify whether we really

1 need both and how to -- do we use them at the
2 same time or not, you know.

3 DR. ANTONELLI: I can make this quick
4 because three of the things will be affirmations.
5 But I guess I'll start first by once again
6 complementing the staff. You guys are just
7 amazing and thank you for the prep and your
8 positive energy and support in general. It's
9 wonderful to work with you.

10 The voting thing I found a bit
11 disturbing as well. I think we have to discuss
12 and decide, you know, do we need to achieve
13 consensus on things because sometimes the
14 outcomes didn't really make sense. This one I
15 think that you just raised, Carol, is also key.
16 Indeed, the deny is sort of was reflected in the
17 conversation I think we had yesterday about would
18 we want to send a statement about opioid
19 dependence or assessments. So there should be a
20 refine and resubmit.

21 But it was really a significant pivot
22 from what the spirit of the measure was. And

1 then I think the other one that I'd like to
2 reflect on, and this may actually come -- I don't
3 know if it's going to land here at the MAP or
4 not, but I was really mindful of how important
5 the conversation was about the quality of the
6 informed consent for the elective surgical
7 procedure.

8 There was a sentiment in the room that
9 that's a process measure that may or may not
10 reflect the patient experience. I really was
11 quite impressed by Bruce Hall's notion of the
12 relationship between the surgeon and the patient
13 and family et cetera. I reflected on that. The
14 measure developer put a lot of thought into that,
15 and by the time it lands here a lot of us said
16 but that's not really where we want to go.

17 So I don't know, you know. If we're
18 identifying a gap here, how does that information
19 get out there to the world of people that provide
20 resources and do measure development, because I
21 really -- I don't know if the measure developer
22 was expecting to get the pushback they got from

1 us. I think we landed in the right place.

2 Probably several years' worth of work
3 went into something that kind of came in here and
4 hit the wall. So I don't know what I'm calling
5 out. Maybe it's an issue of better alignment or
6 synchronization around gap identification and
7 work that's being done to actually fill those
8 gaps.

9 MEMBER ANDERSON: I will just say that
10 I appreciate all my colleagues' comments, so I'm
11 not going to reiterate those. But I am going to
12 add just a couple. One is in reflecting on all
13 the materials which I felt were very well done,
14 it seems as though in some of our discussions,
15 when we pushed a little bit more with our
16 questions, the group's decision in what they were
17 putting forward was not fully articulated in that
18 comment.

19 We found out more about what the
20 group's discussion and decision was and why. So
21 if we could refine that a little bit, I think it
22 would help us in an overall discussion. I know

1 this was hard because it's probably our fault as
2 members. But having the pulled measures at
3 really the eleventh hour was very difficult. To
4 then do all the cross-referencing and everything.

5 But that's our fault. So we need to
6 respond to you a little earlier, and make certain
7 that we get those pulled measures in when you ask
8 for us to pull them, and I think I'll apologize
9 for all of us. But it isn't -- we can't have the
10 same in depth discussion if we're at the last
11 minute trying to do all the cross-referencing.
12 So I would just add those comments.

13 MEMBER HIGGINS: So just like everyone
14 else, I want to, you know, thank the staff and
15 congratulate all of you on great work, and having
16 been at the MAP from the very first year, I think
17 we've come a long way in terms of our tool kits
18 and discussion guides, and I think it's so much
19 easier now than it was when we first started
20 doing this so we've learned a lot.

21 So I want to echo some of the things
22 others have said. So I agree with Kate in terms

1 of the decision to have a voice in voting up and
2 voting down. We're a small group so one person
3 could really lost the vote, I think. I don't
4 have the answer to it just like she said, but I
5 think that's a concept we need to come back to
6 just like she said, so it's what the majority of
7 us think to some extent.

8 And then I kind of want to echo what
9 Ari said about trying to figure out what's the
10 right level for us as the Coordinating Committee
11 and not wanting to relitigate all the discussions
12 at the work group level. I think it's
13 challenging sometimes, you know, but we're
14 getting better at it but I think we should pay
15 more attention to.

16 MEMBER MULLINS: I agree with
17 everything Aparna just said, so I'm not going to
18 restate all of that. I do appreciate not
19 carrying about three or four big huge white
20 binders of information to everyone in these
21 meetings. That's great. Completely different
22 subject on things that were great. The hotel was

1 within a wonderful walking distance of the office
2 so yay on that decision.

3 One thing that I thought was a little
4 confusing for me, it was hard to about the pulled
5 measures. I think it was hard to see what the
6 whole measure list was and then which ones had
7 been pulled for discussion. Then when you're in
8 the measure index on the discussion guide, the
9 measures were arranged by alphabetical order and
10 not numerical order.

11 But then we were talking about them in
12 numerical order and not alphabetical order. So I
13 got confused. I think several other people may
14 have gotten confused. So maybe numerical order
15 might work better for us. I don't know. It
16 would have worked better for me.

17 MEMBER KRAMER: Thanks. Just to
18 reiterate, I agree with all the comments that
19 were made so far. I wanted to quickly point out
20 I thought the co-chairs did a great job of
21 managing the discussion and the process. This is
22 a big room, complicated topics, and I appreciate

1 all the work you did to keep it on track and get
2 us to decisions.

3 One suggestion I had would be around
4 the agenda. We've talked about this offline. We
5 just kind of slid around a little bit and just
6 keeping everyone informed, and making sure that
7 we get everything done at the right time with the
8 right people. It's important. I hope we can do
9 that better the next time.

10 MEMBER HALL: Yes. From the top down,
11 I really appreciated the conversation management
12 by the co-chairs, and the pre-work done by all
13 the working groups was phenomenal. The
14 organization of that pre-work by NQF staff again
15 was phenomenal.

16 The organization of the materials was
17 great. The one thing I kept looking for, and
18 I've already talked to Erin and Taroon about
19 this, I kept looking for that one link that said
20 here's the conceptual picture. Here are all the
21 measures in this program or here are the ones
22 you're thinking about and how they would relate

1 to this program, even to the level to say hey,
2 there were 18 here. Two got full support, four
3 got conditional support. All the rest got, you
4 know, do not support or whatever. Just the big
5 picture. Even to the point of like a super-
6 graphic that ties all the programs together with
7 some lines. That's the one piece of context I
8 was struggling to really assemble. So all good
9 on the organization of the materials, but for
10 that one small nitpick.

11 Even better if I think we, and others
12 have said this, if we could maintain our focus in
13 this conversation on the suitability for
14 rulemaking, and not be revisiting measure
15 development. I think the measure development was
16 done even before the work groups and if anything
17 was reexamined in the work groups. So we should
18 try to maintain that focus.

19 And then the only other big question
20 I had was is there any role for us thinking about
21 removal of metrics? Again I think maybe the big,
22 big conceptual picture of what metrics and what

1 programs would help us think about the questions
2 of removal of metrics.

3 But I don't think we went anywhere
4 into a conversation about metrics that are in
5 programs that should be discussed for removal,
6 you know, metrics that we've put forward in the
7 past but at this point might want to reconsider.

8 I don't know if that's in our scope or
9 not in our scope, but we didn't -- we certainly
10 didn't get that far. Thank you.

11 MEMBER BOTT: On the positive side, I
12 was really happy and really impressed with the
13 responsiveness of NQF staff when I asked a myriad
14 of questions in that last week before the
15 meeting. People were very quick to get back in
16 touch. So that was really appreciated with the
17 chart and the time we had to review materials.

18 On the potential improvement side
19 would be I am a devil in the details kind of guy,
20 but it would have been nice at least in the
21 initial version that I primarily used to prepare,
22 would be to have a link to the technical

1 specifications, such as if the measure had a
2 completed NQF endorsement form it would really
3 help.

4 Sometimes it would help in review
5 because you see what the comments were from the
6 work group and sometimes you don't have enough
7 context. I know there's a summary of the
8 numerous and denominator. Also sometimes
9 measures get labeled as a process measure and
10 sometimes it's confusing. Is this an
11 inappropriate/overuse measure or is this a
12 process measure in that the higher numerator rate
13 the better, and sometimes you just a quick look
14 at the specifications can get to that.

15 Oftentimes, a description of the
16 measure, like in the Excel file, doesn't
17 necessarily reveal that. Also I think having the
18 full tech specs may have helped truncate some of
19 these conversations we're having in this precious
20 time we have together, where people ask about
21 what's the data source. Is this risk-adjusted or
22 not and then other people have to be pulled in

1 who are down at that detail level.

2 If we would have readily had that, we
3 might have been able to avoid taking this meeting
4 time with those conversations to fish around to
5 find the specifications. One other comment on
6 the documents. So we're, especially on Day 2,
7 we're referring to several reports. So I had to
8 root around to find the reports.

9 So I had to root around and find the
10 reports. It would have been nice to just simply
11 have a link to them. It would save some time and
12 save calls to NQF staff on where is the final
13 report. So thanks.

14 MEMBER BRESCH WHITE: This is my first
15 meeting, so I'm feeling a little underwater, just
16 in terms of trying to -- the learning curve is
17 huge. But I do want to thank the staff and
18 commend them for the great work and keeping the
19 conversation going. I thought they were very
20 articulate and clear explaining particularly the
21 change in the rule process for voting. The
22 online access was very helpful.

1 I agree with David's comments about
2 understanding, particularly on the dialysis part,
3 why we were looking at that measure. If we had
4 understood that at the beginning, it would have
5 limited our conversation.

6 I agree with Rich in terms of the
7 voting. I thought it was a little awkward, and I
8 thought sometimes that the way the votes came out
9 didn't legally mesh with the conversation in the
10 room. So and that's it. Thank you.

11 MEMBER BRYANT: Thanks. Also my first
12 time through this process, and I'll just pile on
13 and say really the staff work, sorry the staff
14 work providing us with background materials was
15 really impressive I've got to say. It sort of
16 sets a very high bar for how to get detailed
17 feedback from a group of disparate folks quickly.
18 Maybe not at lightning speed, but effectively.

19 So I think in terms of things that
20 could make it work even better, I'd just like to
21 reinforce the things that have already been said
22 about attention to the broader context. So the

1 summary information about the measures that we're
2 looking at and what the work group
3 recommendations were I think that Bruce was
4 alluding to, but also the interaction between the
5 measures we're looking at and the existing set
6 and to what extent --

7 I mean just even a few sentences about
8 to what extent the measures we're looking at
9 would change the emphasis of the existing set,
10 would make big changes, small changes. Just
11 frame a little bit the context or magnitude of
12 change we might be looking at.

13 You know, in that vein I'd note that
14 it's particularly challenging to sort of think
15 holistically about the measure set which I
16 understand MAP wants to be doing more. When
17 you're thinking about say MIPS, where there are
18 multiple pathways for reporting, including the
19 QCDR measures which I don't even -- I assume
20 we're not making decisions about those measures
21 but we don't even have a list of what has been
22 considered or might be coming up through other

1 pathways, you know, around those data registry
2 measures.

3 So but obviously as part of the
4 context, we're thinking about what the changes
5 that we're looking at here. So this is an
6 example of how more context, so that we can put
7 in, we can have the right frame for what we're
8 looking at.

9 MEMBER LIN: Well ditto, ditto, ditto
10 to everything that's been said but, let me say
11 something in addition. I don't think we can ever
12 over-compliment enough the work of the staff, and
13 I've been seen this for a number of years and the
14 time frames in getting materials out so we
15 commend them.

16 Number two, I want to commend the
17 chairs for what I'm going to call their unbiased
18 chairing. We really appreciate that, and that's
19 very important. Materials are good. We've said
20 all that already. One of the things I suggest is
21 on the agenda is that perhaps staff could stamp
22 every agenda before the agenda comes out the day

1 before with draft.

2 I came with five agendas at this
3 meeting and I had to figure which one I really
4 wanted to pay attention to. So, and I know
5 there's, you know, 5.1, 6 point, you know, 10
6 point whatever but --

7 CO-CHAIR PINCUS: Sam, the agenda is
8 changing as we speak.

9 MEMBER LIN: Yes sir, I appreciate
10 that. I appreciate that.

11 (Laughter.)

12 CO-CHAIR PINCUS: Even what we're
13 doing now.

14 MEMBER LIN: Okay, sorry. But I would
15 suggest just a simple way to solution is a quick
16 optic or visuals, stamp them all draft until the
17 one that comes out the day before, and probably
18 the one we'll bring along to the meeting.

19 I think having decided to attend, sit
20 through in December at least two of the work
21 groups, where the granular activity takes place,
22 I have to, you know, compliment those work groups

1 on the directions they took. Best as I could
2 tell in reading through the materials, you know,
3 it really did capture the essence.

4 It's not easy to capture all of it.
5 The chairs, of course, did a good job and Ron in
6 particular on the hospital. So I have to
7 encourage it, and as a group here we are sort of
8 at the 50,000 foot level. But if you really want
9 to hear some of the nitty-gritty and the
10 intricate materials, if you can, you know, listen
11 in or attend one of the work groups.

12 The thing that I noticed, particularly
13 starting with the work groups was that we are
14 moving a little more towards the trend of patient
15 experience or patient outcome or patient
16 empowerment, whatever word is, you know, the hot
17 one of the day. That's good, because that sort
18 of is going to keep pace with something called
19 outcomes which is, as we all know, you know,
20 structure and process are wonderful and
21 important, but the patient cares about outcomes.

22 They expect us to do structure and

1 process. So I would encourage, certainly from
2 CMS, to be thinking more of sending us things
3 where there is the patient experience, since we
4 now sort of understand that the patient actually
5 has a role in their own care.

6 Yes, I was going to say just lastly,
7 the logistics is always, at least within the
8 room, not outside in the streets, but in the room
9 has been excellent. Again I thank staff, and I
10 don't think we can over, ever over-compliment
11 staff. Thank you.

12 DR. HUNT: Well, I think I'm going to
13 be a bit of a contrarian. I've been to a lot of
14 these types of meetings before, and I find it
15 singularly unhelpful that we can't scapegoat or
16 blame the staff, because any problems we have
17 then falls back on the Committee itself. So I
18 think we should change that in some way.

19 (Laughter.)

20 DR. HUNT: The prep materials were
21 absolutely great. I think links to the current
22 NQF endorsement status of a particular measure

1 may be helpful, as well as the full tech specs.
2 It can be arranged to have it in a hyperlink,
3 such that if we wanted to look for it, we could.

4 I was completely impressed with the
5 pace of the meeting yesterday at 10:30. I never
6 would have dreamed that we would have left by
7 6:00, and it picked up. So I think that goes to
8 the co-chairs in particular.

9 I don't know what to do as far as the
10 voting, but not having the skin in the game for
11 voting, it does seem unsatisfying sometimes when
12 things don't work out. We might want to
13 beforehand consider something like two rounds of
14 voting when a clear yes or no wasn't decided, in
15 which case the category that got the least amount
16 of votes was thrown out and perhaps you would
17 tend towards something more definitive. But
18 again, I'm no expert in this. That's just my two
19 cents.

20 DR. WILSON: Well, I have to echo that
21 the work of the staff and the chairs is
22 phenomenal, and I also really appreciate that the

1 Committee takes its role so seriously. This
2 Committee takes its role so seriously. I will
3 say that this is the first year where I actually
4 listened all day, each day to every work group
5 and man, is that very helpful.

6 So I think that -- I mean it's huge
7 commitment of time, but listening in on the work
8 groups or attending in person is very, very
9 helpful, and I think helps us with the let's not
10 rehash what the work group did, because I --

11 There were moments yesterday when I
12 thought well this is like the old days with the
13 CSAC and the Board, you know, where we're
14 rehashing with the CSAC, and of course, you know,
15 we eventually said CSAC rules. So just throwing
16 that out.

17 And I had it written on my piece of
18 paper too about thinking procedurally about,
19 before we start. Well, do we want to do two
20 votes? Do we want to revote? Do we -- how do we
21 handle it when it gets a little awkward? So
22 again, I go with David. You know, that's a

1 procedural issue for you guys to think through.
2 But we couldn't do it when we needed to do it,
3 when we wanted to do it because we hadn't done it
4 all day, you know. So which I think was the
5 right decision.

6 I think just a little bit of clarity
7 on, you know, like okay. Like here's the whole
8 current list or a link to the whole current list,
9 and now we're going to look at these four
10 substantive measures. We're going to talk about
11 all four of them, so you're going to have to
12 really pay attention.

13 Whether it's 172 or 173 or, you know.
14 But having the conversation as a group, and being
15 able to think about how those either work for, as
16 additions to the current stat or replace them.
17 That kind of thing would be really helpful. So I
18 love the idea of being able to kind of link to
19 the current set of measures. That's it.

20 MEMBER SAKALA: So again, kudos to the
21 overall quality from staff and co-chairs, and
22 also of the materials. I want to echo what Bruce

1 and others have said about the -- getting to the
2 high level of a view, bringing a view in this
3 room of the federal programs, their composition
4 and how we might be altering them with the work
5 that we do over these two days.

6 I think that would be, you know, very
7 -- a very helpful frame for us, and I think that
8 is consistent with our charge. I felt during the
9 hospital work group discussion yesterday a little
10 bit like we were swimming in molasses, and I
11 don't know how to fix some of that because there
12 are so many factors that come to bear that came
13 into that conversation.

14 But it was frustrating and yes, people
15 were saying I'm not going to know their evening
16 plans, notifying people that there are going to
17 be changes. And also the tension between the
18 voting and the qualitative comments that, you
19 know, maybe we need to smooth out the voting, but
20 also to realize that it's all good.

21 And just one more thing, the
22 attribution discussion was extraordinary. I

1 thought very helpful and rich, and advancing my
2 knowledge and also I think the process moving
3 forward. It's the right time for the iterative
4 step, so thank you for that.

5 MEMBER SCHLAIFER: I'll just start out
6 by reiterating the attribution comment. It was
7 definitely the fun part of, you know, hearing
8 what was going on there and being able to --
9 having it explained in a way that we can take it
10 back to others that have been very interested in
11 what you're doing here I'm very excited about.

12 First just want to say yes, thank you
13 to the staff and thank you for all the process
14 improvements over the years. I know the staff
15 that prepared this, you know, five-six years ago
16 put just as much work into it, but it wasn't as
17 easy to use. Having the links and being able to
18 jump back and forth between the programs and
19 measures, especially for those of us that when
20 we're talking about programs that I know nothing
21 about, you know, when it gets to inpatient
22 psychiatric care or something that I know nothing

1 about, it really helps to be able to jump back
2 and forth that way, especially for those
3 programs.

4 I mean all of us are very into certain
5 programs and not so much into others. So having
6 the existing measures, especially in those
7 programs we're not as familiar with would be
8 very, very helpful. So that would be the only
9 one improvement I would say with all the links
10 and everything there.

11 I think as far as the voting, just a
12 couple of really -- some that's been kind of
13 measured to get into the weedy parts of it, and
14 from someone who -- as speaker of the house for
15 various pharmacy associations, very into the
16 minutiae of Roberts Rules of Order, we're looking
17 for consensus.

18 So I think when someone said, you
19 know, we can't revote. Well in a consensus
20 discussion, you can keep discussing until you get
21 to consensus. So I think I would suggest that
22 when we got to a point where we had a vote we

1 weren't comfortable with, that it would have made
2 sense to revote until we got to a vote that we
3 were comfortable with.

4 Not that you want to do that often,
5 but there's -- I don't think there's any rule
6 that says we can't revote. So that's just a
7 suggestion. I think it would have gotten us to
8 where we wanted to be. I also just wanted to
9 mention there was one comment at one point about
10 why are we pulling measures when we're not going
11 to vote on them and we're not going to change the
12 recommendation?

13 And I think that the pulling of
14 measures to get to the discussion to make
15 everyone comfortable to support what the work
16 group did serves a purpose, and I think we should
17 continue to be comfortable with that and not
18 think you can't pull a measure if you don't
19 disagree. I don't know if I just said that or
20 whatever. I think you know what I meant there.

21 So I just -- just thanks again for all
22 the pre-work. It was just fabulous to be able to

1 jump back and forth and get to exactly what we
2 need.

3 MS. RUBIN: Koryn Rubin. I'm filling
4 in now for Carl for the AMA. Thank you for all
5 the pre-work and, as someone who's been
6 intimately involved with this process for several
7 years and having a seat on the Coordinating
8 Committee since the inception, it's gone a long
9 way. I think we got the materials maybe like one
10 day earlier than last year, which is always
11 helpful. The more time the better to prepare.

12 With the -- in general, I think the
13 new categories were effective. But at the --
14 whether it's here at the Coordinating Committee
15 or at the work group, there are sometimes some
16 inconsistencies based on like the approved kind
17 of definitions in terms of what can and cannot
18 apply. So if there's a way, you know,
19 preliminarily to, you know, highlight which
20 categories apply based on the status.

21 So you know, this has NQF endorsement
22 so it, you know, falls into two of the three

1 categories as opposed to four of them. Then also
2 in terms of with the pulled measures, it would be
3 helpful if they can be more easily identified.

4 So maybe they just even go in the head, the email
5 that said, you know, these are the measures that
6 were pulled. If you could just put it front and
7 center and then also who pulled the measure.

8 There was a little inconsistency with
9 pulled measures from last year to this year. I
10 recall last year there were some kind of rules to
11 the road in terms of pulling measures, and you
12 had to provide a little bit of an explanation
13 with your pulled measure. That would be helpful,
14 especially since that information comes late, so
15 that you're aware of what you're looking at and
16 can come a little bit more prepared in a short
17 time frame.

18 MEMBER QUERAM: Thank you. Going this
19 late in the process, I reminded of a saying that
20 others have used when they're in this position.
21 Just about everything that can possibly be said
22 about the subject has been said, but not

1 everybody has had a chance to say it.

2 So I will just align myself with
3 comments about the quality of the staff and
4 quality of the materials, and Marissa's comments
5 about the voting procedure.

6 MEMBER BARTON: I'm going to pile on
7 my thanks for the staff and the chairs, and about
8 the measures. I've heard, you know, we have
9 things sorted by title and the suggestion maybe
10 sort them by number, and this is just like a
11 radical idea. There may be some software
12 solution out there that would allow this to be.

13 You know, I'm thinking Excel but I'm
14 old, right. So where you could sort it several
15 different ways and you could have a field for if
16 it was pulled and field for how it had been voted
17 by the work group, and then we could sort them
18 however we wanted.

19 MEMBER QASEEM: Well, let me just
20 start out by what works. I think it's -- I have
21 to agree with everyone that NQF staff, it's
22 amazing under the leadership of Helen and Alyssa.

1 But I have to say that Erin, Taroon and Yetunde
2 sitting next to me really kept me on track, and
3 she has promised me that I'll always sit next to
4 her, because I didn't know what measures or what
5 are we doing. So it is my seat guys. No one can
6 take this one. And then of course thanking Harold
7 and Chip.

8 (Off mic comments.)

9 MEMBER QASEEM: Harold and Chip, you
10 guys ran an amazing meeting, keeping us on time.
11 They always say the best meetings are the ones
12 that finish ahead of time. I think we're heading
13 in that direction. So I'm not going to get into
14 the numerical orders and all that. I already
15 mentioned it to you guys. I think that's an easy
16 fix.

17 Two suggestions that I'd like to make
18 are one is I'm still struggle with this whole
19 revise and resubmit category and do not approve
20 category. You guys saw the struggle yesterday,
21 and we're not going to of course come up with a
22 solution right now. But I'd really strongly

1 encourage you guys to look into this, as to how
2 we can differentiate, because I don't think that
3 the measures we voted, we were inconsistent
4 ourselves, right. This is something to really
5 start thinking about.

6 And the MAP Coordinating Committee
7 voting, I've been thinking about it. I feel like
8 that, you know, many of us are on various
9 governance committees and all. Maybe we should
10 just have a thumbs up and thumbs down vote, and
11 let me tell you why. I think that the subgroups
12 of MAP are spending really ample amount of time.

13 We do not spend that much amount of
14 time when we're discussing those measures. They
15 have all the detailed information in front of
16 them, and I really hesitate overturning their
17 decision without really having full knowledge of
18 depth of knowledge what's going on.

19 I think what we need to start thinking
20 about as a Coordinating Committee is that we
21 discuss the measure. I'm not saying that. But
22 we vote just thumbs up and down, and if it's a

1 thumbs down and essentially which means it's to
2 be sent back to the Committee. They heard the
3 concerns from this Coordinating Committee and
4 what do you think based on these comments? Do
5 you still stand by those?

6 I just don't think we spend enough
7 time over here, and I don't think we should be
8 turning thumbs, giving thumbs up or down to any
9 of the measures that were here unless we do have
10 all the information and we start reviewing the
11 measures in detail. I'm very uncomfortable with
12 this process, to be honest with you, in
13 overturning the --

14 I think the hospital group and all the
15 clinician group, they spend like almost --
16 because I have been in those groups and Amy you
17 too, right. So you guys end up spending like
18 maybe 45 minutes to an hour on just one single
19 measure.

20 I think it's just unfair. Then why do
21 we even have those subgroups if we don't trust
22 their judgment? So something to think about,

1 that maybe we need to revise our policy in terms
2 of voting.

3 CO-CHAIR KHAN: Anyone I guess on the
4 phone? So it's Doris and --

5 DR. LOTZ: Yes. My travel was
6 cancelled at the last minute, and it may have
7 been a matter of routine for staff to be so well
8 prepared to integrate folks remotely into the
9 meeting. But they did a fabulous job, so I want
10 to thank them for that.

11 But also specifically thank the
12 chairs. I never felt like I wasn't part of the
13 discussion, and sometimes that also happens when
14 you're working remotely. So I really appreciate
15 that. Also, the folks around the room. I always
16 feel like more meaningful content will come from
17 a large gathering like this when people are
18 comfortable disagreeing with each other and
19 speaking their mind, and I felt like that was the
20 case as well, so many thanks to go around the
21 table there.

22 With respect to doing things a little

1 bit differently or contemplating kind of how
2 things could be otherwise, I think about our
3 title as being that of the Coordinating
4 Committee, and yet it seems like we approach
5 things still in their programmatic silos.
6 There's a tremendous amount of imperative to look
7 for some economies in measurement.

8 I think that's, you know, looking to
9 purge the structural process measures, to look
10 for outcome measures. One mechanism to go about
11 doing that would be, you know, we talked a little
12 bit about feedback on implementation in the
13 Medicaid space. But it seems to me that feedback
14 on implementation could be good across the whole
15 board, and perhaps it's done.

16 But I didn't, I didn't see it if it
17 was there in the preparatory materials. And
18 also, you know, it's very hard, I think, for
19 maybe the work groups to think about what to
20 eliminate. I totally concur with what everyone
21 said about them being subject matter experts
22 around the table.

1 But I'm wondering if to be
2 deliberately provocative, to suggest in advance
3 of the work groups. Perhaps it has to come out
4 of a balanced committee like this; perhaps it
5 comes from NQF staff to say have some substantive
6 discussion about the elimination of the following
7 measures. Are they still serving their purpose?
8 Are they being used appropriately?

9 Maybe the sword in that discussion is
10 just to wholesale think about eliminating all
11 structural and process outcomes. That's very
12 provocative, I realize that. But some way of
13 getting their input in that regard, and then
14 expanding the Coordinating Committee role in
15 looking across programmatic silos. Someone
16 mentioned already, and I'm really sorry. I don't
17 know voices and names, so it's hard to
18 coordinate.

19 But the idea of taking more of a
20 patient perspective was mentioned. That's, I
21 think, a very good way to think across measure
22 sets, to look at the patient experience, which

1 wouldn't necessarily compartmentalize things to
2 outpatient hospital, inpatient hospital, renal
3 disease, that sort of thing. That might be a way
4 to also become both more meaningful and to have a
5 more strategic measure set that, you know, could
6 be adopted broadly and implemented broadly, and
7 hopefully be meaningful as well. So thank you
8 for that.

9 CO-CHAIR KHAN: Thanks. Barrett.

10 MEMBER NOONE: Hello. Can you hear
11 me?

12 CO-CHAIR KHAN: Yes.

13 MEMBER NOONE: I just wanted to echo
14 what everyone has said. I think that the staff
15 deserves a lot of credit, especially when we are
16 tuning in remotely and they've been terrific in
17 following this whole conversation.

18 Congratulations to the leadership and
19 chairs of the committees who have really guided
20 us through these two days of deliberations. So
21 thank you very much for letting me participate
22 remotely.

1 CO-CHAIR KHAN: Thank you so much.
2 Foster.

3 MEMBER GESTEN: Thanks Chip. Again,
4 I just, you know, want to put my thumb down on
5 all the positive things that were said about
6 staff and you Chip and Harold as co-chairs. The
7 one thing I didn't hear that in terms of a
8 suggestion going forward was in terms of getting
9 this larger picture, what I called sort of the
10 20,000 foot view, all the measures in the program
11 which would help understand what the place is of
12 new suggested measures or perhaps invite
13 conversations about eliminating measures, the one
14 thing I think that would be useful is to better
15 understand what happened to previous suggestions
16 to CMS, and get that feedback about measures that
17 were maybe recommended that weren't taken up, or
18 measures that were recommended to not be taken up
19 that were taken up.

20 Again, I don't think it has to
21 necessarily change the process or the criteria
22 that the Coordinating Committee or the groups use

1 in evaluating the measures. But I think
2 sometimes it's -- I know we found it helpful in
3 the Medicaid Task Force to better understand how
4 CMS was thinking and using and what some of the
5 constraints were.

6 I think that might be just useful
7 context, you know. If it comes out in some
8 fashion that I've always missed, then you know,
9 my apologies. But it always feels like a bit of
10 an unknown to me.

11 CO-CHAIR KHAN: Thanks. Steve Wojcik.

12 MR. WOJCIK: Yes, hello. I agree with
13 most of the comments. I just had one and I
14 apologize. I had to go away for ten minutes to
15 talk to a reporter, so I hope this wasn't
16 covered. But following up on the reaching
17 consensus, I'm wondering if when the process,
18 when we don't reach 60 percent and our decision
19 then is contradictory to or especially if it's
20 the exact opposite of what the work group
21 recommended, I wonder if we should treat that
22 somewhat differently than where we don't reach

1 consensus but it's in the same direction or the
2 same recommendation as the work group, because I
3 believe that might have happened once yesterday
4 towards the end. I can't remember which measure,
5 and it was treated the same way as one where it's
6 in the same direction.

7 It just seems to that that's a bigger
8 issue than if our failure to reach consensus just
9 is settled around confirming or close to what the
10 work group decided. Apart from that, I thought
11 it was great and I was glad to be able to
12 participate and have the opportunity. Thank you.

13 CO-CHAIR KHAN: Thanks. Brandon.

14 MEMBER HOTHAM: Yes, can you hear me?

15 CO-CHAIR KHAN: Yes.

16 MEMBER HOTHAM: Okay, yes. I will
17 echo a huge thanks to you, the staff. My travel
18 was also cancelled at the last minute due to
19 inclement weather and they were exceptional in
20 helping me to actively participate remotely. So
21 I greatly appreciate that. I will also, in terms
22 of a delta, agree on the voting process.

1 You know, I think there's been some
2 mention of, you know, a possibility of moving to
3 a structure that allows maybe getting rid of one
4 of the categories that got the lowest volume of
5 support.

6 I would just agree with reevaluating
7 the voting process to make it more clear in terms
8 of category truly gets consensus from the group.
9 But other than that, you know, I agree with all
10 the comments that have been made by the rest of
11 the Committee members, and thanks.

12 CO-CHAIR KHAN: Thanks, and finally
13 Steve Brotman.

14 MEMBER BROTMAN: Hi Chip, thanks.
15 There are so many things that worked well and
16 they continue to just get better each year.
17 Integrating us remotely, this is the first time
18 I've been remote and it was actually a great
19 experience. I appreciate from the staff. They
20 did everything they could and really worked very
21 hard on it.

22 We had wonderful discussions around

1 the room, very robust discussions around the
2 room. I was very impressed this year. The
3 decision guide with links this year was
4 excellent. The link the NQF status would be
5 helpful, but other than that kudos to the staff.
6 It's really a hard thing to do. It's very much
7 appreciated from our point of view.

8 Decision categories worked fairly well
9 with some hiccups, you know. But it's still, I
10 think, a work in progress. So but that's going
11 to continue to evolve. Also there was great
12 flexibility to pull measures for discussion ad
13 hoc and have the measure developers available for
14 questions. That was really appreciated. The
15 work of you guys the co-chairs was truly amazing,
16 and you really deserve tons and tons of credit.
17 Thank you for everything.

18 The attribution presentation was
19 excellent. That was one of the best
20 presentations we've seen, I think, and on the
21 side of what could be improved, I parrot the
22 remarks about the consensus process, but I don't

1 have any. Those comments were made early. I
2 don't have any direct solutions.

3 And also, this is probably a new
4 comment that I haven't heard. When a measure is
5 pulled, it would be helpful and this happened
6 most times but it wasn't always consistent, and
7 that is what is presented should be a concise
8 history of the measure issues that the work group
9 had and some clear questions from the onset of
10 when it's being pulled.

11 So maybe there's a structural
12 organization way to address this, to state that
13 point of contention when a measure is being
14 pulled, so that everybody is on the same page
15 from the get-go and there's not a lot of
16 discussion, and then the contention points come
17 afterwards. One piece of advice I have for new
18 members, since I've been doing this for quite a
19 number of years.

20 I would wholeheartedly recommend that
21 new members sit in as much as possible or listen
22 to the individual work groups. Over the years,

1 I've found that to be one of the best ways to
2 sort of integrate into the Coordinating Committee
3 and just come with your feet ready to run, so
4 that all the issues are not new to discuss. It
5 really helps out a lot.

6 I would also encourage to pull,
7 continue to pull measures for discussion even if
8 there's no vote, because that's a great
9 opportunity to provide additional information and
10 flag some issues, and other than that, I want to
11 thank everyone. This was a wonderful cycle.

12 CO-CHAIR KHAN: Thanks, Steve.

13 CO-CHAIR PINCUS: So I have a couple
14 of comments. Number one is the staff is
15 incredible, I mean in terms of the way in which
16 they facilitate and helped this and put together
17 behind the scenes so much material and
18 information and condense it. Yetunde, Ken, Erin,
19 Taroon, Helen. Just really remarkable.

20 Also, I think the engagement of the
21 members of the Coordinating Committee is really
22 incredible. I mean really people feel passionate

1 about a lot of these things, and they're willing
2 to discuss it intensively and intelligently.

3 I think that's really important, and
4 obviously also the work group members as well,
5 and also CMS has really, you know, engaged in
6 this process fully and receptive to the
7 discussions and engages in discussions, I think.
8 So it's a very, very productive process that we
9 have.

10 A couple of things in terms of
11 improvements. I think what people have suggested
12 in terms of having some way of displaying sort of
13 each program, the overall context in terms of the
14 measures, what's been added, what's been removed,
15 what's been the response, you know, as opposed to
16 sort of the response to previous suggestions.

17 I mean we get that in the Medicaid
18 Task Force. We sort of get that. It's only one
19 program so it's easy to do. But to sort of get
20 that succinctly over time would be very helpful.
21 I think the voting is a problem, but you know,
22 I'd like -- it would be useful to hear back from

1 CMS about what would be helpful to them in terms
2 of the vote.

3 How much does the vote really matter,
4 especially the fact whether it reached the
5 consensus on support versus these other
6 categories that are less than support. How
7 important are these distinctions, because it's
8 not a, you know, there's not really a strict
9 threshold for those, I mean for the conditional
10 one.

11 It's clear that if you know
12 specifically what you want, and we can try to get
13 that done. But for the revised use of NIT, which
14 is a replacement for the support direction, you
15 know, it gives a little bit more specificity but
16 it's, you know.

17 And maybe just having that it may give
18 consensus for support and if not, here's the
19 distribution across the other categories. That
20 may be sufficient, I don't know. But that's
21 something that would be helpful to get CMS'
22 response to.

1 Having a discussion about a cross-
2 cutting issue like accountability was incredibly
3 useful. I think it would be useful to have
4 something like that, more specifically something
5 -- I'm not totally satisfied with how we deal
6 with gaps.

7 I think having some way of addressing
8 gaps, both within programs but across programs
9 and linking that to a more in depth discussion
10 about what is in process within the development
11 process that CMS is doing would I think be a
12 useful thing to have, almost in the same vein as
13 the accountability discussion we had, and so I
14 would make that suggestion.

15 CO-CHAIR KHAN: Okay. Well I'll close
16 out, I guess. We got everybody in terms of the
17 members commenting and, you know, just restate
18 our appreciation, I think the whole Committee's
19 appreciation to the staff for really making the
20 meeting possible, by lining everything up in a
21 way that could be comprehended and discussed.

22 Second, I know it's always an issue

1 whether a body above the bodies that spend a lot
2 of time on a matter should have the power to, in
3 a sense, veto.

4 But on the other hand, I think if we
5 look at the number of measures considered
6 overall, and we look at the focus that we put on
7 really, except for the hospital area but even
8 there very few regarding the total end, and I
9 think we do have a fairly expert group here, and
10 you know, even though it might not have been as
11 explicit enough, there was a sense for the
12 context that most of us had.

13 I guess I think I would err on the
14 Coordinating Committee taking action, although I
15 do think we need to reexamine the vote. I think
16 if you look at the votes, and this is only my
17 head which is by its very nature not scientific,
18 we sort of had two kind of votes.

19 We had a vote that was completely
20 flat. It was like -- like it was just spread
21 across the four, or we had these votes, and I
22 think we had at least two if not three that were

1 above 55 percent for one. On that last one, when
2 the one was 57 percent and we went and took the
3 four percent below it, I thought wow. That just
4 doesn't look right.

5 I think we need to reexamine that, and
6 I'm not saying that 60 is the wrong threshold, or
7 maybe we should just be voting, you know, it
8 should be binary. I don't know, but I think we
9 do need to reexamine that, and whether we have a
10 vote like that where you're within shouting
11 distance of 60, whether we take the vote again
12 just to see whether anybody would change,
13 considering where we are. Maybe that's what we
14 do.

15 But other than that -- oh, let me say
16 one other thing. No one, I don't think anyone
17 else has commented on this. Gerry Shea and I
18 many, many years ago chaired a strategic planning
19 committee for the MAP, and I can't even remember
20 which year it was now, and one of the major
21 recommendations we made was the, I guess it
22 manifests on the slide that Helen talked about,

1 the feedback loop.

2 I think just as with the gaps, I don't
3 think we're there yet in terms of a process for
4 identifying it clearly that we can all feel
5 comfortable with. I think, I'd like to stress
6 that I think that this notion of the feedback,
7 like what's really happening with all those
8 things that are out there that we can get our
9 teeth around.

10 I'm working on a presentation right
11 now on the Medicare fee-for-service, pay-for-
12 performance and other programs for a speech I'm
13 giving in Israel, and I'm having really -- and
14 I've asked a number of people to help me look at
15 the literature. There's not much of a feedback
16 loop in terms, you know. There's great stuff
17 about how readmissions we're reducing, but
18 there's not that much literature about what that
19 really means.

20 And then with the other metrics, we
21 can just go on and on. So I think that that
22 feedback loop is something we really need to work

1 on, and I'm not sure that this is the place that
2 can be done, but that we need to think about. So
3 with that, I'll conclude. It's now 20 minutes to
4 1:00. I think we're going to reconvene at 1:00,
5 is that right?

6 MS. O'ROURKE: If everyone could come
7 back a few minutes before 1:00. We have some
8 hard stops at 1:30 and ASPE is a 30 minute
9 presentation. So we want to get to a few people
10 before Karen and Nancy begin their presentations.
11 So maybe if we --

12 CO-CHAIR KHAN: Okay. So why don't we
13 say literally 15 minutes, which will get us back
14 here about three or four minutes before 1:00, and
15 then we'll start there. So get your lunch and
16 we'll see you in a few minutes.

17 (Whereupon, the above-entitled matter
18 went off the record at 12:39 p.m. and resumed at
19 12:55 p.m.)

20 CO-CHAIR KHAN: If everybody could
21 return to their seats, and we'll get started with
22 the last part of our program, and we're going to

1 have -- Nancy's coming.

2 MS. O'ROURKE: She'll be here at one.

3 (Off mic comments.)

4 CO-CHAIR KHAN: Okay. So just I guess
5 for 30 seconds, I will -- before we go to that,
6 just say that this process is very important to
7 me, and I really appreciate everybody's
8 participation. I guess back many years ago, it
9 was probably mine, but other people's brain child
10 was this meeting and this process that we have
11 today, when we -- when Jordy Cohen and Dick
12 Davidson and I many, many years ago formed the
13 Hospital Quality Alliance.

14 That was sort of a multistakeholder
15 group, but still has been started by the
16 hospitals. We envisioned a process like this,
17 working with CMS and hopefully with other payers,
18 and it's great to see it actually in place and
19 working. In the -- obviously it had to find
20 another home, and NQF was the logical home.

21 And so some of us, I think, you know,
22 want to see this continue, and we are going to

1 actually need to get funding at a point in the
2 near future, because we're at the point of the
3 cycle again.

4 And so to help that process and to
5 inform people, because I don't think it's always
6 clear to everyone, even though we've got so many
7 hundreds of people that are very active in the
8 NQF committees and task forces and work groups
9 and then -- and the board, I'm not sure the
10 outside world every really understands quite what
11 NQF does.

12 So the Federation is funding a project
13 with Kristine Martin Anderson and her team that
14 Booz Allen's going to undertake, to do sort of an
15 analysis of how NQF does meeting its various
16 missions, and also what the cost of achieving
17 that should be going forward, and hopefully when
18 that's completed in about two months, it will be
19 helpful.

20 So I don't know whether any of you
21 necessarily will be interviewed. Some of you may
22 be, because they will be talking to some of the

1 stakeholders in the process of doing the survey,
2 or they will be surveying people. So you may be
3 queried and if you do, I hope you'll be
4 cooperative and obviously open about your point
5 of view, but cooperative.

6 So I just wanted to let you know that
7 we're doing that, and that we will be beginning a
8 process. There's a thing called Friends of NQF
9 that I hope all of you will be active in in the
10 upcoming months, as we gear up to make sure that
11 the funding continues. So with that, let me pass
12 it over to Erin and let her start.

13 MS. O'ROURKE: Thanks Chip, and thanks
14 to all of you for sticking with us for one more
15 session, and having a working lunch that
16 hopefully we can let you out a little bit early.
17 But we did want to bring up one more cross-
18 cutting issue, obviously a topic we've spent a
19 lot of time grappling with over the years.

20 In particular, we're looking for some
21 guidance from the Coordinating Committee on the
22 consideration of sociodemographic factors, as we

1 move to an era of value-based purchasing and
2 there's obviously strong sentiments across the
3 stakeholder spectrum on this issue, and how MAP
4 can really do its work most effectively and
5 ensure that we're making fair recommendations
6 that will really work to improve health care for
7 everyone.

8 We know this is a very challenging
9 topic. We don't expect any solutions to come
10 here today. But rather we want to just keep you
11 abreast of some developments in the field, and
12 look for any guidance you might have on how we
13 should consider some of these new findings and
14 new research as we continue to do the pre-
15 rulemaking work.

16 So I think we with that, we are going
17 to have a presentation from ASPE on the findings
18 of the IMPACT Act study. But before that, we
19 have a few Committee members with hard stops that
20 we want to hear from, so Bill, if I could turn to
21 you and then Pierre and Kate, if you wouldn't
22 mind giving a brief update on the 21st Century

1 Cures Act and some of the implications of that
2 law.

3 MEMBER KRAMER: Thanks very much,
4 Erin. This is a little bit out of order. I'm
5 reacting to a presentation that we haven't seen
6 yet. But I did read the ASPE report, so I'm
7 reacting to that, as well as the discussions
8 we've had about this at NQF Board and many, many
9 committee meetings and so on over the last
10 several years.

11 First, I want to express appreciation
12 for the excellent work that ASPE did, as well as
13 the great work that Helen Burstin and her team
14 have done here at NQF, and the work that Kate
15 Goodrich and her team at CMS have done on this
16 issue over the last several years.

17 I think the ASPE study makes a
18 significant contribution to our understanding of
19 the interplay between lower socioeconomic status,
20 clinical risk factors and disparities in care. It
21 occurred to me in reading this that the deeper we
22 go into this issue, the more we realize that it's

1 very complex and in some ways the solutions now
2 are less clear than we may have thought
3 previously. But our understanding of the issues
4 and therefore what we should do about it
5 hopefully is advanced.

6 In the discussion of this issue, one
7 topic keeps coming up that is a very sensitive
8 one, but I think needs to be addressed head on,
9 and that is -- the question is often framed what
10 factors are within a provider's control?

11 It's often stated that providers
12 should not be held accountable for factors not
13 entirely within their control and I understand
14 this. It's a very natural human response. I
15 just had my performance review meeting with my
16 boss, and we had this exact discussion. How much
17 were we able to influence CMS regulations?

18 So but I'm concerned that framing the
19 issue this way may be a dead end, and I'd like to
20 suggest some alternatives. In a patient-centered
21 health care system we should be asking instead
22 whether the patients got the care and services

1 that they needed.

2 For example as we know, some low
3 income patients live in neighborhoods that have
4 poor public transportation. They might not have
5 access to a car. They might not even -- so it
6 makes it more likely they'll miss a follow-up
7 appointment after hospitalization.

8 Should the provider say well, too bad,
9 that's not my problem? Of course not. Most
10 providers are going to do whatever they can to
11 try to provide those -- arrange for those
12 additional services that would help them get the
13 care that they need.

14 Is that totally within their control?
15 No, that's the wrong question to ask. The
16 question asked is what can we do to encourage and
17 support physicians who are trying to do the right
18 thing for their patients, and that includes those
19 kind of supports that they need, in addition to
20 the immediate and direct clinical care.

21 So my concern is that narrowing the
22 focus into things that are just under the direct

1 control of providers, what is the risk of
2 overlooking the other services that may be needed
3 to provide care to patients, taking into account
4 their special circumstances?

5 So I would recommend that we shift the
6 conversation from is this in the provider's
7 control to is the patient getting the services
8 she needs, and figure out how to do that, solve
9 that problem.

10 One of the important findings in the
11 ASPE study was the point they made about the
12 work, the existing state of the art in terms of
13 clinical risk indicators, and the observation
14 that while we've relied on these for years, there
15 in fact still needs to be improvement in the
16 science of clinical risk indicators and clinical
17 risk factors. So I strongly encourage us to
18 support that.

19 I wanted to make sure we're all clear
20 that there's a fundamental difference between
21 socioeconomic factors and clinical risk factors.
22 While the statistical analysis of those has some

1 similarities, there are fundamental differences.
2 For clinical risk factors, we accept the fact
3 that sicker patients have worse outcomes. We
4 understand that, we accommodate that and we
5 adjust for -- we adjust some things for that
6 appropriately.

7 However, for socioeconomic risk
8 factors, I believe we should not and do not
9 accept that people of different socioeconomic
10 categories should get different outcomes. Now we
11 observe that they do get different outcomes, but
12 I don't think they should. I don't think anyone
13 believes that they should get different outcomes,
14 so it's a fundamental difference.

15 So we should not automatically say
16 since there are differences, we should adjust for
17 them in the measures the way we do for clinical
18 risk factors. They need to be treated
19 separately. Even though the statistical methods
20 might be similar, they're fundamentally different
21 in what we, I think all of us as involved in the
22 health care system believe should be done.

1 Finally, I was pleased to see the
2 recommendation regarding financial support for
3 providers, to achieve better outcomes for
4 beneficiaries with socioeconomic status risk
5 factors. This makes sense to me. We recognize,
6 I think, that caring for disadvantaged patients
7 probably requires additional resources, and we
8 ought to pay providers accordingly.

9 The last thing we want to do is make
10 it more difficult for the outstanding providers,
11 physicians, nurses, hospitals and so on who are
12 doing good things for these patients. The flaw
13 in the current system is in the payment models,
14 not in the measurements. So accordingly, I think
15 we ought to be focusing on fixing the payer
16 models explicitly, rather than trying to do it
17 indirectly through the risk adjustment of the
18 measures.

19 So the bottom line, my recommendation,
20 my recommendation based on my understanding of
21 the issues and further enhanced by this ASPE
22 study is that we ought to keep the measures pure,

1 so that we can clearly observe disparities in
2 outcomes. Understand what's causing those
3 disparities and address them.

4 Second, that we risk adjust the
5 payments to providers to recognize the higher
6 cost of caring for disadvantaged patients.
7 That's obviously beyond the scope of MAP's work,
8 but we can make that recommendation to somebody
9 who's working on the payment models. I think we
10 ought to all be working explicitly, as ASPE
11 recommends, on the goal of improving health
12 equity.

13 I'll speak, I can speak I believe on
14 behalf of most if not all consumers and
15 purchasers here and outside this room, that we
16 would be very happy to work with physicians,
17 hospital systems and others on the payment models
18 to get this right, so to make sure people get the
19 care they need.

20 CO-CHAIR KHAN: Thanks, Bill.

21 MS. O'ROURKE: Pierre, did you want to
22 give people just a quick update on the 21st

1 Century Cures Act?

2 DR. YONG: Sure. Thanks Erin, and I
3 think the comments beforehand actually nicely
4 lead into just this quick update for folks who
5 aren't familiar with the Cures Act, which was
6 passed in December of last year. There is a
7 provision in Cures Act which addresses SES in
8 particular relative to the hospital readmissions
9 reduction program.

10 What it says is that -- it says that
11 the HRRP program, which includes all the
12 readmission measures which are not currently risk
13 adjusted for SES, they'll have been part of the
14 NQF pilot, that the program be restructured a bit
15 so that we group hospitals into like groups. So
16 you may have heard of the stratification sort of
17 approach, which MedPAC put forward a couple of
18 years ago as a recommendation.

19 But essentially you stratify providers
20 or hospitals in this case by full eligible dual
21 status. So the proportion of full eligible dual
22 seen by that provider. So you are then comparing

1 hospitals with similar, seeing similar
2 proportions of dual eligibles. So it's this like
3 compared to like sort of approaches, as some
4 people call it.

5 So that's what it's done. It says we
6 can also consider the ASPE recommendations
7 relative to risk adjustment of the measures, but
8 the first sort of step forward is this
9 stratification in terms of assessing the
10 penalties not on the measure side. The other
11 piece of this is also that the program and this
12 adjustment is done in a payment, in a budget-
13 neutral fashion.

14 So there's no change in the overall
15 sort of penalties assessed on providers at the
16 overall program level, compared to the current
17 approach. There are also some other provisions
18 in there. MedPAC is required to do a study
19 relating to readmissions, but the main pieces are
20 what I described so --

21 CO-CHAIR KHAN: Thanks. I guess just
22 in response to Bill, I think in an ideal world or

1 a world where we had confidence that there would
2 be an ongoing reconsideration of policy, I agree
3 with you. But I think in the reality of what is,
4 I think that the last thing you want to do in an
5 admission policy that's fixed is penalize the
6 very people you want to be reaching out, and
7 worrying about the social determinants of health
8 of their patient population, as well as worrying
9 about the care inside the four walls of the
10 hospital.

11 So I think, you know, in an ideal
12 world it's great to talk about having risk
13 adjustment that includes social determinants on
14 DRGs, but that ain't going to happen any time
15 soon and we have to deal with the reality of are
16 we penalizing the wrong hospitals in the way that
17 readmissions work.

18 So I agree that it's good to have the
19 pure measure, because we don't know necessarily
20 why certain hospitals are being penalized. I
21 mean whether or not it's what they do inside the
22 four walls or because of the situation of these

1 other patients. But they do tend to be patterns,
2 and I think we need to recognize that in the
3 current policy mix, which can be done under
4 current authorities if CMS chose to do it.

5 That's sort of the problem we face.
6 I mean it worries me too not to have, you know,
7 everybody sort of measured the same way in terms
8 of readmissions. But I think -- I think
9 considering realities, I guess that would be the
10 position that hospitals would take, and I think
11 it's a sensible one considering that we don't
12 have a process to do what you described yet.
13 That's just sort of my response. But what do we
14 do next?

15 MS. O'ROURKE: So we should have Karen
16 Joynt and Nancy De Lew on the line. They're
17 going to provide an overview of the findings from
18 ASPE's study that came out of the IMPACT Act.
19 Karen and Nancy, do we have you?

20 MS. DE LEW: Yes. It's Nancy De Lew.
21 I'm on the line. Karen, you're on?

22 DR. JOYNT: Yep, we're both here.

1 MS. DE LEW: Terrific. We're in
2 different parts of the country, so we're not
3 sitting next to each other. I want to thank you
4 all for welcoming us to the conference today, to
5 the meeting today.

6 I'm going to start, do a couple of
7 slides. Then I'm going to turn it over to Karen.
8 We also have other members of our team who are
9 with us, and I know that we may well have folks
10 who helped us on this report.

11 We had a number of people participate
12 on our technical expert panels as we pulled this
13 material together, and if any of those
14 participants are on the line, we want to thank
15 them as well.

16 So I want to start. Let's go to the
17 next slide please. I want to start by talking
18 about the big picture, why social risk is
19 important as we move to value-based purchasing in
20 the Medicare program, a topic that many of you
21 are very familiar with, and know intimately.
22 Social risk factors we all know, play a major

1 role in health.

2 As we began this work, we were
3 thinking about some of the discussion that's
4 taken place about social risk factors. You see
5 several of those items on the slide right here.
6 Some people have thought that beneficiaries with
7 social risk factors have worse health outcomes,
8 because the providers they see provide low
9 quality care, that value-based purchasing could
10 be a powerful tool to drive improvement in care,
11 and to reduce disparities. That's one argument
12 that we've heard.

13 We've had others argue that if those
14 beneficiaries have worse health outcomes due to
15 factors beyond providers' control however, the
16 value-based purchasing could inappropriately
17 penalize providers that care for them, or could
18 result in providers becoming reluctant to care
19 for these populations.

20 CO-CHAIR KHAN: I'm sorry. Could you
21 all speak into the phone, because we're having a
22 little trouble on this end.

1 MS. DE LEW: Sure. So I'll try to
2 speak a little louder. Is that a little better?

3 CO-CHAIR KHAN: Yes.

4 MS. DE LEW: Okay. So as we began
5 this work, we know that these relationships need
6 to be better understood, so that we can align
7 payments and ensure that the value-based
8 purchasing programs we have achieve their
9 intended goal. So that's the big picture as we
10 began this work.

11 Next slide, please. The Congress in
12 the IMPACT Act asked ASPE to provide a series of
13 empirical analyses and provide considerations for
14 providers, for policymakers, I'm sorry. The
15 study that we're going to report on today, the
16 IMPACT Act had several different pieces, and
17 we're going to talk to you about Study A today.

18 What I just want to review here for a
19 moment is the various provisions in the IMPACT
20 Act and tell you where we are in our work, and
21 what's coming over the next number of months and
22 years. So Study A, the study that we'll report

1 on today, is looking at the impact of
2 socioeconomic status on quality and resource use
3 in Medicare, using existing data. So I want to
4 just underline that word "existing data." That's
5 what we'll be talking about today.

6 Study B will tell you a little bit
7 about our thoughts for Study B. We will welcome
8 your input for those today, as well as we've got
9 a mailbox set up. We would welcome your input
10 later as well, about our thoughts for Study B.
11 So in Study B, the Congress has asked us to look
12 at measures using data that we don't tend to use
13 right now in our program, looking at measures
14 like education, health literacy.

15 We'll be looking at income at both
16 the individual income as well as income of the
17 area where that person resides. So that will be
18 our work on Study B. Again, we'll invite your
19 input both now and later. The Congress also
20 asked us to do qualitative analyses of potential
21 data sources, and looking at the broader context
22 surrounding defining socioeconomic status.

1 The Congress asked us to develop
2 recommendations and determine payment adjustments
3 drawing upon all of that work that I just
4 outlined. So a final report is due to the
5 Congress in October of 2019. So what I want to
6 just underline is that the report that we've made
7 available, that we're going to be talking about
8 today is Study A, and then we have additional
9 work that we'll be doing and we welcome your
10 input.

11 So with that, I'm going to ask Karen
12 to start walking through the report.

13 DR. JOYNT: Great. Thank you so much.
14 I've never been accused of talking quietly, but
15 if you can't hear me tell me to -- tell me to
16 speak up. Okay. So I'm going to give an
17 overview of what we did in the report, and I'm
18 going to try to give sort of a mix of a broader
19 review, where we saw similar themes, and as well
20 as some specifics to give you sort of a flavor
21 for what we did on each program.

22 I would invite you to look in the

1 report and the appendix for any specifics you
2 might want on any particular program. So the way
3 that we set up the project was to take a
4 consistent set of social risk factors, and to
5 examine the relationship between those factors
6 and performance under the measures that
7 constitute each of the Medicare payment programs
8 you see there on the slide.

9 The programs certainly vary, and the
10 number of measures they have and then how those
11 are translated into payments. But we tried to be
12 as consistent as possible in our analyses across
13 programs. You can see here we grouped them into
14 hospital programs. So the very familiar
15 readmissions reduction program, value-based
16 purchasing and hospital-acquired admission
17 reduction programs are three programs that
18 contain a number of very similar ambulatory
19 quality measures.

20 So the MA Quality Star Rating Program,
21 Medicare Shared Savings Program and the new
22 Physician Value-Based Program which will sunset

1 and be replaced by MIPS in a few years, and then
2 three programs in the facility setting, doctor
3 office facilities, nursing facilities and home
4 health agencies and home health agencies, with
5 the caveat that the nursing facility and home
6 health agency program are in the measurement and
7 not payment phases. So we only looked at
8 measures for those and didn't have programs to
9 evaluate.

10 Next slide, please. So across our
11 analyses, we had really two main findings. I
12 think the consistency of our findings is
13 important. We found that across most measures,
14 beneficiaries with social risk factors, excuse
15 me, had worse outcomes than quality measures,
16 regardless of the providers they saw. Meaning we
17 are looking predominantly within provider
18 analyses, and dual enrollment status was the most
19 powerful predictor of poor outcomes.

20 So typically dual status explains a
21 fair amount of the racial and economic
22 disparities, for example, intended to dominate

1 most of the measures though not all.

2 Our second finding, moving to the
3 provider level, was that providers that
4 disproportionately served beneficiaries with
5 social risk factors also tended to have worse
6 performance on quality measures, even after
7 accounting for their beneficiary mix. Under all
8 five value-based purchasing programs in which
9 penalties are currently assessed, these providers
10 experienced somewhat higher penalties than did
11 providers serving fewer beneficiaries with social
12 risk factors.

13 So as I think was set up quite nicely
14 by these pre-comments, I think we had gone into
15 this set of analyses thinking we might find a
16 simple answer, that this would be a beneficiary
17 issue. There would be a very specific quality
18 signal we could relate directly to the
19 beneficiary characteristics, or that it would be
20 a provider issue and the poor outcomes we see
21 would be all about provider quality.

22 And instead, really across settings,

1 we found that those are true, and you'll see that
2 echoed in the way we sort of took this in terms
3 of next steps. But also you'll see it in the
4 analyses that we'll walk through in a moment. We
5 did not find a simple answer, but rather that
6 this is a complex combination of both beneficiary
7 and provider characteristics and performance.
8 Next slide, please. Rachel, do you want to do a
9 slide or two here?

10 MS. ZUCKERMAN: Sure. So I will sort
11 of walk through these two findings in some of the
12 readmissions program, and then I'll go back to
13 Karen. So this first finding that beneficiaries
14 with social risk factors had higher readmission
15 rates, regardless of the providers they saw, and
16 we found that dual enrollment status was the most
17 powerful predictor of a higher rate of
18 readmission, as Karen just explained.

19 So if we look -- if you're looking at
20 this table here, in the first column we're
21 looking just at the social risk factor alone, and
22 you can see that the odds ratio is highest for

1 dual status. Dually enrolled beneficiaries have
2 a 24 percent higher odds of being readmitted,
3 just looking at the raw readmission rates.

4 Then if we go to the middle column, we
5 also adjusted for the medical risk that is
6 contained in the readmission measure, and we see
7 that the odds of readmission for duals goes down
8 to 13 percent greater odds. And then finally
9 when we adjust for other social risk factors,
10 that drops to ten percent greater odds.

11 So we do see that each of these
12 things, the social risk factors and the medical
13 risk, decreased the odds of readmission, and that
14 across the board dual status is the strongest
15 predictor and in fact once we adjust for both
16 medical and social risk, only dual status and
17 urban beneficiaries were more likely to be
18 readmitted.

19 So if we go to the next slide. Can we
20 go to the next slide please? Yes, thank you. So
21 the second finding is looking more at the
22 provider side of things. So this looks very

1 similar in terms of the odds ratio, but here
2 we're looking at providers treating beneficiaries
3 with social risk factors, and in this case for
4 the hospital measures, we looked at hospitals
5 with the highest 20 percent, the highest 20
6 percent of hospitals based on their
7 Disproportionate Share Hospital or DSH index.

8 Just looking at this first row, heart
9 attack, we see that hospitals -- these safety net
10 hospitals had a 20 percent higher readmission
11 rate than other hospitals, or sorry,
12 beneficiaries. Yes, beneficiaries going to these
13 hospitals had a 20 percent higher readmission
14 rate, and then when we adjust the comorbidities,
15 that goes down to 14 percent, and again adjusting
16 for safety net status brings it down to nine
17 percent.

18 So patients who are at safety net
19 hospitals have five to nine percent higher odds
20 of readmission after controlling for all measured
21 medical and social risk factors. So this is
22 similar to what we saw at the beneficiary level,

1 looking at the provider level.

2 Go to the next slide. Then when we
3 look at how the program affects this, we're
4 comparing safety net hospitals, again top 20
5 percent of the disproportionate share, and that's
6 to all other hospitals, and we see that a larger
7 proportion of hospitals are penalized, and their
8 penalties were slightly higher, about \$40,000
9 higher over the year.

10 So safety net hospitals were more
11 likely to be penalized and had slightly higher
12 penalties than other hospitals. So again, we see
13 that the -- in this case, the program itself has
14 a much smaller impact than the measure, and that
15 sort of changed throughout. The findings at the
16 measure level were consistent; the findings at
17 the program level depended on the program itself.

18 Go to the next slide. And I'm going
19 to hand it over back to Karen at this point.

20 DR. JOYNT: Thanks, Rachel. So if we
21 think those three slides that Rachel just talked
22 through, and we sort of have equivalent ones in

1 the report for all of the programs, we ended up,
2 as we mentioned at the beginning, with pretty
3 consistent findings. We found, for example, the
4 odds associated with readmission to be consistent
5 across ACO analyses, physician group analyses and
6 hospital analyses.

7 We found that hospitals that we
8 considered to be the safety net were more likely
9 to be penalized in the hospital readmissions
10 reduction program, in the hospital-acquired
11 condition reduction program and the value-based
12 purchasing program. So we found consistent
13 findings across the programs, and again, we'll
14 defer to the report for details in the interest
15 of time.

16 But overall, we found that
17 beneficiaries of social risk factors have poor
18 health outcomes regardless of the providers they
19 see, and providers serving these beneficiaries
20 have poorer performance regardless of the
21 patients they serve. Of course now we come to
22 the complexity, which is that these analyses

1 can't determine why patterns exist.

2 As was brought up in the speakers
3 prior to us, beneficiaries may have poorer
4 outcomes due to higher levels of medical risk,
5 worse living environments, challenges in
6 adherence and lifestyle or bias, and providers
7 may have poorer performance due to fewer
8 resources or a mismatch between resources and
9 clinical workload, lower levels of community
10 support or worse quality of care.

11 Unfortunately, many of these factors
12 on both the beneficiary and provider side are not
13 easily measured with our current data.

14 Next slide, please. So what are some
15 potential policy solutions? And I'll just walk
16 through a few here to set up some of our
17 simulations. As many of have discussed, we can
18 simply adjust the quality and resource use
19 measures, which some would argue could make
20 comparisons more equitable and reduce the risk of
21 decreasing access to care for high risk
22 beneficiaries.

1 Others might argue that that makes it
2 more difficult to track and address disparities
3 by varying the disparities within the measure,
4 and could excuse low quality care if the
5 adjustment is done broadly. Here, there's
6 clearly no right answer. We simulated it anyway,
7 so we'll show you that. But the answer here
8 likely differs by measure.

9 Another adjusted solution has been to
10 stratify measurement or payment, which largely
11 has the same pros and cons in terms of
12 potentially making comparisons more equitably,
13 but running the risk of making it difficult to
14 address disparities or excusing low quality care
15 if done broadly.

16 Finally, creating bonus opportunities
17 for improvement if a program does not already
18 have such an opportunity, or equity, or anything
19 else that one might want to do to sort of tweak
20 the structure of value-based purchasing in a way
21 that's felt more -- perhaps to add on some
22 opportunities to address some of the social risk

1 factors.

2 Next slide, please. Some of the
3 policy options that have been proposed were
4 already mentioned. So MedPAC has proposed
5 stratifying hospitals into ten groups by social
6 risk, and in the 21st Century Cures Act, as
7 Pierre noted, it suggests stratification into
8 groups by proportion of fully and dual enrolled,
9 and also has a consideration about the IMPACT
10 report, and excludes certain patients and certain
11 readmissions, to try to make the measure a little
12 bit more precise.

13 Next slide, please. Well here, I'm
14 going to talk through what we did in the report
15 in terms of simulations, without placing any
16 value judgment on any of these three options for
17 now. I'm going to show you an example of each of
18 those three types of solutions.

19 So if you start in the first column
20 there, you can see the current average HRRP
21 penalty in thousands of dollars, that the state
22 committed 191,000 and all other hospitals at

1 150,000 and the difference on the bottom there in
2 bold at 41,000.

3 Adding dual status to the risk
4 adjustment model, which is Simulation 1, narrows
5 the gap between safety net and all other
6 hospitals to about \$16,000. Stratifying
7 hospitals into ten groups, which is similar to
8 what MedPAC had proposed and similar, although
9 not with quite the same variables, as is in 21st
10 Century Cures.

11 Simulation 2 you can see actually
12 flips the penalty difference between safety net
13 and all other hospitals because it's by
14 definition distribute the penalties across the
15 very different groups of hospitals, and
16 Simulation 3 in this case was simulated adding an
17 improvement bonus, in which we allowed each
18 hospital to buy down its penalty based on its
19 improvement in the prior year.

20 You can see that all hospitals were
21 able -- not all. On average, hospitals were able
22 to buy down a penalty a little bit with both

1 groups dropping.

2 So the safety net dropping from 191 to
3 176 and all other hospitals dropping also, that
4 did not reduce the difference between safety net
5 and all other hospitals, because the safety net
6 was not in fact improving faster than other
7 hospitals were.

8 Next slide, please. Here we're
9 showing a very similar set of simulations, this
10 time in the Medicare Advantage Program. So the
11 Medicare Advantage Program rewards quality stars
12 based on performance across a wide array of both
13 patient level and contract level measures, and in
14 the current program, the average star rating for
15 a high dual or low income subsidy status
16 contract is 3.48 stars, which you can see in the
17 left-most column.

18 Below that you can see the average
19 star rating for all other contracts, which is
20 3.78 stars. Now with four stars, you get a
21 bonus. So in the Medicare Advantage Program,
22 about 26 percent of the contracts in the highest

1 group of duals compared to 53 percent of other
2 contracts actually meet that four star threshold.

3 So again, an example of a difference
4 in performance that correlates with proportion
5 dual. As we can see at baseline, there's about a
6 .3 star difference between those two. If you go
7 to Simulation 1, in which the adjusted measures,
8 only the clinical measures, not the contract
9 level measures for dual status, you can see that
10 it narrows the gap only minimally, in part
11 because those measures only make up a subset of
12 the scores that go into this program, and in part
13 because the differences on many of the measures
14 were fairly small.

15 If you move one more column to the
16 right to Simulation 2, you can see the
17 categorical adjustment index, which is an
18 adjustment index that takes into account both
19 dual status and disability status, as the
20 original reasons for Medicare entitlement, and
21 that will be implemented as an interim adjustment
22 in Plan Year 2017.

1 You can see that narrows the gap a
2 little bit also, by giving a small bounce to the
3 high duals or LIS contracts. In the third
4 column, you can see a simulation for adding an
5 equity bonus, which I will say right now we made
6 up as sort of a back of the envelope idea, in
7 which we measured the disparity, the average
8 disparity on the clinical measures, and awarded
9 contracts extra stars if they had a low average
10 disparity.

11 You can see here that that led to a
12 narrowing of the gap to some degree, with more of
13 an extra equity bonus being received by the high
14 dual contracts than the other contracts.

15 Next slide, please. But, and herein
16 lies the complexity that was presaged in the
17 comments prior to us and then brought up by Nancy
18 as well, one solution will not address all the
19 causes. We can talk about certainly the
20 multitude of factors that lead to beneficiaries
21 with social risk factors having worse outcomes.

22 I had mentioned those before, but

1 they're on this slide again. If we think about
2 how pervasive, persistent and deep-seated of a
3 problem this is, I think it becomes pretty
4 apparent that just talking about adjusting the
5 measures probably misses the opportunity sort of
6 inherent in value-based purchasing, to think
7 about how these both measures and programs might
8 be leveraged in a way to really to start to
9 change that conversation.

10 So the next slide, please. As a
11 result, we came up with the help of our CMS
12 colleagues and lots of other folks around the
13 department, with sort of a broader strategy and
14 how we can start thinking through how to account
15 for social risk in Medicare payment programs.

16 These are much more considerations for
17 future development and discussion than they are
18 highly specific recommendations, but we do hope
19 that they dovetail with a lot of what you all
20 have been thinking as well. So the first part of
21 the strategy is to measure and report quality for
22 beneficiaries and social risk factors, which is

1 very germane to this group.

2 The second is to set high, fair
3 quality standards for all beneficiaries, again it
4 will feel familiar to this group. The third is
5 to reward and support better outcomes for
6 beneficiaries with social risk factors. So I'll
7 walk through each of those in turn.

8 Next slide, please. So the first
9 strategy is to measure and report quality for
10 beneficiaries with social risk factors. The
11 first consideration is to consider enhancing data
12 collection, developing statistical techniques to
13 allow the measurement and reporting of
14 performance for beneficiaries with social risk
15 factors on key quality and resource use measures.

16 We realized in doing this that we've
17 created a, I don't know, 600 plus page document
18 full of really an enormous amount of information,
19 that could be really instructive to track over
20 time and to help us understand the changes in the
21 patterns of quality and of disparities. We felt
22 like this shouldn't be a one-off, but rather sort

1 of a start in thinking through how, what we might
2 need to do from a data and statistics standpoint,
3 to make it feasible to actually see what our
4 disparities are and what our performance is for
5 these beneficiaries.

6 The second consideration is to
7 consider developing and introducing health equity
8 measures or domains into existing payment
9 programs, to measure disparities and incent to
10 focus on reducing them. I'll again admit that we
11 don't know what this means or what it looks like,
12 but we'll very much look to input and guidance
13 from all of you.

14 And third, to prospectively monitor
15 the financial impact of Medicare payment programs
16 and providers disproportionately serving
17 beneficiaries with social risk factors. As these
18 programs continue to broaden and as they move
19 into multiple different types of beneficiaries in
20 different types of specialties and models,
21 keeping this front of mind will be important.

22 The second component is to set high

1 fair quality standards for all beneficiaries.
2 First, measures should be examined to determine
3 if adjustment for social risk factors is
4 appropriate, and the determination for any
5 measure will depend on the measure and its
6 empirical relationship to social risk factors,
7 which is exactly what NQF has been leading the
8 charge in doing.

9 Certainly, all measures should not be
10 considered to be the same when it comes to this
11 particular consideration. So we sort of leave
12 this here as an invitation for continued
13 discussions on this issue.

14 The second component we've also
15 brought up before, which is that the measure
16 development community should continue to study
17 program measures to determine whether differences
18 in health status might underlie some of the
19 historic relationships between social risk and
20 performance, and whether perhaps adjusting for
21 health status might improve the ability to
22 differentiate true differences in performance

1 between providers.

2 That would be things like frailty,
3 functional status, disease severity, things in
4 which there are likely differences between
5 subpopulations and the better we can understand
6 them both, the more equitable the measures and
7 programs can be, and the better idea we'll have
8 about the types of beneficiaries that might
9 benefit the most from quality improvement and
10 intervention.

11 Next slide, please. Finally, the
12 third strategy is to reward and support better
13 outcomes for beneficiaries with social risk
14 factors. The first consideration is to consider
15 creating targeted financial incentives within the
16 value-based purchasing program, to reward the
17 achievement of high quality and good outcomes or
18 significant improvements among beneficiaries with
19 social risk factors.

20 Certainly, we've seen some encouraging
21 news, I think, from the hospital readmission
22 reduction program for the Massachusetts

1 Alternative Quality Contract, suggesting that
2 perhaps beneficiaries with social risk factors
3 might gain the most from these programs. And so
4 kind of really leveraging that could be an area
5 with a lot of promise.

6 The second consideration would be to
7 consider using existing or new quality
8 improvement programs to provide targeted support
9 and technical assistance for providers that serve
10 beneficiaries with social risk factors. For
11 example, one thing that we found in a few
12 programs, particularly the physician value-based
13 payment modifier program is that physician groups
14 serving high risk populations were less likely
15 even to successfully report.

16 So if their infrastructure needs or
17 technical assistance or support needs to even
18 make sure that all providers that serve
19 vulnerable beneficiaries can be part of these
20 programs, there really may be some things that
21 using the existing technical support resources
22 could potentially really help some of these

1 groups.

2 Third, considering developing
3 demonstrations or models focusing on care
4 innovations may help achieve better outcomes for
5 beneficiaries with social risk factors. We need
6 to know more about how we can do the things that
7 these beneficiaries need, and some of those may
8 require some creativity and innovation that sort
9 of aren't easy within current systems that might
10 be more feasible within demonstration models.

11 And finally, further research to
12 examine the cost of achieving good outcomes for
13 beneficiaries with social risk factors, to
14 determine whether current payments adequately
15 account for differences in care needs, and this
16 is certainly the idea behind DSH payments, for
17 example, and could be an important area to learn
18 more about in the future, particularly under
19 alternative payment models.

20 We'll turn now to Robin to tell you a
21 little bit for our next piece of work.

22 MS. YABROFF: Great. Thank you,

1 Karen. Hi, this is Robin Yabroff, and I'm going
2 to give you a very quick overview of some of our
3 plans for Impact Study B. As a reminder, this is
4 -- the goal of this study is to evaluate social
5 risk factors and performance using new measures
6 of social risk, new data sources.

7 So to give you a quick overview, we
8 plan to build on the first report to Congress,
9 the framework that Karen has described so well.
10 We'll be looking at a number of different social
11 risk factors at the beneficiary, provider and
12 program level, and we will use the conceptual
13 framework in a series of recommendations for data
14 sources and measures from reports from the
15 National Academies, and there's a series of five
16 reports the picture is showing here on the right
17 side of this slide, Accounting for Social Risk in
18 Medicare Payments.

19 We will also explore new measures of
20 social risk, and this is part of the conceptual
21 framework that the National Academies came up
22 with, which include things like socioeconomic

1 position, race-ethnicity, gender, social
2 relationships and residential and community
3 context. We will also be evaluating medical or
4 social risk factors that are prevalent in dually
5 eligible beneficiaries, things like frailty and
6 disability, and then finally examining program
7 impact and policy solutions.

8 Next slide, please. So just to give
9 you a better sense of exactly what we will be
10 doing within our evaluation of new measures of
11 social risk, we have a series of survey database
12 projects using the Medicare current beneficiary
13 survey, which is about 15,000 beneficiaries a
14 year, and also the American Community Survey,
15 which looks at both the individual and area
16 levels.

17 We'll be doing a series of parallel
18 analyses to evaluate which social risk factors
19 are the strongest predictors of poor outcomes.
20 We'll also be evaluating interrelationships
21 between individual and contextual measures of
22 social risk and outcomes, to give us a better

1 sense of how well these measures correlate, but
2 also which -- where it's most important to
3 include these sorts of measures, and then how the
4 risk factors influence provider performance.

5 We're also going to be doing a series
6 of claims-based data projects, where we are going
7 to be identifying and validating new measures of
8 medical risk factors that are prevalent in dually
9 eligible beneficiaries, and then similarly
10 assessing relationships with outcomes and
11 evaluating the influence on provider performance.

12 Next slide, please. So with that, I
13 want to open it up for questions. I also want to
14 note that I just sent a note to everyone, which
15 includes the contact information for any feedback
16 you might have on this report or any other
17 suggestions you have, and that is [aspeimpactstudy](mailto:aspeimpactstudy@hhs.gov)
18 at hhs.gov.

19 So that is a new mailbox we recently
20 started that we'll be using to collect feedback
21 from anyone who has comments. So with that, I'm
22 looking forward to your feedback and questions.

1 Thank you.

2 CO-CHAIR KHAN: Thank you so much,
3 guys. Okay who? I see David and Harold right
4 now.

5 MEMBER BAKER: This is David Baker.
6 I just want to thank you for a really incredible
7 presentation. It was just so clear and
8 thoughtful. So my first comment is you talk
9 about these unmeasured health factors, and I
10 can't stress how important that is. There is
11 incredibly robust literature on the importance of
12 health status.

13 You talk about frailty, but even self-
14 reported overall health. As simple as that one
15 question is, it's an incredible predictor of
16 hospitalization, mortality, et cetera. Before
17 you do a lot of research, you should look at the
18 studies that have been done using the health and
19 retirement study, and I'd be happy to share some
20 of the work that I've done and that others have
21 done using that, because that's a great source of
22 data for looking at this.

1 MS. YABROFF: Thank you very -- this
2 is Robin. Thank you very much. I appreciate
3 that, and certainly we'd be interested in you
4 forwarding those studies. And when you refer to
5 this, the simple one item question how would you
6 rate your health; excellent, very good, good,
7 fair, poor, correct?

8 MEMBER BAKER: Exactly.

9 MS. YABROFF: Yes, yes.

10 MEMBER BAKER: But you know, it's just
11 a start obviously, but it's so important to
12 recognize that a lot of these measures that
13 you're using for socioeconomic status, they are
14 almost certainly, as you pointed out nicely,
15 they're proxy measures for differences in health
16 status. If you look at patients, for example,
17 with diabetes and what proportion of patients,
18 you know. You adjust for comorbidities.

19 But what's the prevalence of
20 microvascular disease in those patients? Again,
21 huge differences. When we were using the health
22 and retirement study data about 15 years ago, we

1 were looking at people who are sort of in the ten
2 years before hitting Medicare, and overwhelmingly
3 the most important predictor of their health
4 outcomes we're looking particularly at race-
5 ethnicity but also socioeconomic factors.

6 Overwhelmingly, it's a baseline health
7 status, right. So if you don't have that
8 information, you know, really you're missing the
9 boat on ability to adjust, and really understand
10 what the differences in this is.

11 MS. YABROFF: Yes. Thank you for that
12 suggestion. It is something that we are
13 considering, and we do in fact have, that
14 question in the Medicare current beneficiary
15 survey.

16 MEMBER BAKER: Oh great.

17 MS. YABROFF: Yes, and we plan on
18 using it. So yes, go ahead.

19 MEMBER BAKER: Just the other things.
20 You talked about rewarding achievement, and
21 that's great. But I'll give an example of Mount
22 Sinai Hospital in Chicago. One time their CEO

1 said that they measure their cash on hand not on
2 days but sometimes in hours. So you know, to
3 reward organizations for performance improvement,
4 they don't have the cash up front to implement
5 the programs, many of which are evidence-based
6 programs, community health workers and such.

7 They don't have the money to implement
8 those, to be able to get the bonuses later on.
9 Which gets to Bill's comment right at the start,
10 you know, about the need to have adjustment for
11 the payments right up front. So you know, I
12 applaud that idea, but the reality is much
13 different.

14 CO-CHAIR PINCUS: Really an incredibly
15 sophisticated approach that you've used to this,
16 and I'm really thinking through all, both the
17 scientific and the policy questions in a really
18 good way. One question I had, both in the I
19 guess Study A and your plans for further studies.
20 To what extent did you look at the extent to
21 which behavioral health conditions had an impact
22 on this, both behavioral health conditions that

1 were identified in claims, but also ones that
2 were not -- that were or might not be identified?

3 DR. JOYNT: This is Karen. That's a
4 great question. We didn't in quite the sense
5 that you ask. We certainly noted when we
6 examined patient characteristics based on claims
7 across programs, that typically most of the
8 individuals with social risk factors have
9 significant higher proportions of prevalent
10 mental health diagnoses in claims.

11 My recollection is two to three times
12 higher in the dual versus non-dual group. I
13 believe some of the quality measures incorporate
14 some pieces of that, but certainly not in the
15 kind of detail that you're asking, and we didn't
16 do any additional looks at other data sources in
17 terms of where one might find that information
18 outside of claims.

19 But I think it's a tremendously
20 important area to think about, especially as we
21 think more about many of the alternative payment
22 models and other systems, really thinking about

1 how to integrate behavioral and medical type
2 health services. So it's a great point.

3 MS. YABROFF: Hi, this is Robin. I
4 just want to add to that and say that it is a
5 great point and your timing is perfect, in that
6 it is something we can think about carefully as
7 we start exploring some of the different measures
8 of not only self-rated health but different
9 measures of a lot of our other health status
10 measures.

11 CO-CHAIR PINCUS: Just to say that
12 we'd be glad to talk to you further about it.
13 We've recently been just completing a
14 Commonwealth Fund study around kind of the
15 interface between behavioral health and general
16 health, and some issues around quality
17 measurement.

18 MS. YABROFF: Hi, this is Robin again.
19 I just want to make sure. Could people please
20 announce their names when they're asking
21 questions? So it make it a lot easier for us --

22 CO-CHAIR PINCUS: This is Harold

1 Pincus at Columbia, okay.

2 MS. YABROFF: Got it. Thank you.

3 CO-CHAIR PINCUS: Aparna.

4 MEMBER HIGGINS: Okay, thanks. This
5 is Aparna Higgins. So I have a couple of
6 questions and one suggestion, so I'll kind of go
7 through them. So I think one of the earlier
8 slides you had presented, you had talked about
9 how after adjusting for some of the provider
10 characteristics, you still found differences -- I
11 mean so after adjusting the beneficiary
12 characteristics, you still found differences in
13 the performance of these hospitals.

14 So when you looked at the data, do you
15 see a lot variability among hospitals that had a
16 higher proportion of DSH? And I have a follow-up
17 question to that, based on your first -- answer
18 to that first question.

19 MS. YABROFF: Sorry. Can you say that
20 one more time? So did we find a -- are you
21 asking the disparity difference across hospitals?

22 MEMBER HIGGINS: Right. So if you

1 look at hospitals that have, you know, a higher
2 proportion of DSH patients, you know, at usually
3 the 20 percent threshold. So I'm wondering if
4 you looked along a continuum, did you see, you
5 know, if it's five percent versus 20 percent
6 versus, you know, 50 percent? You know, do you
7 see a lot of variability in terms of when you
8 move that threshold like you were -- I don't know
9 if you modeled it, but I was curious.

10 MS. YABROFF: Yes. So I'll answer
11 that in a couple of ways. It differed a little
12 bit by programs. So there's a couple of graphs
13 in the report looking at either DSH index or a
14 proportion of dual as a continuous variable and
15 relating that to performance.

16 And perhaps from a value-based
17 purchasing, or if you look at a combined
18 performance across the three hospital programs,
19 which is at the beginning of the hospital
20 section, it's a reasonably linear relationship.
21 There's not an obvious threshold where we made
22 the cut for DSH index, use a presentation of

1 having a specific group. But the relationship
2 was visible across the entire spectrum.

3 One thing we found that was very
4 interesting was that in the Medicare Advantage
5 Program, the line was instead shaped a little bit
6 like a swoosh, for any Nike enthusiasts out
7 there, in that there was clearly a negative
8 relationship between proportion of dual and
9 performance out to the end, and then it did seem
10 like at the highest proportions of dual low
11 income subsidy individuals, there was really an
12 uptick in performance, suggesting that perhaps
13 the contract that had really focused on providing
14 the types of services or interventions or
15 whatever that these folks might particularly
16 benefit from have had some success in doing so.

17 Certainly that will be, I think, an
18 interesting area for us and others to learn more
19 about in the future. In terms of the disparity,
20 we did look in a couple of settings to find out
21 if disparity varied by proportion duals with high
22 or low disparities. That was -- that was pretty

1 all over the map. We didn't find a very obvious
2 connection between proportions or quality and the
3 magnitude of the disparity.

4 MEMBER HIGGINS: Okay, thank you.
5 Then just real quickly, I think you mentioned
6 your Study B, you were going to be looking at
7 survey measures. You mentioned MCBS. I think
8 the other you might be looking at this already on
9 the MA side is the HOS survey, where they do ask
10 questions about, you know, health status. So
11 something you might want to think about.

12 MS. YABROFF: Yes, thank you. We
13 looked at performance on those measures in the
14 Medicare Advantage Program, but we didn't use
15 those to examine other measures, if that makes
16 sense. So we sort of took the first step into
17 the medical and/or what is it, physical and
18 mental health measures and looking at them, and
19 certainly differences by dual status, but did not
20 apply those to other measures within MA. That's
21 a terrific idea.

22 MEMBER HIGGINS: Okay.

1 CO-CHAIR KHAN: Okay, other questions?
2 Do you have any other questions?

3 DR. ANTONELLI: This is Rich Antonelli
4 from Boston Children's Hospital. This is -- if I
5 was empowered to give out an Oscar, you guys
6 would get it. Congratulations. Thank you for
7 the inspiration and the good work. This is
8 something that we're thinking about a lot in
9 Massachusetts, where we're developing
10 methodologic approaches to embedding social
11 determinants of health into our Medicaid program
12 across the age spectrum.

13 That said, I'm especially interested
14 in your comparison about the provider performance
15 on certain measures. To the degree that we could
16 get data, that you could get some data that isn't
17 necessarily the same Medicare population, I'm
18 wondering what's the impact on a delivery system
19 that has a Medicare service line and a non-
20 Medicare service line? Does this caring for this
21 population, if there's a substantial commercial
22 presence, in fact elevate performance across the

1 board or drag it down?

2 It would be interesting to see the
3 comparability and then also I want to build on
4 what Bill's wisdom was at the beginning. It
5 isn't just an issue of giving more money to the
6 providers; we have to think very creatively
7 because a one-size-fits-all intervention won't
8 work. So I'll stop there, but I wonder if you
9 can comment about that.

10 MS. YABROFF: Yes no. We appreciate
11 that. Certainly Massachusetts has had -- has
12 been the home of a number of very interesting
13 programs and efforts to try to think through
14 this. I think -- I honestly don't know the
15 answer to your question, but it sure would be a
16 great thing for someone to figure out.

17 You know, there's efforts within the
18 Department to try to harmonize and think through
19 what multi-payer programs would look like, or how
20 we could have a system -- quote-unquote system in
21 which various incentives from various purchasers
22 sort of augment one another.

1 I don't know that we have the data
2 right now to know what those patterns look like.
3 We certainly don't. I don't know if other folks
4 do, but it's certainly a tremendously important
5 area. You can imagine that depending on what
6 proportion of your practice is Medicare/Medicaid,
7 a whole slew of different private purchasers,
8 whether or not those are in Medicare Advantage or
9 not, whether or not they're in alternative
10 quality contracts could really change the benefit
11 for investing in the kind of systems it might
12 take to do some specific interventions.

13 So that's obviously -- that was the
14 great comment, and if you know the answer, please
15 tell us.

16 DR. ANTONELLI: Well I have a
17 suggestion, and it actually is to build on a
18 comment I made to the NQF staff at the break, and
19 we were -- a study was done with the
20 Massachusetts Blue Cross/Blue Shield alternative
21 quality contract, and the headline was that this
22 approach in fact reduced disparity.

1 But the problem that I had with that,
2 and I wasn't connected with the study although I
3 am a clinician in Massachusetts, the problem is
4 that those patients were able to be commercially
5 insured to begin with. So to the degree that you
6 can reduce disparities for a commercially insured
7 population, that's wonderful. But you know, I
8 really have significant concerns about the
9 representativeness of low resource populations
10 that are commercially insured versus a vulnerable
11 population.

12 So here's my suggestion. If your
13 analytic team could actually look at some of the
14 data elements that were reported in the BCDS
15 Massachusetts AQC, to see if any of those things
16 cross-walk into the measures that you were
17 looking at. It wouldn't be definitive, but it
18 may be directional.

19 MS. YABROFF: That's a terrific idea.
20 I saw that study, and I will go back and look at
21 the details with that eye.

22 CO-CHAIR KHAN: Okay, Bruce. Okay,

1 Bruce. Oh Mary?

2 MEMBER BARTON: Hi. This is Mary
3 Burton from NCQA. I was curious that on the
4 slide where you mentioned the pros and cons of
5 risk adjustment, you said that the issues with
6 stratification would be the same. That strikes
7 me as not immediately apparent, why presenting in
8 a group just to a straw person, you know, all the
9 high duals I'll say health plans, because that's
10 my world, and comparing them to each other and
11 creating benchmarks within that pool, would not
12 have the effect of showing -- it would still show
13 everybody's actual rate, but you would be going
14 to pay because of the way that, you know, the
15 payments are based on benchmarks on -- with a
16 different threshold. So that you would not be
17 changing the measures, but you would be
18 facilitating a change in the payment.

19 So I'm curious, how do you see that as
20 being subject to the same cons as risk
21 adjustment, which by itself would obscure the
22 actual performance?

1 MS. YABROFF: That's a great point.
2 I think the devil is in the details, and that is
3 to say that when and where you adjust versus pay
4 versus compare, do you report unadjusted
5 performance, do you report relative performance?
6 How you operationalize any of these fixes could
7 address some of the cons and augment some of the
8 pros, and I would suspect there are better and
9 worse ways to implement many of these things.

10 So that is to say it would depend how
11 it were done. Certainly if you gave everyone
12 just a score, a within stratum score or something
13 like that, that would be very different, showing
14 actual performance within strata. So I think it
15 would depend how these things would be
16 operationalized, which is obviously a much bigger
17 challenge in many ways.

18 CO-CHAIR KHAN: Thanks. Bruce.

19 MEMBER HALL: Bruce Hall from the
20 American College of Surgeons. Thank you all,
21 Robin and Karen and Nancy and teams for doing
22 this work. Fantastic work, generating important

1 insights for all of us. These are topics that
2 all of us measurement folks worry about and lose
3 sleep over.

4 You said at one point early on, I
5 forget which piece of the presentation it was,
6 that you noticed that even after adjusting for
7 beneficiary mix, providers still had -- these
8 providers still had some performance gaps. But
9 then you correctly, I think, go on to say those
10 may be associated with other resource issues and
11 other operational issues.

12 I think that's correct, and I think
13 what that shows us is that, you know, maybe we're
14 at a time where we should flip this paradigm
15 around. So those of us who are measurement
16 wonks, we always think that some day we're going
17 to be able to tease out enough factors that once
18 we've adjusted for all those factors, we'll be
19 left with some true performance gap for that
20 provider, showing, proving to all of us that that
21 provider was, you know, a bad person to begin
22 with.

1 It's just a matter of teasing out what
2 the proportions of different populations are and
3 whether they have resources or not. But the end
4 of the day, the numbers that are left are going
5 to be the residual, and that residual is going to
6 indicate that that provider was bad.

7 If we could just flip from the start
8 and say to ourselves whenever we notice
9 performance isn't reaching a benchmark, we're
10 going to assume that those are good people, good
11 teams who don't have the resources, and then we
12 start teasing out the ways they don't have the
13 resources.

14 They don't have the resources to
15 address dual eligibles. They don't have the
16 resources to address literacy, so on and so
17 forth. We would find ourself in a very different
18 policy position. We'd be finding ourself wanting
19 ways to correct for those deficiencies, instead
20 of trying to make sure that we've removed enough
21 factors that we justfully penalize somebody.

22 So that my pie in the sky comment.

1 Now I'm going to switch to a granular comment
2 that's concrete. As the recent chair of the
3 Readmissions Standing Committee, along with
4 Sherrie Kaplan, and I'm still on that committee
5 but no longer chair, we had a number of our
6 measures in the recent round go through the SDS
7 trial period.

8 For those of you who noticed the
9 announcement, only a couple, only I think two of
10 the measures ended up with any SDS adjustment in
11 the final version. But I want to make it clear
12 to everyone in this committee and everyone
13 listening that I think that's because the
14 available metrics tested just weren't on the
15 mark.

16 I think everyone acknowledged that.
17 There just wasn't a lot of data at that time
18 easily available to roll into that trial period,
19 and so we didn't see a lot of factors with big
20 influence on those metrics. But that's because
21 there just, I think, wasn't a fully developed
22 approach. It was the opening salvo.

1 But those results should not be viewed
2 as the Readmissions Committee or anyone in NQF
3 saying SDS adjustment is not important. That
4 would be the wrong message. The message should
5 be we tried it this first round. We weren't
6 sophisticated enough to really show the impact.
7 That work is ongoing and continues, and it is not
8 a statement that SDS adjustment is not important.

9 The final -- the final approvals for
10 the readmissions and other measures recently
11 came along with four qualifications or
12 recommendations from CSAC, and I think those are
13 important for everyone to read and think about.
14 But still at the end of the day, they are mostly
15 centered on the measurement challenge, on the
16 work challenge of did we get all the factors we
17 could have gotten.

18 I would ask all of us to go back to
19 either Karen or Robin's Slide No. 72, which
20 showed this multicolored circle with six, you
21 know, different circles and different colors
22 around it. Go back maybe one more or yes,

1 something like that, which shows that, you know,
2 risk adjustment is just a little piece of what we
3 should be shooting for here, and until we can get
4 the policy support to be paying attention to all
5 of these colors, I think we're going to be
6 falling short of our charge for our patients.
7 With that, I will shut up.

8 CO-CHAIR KHAN: Okay. Rhonda.

9 MEMBER ANDERSON: I really appreciate
10 the work that's been done, and this follows up
11 actually. My question was going to -- my comment
12 was going to be what Bruce made about the trial
13 period. But my question is I think probably to
14 Helen or someone from NQF, in terms of these
15 findings and this work to date, how is it going
16 to affect the work that you have been doing, and
17 maybe an extension of the trial period. I'm not
18 exactly sure of the next steps.

19 MS. O'ROURKE: Sure. We actually had
20 a couple of slides that we put together. If you
21 could go to Slide 84, which shows some of the
22 results of our trial period. 83's a background

1 on the trial period.

2 DR. BURSTIN: Basically for those of
3 you who aren't aware, we've been doing this trial
4 period now for about a year and a half, I think,
5 overall looking and actually it's at all measures
6 that come before NQF, to consider whether there's
7 both a conceptual and empiric basis for
8 adjustment.

9 We were actually very heartened to
10 see, I think, that the IMPACT report said that
11 same mantra, conceptual plus empiric. I think
12 what we generally found though is that many
13 measures for which there was a conceptual basis,
14 vis-a-vis saying it in English, a logical reason
15 why you think social class, social risk could be
16 a factor, we have not seen very many measures
17 where the empiric data supports that.

18 Meaning the available variables, as we
19 just heard from Bruce, and I think eloquently
20 described by the ASPE folks, are not yet
21 available to show some of that difference. And
22 so as you could see this here, very few of the

1 measures to date have gone through with
2 adjustment, you know.

3 One example, there was a measure that
4 looked at the coordination of care for children
5 with special health care needs, where the
6 education of the parent was such a critical
7 factor in it. That measure was in fact adjusted
8 for that. There was a SNF measure that adjusted
9 for marital status and insurance status.

10 So there were a couple where it did
11 logically come through. So I just want to put up
12 these four statements that Bruce had mentioned.
13 So when those -- the readmission measures in
14 particular came through recently, the CSAC and
15 then ultimately the executive committee of the
16 board recommended that those endorsements, move
17 forward with these four statements attached to
18 them.

19 The first was that we recognized this
20 is not a closed door, as I think you just heard.
21 As better data get, become available, we do see
22 it as something that, as part of the annual

1 update process that measures come forward,
2 measures that had a conceptual basis, that didn't
3 have an empiric basis will be asked to consider
4 what new adjusters can you potentially update
5 your analyses?

6 The second thing is that I think we
7 actually put this forward a while ago, but I
8 think very much bolstered by the IMPACT report as
9 well, is this idea that it's really time to think
10 very much about this next generation of risk
11 adjustment broadly, considering better clinical
12 factors, clinical complexity, health status. We
13 very much want to take that and we'd love to do
14 that in partnership obviously with our federal
15 partners.

16 I think the third is that given the
17 concerns about the potential unintended
18 consequences on the safety net, and this was
19 before the 21st Century Cures Act came out, we
20 specifically wanted to encourage MAP and the NQF
21 Board to consider other approaches like payment,
22 again very clearly outlined in the IMPACT report.

1 Measurement and risk adjustment is not
2 the only approach here to fix concerns about
3 unintended consequences, but it is one certainly.
4 And then finally, as some of you know, we have a
5 Disparity Standing Committee actively doing work,
6 creating a measurement road map to think about
7 how you can reduce disparities through
8 measurement.

9 One of the things they've been
10 specifically tasked with is considering some of
11 these questions that kept coming up with our
12 committees, about should you potentially adjust
13 for hospital or community level factors. So we
14 will, we will tee that up for them. In terms of
15 next steps for the Disparities Committee, they
16 will have a formal review of all the measures
17 that have been part of the trial period at their
18 May-June in person meeting.

19 We'll then have them make a
20 recommendation to the NQF Board for their meeting
21 in July, as to whether NQF would make this a
22 permanent change to our policy, to allow measures

1 to be considered for social risk factors. At
2 least in talking and very much supported by the
3 IMPACT report, it seems that we have not seen any
4 evidence of a down side to necessarily allowing
5 the discussions to happen.

6 I think our bar is probably pretty
7 high, given how difficult it's been for measures
8 to get through. But that will be a final change
9 in July. But I do think, just as a take-home for
10 us at least, the IMPACT report was very, I think,
11 affirming, that our approach of requiring both
12 conceptual and empiric basis was right.

13 I do think though, which we've also
14 agreed with, that it can't just be about
15 measurement and risk adjustment. You've got to
16 think about the payment levers, and whatever
17 other levers could be done. And then finally
18 something else we'll ask the Disparities
19 Committee to address, and this committee as well
20 if you'd like, is one of the other really
21 important recommendations I think of the IMPACT
22 report is the idea that we need a set of health

1 equity measures.

2 That's something we're going to have
3 the Disparities Committee really begin to help us
4 think through. We've done some of this work over
5 the last several years. But I, you know, very
6 much would welcome your thoughts about what would
7 be an important starter set of what those health
8 equity measures would look like, as we continue
9 to move forward in this.

10 CO-CHAIR KHAN: I guess thank you
11 Helen, and I guess it's, you know, the whole
12 thing is very troubling, as Bruce pointed out,
13 and as the study showed. The lower income tend
14 to have a double whammy. They tend to be sicker
15 and they tend to go to institutions that, at
16 least right now, are not as good -- don't have as
17 high quality care as other institutions treating
18 other populations of Americans. So a lot to do
19 with -- we need to do to improve on that. So
20 with that, have we I believe done our work?

21 MS. O'ROURKE: We're done.

22 CO-CHAIR KHAN: Okay. I think with

1 that, we're done. I want to thank ASPE -- are
2 they still on the phone?

3 MS. O'ROURKE: Yes, they're still on
4 the phone.

5 CO-CHAIR KHAN: Okay. I want to thank
6 them for super work, and we'll look forward to
7 the next edition of your work. Obviously some
8 people have made suggestions here, and I think
9 everyone here now is really keyed in.

10 So I'm sure you'll be getting cards
11 and letters and suggestions, as well as hopefully
12 maybe some other gifts of -- to help you along as
13 you do the next part of your task. So with that,
14 Harold anything else? Oh I'm sorry, I'm sorry.
15 I forgot about public.

16 CO-CHAIR KHAN: Any public comment?

17 OPERATOR: At this time, if you'd
18 like to ask a comment, please press star one.

19 (No audible response.)

20 OPERATOR: And there are no public
21 comments at this time.

22 CO-CHAIR KHAN: Okay. I'll pass the

1 baton to Harold.

2 CO-CHAIR PINCUS: Well again, let me
3 just thank certainly ASPE staff, NQF staff, and
4 probably most of all the members of the
5 Coordinating Committee, because it's been a very
6 efficient and substantive and I think effective
7 way in which we've met our mandate. So thank you
8 all. Safe travels.

9 DR. BURSTIN: I'll just add my thanks
10 to everybody as well. We recognize you're
11 volunteers. You put an incredible amount of work
12 on your plates and I'm just delighted that all of
13 you are willing to participate. Your suggestions
14 for improvement are really heartwarming to us.
15 We continue to want to make this a better
16 process.

17 In fact, we did some things with the
18 work group we'll need to bring to you, including
19 the holistic review of the measure sets. We made
20 sure of that to follow, since that will be in the
21 final report. Not in the spreadsheets, but in
22 the final report that we put forward to CMS. So

1 we'll make sure all of you have an opportunity to
2 review that, and we'll think about ways to
3 incorporate that further into the process for the
4 Coordinating Committee going forward. So thank
5 you all and safe travels.

6 CO-CHAIR KHAN: Great. So I guess we
7 are adjourned. Thank you.

8 MS. O'ROURKE: I just want to jump in
9 and thank you so much, Chip and Harold, for your
10 leadership over the past two days in getting us
11 through this incredible volume of work.

12 I echo my thanks on Helen's for all of
13 the work all of you have done over the past few
14 days. We greatly appreciate it, and safe travels
15 home and our next meeting will be in August, to
16 review the work of the Medicaid core set task
17 forces. That will be a web meeting, and then we
18 will keep you updated on the release of the pre-
19 rulemaking reports in the coming weeks. Thank
20 you.

21 (Whereupon, the above-entitled matter
22 went off the record at 2:11 p.m.)

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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
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