NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP COORDINATING COMMITTEE MEETING

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TUESDAY
JANUARY 26, 2016

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The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 10:00 a.m., Harold Pincus, Co-Chair, and Foster Gesten, Acting Co-Chair, presiding.

PRESENT:
HAROLD PINCUS, MD, Co-Chair
FOSTER GESTEN, MD, FACP, Acting Co-Chair
RHONDA ANDERSON, RN, DNSc, FAAN, American Hospital Association
MARY BARTON, MD, MPP, National Committee for Quality Assurance *
STEVEN BROTMAN, MD, JD, AdvaMed
JAYNE CHAMBERS, Federation of American Hospitals
MARK R. CHASSIN, MD, FACP, MPP, MPH, The Joint Commission
MELISSA DANFORTH, The Leapfrog Group
CHRISTOPHER M. DEZII, RN, MBA, CPHQ, Pharmaceutical Research and Manufacturers of America (PhRMA) *
LYNDA FLOWERS, JD, MSN, RN, AARP *
DAVID GIFFORD, MD, MPH, American HealthCare Association
RICHARD GUNDLING, FHFMA, CMA, Healthcare Financial Management Association *
APARNA HIGGINS, MA, America's Health Insurance Plans
GAIL HUNT, National Alliance for Caregiving

CHIP N. KAHN, III, MPH, Federation of American Hospitals *
WILLIAM E. KRAMER, MBA, Pacific Business Group on Health
SAM LIN, MD, PhD, MBA, American Medical Group Association
LISA McGIFFERT, Consumers Union
ELIZABETH MITCHELL, Network for Regional Healthcare Improvement *
R. BARRETT NOONE, MD, FACS, American Board of Medical Specialties
FRANK G. OPELKA, MD, FACS, American College of Surgeons *
AMIR QASEEM, MD, PhD, MHA, American College of Physicians
CAROL SAKALA, PhD, MSPH, National Partnership for Women and Families
MARISSA SCHLAIFER, RPh, MS, Academy of Managed Care Pharmacy
CARL SIRIO, MD, American Medical Association *
MARLA J. WESTON, PhD, RN, American Nurses Association
STEVE WOJCIK, National Business Group on Health*

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT:
RICHARD ANTONELLI, MD, MS *
MARSHALL CHIN, MD, MPH, FACP

FEDERAL GOVERNMENT LIAISONS PRESENT:
KATE GOODRICH, Centers for Medicare & Medicaid Services (CMS)
KEVIN LARSEN, MD, FACP, Office of the National Coordinator for Health Information Technology (ONC)
CHESLEY RICHARDS, MD, MH, FACP, Centers for Disease Control and Prevention (CDC)

WORKGROUP CO-CHAIRS PRESENT
BRUCE BAGLEY, Clinician Workgroup *
CAROL RAPHAEL, PAC/LTC Workgroup *
ERIC WHITACRE, Clinician Workgroup *

NQF STAFF:
HELEN BURSTIN, MD, MPH, Chief Scientific Officer
MARCIA WILSON, Senior Vice President, Quality Management
TAROON AMIN, NQF Consultant
WUNMI ISIJOLA, Administrative Director
ANDREW LYZENGA, Senior Director
DEBJANI MUKHERJEE, Senior Director*
ERIN O'ROURKE, Senior Director
SARAH SAMPSEL, Senior Director *
AMBER STERLING, Project Manager
JEAN-LUC TILLY, Project Analyst
REVA WINKLER, Senior Director *

ALSO PRESENT:
DAVID BAKER, MD, MPH, FACP, American College of Physicians
SHAWNN BITTORIE, CommPartners
HEIDI BOSSLEY, American Medical Association
EMILY BROWER, American Medical Group Association
CAROLE FLAMM, MD, MPH, Blue Cross Blue Shield Association *
NANCY FOSTER, American Hospital Association
RABIA KHAN, Centers for Medicare and Medicaid Services (CMS) *
ALAN LEVITT, MD, Office of the National Coordinator for Health Information Technology (ONC) *
TERESA LEE, Alliance for Home Health Quality and Innovation
SANDRA ROBINSON, American Academy of Dermatology *

*** Present by teleconference**

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

(10:00 a.m.)

MR. AMIN: So good morning, everyone. Thank you all for making it here in person and virtually on this amazing snow conditions that we were under. I want to welcome you all to the coordinating committee meeting and our CMS partners. I'm going to turn it over to the Chairs to just say a few words of welcome and then turn it over to Helen to do our welcome, introductions, and disclosures.

CO-CHAIR PINCUS: Welcome, everybody. Those on the phone, it's Harold Pincus. I'm sad that Beth McGlynn, my partner in crime, is not going to be able to get here. She has an illness in the family that she needs to attend to, but we are ably assisted by Foster Gesten, who's here, who -- Foster and I have worked together on a number of other different NQF and other projects, and so we'll do this together.

It's going to be a challenging meeting, obviously, because of both the sort of

tele-members as well as the difficulty people have had in getting here. It's sort of interesting to me that two days ago, I was cross-country skiing in Central Park, and fortunately, we were able to get a train to get here yesterday. Foster?

ACTING CO-CHAIR GESTEN: Yes, just happy to be here. I know Beth McGlynn, and I'm not Beth McGlynn, but hope to help out the process. I really appreciate having snow here, which really makes me feel welcome, coming from upstate New York. It feels really familiar, and it's actually like the first winter I've really experienced, so look forward to a great day.

DR. BURSTIN: Great. Good morning, everybody. Helen Burstin, Chief Scientific Officer here. Thank you so much. I'm actually amazed how many of you are in the room, which we know is not easy. We were betting yesterday. I had said half of you, and I think you've actually -- I think I won the bet, so thank you.

And thanks to all of you who will

spend a lot of time with us virtually. In some ways, probably harder than it is to be in the room. We can't feed you, so we apologize for that, but first thing we're going to do is go through the disclosures, which will be a little interesting because we have a blend of those in the room, as well as those on the phone.

And some of you -- I think what I'm going to do, it's a little unorthodox, just to make it easier, is I'm quickly going to do the script for both organizational members as well as subject matter experts, and then we'll run the room, and then we'll run the people on the phone, so you'll know who you are, if you're an organizational member or a subject matter expert, as I go through this, and if you don't know, I will tell you as I run through it.

So briefly, we're going to combine disclosures with introductions, as we often do. We'll divide it into those two categories. Briefly, organizational representatives, which the majority of you are, we expect that you're

representing the interests of a particular organization. So in light of your status as an organizational rep, the disclosure of interest is fairly minimal.

We really -- just one limited question regarding whether you, individually, have any interest of $10,000 or more in terms of an entity of the work related to this committee. Tell us who you represent, if you have anything to disclose, and we'll go around the table and do that.

If you are, in fact, I've got a list of these, a subject matter expert at the table, you sit as individuals. You are not here as organizational representatives, so we ask for a bit more detail. Now again, we've seen your CVs, we picked you to be at this table, they're very long and lovely, and we can't have a recitation of those, since we already lost an hour this morning, so if you could, please give us a sense, overall, of disclosure of any activities you think are relevant to the subject matter of the

committee's work over the next couple of days, particularly anything regarding grants, consulting, or speaking arrangements.

Again, only if relevant to the committee's work, and as individual members, again, you're here as a subject matter expert, not as an organizational representative. So I think we'll proceed. Let's start with the Chairs, perhaps, first, and then we'll run the table, and then we'll figure out which ones of you are online, if we have that list, and we'll come to them second.

CO-CHAIR PINCUS: So this is Harold Pincus. I work for New York Presbyterian Hospital and Columbia University as well as being a senior scientist at the RAND Corporation. I've been a consultant for Mathematica. I'm on the advisory committee for NCQA to develop a measure and agenda at the interface between behavioral health and general healthcare.

ACTING CO-CHAIR GESTEN: Good morning. Foster Gesten. I'm the Chief Medical Officer in

the Office of Quality and Patient Safety at the New York State Department of Health, and I'm here representing the National Association of Medicaid Directors, and I have nothing to disclose.

DR. BURSTIN: Excellent. Let's go over to this side. David.

DR. BAKER: David Baker. I'm Executive Vice President for Healthcare Quality Evaluation at the Joint Comision. I have no financial disclosures, but I will disclose that some of the measures, at least one that will be discussed, is a joint commission measure, and I'll recuse myself from discussion.

DR. BURSTIN: Perfect. Thank you. Barry.

(Off microphone comments.)

MEMBER SAKALA: Good morning. I'm Carol Sakala, a program director at the National Partnership for Women and Families, and I have nothing to disclose.

MEMBER WESTON: And I'm Marla Weston. I'm the CEO for the American Nurses Association.

I have nothing to disclose.

MEMBER O'BRIEN: I'm Shawn O'Brien, and I represent the AFL-CIO. I have nothing to disclose.

DR. CHIN: I'm Marshall Chin. I'm the disparities person from the University of Chicago. One of my grants comes from the Merck Foundation. It's a philanthropy funded by Merck Company. I've been working with the America's Essentials Hospitals and Joint Commission on some disparities work. I'm on the National Advisory Board for Medicaid Innovation, which is affiliated with the Medicaid Health Plans of America.

I supplied some unpaid medical assistance to some of CMMI projects having to do with disparities. Oh, I'm the President of the Society of General Internal Medicine this year.

MEMBER ANDERSON: I'm Rhonda Anderson. I'm with the AHA seat, but also CEO of Children's Hospital with Banner Health in Arizona. I have nothing to disclose.

DR. RICHARDS: I'm Chesley Richards from the Centers for Disease Control and Prevention. I have nothing to disclose.

MEMBER KRAMER: Morning. I'm Bill Kramer with the Pacific Business Group on Health. I also co-chair the Consumer Purchaser Alliance funded by grants from the Robert Wood Johnson Foundation.

MEMBER GIFFORD: I'm Frank Gifford. According to the New York Times, I'm a declining rare species of geriatricians. I represent the American Healthcare Association and Nursing Home and Assisted Living organizational. We are a measure developer, and we've had some measures, but none here for today, and I have a bunch of 401(k)s. God knows what they're invested in, but they're going down, so it can't really help anything, as far as I know, so I don't think I have anything to disclose.

MEMBER McGIFFERT: I'm Lisa McGiffert with Consumers Union. We're the advocacy arm of Consumer Reports, and I run the Safe Patient

Project, where we work on policies to reduce medical harm, and we collaborate and organize patients who have been harmed by medical care so that they can get involved locally and nationally in committees like this and other activities. I have nothing to disclose.

MEMBER SCHLAIFER: I'm Marissa Schlaifer, I work for CVS Health, and I represent the Academy of Managed Care Pharmacy.

MEMBER BOSSLEY: Heidi Bossley, consultant to the American Medical Association. Carl's on the phone and on the webinar, so I'll defer to him, but if he's not here, I'll --

MEMBER SIRIO: Good morning, folks. I couldn't get a plane in, but this is Carl Sirio, nothing to declare, and Heidi and I will be going a little bit of tag team, as I have to be on and off a couple times today.

MEMBER HUNT: Hi. I'm Gale Hunt. I'm the President and CEO of the National Alliance for Caregiving, and I'm also on the board of PCORI, the Patient-Centered Outcomes Research

Institute, and I have nothing to declare.

DR. GOODRICH: Hi. I'm Kate Goodrich. I'm the Director of the Center for Clinical Standards and Quality at CMS, and nothing to declare.

DR. BURSTIN: Great. And we'll at least allow him to sit down, but I will have him introduce himself and see if you have anything to disclose.

MEMBER QASEEM: Sure. Amir Qaseem, Vice President, American College of Physicians, and no disclosures.

DR. BURSTIN: And, Amber, can you tell us which committee members are on the webinar who I can call on? We've heard from Carl. Carole Flamm, are you with us this morning?

DR. FLAMM: Yes, I am. Hi. This is Carole Flamm. I'm Executive Medical Director at Blue Cross/Blue Shield Association, and I have nothing to disclose.

DR. BURSTIN: Great. Thank you. Chip, are you on with us? Chip Kahn? He may

only be on the webinar portion, perhaps? Chris Dezii? Chris, are you with us this morning?

MEMBER DEZII: Yes, I am, and good morning. Chris Dezii, Bristol-Meyers Squib, Director of Healthcare Quality and Performance Measures, and I represent the Pharmaceutical Research and Manufacturers of America.

DR. BURSTIN: And do you have anything to disclose?

MEMBER DEZII: Oh, nothing to disclose. Sorry.

DR. BURSTIN: Okay. Thanks, Chris. Elizabeth Mitchell, are you on with us?

MEMBER MITCHELL: Hi. Thanks, Helen. Elizabeth Mitchell, President and CEO of Network for Regional Healthcare Improvement, and I have nothing to disclose.

DR. BURSTIN: Great. Thank you. Anybody else? Lynda Flowers, are you on with us this morning?

MEMBER FLOWERS: I am. Linda Flowers, Senior Policy Advisor with the AARP's Public

Policy Institute, and I have nothing to disclose.

DR. BURSTIN: Excellent. Welcome.

MEMBER FLOWERS: Thank you.

DR. BURSTIN: Missy, are you on the phone with us?

MEMBER DANFORTH: I am. Good morning. I'm Missy Danforth, Vice President of Hospital Ratings, representing the Leapfrog Group, and I have nothing to disclose.

DR. BURSTIN: Excellent. Thanks, Missy. Rich Antonelli, are you on with us?

DR. ANTONELLI: Yes. I am here in Boston. Rich Antonelli. I have no conflicts of interest to disclose.

DR. BURSTIN: Excellent. Thanks, Rich. Richard Gundling, are you on with us?

MEMBER GUNDLING: Yes, I am. This is Richard Gundling, and I represent the Healthcare Financial Management Association, and I'm the Vice President for Healthcare Financial Practices, and I have nothing to disclose.

DR. BURSTIN: Steve Brotman, are you

on with us?

MEMBER BROTMAN: Yes. Steve Brotman of AdvaMed Advance Medical Technology Association. Nothing to disclose.

DR. BURSTIN: Excellent. Thank you. Steve Wojcik, are you on with us this morning?

MEMBER WOJCIK: Yes. Steve Wojcik, National Business Group on Health, and I have nothing to disclose.

DR. BURSTIN: Are there any other committee members on the phone who we have not introduced who are on with us this morning?

MEMBER OPELKA: Hello? I'm Frank Opelka, can you hear me?

DR. BURSTIN: We can here you. Yes, thank you.

MEMBER OPELKA: Yes. I've joined the American College of Surgeons, and I have nothing to disclose.

DR. BURSTIN: Great. Thanks, Frank. Anyone else online? All right. Wow, remarkable. I think we have a -- we certainly have a quorum.

So just lastly, if, you know, this is -- as part of this process, we always ask an opportunity for anyone at the table, or virtually at the table, to ask any questions of anyone else in terms of what they have raised in terms of their disclosures. Would anybody like to raise any questions?

Okay. So just one request. If at any point during the course of this meeting today or tomorrow you have any concerns about potential lack of disclosure, bias, anything along those lines, obviously, organizational representatives are going to represent their organizations, but if you have any concerns, please come to the chairs, or to any of us. It's always better to have those issues ironed out in real time rather than post hoc, so we would welcome, you know, any discussions, any irregularities due to conflict of interests or bias. Please speak up, and we'll take care of it.

So other than that, I will turn it back to the chairs. Thank you.

CO-CHAIR PINCUS: So as I mentioned before, this is going to be a challenging meeting, both with the people online as well as the shortened timeframe that we have, and so our main job over the course of the next few days is really to respond to the CMS list of measures under consideration and go through the recommendations from the, number one, Post-Acute and Long-Term Care Workgroup, then the Clinician Workgroup, and then the Hospital Workgroup, and those are the key issues that we have to go through at this time.

Before we get into that, we're going to have some discussion about some of the strategic issues and also some of the issues that have come up in a cross-cutting way across the workgroups that have met so far, and Taroon is going to lead us through that.

And then after we clarify some of the issues and have some discussion about that, that may help further with the discussion of going through the individual recommendations.

After we go through the three workgroup reports, which, hopefully, we can do today, but we are considering that there's a possibility that it may go over until tomorrow in terms of the Hospital Workgroup. Then there's some broader longer range strategic issues to go over in terms of the progress of the MAP so far, what we've learned, how we can improve the process over time, and particularly, to go through some of the core concepts that came up under the vital signs report from the National Academy of Medicine, and to think about how that might be able to help us with thinking about the issues of alignment.

Initially, what had been in there was to have breakout groups, but it looks like that's not going to be feasible with so many people online, and so we're going to have, sort of, a general discussion about that. So let me turn it over to Taroon to walk us through some of the, sort of, key strategic issues to discuss before we enter into going through the reports of the

workgroups.

MR. AMIN: Thank you, Harold. One of the things that I'll do first to just start out is to talk a little bit about the role of the coordinating committee within the process and highlight a few points. I also wanted to point out a few administrative elements of today's meeting, given that a number of our committee member colleagues are participating virtually, and I'll turn it over to my colleagues.

Actually, with that -- actually, I should just quickly just introduce myself, and I'll turn it over to my colleagues just to introduce themselves from the staff's perspective. My name is Taroon Amin, I am an NQF consultant supporting the Measure Application Partnership, in addition to a number of outcome measures projects.

And actually, if we could just introduce staff real quick before we move on. Wunmi, if you can introduce yourself, please.

MS. ISIJOLA: No problem. Good

morning, everyone. My name is Wunmi Isijola. I'm an administrative director here at NQF. This is my second year with the coordinating committee and I work with a host of projects here at NQF, so looking forward to the next two days.

MS. O'ROURKE: Hello, everyone. I'm Erin O'Rourke. I'm a senior director here at NQF supporting the MAP. It's my first year with the coordinating committee, but actually my fifth year with the PAC, LTC, and hospital workgroups.

MS. STERLING: Hi. I'm Amber Sterling, the group projects manager here at National Quality Forum, and this is also my first year with the MAP coordinating committee, so I'm excited to see how this meeting goes today.

MR. TILLY: And I'm Jean-Luc Tilly. I'm a project analyst here at the National Quality Forum. I also worked with the MAP Hospital Workgroup.

MR. AMIN: Okay. Thank you, all. Oh, Marcia Wilson, our new senior vice president working on our quality measurement group, so feel

free to say hello to some of the NQF staff, and a tremendous appreciation for the multiple staff members that were able to come in and setup the room for tech and support services here, in addition to our lunch and fruit, which is difficult to find, apparently, given the weather, so we really appreciate that.

So jumping into a little bit of the recommendations here, and then I'll turn it back to Wunmi to talk a little bit about how we're going to do comments for the workgroup that is in the room, and then those that are participating virtually, how the voting process will work, and then just for our stakeholders in the room and those that are on the phone, how we will handle our public comment periods, given the change in the agenda.

So with that being said, one of the key things that we wanted to outline here is, clearly, the role of the coordinating committee is to review the recommendations of the various different workgroups. One of the key elements

that came up during our discussions last year, and one of the key elements of feedback that we received, both from the workgroup members and coordinating committee members, was folks wanted to take more of an aerial view, more of a strategic view, of what's happening across the workgroups and not get bogged down by individual measure-by-measure discussions.

And so one of the key changes that you'll see in this year's agenda is that we've asked each of the workgroups and the chairs, to the extent that they can participate, given the change in schedule -- changing time periods that we had to deal with, we've asked them to present and outline some of the key -- they'll present the measures in the programs that were evaluated, and then they'll outline the strategic issues that emerged in their workgroups and the relevant input from the MAP Dual Eligibles workgroup.

Actually, if you can go back to that slide. We'll ask the staff leads and the coordinating committee chairs to present any

individual measures that have been pulled for discussion by members of this coordinating committee. It is key that the -- it is critical that the coordinating committee members who've pulled the measure for discussion identify the particular elements of the workgroup recommendations that they disagree with, and all of the other measures will be considered ratified by the MAP coordinating committee.

Again, it's just -- that is the method that we will be using as we get to the workgroup deliberations, and again, this sort of format was put in place this year to address many of the comments that you raised during your round-robin discussion last year on improvements. So you'll see more of a strategic discussion around the key issues that emerged within the workgroups and then across workgroups.

Erin and I will be spending a little bit of time at the beginning of this meeting talking about the key process and strategic issues that emerged across the different

workgroups. Harold?

CO-CHAIR PINCUS: So are there any questions or concerns about that process, because it does, in some ways, limit some of the discussion around the things that are on the consent calendar, but it does allow people to pull things off and have further discussion. Good.

MR. AMIN: Okay. So with that being said, I'll actually turn it over to Wunmi to talk through how we'll try to handle, you know, comments to facilitate discussion in the room, and then how we'll handle the voting process and also the public comment period. So with that, Wunmi.

MS. ISIJOLA: Great. Thanks. So as we've done in the past, if, in fact, you would like to make a comment, please use your tent cards. We will be monitoring the chat, so if you do have a comment or question, please raise your hand in the chat box, and we'll line you up in queue to make comments.

As we get closer to the voting portion, please ensure that you are logged in in your personalized link that was sent this morning. We will be voting live on the webinar platform. You all should have received a personalized link. If you have issues getting into that, please let us know and we'll moderate that accordingly. But just in order that we're streamlining the discussion and commenting, we ask that you use your tent cards, and we'll be sure that those on the phone are engaged as much as possible.

MR. AMIN: So, Wunmi, question for you, so the individual link that members received, that would bring them to this web platform here, so I would encourage you all to login, and if you have any trouble logging in at this moment, let us know so we can address any login issues before we get to the voting. So I would encourage you to do that.

And for those on the phone, if you have any questions seeing where the chat feature

is or the raise hand function is on the webinar platform, please let us know through the chat feature.

MS. ISIJOLA: Yes.

CO-CHAIR PINCUS: And so login applies to everybody in this room as well as everybody on the phone.

MS. ISIJOLA: That is correct.

DR. FLAMM: This is Carol Flamm. Can I just ask where the email came from with the personalized link because I don't think I'm seeing that.

MS. ISIJOLA: It came from Shawnn, so it should have been NQF com partners link, and we can resend that off again to the entire committee.

DR. FLAMM: Thank you very much.

MEMBER KAHN: This is Chip Kahn just to say I didn't have any conflicts.

MS. ISIJOLA: Thank you, Chip.

MEMBER SCHLAIFER: When you login, it's already populated with some email address.

Do you want us to leave that or put our own email address?

MS. BITTORIE: You can actually change the email address. That was just for the initial registration purposes.

MEMBER SCHLAIFER: Okay.

CO-CHAIR PINCUS: When it comes time for voting, will there be something popping up that --

MS. ISIJOLA: That is correct. So you'll see the screen that'll prompt you what choices you should select.

MR. AMIN: We'll, inevitably, have some challenges when we get to that point, just the nature of the process, but if there are any issues, please let us know. We'll connect you to Shawnn, who's also on the phone here, as we just heard from her, so we'll try to address those issues as proactively as we can.

Are there any other concerns or questions about, sort of, how today's meeting, sort of operationally, how that will work? And

I'm also looking to my NQF staff, colleagues, if there's any other issues that I have not covered here as it relates to voting.

The last thing I will just note, for the stakeholders that are participating in this meeting, is that, obviously, we'll do our best to participate and keep the public comment periods. Yes, for those in the room, you know --

MS. ISIJOLA: Just please turn off your speakers if you're in the actual room.

MR. AMIN: That's, obviously, okay. So public comment period, so obviously, we try to do our best to keep the public comment periods to the time that is in the published agenda. Clearly, that's going to be very difficult to do during today's meeting. It would be challenging to stop and have a public comment period for the clinician programs while we're still discussing PAC/LTC, so we will address the public comments prior to -- we'll have a public comment period prior to each of the workgroup report-outs.

And so that's really more of a comment

for the stakeholders that are participating in this process, not really a comment for the workgroup members here, the coordinating committee members.

CO-CHAIR PINCUS: Let me just make one comment that members of the MAP Coordinating Committee have already, essentially, pulled a number of measures off of the consent calendar. After we hear the report from each of the workgroup chairs, we will ask people if they have any other -- any other people want to pull other measures off, but there's also the opportunity for people to take measures that they had pulled off and put them back on the consent calendar.

So we want to make sure people are aware of that.

MEMBER SIRIO: Harold?

CO-CHAIR PINCUS: Yes.

MEMBER SIRIO: This is Carl Sirio. Just a quick question. Did I hear you correctly that those measures that have been pre-specified as being up for discussion and pulled are already

off that consent calendar?

CO-CHAIR PINCUS: Yes.

MEMBER SIRIO: Okay. Good. Thanks.

CO-CHAIR PINCUS: But like I said, there's an opportunity, after we've had some of the strategic discussion upfront, people may reconsider that and put them back on the consent calendar, so that's an option.

DR. BAKER: Just a question. If it's been sent, I still haven't received anything.

MEMBER DANFORTH: Hi. This is Missy on the phone. I had a quick question. Should the folks on the phone that want to get into the queue, once we start that, use the raise hand option that I see on the webinar?

MS. ISIJOLA: Yes, that's correct.

MEMBER DANFORTH: Okay. Thank you.

MR. AMIN: Okay. So again, just as a quick recap, we will have two sessions this morning, process and strategic issues that spanned across each of the workgroups, and then each of the workgroups will follow this format of

the strategic issues that emerged within the workgroups, the measures that have been pulled, and then all the other measures are considered ratified.

So with that, let me turn it over to Erin to kick it off.

MS. O'ROURKE: Thanks, Taroon. Next slide, please. You can actually go two forward. So I just wanted to give you an overview of how we got to where we are now and the process that the workgroups used to make the recommendations that they did about each measure under consideration.

So the pre-rulemaking approach was revised for 2015/2016. The workgroups took a three-step approach to the analysis and selection of measures. First, they developed a program measure set framework. This was really a tool they used to help organize themselves and give them a snapshot of what was in the program currently.

For the majority of the programs, they

used the national quality strategy. Some of the clinician programs also linked to topic to give a better idea of what specialties might be currently covered.

They then took a look at the measures under consideration for what those might add to the program measure set, and then finally, they identified and prioritized measure gaps for programs and size.

We also convened the Dual Eligible Beneficiaries Workgroup to provide cross-cutting input. The Dual Eligible Workgroup sent a liaison to each of the three setting specific workgroups to ensure there was a voice for that population at each workgroup meeting. We also convened the workgroup via web meeting to review all the work done by the three setting specific workgroup and offer up some additional input for the coordinating committee about special considerations for the dual eligible population.

Next slide. So the MAP workgroups were asked by the coordinating committee last

year to please reach a decision on every measure under consideration. We heard your concern that it's challenging to be the first body to really vote, so we pushed the groups to not have split decisions this year, so you do have the benefit of a preliminary recommendation about each measure under consideration.

The decision categories were standardized for consistency. I will run through those on the next slides. The decision categories were determined for the two pathways, depending on the extent of testing noted by CMS. Measures under development, that is, measures that have not completed testing, and fully developed measures were those that had completed the testing phase.

And each decision by the workgroup is accompanied by the rationale explaining how the group got to that decision.

Next slide. So on this slide, you'll see the decision categories and some examples of rationales for the measures that are fully

developed. The workgroups were given the option to support, conditionally support, or not support fully developed measures.

Next slide. For measures that were still under development, the groups were given the decision to encourage continued development or to not encourage further consideration or to say that they had insufficient information to make a decision about that measure.

Next slide. So this slide briefly shows you the MAP measure selection criteria. I won't belabor this because it's probably familiar to most of you. Essentially, these are the characteristics of an ideal program measure set from the MAP perspective. These aren't intended to be a check-the-box list of things the measure should hit; rather, what MAP would like to see a measure set achieve.

Next slide. So to help facilitate the workgroup consent calendar voting process, staff conducted a preliminary analysis of each measure under consideration, and it's an algorithm that

asks a series of questions about each measure under consideration.

We used the measure selection criteria to develop this algorithm. It was approved by the coordinating committee. As you might remember, this is what we spent the bulk of our time at the September pre-rulemaking kickoff in person going through, and it's intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for discussion.

Next slide. So we did have a number of key lessons learned from 2015/2016 so far, and we wanted to bring these to the coordinating committee for your consideration and input. To give you a little bit of background, we had 141 measures evaluated this year. The majority of those were under development, 91 of the 141, and 50 were fully developed.

We had a number of concerns come up about the measure under development pathway that we thought warranted coordinating committee

discussion. Several stakeholders raised concerns that measures going through the under development pathway may not be treated differently than measures that are fully developed when it comes to the rulemaking process and what CMS is doing with MAP recommendations, so therefore, MAP might be making a positive recommendation to encourage continued development, but the recommendation is being received by CMS and the broader community as a support for that measure, essentially without any conditions.

Conversely, we also heard some concerns that having this second pathway for measures that are still under development might slow the process too much and slow the implementation of important measures.

Some additional concerns: MAP does not have a mechanism to bring back measures under development once they're fully specified, tested, or NQF endorsed, and finally, some MAP members suggest that we might need a new decision category, something along the lines of revise and

resubmit for consideration, to add to the under development pathway.

So a second key issue that came up was how we might submit measures for consideration that are not on the formal MUC list. So stakeholders asked for clarification from CMS and MAP on how we can provide input on measures that are not on that formal list but could potentially be considered for future years.

CMS has indicated that measures can be submitted through the JIRA tool for consideration prior to finalizing the MUC list and that MAP is encouraged to identify additional measures as gaps in the program for CMS to consider in the future.

MAP does not have the ability to add measures to the MUC list during the pre-rulemaking process, but as I noted, we can suggest additional measures for CMS to consider in future cycles. And we do write these suggestions up in the written deliverables, and just a note that it's difficult to formally

evaluate these measures the same as measures under consideration, given that we've got limited information.

They don't go through the process that CMS puts the formal MUCs through. We don't have the opportunity to pull the background information on those measures that we provide to the workgroups in the preliminary analysis, so that's why they are not added to the formal list of measures under consideration, but rather, handled as potential gap fillers and included in the written reports.

So I think with that, I will turn it to Harold for discussion.

CO-CHAIR PINCUS: Okay. So there were two, sort of, overarching issues that came up during the discussions. Number one is, the concern is that this year there's a much greater proportion of the measures that are under the measures under development category, and it raises questions about, what are the consequences of saying that we support their continued

development?

Does, technically, apparently, the measure does not have to come back to us as it gets more operationalized, so how do we handle that? What is the meaning of when we say we support continued measure development for a measure that's not really developed?

Secondly, if members of the MAP do have suggestions for alternative measures, is there a pathway to get those being considered? So why don't we open it up for discussion on those two issues, and then maybe after we have some discussion, I'll ask Kate to maybe respond to some of the issues. Lisa?

MEMBER McGIFFERT: Well, I'm glad this is being taken care of at the beginning because a number of the measures that I pulled were for this very reason. I couldn't figure out exactly what encouraged continued development meant as a decision. In some instances, it seemed to mean keep going until it's endorsed by NQF; in other, more frequently, it was a process measure that

the group said continue development, and we're concerned that it's not getting at the outcomes, and it wasn't clear to me what that would mean.

Does that mean change it and try to develop that or continue developing the process measures? So I was very -- I felt that there wasn't consistency in the use of that phrase, so I'm glad you're thinking about using other phrases, and I think, you know, for the public and for the developers, it's kind of unclear what the message is if we're saying, here's a process measure. We have a lot of concerns; one of them is that it doesn't get at outcome, and we want you to continue to develop it.

I'm not sure that that message gets to the developer.

CO-CHAIR PINCUS: So just to clarify, so in some ways you're raising a question of what's the it.

MEMBER McGIFFERT: What does it mean, encourage continued development?

CO-CHAIR PINCUS: Yes, are you

continuing the development of this and refining this particular process measure, or are you trying to get at something even better than that?

MEMBER McGIFFERT: Yes, because obviously, in some of the workgroup rationales, they're listing all the things that are of concern with a process measure, and their list clearly says, we're concerned about these things that would, maybe -- in my opinion it meant, go back and come up with a whole new measure. This one -- but the term was, encourage continued development, which could also mean, take this measure and keep developing this measure, so that was the confusion.

MEMBER GIFFORD: So actually, I'm glad we're bringing up that issue, and I've been giving it a lot of thought. So harking back to my state days, I decided to go back to the statute and look at what the authority is, because there was a lot of discussion in several of the workgroups in CMS about this issue.

And I think the MAP, in the statute,

is to provide feedback on measures that are under the MUC list. There's nothing about voting or approving, and as Helen has pointed out, we have no authority, and CMS can completely ignore. We're advisory.

So we can say what -- we can create any categories we want and they can ignore them; however, the burden is that the Secretary shall take in any feedback that the MAP gives on the measures in rulemaking, address it in rulemaking. So it's -- frankly, more important than the labeling of the measure is the feedback about the measures that then have to be addressed in rulemaking.

And, you know, we heard a lot about deadlines and timelines, so they couldn't get certain things done that some of the workgroups were concerned about, and I feel really bad for CMS, and if I was at CMS, I would do exactly what they have done.

But we have, I think, a statutory, fiduciary responsibility under the statute to

provide feedback on those measures, and then HHS, and the Secretary, and CMS can say whatever -- you know, then it has to provide a rationale, which is Congress said we had to do the timeline, so that's why we're doing it this way, or, you know, we're ignoring this because we have to do A, B, and C, but the burden then falls back on them for that.

And so I think at the long-term care workgroup, many of the members felt and did not review many of the measures because 100 percent of the measures came through the guise of under development, and so they all said, oh, well, we'll get to see them again, and so many of the members around the table hadn't even reviewed, in detail, many of the measures, including both chairs, and said that to me.

And so I think to Lisa's point, what is the it, or what does it mean, I think it's really important that we think about it because, in essence, what happened in the statements at the long-term care workgroup from CMS was that,

yes, you know, they might bring them back, but they don't have to bring them back, and they'll consider it.

But because in the measure under development category, the discussion of the feedback on the measures was sparse. And so it actually allowed us to sort of -- it almost was a loophole, and I don't think CMS was trying to use it as a loophole, but it creates a loophole for them just to put any measure on measure under development, and they actually put NQF-endorsed measures in the category of under development, which it wasn't clear why they did that. But as soon as it was that way, then everyone just said, well, it'll come back, and we'll hear some feedback, but we'll get to see it again, but then there was a discussion that it's not been seen again.

So I think what I would encourage you to think about is, rather than the categories, or something like this, is that, we say to CMS when we think measures need further work, that the

recommendation to the Secretary would be that they come back for NQF endorsement, because a lot of these measures are moving so fast they can't get NQF endorsement and meet any timeline, that they come back within a certain timeframe, and we give them some more guidance on that, and then the burden falls on them during rulemaking to say why they're not going to come back and what's going to happen in future rulemaking.

And it gives them the opportunity for stakeholders to talk with Congress about the timelines and everything else. But I think it's more important us focusing on the feedback than actually, I think, the categories of what's happening out there, but the labels do have an impact, and the impact by having this was, we don't have to go as far and deep on this measure, when it has the exact same, essentially, measure under development has the same impact as support with no recommendations.

CO-CHAIR PINCUS: So just to clarify, when we say -- for the measures under

consideration, we can support, we do not support, or we support with conditions, and for the do not support and the support with conditions, the MAP specifies what those conditions are or what the reasons are for not supporting.

But what you're suggesting is that if the measures that are measures under development, if we support their development approach, we should also have some specific comments to help guide the development. Is that what you're proposing?

MEMBER GIFFORD: No, I think I can go a little further. I mean, if you look here, the decision to vote to support further development is the equivalent of, from a CMS standpoint and statutorily, of voting that we support the measure. Has the exact same equivalent. It is the equivalent of voting support, and I don't think that that's the impression and intent of that, and nor is that the process for the MAP that was laid out in the statute.

And so I think what's probably more

important is the type of feedback, whether it's support or not support, or whatnot, because they can proceed with do not support. They just have to put a rationale of why the body says do not support or go forward, but again, really, the burden falls on what the comments are that we make.

ACTING CO-CHAIR GESTEN: But just building on Harold's suggestion, what I'm hearing you say, David, is that while you're making a recommendation that these circle back, give it to NQF and MAP, ideally, that what's an unintended consequence is not having the detailed comments about that development, which may be varied. Lisa's comment was, she's not sure what the issues were.

My guess is, in many of them, there's more than one issue and more than one opinion about what needed to be developed, so at the very least, that one of the forwards could be to not just, sort of, pass them along the way, but to articulate what some of those issues are, which,

as you say, creates some obligation to respond to those issues going forward. Is that --- am I right about that?

MEMBER GIFFORD: Yes. I mean, there was a wide range of measures for the long-term care under development. There were some, as I said, that were at fully NQF endorsed and in use out there right now that I think CMS wants to tweak, so they put it under further development, so that wasn't really portrayed in the presentation.

To the other end, there were a couple measures where the only details that the group had was a numerator-denominator definition, and at that, it was specified in very broad general terms. And specifications for the measure came out after the group and actually is still open for comments right now, as of today, from CMS.

So essentially, what it means is CMS can put on the MUC list just a measure saying, I think I'm going to have defined the numerator/denominator in this way, and we may

risk adjust it in the future, and then we're going to go, well, I don't really know, and you can't even comment on it, and so it's almost insufficient information.

So I think that similar to what you're saying, I agree with, sort of, that caveat of understanding that it's less about this labeling and more about that feedback, what we have, and I think if the measures really -- certainly, measures that are not NQF endorsed, I think we should just sort of have as a standing recommendation that they come back within some timeframe after specifying in rulemaking, that they come back, you know, whatever is a reasonable timeframe, 18 months, 24 months, they come back. Then the burden falls on CMS to say why they're not getting NQF endorsement.

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

MEMBER SCHLAIFER: I think that -- at first, I think it was very helpful to hear, for those of us that are not associated with a

workgroup, from someone who had to actually operationalize these. When I was reviewing this, I find the fact that, you know, you mentioned that there's not that much difference between support and then the support continued development, even though there may not be any -- we're sending very positive messages to both, I think it's very helpful to this group because we've been in the position up to now that either we support, which is, yay, this is perfect, go forward, or we reject, and I think being able to say this is -- you know, I appreciate the staff finding a way for us to say, we like what you're doing, we think there's a need for this, but you got some work to do, because I think we've really struggled over the past several years when, you know, support was too strong and reject was too negative.

So I just appreciate this other option.

CO-CHAIR PINCUS: Marla?

MEMBER WESTON: As I listen to this

discussion, I'm recalling that last year we made the decision that if we conditionally support it, that the conditions would be monitored by CMS. So for example, if we support, you know, we're supporting something that's NQF-endorsed if there was some very specific condition that, in essence, we would conditionally support for that condition. It's sounding as if we actually have a fourth category, which is, encourage continued development, which is, in my mind, not the same as conditionally support.

Encourage continued development is almost saying, this is a measure gap area, this is a really important area, but this measure is not specified enough to even say that we would support it with conditions. I don't know if I'm muddying the waters. It's not ready for prime time.

So I think in some ways, what we're saying, and why we always wanted this category of this encourage continued development, is to say this is a gap area and do go forth and do

continued work, but there is not enough specificity here to be able to say that this is a good measure or not, because the specificity is not in the measure.

CO-CHAIR PINCUS: Frank, you're on the phone. I think you raised your hand?

MEMBER OPELKA: Yes, I sent in a couple of comments in the chat. I mean, I have two comments that were general. One was to the overall measurement applications, partnership, and their need for us to make sure that the initial review that we did in the MAP was tying measurement application to payment systems, but those payment systems are changing.

And as those payment systems are changing, the measurement science also changes, so we have to, at least at some point, strategically think ahead about how we are doing that and reviewing that and looking at that.

The other point that I sent in was there was a comment about almost an absolute requirement of NQF endorsement. While I

completely support NQF endorsement, that is, in my estimation, an older science of measurement that was tied strictly to older payment systems, and there are efforts by all the specialties and disciplines that are dealing with clinical datasets that are moving into a much more sophisticated measurement science that's not payment system-centric, but it's more patient and condition specific-centric, and those are in response to actions that CMS is taking.

So any effort to try and narrow that focus, I don't think serves the patients or the clinicians who are trying to drive quality measurement and improvement. And again, I support NQF endorsement, but it is not the be all and end all because it needs to also mature with what's happening in the field.

CO-CHAIR PINCUS: Taroon.

MR. AMIN: So I just want to provide clarification in terms of the intent, but David, in particular, is raising some questions about how it's being operationalized, which is,

respectfully, a different question than I think was the one for discussion, but the definition and the intent of the measure under development pathway, and this is something that Marla and both Lisa brought up, as you guys laid out last year, was specifically defined by the level of testing that the measure is -- how it's specified in the measure under consideration list.

So if a measure comes forward -- a measure comes forward, and it is not fully tested for the setting for which it's being proposed, it is automatically put into the measures under consideration pathway. So that's the definition of how something goes into the measure under development pathway versus a measure that's fully specified.

Now, the extent or the results of the testing is -- you know, that's up to interpretation. And there were cases in this year's pre-rulemaking where there were endorsed measures that were in the measures under development pathway, but it was because the

measure wasn't -- well, there may be reasons why that would be the case, meaning that the measure was not tested for the setting it's being proposed for.

So that was the intent of the coordinating committee's -- you know, when we first developed this. Now, I think there's questions being raised about how it's being implemented or used, or that feedback's being used. So I think, certainly, would welcome some conversation or feedback from CMS about that.

Just, as we laid out, I just wanted to clarify what the definitional intent of the measure under development pathway was as you structured it in your test.

CO-CHAIR PINCUS: So are there other comments about this issue?

ACTING CO-CHAIR GESTEN: I just have a question of what you just said, Taroon. So is the previous world before this category existed one in which these are measures that likely would not have met criteria and simply would have been,

probably, voted off the island? I'm just trying to figure out what problem this -- so I'm trying to remember back to what problem or issue this solved, and it seems like it was something like, as somebody said, maybe Marla, you said it previously was either yes or no, and it was, my words, sort of harsh because there were some measures that were promising, but did not have a specific condition.

It was, really, just kind of a ripeness issue, or it had multiple conditions, and it didn't just lack NQF endorsement or testing. It was really -- there wasn't enough information in some cases to even make a judgement.

So I mean, the plan B of not having these categories if, in fact, they don't circle back, was it fair to say that many of these would simply be voted as a do not support, and that's what happened previously?

MR. AMIN: I think what we were finding was it was more of do not support and

conditional support, and the conditions were multiple, but I'd welcome feedback from her and others on exactly what that issue was. And there was a growing number of measures that, again, were coming through this process that folks were getting very frustrated about because there wasn't enough there to do much with, but there was a response to CMS about, CMS was -- so this is, sort of, setup for a conversation for tomorrow, but CMS was articulating that they wanted some early feedback before spending a lot of dollars, in terms of testing, on whether or not a multi-stakeholder group, such as the MAP, would, sort of, recommend continued development.

So I think I would probably be speculating about where it would end up, but that was the historical problem that we were trying to address.

CO-CHAIR PINCUS: Let me see if I can summarize. I know David and David both have comments, but if I could summarize what I think is being discussed and potentially pose a

suggestion. If we change the encourage continued development category so that it was clarified that it was specifically designated for measures that are not explicitly defined and in fact, that CMS acknowledges is on the process further development and wanting early input on that.

And that also, make it so that it is expected that even if we encourage continued development, there would be comments fed back to CMS about the direction or issues to consider in further development of that measure, and also, had some expectation that as it was developed it would come back if it was going to be seriously considered for implementation. Would that solve the problem?

MEMBER GIFFORD: I think the explicit expectation that it would be coming back should be --

CO-CHAIR PINCUS: Coming back, but only if it was really being considered for implementation, not --

MEMBER GIFFORD: I will be surprised

and shocked if the post-acute measures that were passed through the workgroup, regardless of what we decide today, do not show up in the rulemakings for -- that come out in April and May for the various post-acute settings.

And so I think -- CMS can't comment on that now, but I think there needs to be a pathway for CMS to meet this aggressive timeline that Congress has set out often, the changes in the payment models that they're testing, the need for measures that were stated out there, and I think that measures -- and I like that we created this section last year of encouraged development, and I don't think I would want something that would slow the process down, but I think having them have to come back at some point, because even when they put it in rulemaking, there's still a date out in the future when they implement it, and even some of the information that would we need to really, I think, evaluate the measures cannot be collected until they issue a rule and actually start collecting the data, and so they

need to be able to do that.

But I think we expect, I think, collectively some iterative bring-back understanding of that process, and right now, that does not exist.

CO-CHAIR PINCUS: David.

DR. BAKER: I think the problem is everything in this conditional support category, it's so heterogeneous. They're those ones that are just one small step away, and they're those ones that, gosh, we like this idea. We don't know if you're ever going to be able to do this, right?

So as David, I think, alluded to, to me, it's all in the comments and I would favor, do not support, but we would support it if you did this, or do not support, but, wow, this is really a questionable idea. We don't think that you're ever going to get there. I mean, to me, it's all in the comments.

To say something like, conditional support, we like this idea, but the numerator and

denominator are completely unspecified, conditional support for that, I can't say that I --

CO-CHAIR PINCUS: Well, conditional support is encourage continued development.

DR. BAKER: No, but I'm just saying, some of the ones that are in that conditional support, to me, they seem like a very heterogeneous category, but I assume there's others, but, you know, I think the conditional support category is problematic from the measures that I looked at. It's still very heterogeneous.

CO-CHAIR PINCUS: Amir?

MEMBER QASEEM: I mean, something along the lines of what David was saying, and actually, these three categories, I see them subcategories of do not support. I think we do still need to send this message out that we are not supporting these measures, and here's the reason we're not supporting because once we start categorizing these six, you're giving so much option.

And what ends up happening is, many of these measures, I think something along the lines of what David is saying. And Kate, I always feel bad whenever you're sitting in these forums.

MEMBER McGIFFERT: I want to be clear that I like the category, I just don't know what it means, and I know that, you know, we needed it to get away from just support, not support, but I want to bring the conversation back to process and outcomes, because that's what I care about.

And I think that we have to be really careful, to me, there's so many process measures on this list, and if we -- CMS goes down that path, it'll be years before we'll see outcome measures, because that's where everybody's lining up to do, rather than send it back to the developers or to new developers to say, look, this is a really important measure.

I mean, we need to measure these things falls, drug -- medication reconciliation, whatever, we need to measure these things, but we need an outcome measure. We need something

that's more meaningful than what we have right here. We don't want to encourage to go down the path of a check-the-box measure or, you know, a measure that's not being influenced.

That's sort of my point is, how to communicate that in a way that would encourage further development of outcome measures or to not encourage CMS to go down the path where it'll be, you know, five, seven, ten years later when we finally say, oh, this process measure is topped out and not really giving us what we need, and let's get an outcome measure.

ACTING CO-CHAIR GESTEN: So let me just remind folks on the phone that if you want to get in queue and make a comment by using the Web site to do it, just click on the raise your hand function and we'd be happy to call on you, but, Erin, did you want to --

MS. O'ROURKE: Yes, I just wanted to clarify a little bit. To answer what Lisa was saying, so we do include a rationale for every measure, including the ones that go through the

under development pathway, so there are the comments from the discussions at the workgroup level and the coordinating committee are transmitted to CMS, along with a decision about a measure under development, so it doesn't go in isolation.

We also take the feedback like you were saying about, you know, this is a good process measure, but we need to get to an outcome and include that in the three written deliverables that we submit to CMS, so those comments are captured and sent along.

CO-CHAIR PINCUS: Kate, do you want to say something about what you would find from CMS' perspective most helpful in terms of the kind of feedback that you would get on these issues?

DR. GOODRICH: Sure. The comments actually are the most helpful. It's not so much the category. And what we do, similar to what Erin was just saying, so we get, you know, the determination of support, do not support, whatever, with all the comments with that, and if

we decide to go forward with proposing a measure in a regulation, we always address what the MAP said about it, not just the category, but we do our best to also address the comments around that category.

So if it was conditional, you know, why we decided to go ahead and propose it if the conditions had met, if we intend to send it in for NQF endorsement, whatever it might be. I will say there have been quite frequent instances when we have one that do not support, but it has happened for a variety of reasons, but the comments around it are, without doubt, the most helpful.

And our staff also take copious notes during the recruit meeting so that we can capture as much as possible. So I don't know if you want me now to sort of address the feedback loop issue.

CO-CHAIR PINCUS: Why don't you do that.

DR. GOODRICH: Yes. So this is

something that has come up every year in the MAP around feedback loops and needing things to come back, and I think we've always been supportive of that, we've never had a process for it. And this year's batch of measures was different from previous years in that we did have more measures that were under development than ones that were fully developed, and there's a couple of reasons for that, well, I can think of three main reasons for that, one of which is, it just happens to fall in our measure development time lines.

You know, we have an umbrella contract, we sort of do all of our contracts at the same time, many of them are at the point now where they're at a place where we can actually send it in to the MAP, so that's number one. Number two, to get to Giff's point, which I also want to address, is the IMPACT Act, and the statutory requirements around deadlines from the IMPACT Act, and the need to develop measures very quickly to meet those statutory deadlines, which is why that group saw so many not fully developed

measures.

And then number three is, we get a lot of measures from medical specialty societies for consideration for the clinician workgroup and for the, what is now, upcoming MIPS program. And, you know, we work very closely one-on-one with the societies who are developing measures. Some we work more closely with than others, depending up on the degree of engagement they want to have with us, and often get asked to put things on the list early in order to get that feedback about directionality to know whether or not they should continue to put resources in to further develop the measures.

I will say, not every measure that's been sent to us makes it on to the list. There's some we know are duplicative, or for whatever reason, we know we're not going to actually consider them, so they don't go on the list.

Regarding the feedback loop so I want to start with the post-acute care workgroup and then talk about it more broadly. So this year

was a very challenging year for us with post-acute, as you know well, Giff, so we have statutory requirements to get specific measure domains in place, in programs, and begin data collection by certain dates that drove this timeline.

So that group did get some measures that were pretty early on, but, you know, folks are still working on, including the ones that you mentioned, I think that you're probably referring to the Medicare spending for beneficiary measures, which is the payment measures for, or efficiency measures, for the post-acute care settings.

You know, we have deadlines. I don't know what to say. We would much rather have brought something that was more fully developed. You know, the other choice was to not bring it at all, because the statute doesn't require us to bring it to the MAP. We never seriously considered that. We figured it was better to bring something rather than nothing, so that's

what we did.

So I actually talked with my team quite a bit after the post-acute care workgroup, because they understood and heard the frustrations, and I think were feeling it themselves, so we have committed to bringing those measures back to the MAP if there's a way we can do it before next December, we're looking at whether or not we can do that as, sort of, part of an ad hoc group.

While I, of course, cannot say, ever, what we would do in rulemaking, you probably would be shocked if we didn't put those measures in regulation because we have statutory deadlines. I mean, there is just this reality about that. So that's related to that. That is just a timeline situation that is very tough.

But we started to have more and more discussions at CMS around how we can work with the NQF staff to develop a feedback loop process. I would say both for measures that come through that are in various stages of development. I

think it's been articulated why we bring these measures early, and that's absolutely right, so I think those can come back.

I also think ones that are implemented in programs we have some experience with, we know how they're performing, we need to understand from you what information to understand how the measures are performing would be most useful to come back. Now, that's adding more of a workload to NQF, and to the MAP, by the way, and so we have to think through what's the most efficient way to do that, and that involves thinking through our contracting cycles, and all that kind of stuff, but we can do that, we will do that, we are making a commitment to do that.

So what I'd like to see is over -- you know, we always do a debrief with NQF in about February, after the MAP cycle is over, about what could have gone better, how can we improve it for next year, what do we hear from the MAP that, you know, we should do differently? And so we will do that again this year, but I would like our

teams to maybe use some of our LEAN tools we've used together in the past to improve other processes, to think about how we can develop these feedback loops for these two buckets of measures.

I will say, one thing that, I don't know if it's going to be a challenge or not, but it's -- we have to explicitly consider it, is, how do we bring back measures? I think bringing back the measure that CMS is developing, we can easily develop a process to do that, but a lot of these measures are ones we don't develop, so it'll be on us, but I also think with support from all of you here, and from the NQF staff, to work with those developers who submit measures to us for consideration to also bring those back, and so what does that process look like?

We think that this process will be enormously helpful for us. One of the things I was saying earlier to Harold, and to Helen, and Taroon is that, we actually do this ongoing evaluation of how the measures are doing

internally. It's part of our measure maintenance process. We look at the performance, we look at the variation, we look at the unintended consequences, so we've been doing that forever, but what we haven't done is we haven't brought it here.

But I think it would be helpful for us to understand what information, presented how, would be most useful for this body to give us further input. We obviously will have input into that too, but we need to hear what you guys think would be most important to see, because we're probably going to have to modify some of our internal processes to do that, which is fine. We can definitely do that.

But I do want to say, we are committed to doing that. We already have plans to bring the post-acute care measures back to the MAP earlier, but we want to do it with everything.

CO-CHAIR PINCUS: So let me just say that I strongly endorse this notion of giving us, sort of, more feedback about the experience with

measures. I think that, many times, I feel that I'm in kind of a vacuum about what actually happens out there. I mean, you know, some things I track, some things I don't track, but to understand what the implications are, what's been learned, especially, and I also agree with you that there needs to be some efficient way to do this so that we're not just inundated with so much data that it's incomprehensible.

So that I think we need to think about ways by which we can build out formally into the process in the most efficient way possible. And number two, it also sounds that, again, trying to summarize, I think, where we are on this specific decision -- specific issue of these decision categories is that, yes, this encourage continued development is a subcategory of do not support, and that for all the categories, potentially even the ones for support, that to enrich our conclusion of comments back to CMS so that the more comments we provide are -- that can influence their decision making and adjust how

they're implementing it, the better.

ACTING CO-CHAIR GESTEN: So I think the comments, Kate, are really encouraging and really respond to the issues that people had about the measures under consideration. A question, which may be too much in the weeds, but assuming a process in which measures under development have some specificity, comments, that are useful and productive, and then there's those things have been developed to the point where you're looking for feedback.

Do you have thoughts about what you need from that second boomerang process from MAP, and I'm thinking, do these measures not go through the workgroups? Do they go through the workgroups? Do they come directly to the MAP? Do you need -- do you envision a different process?

Because if I'm hearing you correctly, time is one of the issues that you confront relative to having a second bite at the apple, if you will, to look at these.

DR. GOODRICH: I'm not sure of the answer, but what I will say, we will have to think together about how this integrates with ongoing feedback that we get on our measures through our regular measure development process. We have multiple public comment periods as we're developing measures, when it comes to NQF for endorsement, there's that process, and so, you know, we get a lot of feedback on the measures along the way.

And so thinking about what is the value add above and beyond what we are -- I think there is one, because it's more around implementation than it is around the actual, like, science and anything behind the measure. You know, I don't know the answer, but we do have to think very explicitly, given all the other feedback that we continue to get on the measures, what makes the most sense, and is the most efficient.

And, you know, right now, you know, we -- the way we do this work collectively is, we do

it as one big batch process once a year. And so I think that's part of the problem, right? If we had a way to do it, sort of, idea, I'm looking at Kevin, sort of as single piece flow, or multiple smaller batches, or something like that, there probably is a way we can get to much more efficiency with this.

DR. BURSTIN: Just a quick comment. Thank you so much, Kate, that was incredibly encouraging and I think we would very much commit to us working together, and there's a lot of opportunity for leaning out the processes. And as many of you know, we've now completely blended the teams that work on MAP and endorsement. They are not different teams. They are the same people who do both.

So as we're more and more blending our data on all of these measures, this is a great opportunity, I think, for us to do a collaborative lean kind of effort to really go soup to nuts and see where we need data, on what, and how to best keep that information flowing, so

thank you so much.

CO-CHAIR PINCUS: Anybody online that is also wishing to comment? Kevin?

DR. LARSEN: Suggestions, we need to think through, this is a committee largely giving its advice to Medicare, but we know that many other groups look to this and that the measures, we're hoping, are actually aligned across many other domains. I think things specifically of the states that are choosing measures for their state innovation models, part of my work is to give technical assistance to states as they build their measure sets.

And this committee might consider, as it looks at feedback, not just the getting feedback from the use of these measures in Medicare programs, but where else are these measures actually being aligned and use that as a sort of second part of the analysis.

You know, you don't want to take too big a bite of the apple because that can be, you know, an endless set of analysis, but for some

key and core things, we hear over and over again that people are looking to the Medicare measure sets as the starting place for where they would find measures for use in other kinds of aligned programs.

CO-CHAIR PINCUS: Other comments on this issue? Now, it seems we did not comment on the second issue about the ability of the mechanism by which MAP members can suggest additional measures. Are there comments or issues that people want to bring up about that? David?

MEMBER GIFFORD: So we talked a little bit about this last in the fall and I think I would disagree with -- agree and disagree with the comment that we're not allowed to add measures. We can't add measures to MUC list because CMS has a process for it, but the statute that gives us authority is to give feedback to the Secretary, and if you read it through it's clear that there's supposed to be a balancing between new measures that are not NQF endorsed,

but thinking about NQF-endorsed measures.

And so I would say that there is a -- one of the things that the MAP workgroups and the MAP can do is certainly review other NQF-endorsed measures on the same topic, particularly when CMS is coming forward with unendorsed measures, and give feedback as to whether they should be thinking and looking at other measures.

So we can't add measures, but again, I think our statutory responsibility is to provide the Secretary with feedback. And if there are other measures, I think we should be looking at those other measures and making some comment as to whether we think those -- CMS should be looking and considering those other measures.

And as we've heard, we're advisory. They can ignore it. They can -- but they then have to comment as to why they're ignoring that. And I think that that issue came up a number of times in last year's cycle and again in this year's cycle as well. And both times it was

stated that the NQF staff felt they could not add or have a discussion, and so the discussion was tampered down and not raised by the group.

And I think that that's wrong and I think we should allow that discussion to be brought up and there should be some awareness of other measures that are NQF endorsed, not the open world out there, because they've gone through this body has said that those measures are out there and that there should be a look at that.

And it very well may be, and I know in one of the cases, I think the CMS measure came through, probably is the one that should go through, but there was no discussion of that, and it left a lot of stakeholders with a sour taste in their mouth.

CO-CHAIR PINCUS: So it seems to me that what's being suggested is that the distinction between suggesting another measure and making a comment is really, you know, a distinction without a difference, that if we're

giving comments back on some of these measures, our comments can include saying, have you thought of this other existing measure? Does that make sense? Rhonda.

MEMBER ANDERSON: I think this is appropriate for this question. I know that we've spoken in the past about what are the precious few, if you will, that will make a difference in health in this country? And when we talk about all these significant number of measures, I don't believe that we have always asked that question. Maybe in our own individual minds we have as we've read them, but it seems to me that that is where there may be a gap in what measures come before us and then what measures really are going to make that difference.

So I would just like to introduce that into the comments about how we might be able, from a MAP perspective, to bring forward those that are going to make that difference. Going back to Frank's comment about this -- the changes that are occurring in the payment system, et

cetera, I always ask the question as I read each of the measures in the hundreds that are coming forward, is this, if it's a payment, going to make a difference by the clinician, the hospital, the post-acute care in terms of the final outcomes for those particular individual patients that are being cared for there?

And I think it's really important to always keep that before us.

CO-CHAIR PINCUS: Any further comments online? I'm going to move ahead. Rather than taking a break now, since we're getting close to the lunch break, I thought we just sort of move ahead to the next set strategic issues.

MR. AMIN: Okay. Thanks, Harold. Again, so just a quick reminder, the purpose of this next session is to have some discussions about what major topics emerged across the different workgroups, and again, this is in response to much of the feedback that we received form this group during last year's development cycle.

So during the workgroup meetings this year, there were several strategic issues that emerged during the discussion, and they sort of fit into four different buckets. The first was the need for special consideration of issues that disproportionately affect the dually-eligible population. And second, closely related, was the importance of appropriate risk adjustment for socio-demographic status, demographic factors.

And then the two final ones sort of relate to, actually, the conversation we've had already this morning, around the challenge of performance measure attribution and the need for shared accountability, and finally, the importance of feedback loops.

So the first discussion around the issues that disproportionately affect the dual-eligible populations span four different topics. If we can move to the next slide. The first was care coordination. There was continued encouragement of the development of care coordination measures in and out of healthcare

settings, and to find and measure discharge to community.

Secondly, community resources, providers should facilitate access to community resources, including improved integration of healthcare and community resources. Third, person-centered and clinical measures that support individual health goals and incorporating goals into clinical measures while supporting clinicians in quality improvement with clinically relevant measures.

And finally, the disproportionate impact of risk adjustment for the dual-eligible population.

So moving on to the next slide. The dual-eligibles workgroup recommended some specific elements for the coordinating committee to consider. First was -- and the individual workgroups. The first was to encourage NQF and the MAP to continue to be forward thinking and anticipatory for changing healthcare quality and measurement.

The second was to reinforce the need to explore and understand the differences and implications of risk adjustment for diverse factors, including those that are clinical and social in nature. And third, to continue to move forward with goals to align and prioritize measures across settings, providers, and intended audiences, specifically, consumers.

Moving on to the second major issue related to risk adjustments for socio-demographic factors, the MAP workgroups noted the importance of reducing disparities by selecting measures that adequately identify inadequate resources for special -- for these populations, poor patient provider communication, the lack of culturally competent care, the lack -- the inadequate linguistic access, and other contributing factors to healthcare disparities.

They emphasized across all of the workgroups that all members of the healthcare community have a role in promoting appropriate treatment of all patients and reducing healthcare

disparities. The MAP workgroups, what you probably have already identified in your analysis of the measures that you'll be seeing in front of you today, the MAP workgroup conditionally supported several measures under consideration, pending a review by their relevant NQF standing endorsement standing committee in the NQF/SDS trial period to determine if SDS adjustment is appropriate.

The MAP workgroups encouraged these NQF endorsement standing committees to ensure that all decisions, to include SDS factors in an outcome measures risk adjustment model, should be made on a measure-by-measure basis and should be supported by a strong conceptual and empirical evidence.

And then the MAP workgroups also noted the need for a high --

CO-CHAIR PINCUS: Just a question about that, how does that process get fed back into the process?

MR. AMIN: So broadly, actually, you

know, one of the things that NQF is continuing to work on, which, we hope that we'll have some time to discuss tomorrow as well, is the further integration of the NQF endorsement process and the MAP process. So all of these recommendations and the workgroup rationales, as they are considered, first of all, they're given to CMS to consider as they are thinking about implementing the project, and as these measures come forward for re-evaluation, there's a special consideration for the SDS question when they're reviewed by the standing committees.

CO-CHAIR PINCUS: So let's say in the current crop of measures that we're going to be discussing, as some of these issues have come up where there's, in a sense, a request for consideration of adjustment for socio-demographic factors. Does that then go to the standing committee and then how does that get fed back to CMS in some way?

DR. GOODRICH: So I'm not sure of the exact process of how measures get pulled that

should go into the SDS, I don't know if we're still calling it a pilot, what we're calling it, process, whatever, there is a process for that, I'm just not sure what it is. You'd have to speak to that. We participate in that process. So when measures get pulled, we have our contractors do the analyses, bring them forward, all that stuff.

MR. AMIN: Right. I would just add, Harold, to that question, I mean, there's a key stakeholder group that's part of this process, which are the measure developers. So the key thing that we sort of do is, as we identify these measures that are of special consideration by the workgroups, we inform the measure developers to, you know, undergo the appropriate level of testing, and then when they're ready for measure -- when they're ready for re-evaluation by the standing committee, the standing committee is encouraged to specifically look at this element as part of the validity evaluation.

I would also add that any stakeholder

can raise any measure for an ad hoc review in which there's particular concerns around SDS factors if there's evidence to suggest so. So, you know, some of this is related to the funding cycles of when these projects come up for review, so it's not an immediate trigger. So the standing committee is not looking at it like January or February, but there's a lag as it relates to getting the developers to do initial analysis and then for a relevant standing committee to be convened. Is that sufficient?

I think there's a question. Do you want me to keep going?

CO-CHAIR PINCUS: Oh, Bill?

MEMBER KRAMER: I just want to make sure we're clear on our role, vis-a-vis, the standing committees regarding the risk adjustment methodology. My understanding from what you just said, and reading these slides, is that, while some of the workgroups identified measures as potentially being affected, or be relevant for disparities issues and risk adjustment, but the

task, methodological task, of determining whether risk adjustment is appropriate is being done through that SDS trial and not an issue that the MAP is -- that's before the MAP to debate, or discuss, or determine whether a particular measure should be risk adjusted, is that correct?

MR. AMIN: That is correct. Yes, your characterization is accurate.

MEMBER KRAMER: Great. Thanks.

CO-CHAIR PINCUS: Missy, do you have a comment on the line?

MEMBER DANFORTH: I do. I have a follow-up question that's related to the first question. So there's a few measures that have this pending NQF SDS trial, or pending NQF endorsement, or pending NQF re-endorsement. So in those instances, also where it's up to the standing committee to re-endorse the measure following maintenance, or endorse the measure for the first time.

Once that's done, does the measure automatically go back on to the MUC list?

Because I noticed when I was comparing last year's final report to this year's MUC list, there were several, like, nursing measures, I think, that go brought forward by the Annes here that said conditional support pending NQF endorsement.

So those measures did get NQF -- endorsed by NQF in 2015, then didn't automatically appear back on the MUC list. So I'm just trying to understand with all these measures that say pending NQF something or another, you know, how do we ensure that they actually get back on the list once that conditional -- once those conditions have been met?

MR. AMIN: So this is true, and I think this actually closely relates to the conversation we were just having around the need for, you know, the term that we're using in this context is the feedback loops. You know, currently, the process is, sort of, linear, which is that, you know, the standing workgroups and

the coordinating committee, right, makes a recommendation to the standing committees, and then, you know, the measure sort of moves on, but there is not a -- there is no current process in which that information would be brought back to the MAP to, sort of, close the loop.

And I think Kate has described a commitment by CMS to revisit that question and obviously, NQF will have a responsibility to figure out how that process will work going forward. But I think you can rest assure to a certain extent that there is actually -- there's at least interaction between the MAP process and the endorsement process, so feedback that's provided through the MAP process is considered by the relevant standing committee when that standing committee is reviewing these measures, and at least that part of the process is currently working, I believe.

CO-CHAIR PINCUS: Missy, that answer your question?

MEMBER DANFORTH: Yes, so I mean, I

think, though, the really important thing I'm hearing is though, even though, going back to your answer to the first question, so even though the standing committees are responsible for deciding which measures end up having the socio-demographic adjustment apply, it's kind of going to be up to this group, the MAP coordinating committee, and maybe even the workgroup, to ensure that, sort of, that due diligence is done.

I mean, they're going to have to have some oversight to make sure that this is tracked back through the standing committees and up through the workgroup and to the coordinating committee.

CO-CHAIR PINCUS: Any other comment?

MR. AMIN: Yes. I would just say that, yes, basically, that the conditions are filled, and like any condition that would follow, you know, the conditional support, there would need to be an additional process. And I think that's one of the overarching issues that we discussed this morning, that these conditions are

met, and, you know, a formal feedback process would need to be developed to do that, but your characterization of governance is accurate.

MEMBER DANFORTH: Thank you.

CO-CHAIR PINCUS: David?

MEMBER GIFFORD: I just want to clarify the question Taroon gave to Bill. Is the SDS trial period is now for all measures coming through or just those earlier? So any measure can come in without it and then go into a trial period.

MR. AMIN: Well, let me be specific about what that means.

MEMBER GIFFORD: Yes.

MR. AMIN: Like -- because every measure that is submitted to NQF, I believe it's April of 2015, is in the SDS trial period. Now, that doesn't mean that every measure should be adjusted for SDS. It means that, as part of the validity assessment by the NQF endorsement committee, they should be evaluating whether the risk adjustment approach is valid, and that

includes an assessment of the clinical factors and the relevant social factors.

And so I just wanted to be specific about what that means that a measure is in the trial period. Every measure that is being evaluated by the -- but in this case, when there are specifically measures that the MAP wants the CDP committees to look at, the endorsement committees to look at, they will get that feedback from the MAP and, you know, consider that much -- you know, the feedback from the MAP process is considered, you know, very seriously by the relevant standing committees.

So it's paid special attention. Maybe that's a better way to describe it.

DR. BAKER: A quick question, do the measure developers propose the SDS risk adjustment methodology or are you envisioning somewhat of a standardized risk adjustment methodology across measures? Just thinking about actually being able to implement these on a large scale.

DR. BURSTIN: Thanks, David, and Marshall Chin is here, who's the co-chair with Ninez Ponce of our new disparity standing committee. At this point it is up to the measure developers to propose both what their assessment is of a conceptual basis of why you would adjust, as well as their own empirical analyses. Part of what we're hoping the disparities committee will help us is more of that standardization as we go forward.

This is, frankly, a learning experience, as we're seeing for some of the initial measures that have gone through. Clearly, conceptual basis and the data is still pretty difficult and I don't know if Marshall wants to add anything.

DR. CHIN: Yes, we had our first meeting last week, actually, deja vu here with this table, Erin and Helen were there, as Helen says, it's going to be a learning process. And one of the, I guess, early things for -- you need to find is that it may be a challenge of the

existing measures which are readily available which accrued for such evidence as versus for -- we had a presentation of a more detailed dataset being much more sensitive than for to be included to determine these practically important differences whether you risk adjust or not.

So this will be a learning process, but this is something that may come down the pipe that the existing crude measures may not be sensitive enough for it than yet of reality.

ACTING CO-CHAIR GESTEN: Mary Barton, on the phone.

MEMBER BARTON: Yes, I just wanted to say, from the measure developer point of view, we are working on this, but it will definitely -- I can't imagine a standard process that could work across all measures, given the evidentiary burden of SES. That's one point. And then the second point is, as you might imagine, this is still very early days, as Marshall just said, for figuring out how to implement, given the very sparse availability of relevant data to measure

to the entities that are being assessed.

There's some data that might be available, but we don't know yet how to use it, and then there's a whole bunch of data that we would like to be available that is not yet available.

CO-CHAIR PINCUS: Lisa, then Kevin.

MEMBER McGIFFERT: I just want to be sure I heard correctly that the -- through the NQF process, all the measures will be -- the committees are required to consider the measures for SDS adjustment. And my memory was that that was not to include patient safety measures, so if you would address how those are handled.

DR. BURSTIN: Now, that's a great point, Lisa, and again, it's always heard because I feel like we've explained this in different ways to different groups. I'll just try to be very clear for the MAP. Again, with the SES trial period came out as clearly saying, and the report came out as saying, is that all measures should be considered, but to do so, to actually

move it forward, there has to be a conceptual basis of why those factors would, in fact, be relevant to that outcome.

So to your point about patient safety, for example, hard to imagine easily coming up with a conceptual basis of why an in-hospital safety event would have anything to do with any of the SDS factors. Again, I'm being pretty broad here, but just in general. So most of those safety measures would likely fail on the conceptual basis, which is the first requirement.

You have to get past the conceptual basis before you even then entertain the empiric analyses, so in general, anything that's kind of generally been within the hospital setting, particularly around patient safety, as we've seen so far, have not been measures that have been raised for consideration as part of the panel.

More so, I think, when there are these issues that often extend beyond the walls or have issues that get into other patient factors beyond in-hospital care. Does that help, Lisa? Okay.

DR. LARSEN: I just want to be sure we're also cognizant there are a number of technical questions about how we'll collect and validate this kind of information and ensure the appropriate privacy and security around its sharing. We've been doing some of that through the -- as the national coordinator. In our 2015 certification edition for meaningful use, there is a social and behavioral factors for data collection that you can certify in your electronic health record.

But we got a fair bit of input, as part of that rule, that people are concerned about the increased potential burden of that data collection, and there are also people that are concerned about when and how the information will be used and shared. And that was just the, sort of, front end of the sphere, I think, from this kind of information that, if we want this to be specific to measures and very broadly used across all sorts of measures, there should be some really thoughtful discussion at a strategic

level, how much of that do we want 1000 flowers to bloom and how much of it do we want there to be a kind of cohesive set of the main factors we want to collect and reuse over and over again for the purposes of lots of different measures so we can really be sure that we've nailed things like privacy and security, data sharing, collection burden as part of this process.

ACTING CO-CHAIR GESTEN: So I recognize how early this is in the challenges, Marshall, that you mentioned, and Mary as well, but I'm just wondering, you know, what your early thoughts are or what the early conversation is about, you know, data that suggests that networks and providers that take care of multiple populations may actually be better on a number of quality measures compared to other populations, and/or measures that deal with overuse, for example.

You know, what folks might traditionally think of as challenge and vulnerable populations, those measures may

actually do better. So as folks are thinking about the evidence to support adjustment and look across the country and look at what some systems have been able to do in terms of performance, which may be counterintuitive, or some areas where lower SES populations may do better on certain measures, how is your group thinking about handling this?

In other words, does adjustment go in all different ways? So for overuse measures, would you adjust for folks who are higher income, or different status, or how do you think about that?

DR. CHIN: Well, in some ways, I think like your point, Foster, gets to, what's going to be up on the post on the next slide, that I was actually heartened to hear that the MAP workgroups had agreed that there's a need for, sort of, a high level more encompassing roadmap for reducing disparities.

This will be, like, my fifth year on NQF activities and my impression is that, you

know, there are stakeholders here, NQF, CMS, the payers, the health organizations, they're all well-meaning about disparities, but on the whole, the efforts have been siloed or scattered, or often times, crowded out by other important competing demands.

And so, for example, the committee, when we had our meeting last week, the risk adjustment is an important part, but only one part of the overall charge. Probably more important in the long term is to come up with this roadmap, which is going to be on the next slide, which will incorporate things like, well, how do you think about some of the organizations that do particularly well, for getting to your diverse populations, what are they doing? How do we encourage others to do that, whether it's with technical assistance or other types of incentives?

And the specific charge that you can actually look at goes from, for disparities, the selection of performance measures, the use of

those performance measures, as well as their use within payment programs.

I was thinking, one of the top priorities for the disparities committee for NQF, one of the prior challenges with the other ones, I actually know he's been on them, also, has been that they've been siloed. And as hard as it is to talk about, like, selection of the measure divorced from its use, including the payment, so this is the first of the disparities committee is to get that broad charge.

So it's going to be, in some ways, a more watchful -- the charge we've been given, and hopefully we'll be able to have more when it comes to look -- such as, risk adjustment is only one part of the puzzle for looking at disparities. And your point, too, is very important about trying to encourage, what can we do to encourage different organizations to do a better job, because we know that it is possible to deliver right here and have great outcomes for all types of populations.

CO-CHAIR PINCUS: Why don't we move on to talk a bit more about some of the issues around accountability and attribution?

MR. AMIN: Yes, that was a perfect segue, Marshall. So just to finish up that last topic, I mean, again, just as Marshall pointed out, across the workgroups there was an identified need for a high-level roadmap around the elements that Marshall just pointed out, and there was definitely support for the disparities standing committee to take a more aerial view of this and to inform the MAP process in general.

So again, as we're talking about some of the strategic issues that emerge across the workgroups, the first was this issue about the MAP dual eligibles, the second was a discussion around disparities and risk adjustment.

The third was around the discussion around measure attribution and the share -- and the need for shared accountability, particularly in the way, honestly, even the MAP workgroups are structured, which are generally setting specific

or provider specific, so across several of the workgroups and measure-specific discussions, there was an acknowledgment of the importance of identifying the appropriate accountable entity for patient care and outcomes.

The MAP workgroups encouraged shared accountability for providers for important outcomes, but however, MAP workgroups often found it challenging to define how to appropriately assign patients and their outcomes to multiple organizations, and providers that have a role and influence in these outcomes.

And I would just remind us last year of our discussion around advanced care directives, sort of fit the same domain, an important topic and who's ultimately accountable, and what role do they have in improving those outcomes?

Moving on to the next slide, the MAP workgroups noted the challenge of attribution and the importance of shared accountability in several illustrative examples, which we'll talk

about later on today. The first is around these 30-day readmission measures, mortality measures, and episode-based payment measures that look longitudinally, and the second was around clinician measure -- clinician-level measurement when there is increasing emphasis on team-based care, and the third about how do we advance population health goals in the context of, sort of, setting specific measurement, the example of smoking cessation.

All interesting topics I'm sure we'll get to later on today. The MAP workgroups cautioned that measures and programs need to recognize that multiple entities are involved in delivering care and there is an individual and joint responsibility for improving quality and cost performance, and also identified the need for a multi-stakeholder evaluation of these attributes and issues to provide guidance to the field on theoretical and empirical approaches to attribution to guide measure selection and future rulemaking activities.

And then finally -- and finally there was a discussion around the importance of feedback loops, again, very consistent with our conversation earlier this morning, with MAP workgroup members noting the importance and the need for feedback loops from those using measures under consideration by the MAP workgroups.

This type of user experience can help identify trends in measures, overall performance, overall variation in performance, provide guidance on specific interventions that lead to performance measurement, and understand whether the measure is having the desired effect and to the extent to which the measure is being used.

These feedback loops can also help provide guidance on measures under development. Again, very consistent with our conversation earlier today, and very encouraging that CMS is interested in moving forward with this.

And finally, the MAP workgroups encourage feedback through its enhanced public commenting period to gain insight into user

experience with select measures.

And I know we've had a chance to really move forward and have a discussion around some of these topics already, but, you know, just some conversational topics here, you know, for discussion, but again, these two sessions that we had today, this morning, that Erin covered, and what I've just covered here, is to give the MAP coordinating committee a more strategic view of what we identified across each of the workgroups, and again, there's not necessarily a decision point around these topics, but we would welcome any discussion before we move to public comment period.

ACTING CO-CHAIR GESTEN: Thank you, Taroon. Lisa.

MEMBER McGIFFERT: What this brought up to me is not really shared accountability, but sometimes accountability is shared when it shouldn't be shared. For example, a Medicare patient who gets an infection in a hospital and leaves the hospital, and has to -- and needs lots

of care subsequent to that infection. And, you know, the pay-for-performance programs don't account for that, that responsibility to the hospital, it's a little bit different than what we're talking about here, but there could be -- there often is a cascading event -- effect after something like this happens, and that patient could be in a nursing home, or could be in home healthcare, or some other setting that, you know, that is directly affected by that first act.

And I don't know how to measure that or how to point accountability for that, but I know that's not what people are talking about here, and I think, you know, patients are taken care of -- I understand patients are taken care of by many different providers and I would like to see, you know, some kind of record that follows that patient, and what happens to that patient, but that should also include accountability for the providers who were originally accountable, should be held accountable, for the original patient safety

event, for example.

ACTING CO-CHAIR GESTEN: Barry.

MEMBER NOONE: Well, I have a question about the SDS adjustments. Are they adjusted for each of the measures specifically or is there a general adjustment across the entire measurement category? I was a little confused on that.

ACTING CO-CHAIR GESTEN: My understanding is the former rather than latter, but do you want --

MEMBER NOONE: Thank you.

ACTING CO-CHAIR GESTEN: David?

MEMBER GIFFORD: The attribution one is just so hard. I think the theme and feedback I'd like to give to CMS, and I think they're moving in that direction, is, when measures span providers, this is when the accountability comes up, you need to do that in -- both providers need to have that measure held accountable to them and it needs to line up with other programs, the payment programs and regulatory programs, because measure by itself, or measure that's held

accountable to one provider and not another, does not allow that coordination, the very essence of the law, and some of it's out of sequence, because as Jay pointed out, there's a sequence issue, and I think CMS is trying to remedy that, but it would be worth reinforcing that.

I think the other thing that's not on this list, which I think needs feedback, you may want to think about, and interested to hear other opinions, is, as these measures evolve and as answered on the phone, payment models are changing and everything, should measures be contained to Medicare only fee-for-service, should they be only certain insurer type, or should they be all payers?

And we have mixes of measures out there and I think we're learning more and more that Medicare fee-for-service does not necessarily represent the other populations and/or the practices of those providers, so as we go to attributing stuff, we have a lot of measures that are being developed on claims

because of convenience, and other issues, and trying to balance the claims, or other -- you know, and as EMRs are evolving out there, so I would think it would be helpful to move to all payer measures faster than we're moving in this direction.

ACTING CO-CHAIR GESTEN: Kevin.

DR. LARSEN: One of the areas of interest I see from states and others is how to have accountability -- redefining accountability more broadly, and so I think being explicit about when the measures actually have defined the accountability within the measure specification. What -- so for example, in a lot of the physician measures you need to have two visits with a particular physician so that measure can be counted for that physician.

In newer models, or in places where people want population-based accountability, or -- and some kind of empaneled group that you're accountable for the year, that means that you can't use that measure to measure the success

because the measure itself has said you had to have two visits this year in order for us to actually count you in the measurement.

So I think that that kind of -- those kind of technical issues with how the measures actually are built to the current payment systems should be thought of someplace so that we are clear about measures that we want as the payment systems evolve to this more attributed accountability and population-based care.

DR. BAKER: I just wanted to comment on the disparities issue. Marshall and I have been on this working group for America's Essential Hospital and talking about this, and through that discussion I think the two things that have emerged for me is, first, stratification of existing quality measures, and I know CMS has talked about that, and that's been talked about for many years, but in particular, I think stratification of the measures, the age gaps measures, to be able to look at differences in trust, and being treated with respect, and a

lot of these issues are really cross-cutting and not specific to the elite clinical condition.

And then the other thing is, I think it is probably time for us to move beyond measuring preferred language and actually get at the issue of English proficiency, and if we can capture that information then to be able to look at the proportion of people with limited English proficiency to get an interpreter or a language employment provider, and I think those are two very concrete things that can help us move forward.

ACTING CO-CHAIR GESTEN: Other comments? One of the bullets here, we talked about it a little bit, the second one about learning from the field about how measures are being used. Kate, you talked about the information that you get, you know, on some days, probably more than you need, feedback about how measures are being operationalized, but also, you do your own evaluation, I think like lots of folks may do, either developers or payers, to see

what kind of variation, what kind of changes you've seen over time.

So I think I heard you suggest that bringing some of that information back in some format to be -- yet to be sorted out may be one way of getting more information back from the field, but I just wonder if the group has other ideas about other sources of information, or rather, processes where by information from the field could be brought back to the MAP? Rhonda?

MEMBER ANDERSON: Being from the field, we have every -- almost every payer that has different measures, and when we negotiate our contacts, we have, you know, Payer X versus Payer Y versus Payer Z that has different measures, some are consistent across the board and some are very different.

I'm just wondering if we have, at the national level, asked some of the major managed care companies what they are using and/or why they are using it, because I know they come to the table with a whole set every time we sit down

with them.

MS. STERLING: Kate, do you want to speak about the ongoing efforts with the payers collaborative?

DR. GOODRICH: Yes, so there's an effort, which many of you know about, Amir has been a major participant in it, as have others, I think, on the phone, where America's Health Insurance Plans has convened, many of the large private payers, as well as CMS, physicians, societies, consumers, employers, to develop consensus around core sets of measures for at about seven different sets at this point.

So, as part of that effort, we don't have a process yet, but we are hoping to, in sort of the next step, develop a process to understand implementation of these core sets across the different payers and within CMS, and the impact that that has. And there may be opportunities to collect information, whether it's, you know, hard data, or whatever kind of information would be most useful, not just from CMS, I don't want to

speak for AHIP or other payers, but there may be an opportunity there, especially since, you know, there will be much more alignment, we believe, across payers with certain measure types.

The other thing I also wanted to mention is, you know, one of the sets of analyses that we do with a lot of our measures, particularly our outcomes measures, is looking at the disparities, so looking at performance of providers who have higher proportions of patients who are low SES compared to providers who have lower proportions of patients with low SES.

And so that kind of information, bringing that back to this committee, just to highlight, we do actually have that and we look at that, you know, for many of our measures, especially our outcome measures, might be useful to this committee as well.

CO-CHAIR PINCUS: At some point it might be useful to solicit from the coordinating committee what type of information would be most useful about the experience with individual

measures and to actually try to think about how one could, sort of, format that information.

Any other comments, either online or in the room? So we're actually running about an hour ahead, which is good. So, that's good. And we're about to ask for public comment on this first section, and then what we thought would be, just to give you sort of a heads-up about our discussions about the schedule, is maybe have the post-acute care, long-term care, workgroup introduce issues and then break for, you know, lunch very briefly, and then come back and discuss the measures that have been pulled.

So before we do that, Lisa?

MEMBER McGIFFERT: I just wanted to clarify what you just said is that you have some data that you could bring to us and did you say please do? I didn't hear you say that, but I --

CO-CHAIR PINCUS: Yes. Well, yes, it's please. Yes. Well, from my perspective, yes, but I think we want to, you know, think about it in a systematic way, what kind of input

-- what kind of information would be most useful, because I'm sure we could be flooded with all kinds of data, and so it'd be useful for us to think about, what are our priorities, and also what format would be the most digestible way to make use of the data.

ACTING CO-CHAIR GESTEN: I also wonder where in the process it comes, because in the logical place to get information about how measures are being used is usually where they're being reconsidered at some interval and I don't know that there's a clear process whereby MAP or the workgroups are being asked to, after some interval, say, can you re-evaluate these measures and say whether they should be in or not, but maybe I'm missing.

DR. BURSTIN: I think you're right.

ACTING CO-CHAIR GESTEN: Is that right?

DR. BURSTIN: I mean, certainly, there's a logical place for the endorsement path. We have measures come back for maintenance, but

even existing measures are often times put on these lists as well, so CMS could provide information about the experience of existing measures, even if they aren't in a particular program yet.

So again, I think this goes back to Harold's comment about we need to collectively work with all of you to think about the kind of information you would like to see, and then I think this is very much, goes back to Kate's earlier comments about, needing to look across the entire process, across NQF and CMS, and think logically where best to find the best possible information machine.

DR. BAKER: Throw out a couple of concrete things that, you know, the obvious things just to be able to look at the rates and the variation and the trends over time. I mean, we've looked at this for the joint commission and some of our measures, I mean, the performance has not changed at all, and it really makes you question the value of these measures. Are they

really doing anything to promote quality improvement?

So it still may be something that you want for accountability, but those would be basic things, and I haven't seen that. I think we did have that presented a few years ago, for one of these meetings, we had something presented, but I haven't seen it for long.

CO-CHAIR PINCUS: So public comment. Right. So are there members of the public either in this room, let's start with in this room, that want to speak?

MS. FOSTER: Thank you very much, Erin. I'm Nancy Foster with the American Hospital Association. Appreciate the richness of the conversation that you've just had this morning and the issues that you've raised. They are very important. Two quick comments. One is, earlier in the discussion, as you were talking about the measures that come forward and their various states of readiness, one thought might be, having served on the hospital workgroup for

any number of years now, it often strikes me that we're in this state of saying, we like the concept of the measure, but we don't like the measure, and you talked about that.

And sometimes I wonder if we really like the concept of the measure or we like the topic. We want more on X. We don't really like this measure, but we're not presented with that choice of, we would like more on X, but not this measure. So that might be something you'd want to think about including was -- is a sort of -- and it comes to mind as I think about some of the measures that the hospital workgroup dealt with this year.

There was a, I think I made the comment, that we would like more measures of children's health because we don't have very many yet, but the measure that was being brought forward had some issues that we didn't -- that you all will deal with later.

And secondly, to the question you raised a few moments ago about how can we get

more information about the usefulness of measures and so forth, if there's anything the American Hospital Association can do around either the hospital measures or any number of other measures, we'd be glad to help poll our members, do anything. It's a vital part of the process and I am sure we are not alone in being ready to help you get the information you need to make even wiser choices. So thank you.

CO-CHAIR PINCUS: Others in the room? On the phone, Operator, if you can open the lines of the public as well. If there's any public comments through the phone.

OPERATOR: Okay. At this time if you would like to make a public comment, please press star then the number one.

MR. AMIN: I would just like to note for public commenters, this is your opportunity to also make any public comments on the PAC/LTC measures that will be discussed. We'd also welcome those public comments as well.

OPERATOR: Okay. And we do have a

public comment from the line of Sandra Robinson.

MS. ROBINSON: Yes. Hi. This is Sandy Robinson from the American Academy of Dermatology. Like Nancy Foster, I want to thank you for the rich discussion, particularly around measures under development. I'm not sure where you all have landed in that discussion, so I look forward to the written discussion in the report. It's a really important issue, particularly for medical societies that are -- have long term efforts in place to sort of fill the measures' gaps, so we look forward to that.

The more, sort of, specific your feedbacks the better. We use this in -- for refining our measures development programs. And particularly for the American Academy of Dermatology, we're putting in place a clinical data registry, so I also appreciate the discussion about how data systems for measurement is in transition and that it would be sort of helpful to understand the vision of how the endorsement process will be evolving to

accommodate the new way we'll be able to develop measures in the future.

So thank you again for your discussion today and I look forward to reading the final report.

ACTING CO-CHAIR GESTEN: Thanks, Sandy.

MS. ROBINSON: Oh, one further thing. Also to echo what Nancy just said, in terms of how these measures are being used in the implementation, we will have some potential for that as our clinical data registry goes into implementation and look forward to any discussions with CMS or the MAP about how we can feedback information into the process.

ACTING CO-CHAIR GESTEN: Great. And thank you. Any other comments from the line, Operator?

OPERATOR: There are no comments at this time.

ACTING CO-CHAIR GESTEN: David, did you have a comment or was that -- okay.

MEMBER GIFFORD: Just on public comment in general, I think the workgroups and other committees I've been on really have appreciated the switch where public comment comes before discussion, not just before vote or after vote. I think it was really helpful, I've watched, and found that it helped shape the discussion.

And as we think about public comment here, it might be -- I know we weren't necessarily doing any voting, per se, but we were shaping some stuff. What the right timing is, and I'm not sure on discussion issues, but I think the more we can get to public comment earlier, that'll help a lot of us to sort of not have to revisit a topic or comment on it.

Not that I think that there's anything we've said that requires revisiting, but I'd encourage us to think about flipping as much of that around.

ACTING CO-CHAIR GESTEN: To that point, just to remind folks that we're seeking

public comment on the next section of conversation we're going to have on post-acute care and long-term care, so this is an opportunity for some of those comments that may shape or help inform thinking before lunch and after lunch. Taroon, did you want --

MR. AMIN: Yes, we just wanted to -- there's I think three members that haven't had a chance to formally introduce themselves and do disclosures. Kevin, I know you're up and --

DR. BURSTIN: Mary on the phone.

MR. AMIN: And Mary Barton on the phone, and Sam Lin on the phone. Well, let's start with Kevin, introductions and just any disclosures that you may have.

DR. LARSEN: Kevin Larsen, Office of National Coordinator of Health IT and no disclosures.

MR. AMIN: Sam Lin?

MEMBER LIN: Hey, it's Sam Lin, American Medical Group Association, medical affairs consultant. No disclosures.

MR. AMIN: Mary Barton.

MEMBER BARTON: Hi. This is Mary Barton, Vice President for Performance Measurement at the National Committee for Quality Assurance. I have -- I'm obviously a measure developer, but I have no disclosures.

MR. AMIN: All right. Welcome all three of you. Thank you very much for joining us as well today.

Okay, so if we could just move one slide. I just want to review the process before I hand it back to Harold to do some introductions of the -- if you go one more, I believe, that slide. Yes.

So again, I just wanted to remind everybody about how each of these workgroup report outs will occur, just to make sure that we're all on the same page. We will ask the relevant NQF staff supporting each of the workgroups, and the workgroup chairs, to present the measures and the programs that were evaluated.

Again, we appreciate all the workgroup chairs that were able to fight for a time to be able to meet with the changing agenda today. Not all of the workgroup chairs will be able to join us, given the changing agenda, but we appreciate that time.

We've asked them to focus on outlining the strategic issues that have emerged in the workgroups to give you, as a coordinating committee, more of an aerial strategic view of what happened in the workgroups, and then also review the relevant input from the MAP dual-eligible beneficiaries workgroup.

Our co-chairs here for the coordinating committee will ask if any individual measures will need to be pulled for discussion. In your discussion guide, we've already identified those measures that have been pulled in advance of today's discussion, so this may be the appropriate time to encourage you to sort of shift from using the slide deck as your main tool for today's meeting to the discussion guide.

Obviously, we'll be sharing that on the webinar platform as well, but for those of you -- for all of you in the room, and then all of you on the phone, I would encourage you to pull up that discussion guide. Again, if you do not have access to it or have any questions about how to access it, please let our NQF staff know and we'll be happy to point you to the relevant material.

That will be the main material that we'll use to guide the discussion for the rest of the day. And finally, for those -- for the coordinating committee members that have pulled discussion -- that have pulled measures for discussion, please be prepared to review the workgroup recommendations and the particular elements that you have some disagreements with.

Any measure that's not pulled for discussion will be ratified with the workgroup's recommendation.

CO-CHAIR PINCUS: So Taroon, just to clarify, there's not a way to go directly from

the webinar into the decision guide.

MR. AMIN: Is there a link on the left side of that webinar, team? I actually am not plugged into the webinar myself. No, there isn't. So maybe ---

MS. ISIJOLA: We could work on it during lunch.

CO-CHAIR PINCUS: Right. But I just want to know where people have the link, to make sure --

MR. AMIN: So we can resend the link. Is that right, Wunmi?

MS. ISIJOLA: Yes.

MR. AMIN: We can just resend the link to the rest of the coordinating committee and please feel free to use that as the most updated material. But again, I would encourage you to use that as the primary material that we'll use for the rest of the day.

MS. O'ROURKE: And just to clarify, for those working off of tablets, staff are coming around with laptops for you. We'll be

using the web platform to conduct the voting, so if you're working on a tablet, please make sure staff gets you a laptop so that you're able to vote.

CO-CHAIR PINCUS: And also to clarify, so you'll be -- for the examination of these issues and discussion of these issues, we'll be using the link to the discussion guide, but to vote, it's going to be through the webinar platform.

MS. O'ROURKE: We apologize. We know that's a little clunky. We usually have a system in the room to allow you to vote, but given that so many of the coordinating committee members were unable to join us in person, we're merging all of the voting through the web platform.

MEMBER QASEEM: Quick question, so what's the difference between measures identified for voting versus not voting? I'm forgetting. Can you remind me? Some says no vote required versus others say voting required.

MR. AMIN: Some of your colleagues on

the coordinating committee have pulled measures for discussion, that there's a clarifying item on the measure or a clarifying item in the rationale, and so they don't disagree with the workgroup recommendation, but they're looking for clarifying information before they felt comfortable with the measure moving forward.

Again, if there are measures that are pulled for discussion that you do want to change a vote, but the conversation doesn't require a vote anymore, please state that upfront because the voting process, as seamless as we try to make it, is clunky and will take some time to get through. It just is the nature of voting in general. It's not any criticism of the platform, it's just it takes time to get through it.

So with that being said, Harold, I will turn it back to you to introduce the co-chairs of the workgroups and if there are any other questions or comments that folks have.

CO-CHAIR PINCUS: With regard to that, so somebody who just pulled it off for discussion

and not for a vote, going back to our earlier discussion about the meaning of, you know, supporting the direction, if we are simply adding -- in our discussion of those that have been pulled for discussion, will those comments be incorporated into the ultimate recommendation?

MR. AMIN: Absolutely. Any discussion that occurs here will be added. Well, the workgroup -- it's currently labeled the workgroup rationale, it will be updated to say the MAP rationale, and it will include all of the discussion from this meeting.

CO-CHAIR PINCUS: Okay because that's important, because there may be some people that pulled things for a vote really intending for it to be more discussion, and so we want to sort of get that clear as we sort of go through the process.

MR. AMIN: Right.

MEMBER FLOWERS: This is Linda Flowers. You might have said this, I've been having some technical difficulties. So do I need

to close out of this webinar and then go back into another link for the discussion guide or will the discussion guide appear on this webinar?

MR. AMIN: So no, there are -- well, so there are two tools that you should have available to you. You should have the individual linked webinar open, not only to be able to follow along with what's going on in the room, but also to be able to vote, so please do not close that. Please have that available to you.

But we also would encourage you to have the link open in a separate screen, the discussion guide, so that you can follow -- if you have your own questions and you want to navigate through it, you can do that as well.

So that's the purpose of these two tools that are in front of you.

PARTICIPANT: But on the discussion guide, where is the voting? I don't see any place to vote. Will it come up?

MR. AMIN: Once we get to that point in the process, we will take a moment to stop and

walk you through exactly how the voting will occur, but it will show up on your screen and we will walk you through, on the webinar screen, how that will occur.

PARTICIPANT: Okay.

MEMBER FLOWERS: All right, thank you very much.

CO-CHAIR PINCUS: Okay. So do we have Carol and Sarah on the phone?

MS. SAMPSEL: Hi, this is Sarah Sampsel. I'm not sure if Carol was able to join yet. Erin, have you heard back from her?

MS. O'ROURKE: She was in another meeting. She's attempting to step out. She should be joining us in a few minutes. Sarah, if you want to kick us off and we'll open. We'll have Carol join when she's available?

MS. SAMPSEL: Sure. So hi, this is Sarah Sampsel and I'm the NQF senior director who was working with the PAC/LTC workgroup. The PAC/LTC workgroup reviewed 32 measures under consideration for federal programs. They're

listed on the slide. The inpatient rehab, facility quality reporting program, where there were five measures, the long-term care quality reporting program where there were seven measures, the skilled nursing facility quality reporting program, and the skilled nursing facility evaluated purchasing program, the home health quality reporting program, and then the Hospice quality reporting program.

I think as has already been brought up a little bit this morning, the PAC/LTC workgroup is the group that is heavily impacted, and I hate using the word, but by the IMPACT Act. And just to refresh your memory, the IMPACT Act has some goals and some requirements for alignment of measurement across settings using standardized patient assessment data and the MAP -- I think the workgroup really acknowledged the work being done by CMS to meet the requirements of the IMPACT Act, but also acknowledged there's importance in looking at the measures under consideration and the importance of preventing

duplicate efforts, maintaining data integrity, and reducing burden.

And so it was balancing not only the issues of a lot of these measures that were under development or had only been tested as presented to the workgroup in the development phases or tested in one setting, but understanding how those might translate into the bigger picture.

They did recognize the challenging timelines and I think we've talked about that earlier, and really did express some discomfort about supporting measures with specifications that had been not fully defined, delineated, or tested, but I think also welcomed the opportunity to give some feedback to CMS and to the CMS developer contractors regarding some kind of industry input on, perhaps, considerations for the measures, whether it was for the specifications themselves, for testing in certain populations, but also in some of the definitions and work that has gone on in the field for some time.

And then, you know, there was some significant discussion regarding the cost for beneficiary measures which were proposed for four of the programs, and really wanted some consideration to make sure that the measures are inclusive of not only both cost and quality, but considering the concept of value and how that translates, and then we received a number of public comments regarding how the cost for beneficiary measures may or may not translate well to the public and to consumers.

As was discussed just a few minutes ago, there was a lot of discussion about shared accountability across the continuum of care, and specifically we're looking at the post-acute and long term care settings. There are a number of transitions of care and hand-offs of care that need to be considered when looking at alignment of measures.

So the MAP did encourage and discuss the importance of incentivizing creative and improved connections in post-acute and long-term

care, and they did discuss the fact that the IMPACT Act can go, and translation of the IMPACT Act requirements, go a long way toward that route, especially when you're using the same sort of assessment and the same measures across the tools, but there's also the need to reflect the differences in the patient populations when looking at this handoff.

They found it important to promote shared accountability and to engage patients and caregivers as partners, especially the engaging the caregivers and patients in the hospice setting and measures that are intended to improve quality in hospice care and understanding the unique considerations in that care, all to ensure the effective care of transitions and communication.

There was some discussion about recognizing the uniqueness and variability of care provided by the home health industry and the fact that there is not only a lot of regional variation in home health, but also national

variation in home health, and there should be significant discussion about, and consideration of, how you look at benchmarks in home health and how to translate home health measures so that they're understandable to consumers.

And then, you know I mentioned earlier about concerns regarding some of the definitions and specification delineation. I think where we had a lot of discussion was in the discharge to community measures and the encouragement for further development to ensure that the measures are defined appropriately for each setting.

There was also a lot of discussion on the discharge to community measures to ensure that there was not duplication in readmission measures and a lot of that comes down to some of the definitions and coding that still need to be worked out in the measure specifications and testing.

Next slide. Yes, I think I really mentioned some of the bullets on this slide already, but, you know, not only is there a need

to focus on transitions of care across PAC settings, but from the acute setting, and from the hospital setting, to the PAC/LTC providers. Where there was a lot of discussion about that was really, not only in the handoff of the patients, but also the coding, and the fact that some of these measures, the way that they're specified, some of the things that you really need to look at are how codes from inpatient admission to discharge might change and might vary based against the codes that are used for admission into the PAC/LTC settings.

One of the other things that came up is this whole concept of measured care planning and how you actually put that into action and take the measure's path planning into the actual transition of care and ensuring that goals are defined collaboratively between the patients, the providers, and the caregivers, because really, when you come down to quality and assessing things in the future about experience of care, it's really not just about having a care plan in

place, it's about the interpretation and the actual translation of that care plan into action.

And then, you know, I think that has been -- this last bullet has been a theme for quite some time, and that's the idea that there needs to be better data sharing and interoperability of data to facilitate discharge planning and transitions of care. And again, some of that hopefully is going to come out of the IMPACT Act requirement and implementation of those requirements.

And as we move towards standardization or alignment of those tools and measures, the interoperability should hopefully improve, but then there's still the caution of we're looking at different patient populations, and sometimes much sicker populations, in some of these post-acute care settings. Next slide.

MS. O'ROURKE: And, Sarah, I'm sorry to interrupt you --

MS. SAMPSEL: Okay. So before I go here, let me see if Carol had an opportunity to

jump on?

CO-CHAIR PINCUS: Hello, Carol, are you there?

MS. SAMPSEL: Okay. So I will continue. What I just presented were the overarching themes that we felt that the workgroup came up with. There were also some more specific, I guess, themes and comments when we looked at consideration of the set of measures across each of the long-term care settings.

So for inpatient rehabilitation facility, and again, this is one of the QRPs, or quality reporting programs, as mentioned, the measure focus continued to be on implementation of the IMPACT Act, however, the workgroup acknowledged and identified that there are other high-priority leverage areas that are starting to be filled for the IRF/QRP, and so we are seeing some of the gaps in measurement closing in that program.

One of the strong themes with the IRF program is that there is the need for attribution

and ensuring that it's appropriate to the level of care that most impacts the discharge decision and admission to the IRF. And again, this goes back to the whole making sure that there is alignment in the measure and the coding, and ensuring that both admission and discharge are respective, and any measurement for discharge and readmission are aligned with the patient population.

The long-term care hospital reporting program, there is a measure in that program, and in one of the others, regarding the use, and specifically potential overuse of anti-psychotic medication. And two of the things that there was significant discussion for this program had to be with encouraging the exclusion of bipolar disorder.

The way the MUC list was submitted, the inclusion of bipolar disorder in the metric was still, or the exclusion, was still being considered in the testing. And I think we heard pretty clearly from workgroup members that they

really suggested the exclusion of bipolar disorder. And then also thinking about how duration of exposure to the anti-psychotic medications could impact the measure specifications.

And, you know, this goes from the transition of care and then how that duration is implemented, or measured, within the long-term care setting.

With the home health quality reporting, this is the program that really has been up and running longest for CMS, and has the biggest burden of measurement and the largest number of measures. So the overarching theme from the workgroup was a recommendation for a parsimonious group of measures that addressed burden to the providers and ensure that CMS is considering the retiring of topped out measures and exploring opportunities to implement composite measures, and there were composite measures introduced on the MUC list that took a number of the previous individual measures and

considered them, and they're going through the testing phase for the composite measures.

And I think this is in line with what Kate mentioned earlier, is that, CMS is constantly looking at the programs, and home health is one of those programs, and looking at how the measures fit or don't fit, and how the measures need to evolve over time, and specifically, the measurement sets over time.

Next slide. Okay. Skilled nursing facility, with the skilled nursing facilities, some of the measures on the MUC list were measures that had appeared, or adaptations of measures that had appeared on the MUC list last year for IRF. And those are some of the functional status measures, those process measures ensuring that functional status measures are -- functional status assessments are being done, but then change in functional status.

These measures were encouraged for further development because the way they were submitted was adaptations of the IRF measures and

how they had been tested in IRF, and further testing needed to be done in the SNF program. The workgroup really encouraged further development to promote alignment of the assessment tools, and measure reporting across settings, and also consideration of burden in implementation of any new assessments.

I already talked a little bit about the anti-psychotic use measures and here, with skilled nursing facility, it was really -- there's a significant discussion about the special considerations in SNF regarding the prevalence of dementia and how these measures may or may not look with the population with higher prevalence of dementia.

With the skilled nursing facility value-based purchasing program, there was acknowledgment of the importance of 30-day preventable readmission measure, but I think, you know, it's important with all of the 30-day preventable readmission measures that we saw across programs, there was a lot of discussion at

the workgroup across each of the programs, and then in public comment, about ensuring that there's not double dipping or double penalties due to, perhaps, conflicting or 30-day readmission measures that may look very similar in the different programs.

And then finally, the Hospice quality reporting program, which I should mention, is one of the programs that is not impacted by the IMPACT Act. The discussions were about the continuation of gaps in tested and endorsed outcome measures, and the need for continued work on hospital quality measures. There were only two measures on the MUC list for hospice.

But I think there was a lot of support for those measures and that the meaningfulness of hospice visits and care provided as reported by the patients and caregivers are probably one of the critical aspects in assessing quality, and so determining how you measure those aspects and getting feedback from both the patient and the caregiver is really critical to implementation of

the measures. Next slide.

CO-CHAIR PINCUS: Wait, is Carol on?

WORKGROUP CO-CHAIR RAPHAEL: I am on. I just got on, but it's fine to continue, so just let me know if you want me to join in the presentation at any point.

MS. SAMPSEL: Carol, this is Sarah. Do you want to go ahead and pickup on the core concept discussion?

WORKGROUP CO-CHAIR RAPHAEL: Sure. I can pick up on that. I don't -- you know, did we spend a little time on the context and the IMPACT Act? I'm assuming that we did and kind of the very tight timelines that that Act has set up for measure implementation, so I think it's important to understand that, but I'm assuming we framed that for the coordinating committee.

MS. SAMPSEL: Yes, we talked about it not only specifically for PAC/LTC and kind of the challenges for our workgroup, but that was also a broader conversation earlier this morning before you were able to jump on, so I do think that

framework is set, but, you know, I'll defer to Harold if you think we need to talk about that a little bit more.

WORKGROUP CO-CHAIR RAPHAEL: Okay. Great.

CO-CHAIR PINCUS: Yes, that was discussed a lot this morning, and then also brought up by Sarah.

WORKGROUP CO-CHAIR RAPHAEL: Very good. So just to jump in at this point, you know, we developed, now several years ago, core concepts and we were very parsimonious. We really had 6 domains and 13 core concepts that have guided our work, and I would say it is gratifying that the IMPACT Act and the proposed measures by CMS in fact reflect the direction that we have been headed, but we did step back at this point to kind of reassess our core concepts and see if we want to modify them at this juncture.

And I'll just highlight a few of the main points that emerged from that discussion.

And I think in addition to quality of care, we really believe we need to add quality of life, and that encompasses symptom management, particularly for hospice, social determinants of health, particularly in the long-term care area, and just the importance of autonomy and control.

I think the other area which really is very, very much germane to the post-acute long-term care areas, if you're going to reflect the preferences of patients and their families, they really do need access to lower and more appropriate levels of care.

I think the next area that we kind of continued to emphasize is trying to move to outcomes and not just have the processes, but really make sure that we're targeting the outcomes to the fullest extent possible.

On one of our areas where we really wanted to zoom in on the need to establish patient, family, and caregiver goals, we wanted to shift that to not just only establishing the goals, but really assessing the degree to which

the goals have been achieved.

And then in thinking through how we really bring patients and their families in as genuine partners in care, we really came to the conclusion that we need to be sure that education and information are available so that patients and the families have the tools that they need to really be true partners.

Okay. We, you know, are fortunate, we have a member of the Dual-Eligibles Workgroup on our workgroup, and so we are building a bridge to the work that's been done in that area. And that just, I think, reinforces for us where we're already headed directionally, which is we have a number of post-acute and long-term care settings, and we need to be sure that people are receiving care in the right setting at the right time, as well as in the right way, and facilitate the comparison of quality measures across settings by being sure that they're aligned.

We talked a good deal about how to have a common definition of discharge to the

community and how to measure this concept across settings, given the fact that the settings often do serve different populations in different environments, so we need to just be cognizant of that. And then also recognizing the great variability among markets and communities so that resources do vary and we need to take that into account.

And so I guess now it's time to turn to all of you and, you know, ask if there are measures in the development that we should be considering, and are on the MUC list, and that would close gaps in the key areas for us, the key leverage area, the key core concept areas, or the IMPACT Act domains. And then any thoughts you have about a recurring theme as we try to promote more partnerships with inpatient and outpatient settings, what can we do to also promote shared accountability, so thank you.

And thank you to the staff for pinch-hitting for me.

ACTING CO-CHAIR GESTEN: Thank you,

Carol, and thank you, Sarah. We had one question. I just want to make sure if there's a clarifying question from Rich Antonelli, we can get to that, and then I don't know if we're going to break for lunch next or not, but, Rich, did you have a question?

DR. ANTONELLI: Actually, yes, just two quick points. First of all, I just want to commend the team. That is really exciting work. Many of the points that you've raised are actively being discussed now in the care coordination standing committee, and so I think to ensure that there is alignment on these issues around getting to outcomes, but looking across those care teams is going to be essential.

You know, what our standing committee in care coordination, and Don Casey and Gerri Lamb are the co-chairs of that, you know, what we are looking for here is really a dearth of measures that have come forward, and I think some of that you raised in your approach to care planning. So here in my day job, medical

director integrated care, Boston Children's, we've backed away from having an uber-care plan.

But we've got work now around care planning and that enabled us to take a step away from attribution to a single entity and measuring with the patient in the middle around this notion of integration, so it's not so much a question, but really, it's an endorsement of this wonderful approach, and I think if we could cultivate the connection between the standing committee care coordination and the work that's being done here, it will really help us fill some of those gap areas.

WORKGROUP CO-CHAIR RAPHAEL: Well, Richard, Gerri Lamb sits on our workgroup, so she has been a source of really terrific information about the work that you're engaged in.

DR. ANTONELLI: Terrific. Well, thank you.

CO-CHAIR PINCUS: Are there other sort of general comments about the PAC/LTC Workgroup report, about the questions that Carol raised

that you want to bring up now, and so we're going to be discussing general issues right now, if people have them, and then we're going to take a break for lunch, and then we're going to come back and go over individual measures. So, Lisa?

MEMBER McGIFFERT: I had a question about the IMPACT Act. I'm not thoroughly knowledgeable about it, but I noticed that -- I'm wondering if someone can tell us, what -- did the IMPACT Act say you have to have measures about certain areas or is it -- do they specify measures? I noticed that some of the comments, for example --

WORKGROUP CO-CHAIR RAPHAEL: You know, I can start. It was specific about areas that needed to be measured, with dates of implementation. So, you know, the total estimated Medicare spend per beneficiary was explicitly mentioned as a measure, and it's supposed to be implemented in nursing homes in October 2016 and rehab facilities October 2016, et cetera.

There was also mention of measures having to do with discharge to community, all condition, risk adjusted, potentially preventable hospital readmission rates, function, and cognitive function, incidents of major falls, medication reconciliation, so those were all specified in the Act.

And I'll turn to the staff for, you know, amplifying that.

CO-CHAIR PINCUS: Kate, did you want to add to that?

DR. GOODRICH: Yes. It's mostly measure -- I think they call them domains, but some of them have some more specificity around what that means than others.

CO-CHAIR PINCUS: At some point we should talk about, you know, the language in terms of what's called domains versus core concepts versus subdomains versus measurement concepts. Gail?

MEMBER HUNT: Okay. All right. I just had a quick question about why this group

focused so much on bipolar and not other mental illness that could impact the measurement of long-term care quality? Does anybody know? I mean, that was just on the list.

DR. GOODRICH: So I don't know, maybe, Giff, you may know this better. I think the issue was around excluding patients who have bipolar disorder, but you can probably speak to it.

MEMBER HUNT: If I could just say, I understood the rationale for that, I was wondering why just people -- why not people with schizophrenia, for example?

MEMBER GIFFORD: Because the measure excludes schizophrenia, Tourette's, Huntington's. It does not exclude bipolar, which is an FDA-approved diagnosis, which has irked a few providers.

CO-CHAIR PINCUS: Are there other comments sort of on the general issues raised by the PAC/LTC Workgroup, either in the room or for MAP members online? Okay. So why don't we take

a break now for lunch? Let's come back at five after. Is that okay with everybody? So we can do this -- Amber, you're raising a question? No.

MS. O'ROURKE: Carol, thank you so much for stepping out of your meeting to join us. We really appreciate you providing the overview of the PAC meeting.

WORKGROUP CO-CHAIR RAPHAEL: Okay. Thanks, everyone. Bye-bye.

CO-CHAIR PINCUS: Okay, bye. And so we'll be coming back and going over the specific measures, those that have been pulled off of the consent calendar.

(Whereupon, the above-entitled matter went off the record at 12:43 p.m. and resumed at 1:10 p.m.)

CO-CHAIR PINCUS: So now we're going to get into the individual -- the discussion about individual measures that were pulled off of the consent calendar, and based upon our discussion earlier today, I'm going to ask each person who's pulled them off the consent calendar

to just let us know whether they would like to change it from being pulled off for a vote versus pulled off for just discussion, since we're going to include the content of the discussion in the recommendation to CMS.

So it would save a lot of time if it turned out that we -- you know, it wasn't really a re-voting that we needed to do, but rather simply augmenting the discussion and documenting it for CMS.

We're also going to ask whether it's okay to cluster together several different measures that are around the same measurement concept, but that are being applied to different settings. Let's get rid of those so we can sort of condense some of the discussion.

MEMBER GIFFORD: Can I pull one other measure just for discussion purposes?

CO-CHAIR PINCUS: What? I didn't hear.

MEMBER GIFFORD: Can I just pull one other measure for discussion purposes.

CO-CHAIR PINCUS: Yes, I was going to get to that.

MEMBER GIFFORD: Oh, okay. Sorry.

CO-CHAIR PINCUS: To see if there were other measures that people wanted to pull. And then after the discussion of each measure, there will be a response from --

MS. O'ROURKE: Well after the discussion of each measure, we'll look to the person who pulled the measure to say why they pulled the measure, so why you either want to discuss it further for the discussion-only measures or why you disagree with the workgroup's recommendation for the ones requiring a re-vote.

After that, for these we'll turn to our lead discussants Carol and Gail, and they'll share their perspective of -- the lead discussants are welcome to say if they agree with the workgroup's recommendation, they agree with the person who just identified it for a re-vote, or if they have a totally different opinion.

After that, we can open for workgroup

discussion on that measure.

CO-CHAIR PINCUS: Okay. Are there other members of the MAP, either in the room or online, that have additional measures they would like to pull off the consent calendar for discussion? David, you said you had one that you wanted to add for discussion?

MEMBER GIFFORD: Measure 462, the SNF discharge community measure.

CO-CHAIR PINCUS: For discussion, not for vote?

MEMBER GIFFORD: Correct.

CO-CHAIR PINCUS: Okay. Why don't we then proceed, first with 151048, skilled nursing facility, 30-day potentially preventable readmission measure. David, you pulled it off. Do you intend for it to be pulled off for a vote or for discussion?

MEMBER GIFFORD: Discussion.

CO-CHAIR PINCUS: Okay. Did you want to discuss that now?

MEMBER GIFFORD: May I?

CO-CHAIR PINCUS: What?

MEMBER GIFFORD: Yes, I would like to.

CO-CHAIR PINCUS: Okay.

MEMBER GIFFORD: I wasn't sure if that was a question or --

CO-CHAIR PINCUS: Well, the first question was whether it was for a vote or a discussion.

MEMBER GIFFORD: No, it's for a discussion. So the discussion point and the feedback on it is that this measure double counts with the other potentially preventable set of measures that were developed under the IMPACT Act. So the IMPACT Act, there's four sets of measures that we didn't pull, that measure readmissions during the 30-day window after discharge from a PAC provider.

That also developed a 30-day potentially preventable readmission measure during the PAC provider stay, so there's an IRF measure out there. I believe there's one that already exists for LTAC, so they're already out

there. This measure 1048, that we have before us, measures potentially preventable re-hospitalizations during a SNF stay and after the SNF stay if the SNF stay is less than 30 days.

And so it will double count readmissions during that time after discharge with the other measure that's potentially preventable. Now, while it's for a different program, the payment program does not -- other than it specifies in the Act, that they have to develop a potentially preventable measure. It does not say that it has to align with the hospitals, doesn't have to align with anything else.

The rationale that CMS has given in last year's rule, and again, was to try to coordinate care, which we support and agree with, and have supported a measure of re-hospitalization after discharge from SNFs, but now that there is a potentially preventable measure after SNFs, we think that this measure should just be during the SNF stay, otherwise

it's double counting for the other measure. That's the point.

CO-CHAIR PINCUS: So that's the kind of information you'd like to pass on to CMS.

MEMBER GIFFORD: Yes. We -- the recommendation would be to change the specifications measure to be just within stay to align with the IRF measure and align with the greater program of the other potentially preventable measures they have there.

CO-CHAIR PINCUS: Okay. So, Carole?

DR. FLAMM: Hi. This is Carole on the phone.

CO-CHAIR PINCUS: The workgroup discussant. Who were the workgroup discussants?

ACTING CO-CHAIR GESTEN: It was Gail or Carole.

DR. FLAMM: It's fine. I think you may be asking me to sort of chime in. This is Carole Flamm on the phone. I think there's been a lot of great discussion about the overall context of what these measures are trying to

accomplish in terms of creating accountability in the medical neighborhood, and that this isn't a very important area, just speaking from, you know, all the work that has been done around other settings of care and readmission, so I think this will face the same challenges of these are kind of complicated and difficult measures, but it doesn't mean we should let the perfect be the enemy of the good.

So just general support for the direction of this measure. I think the discussion around sorting out how this fits in with the suite of other measures focusing on readmission to sort of refine the signal that skilled nursing facilities are being asked to manage around makes a lot of sense.

So those are just some of the general comments that I would add, as well as, you know, kind of the challenge but the need to deliver the results around this measure in a way, hopefully, that can support both that broad accountability, but also the actionability of the information to

those that are trying to, you know, use the information internally.

CO-CHAIR PINCUS: Are there other comments about this measure? Kate?

DR. GOODRICH: I raised my hand with a full mouth. Sorry.

MEMBER GIFFORD: I would move to put it back on the consent calendar.

DR. GOODRICH: The only point I was going to make is for the program where this would affect payment, which would be the SNF VBP program, would only be using one measure at a time, so it wouldn't be double dinging in that way that we usually talk about it. I understand what you're saying about the overlap, but in terms of -- it wouldn't be, like, double dinging for payment. It would just be a single measure.

MEMBER GIFFORD: I'm assuming that's the language we'll see in the proposed rule.

CO-CHAIR PINCUS: Are there other comments about this measure. Okay. Let's move on to the --

MEMBER GIFFORD: Harold, then I want to make sure, I move to put it back on the consent calendar.

CO-CHAIR PINCUS: Okay. I don't think we have to move it, because it was taken off for discussion, but thank you.

MS. O'ROURKE: Jayne, you had also pulled the discharge to community measure. Did you have similar concerns, additional comments?

MS. CHAMBERS: No, I think what David commented on was the same concern that we had and so I'm fine with that. I appreciate the recognition.

CO-CHAIR PINCUS: Any further comments from the people on the phone? Okay. So let's move on to measure 15207, the fall risk composite measure, so Sam and Lisa both requested that be pulled off. Now, is that for discussion or for re-voting?

MEMBER McGIFFERT: Would you explain the difference? Voting would mean that we're trying to get it off and we want the group to

vote, discussion means we just want to discuss it.

CO-CHAIR PINCUS: Re-voting is if you want to change the recommendation.

MEMBER McGIFFERT: Okay.

CO-CHAIR PINCUS: For discussion is if you want to augment the content that goes back to CMS.

MEMBER McGIFFERT: Okay. I'm happy with discussing since we've been kind of told that's what matters.

CO-CHAIR PINCUS: Okay.

MEMBER McGIFFERT: Do you want me to go forward?

CO-CHAIR PINCUS: Sure.

MEMBER McGIFFERT: Okay. So no surprise that I pulled this one because it was a process measure. When I looked at -- I'm on the patient safety committee at NQF and I look back at some of the information and it indicated there was not a great evidence of the benefit of the measure. The measure includes three parts that

are outlined in the documents we got for this committee, and they appear to be -- well, the information I got for MAP was that the patient is assessed for falls, this was -- a risk was noted in the plan and the plan was implemented, but the actual measure, if it's the same measure that was NQF endorsed, has screening for future fall risk, risk assessment, and a plan of care.

It's just a percentage of who has a plan of care documented, not whether it was actually implemented. So I just -- one of the things that came up when I looked at this is it would be really helpful on the MAP discussions, if it was related to a specific NQF-endorsed item, that that was also on the chart somewhere, and maybe it was on one of the charts. I really like the way you guys have consolidated the information, it's very easy to see, but I mistook this for another measure at one point, and then I realized it was aligned with, I think, 0101.

So my concern is that this does not

actually measure whether these three steps make a difference or prevent falls, and that's what I'm interested in is, a measure of falls. So I would like to have that fourth element of this measure of how many falls the patient had, or counting the falls.

Now, I looked at the comments and someone else, I think Sam is going to talk after me, wanted to eliminate that third part, and I think that third part is pretty essential, that it's documented in the plan, but, you know, I want to see this go a little bit further in actually implementing the plan.

And so, you know, I really wanted to convey that information to CMS that I felt like it just didn't go far enough and there was a lot of discussion in the patient safety committee about these measures that just kind of go to the edge and then they don't really get us where we want to be, so hopefully we can get there eventually.

CO-CHAIR PINCUS: Sam, did you want to

make your comments as well? Is Sam on the line?

MS. BROWER: Hi. This is Emily Brower for AMGA. I told Sam I would chime in on this one.

CO-CHAIR PINCUS: Go ahead.

MS. BROWER: Okay. So I think that -- I mean just to follow up on the previous comment, we would -- I think we have a hypothesis, right, that if we measure for risk of falls and put in a plan, that will reduce falls. What I would ask, and what Sam and I had talked about from the medical group perspective, is just having -- since this was recommended for continued development, that in that continued development, have real specificity and clarity around what is evidence in a care plan and what is evidence that the care plan was implemented.

This is really from a process perspective, right, so that we're not having to do tremendous amount of chart reviews for all these measures, but that if there was -- if it's really clear around the specifications, then you

can do more automated pulls to be able to meet the measure, so it was really mostly a process comment asking for very clear specificity around what does it mean to say it's in the care plan and what does it mean to say it was implemented?

CO-CHAIR PINCUS: Okay. Are there other people who -- actually, Gail or Carole, do you want to respond on this measure?

MEMBER HUNT: Yes. I agree wholeheartedly with Lisa said. I think that without specifying and documenting implementation, and then finding out whether the person actually did fall afterwards, I think it's just a process measure, but an outcome measure would really be important to have.

CO-CHAIR PINCUS: Are there any other comments that people would --

DR. FLAMM: This is Carole, I would just add that this might be a situation where looking at the existing performance data, given that some of these measures have been in place, and kind of looking at where the real performance

gaps are, and is it towards that third element of the sequence that we've been talking about and trying to focus in on that as a composite measure might be able to bring a tighter focus into that. Would this be a helpful piece of understanding how a composite measure might perform?

CO-CHAIR PINCUS: Lisa?

MEMBER McGIFFERT: And I guess it would be helpful if I had one of my -- I had kind of a question about the description. Is this measure 0101? Is that what it is or no? It's something completely different.

CO-CHAIR PINCUS: No, it's 207.

MS. O'ROURKE: I think we've got Alan on the phone from CMS, if he's able to help, or Tara. Operator, could you ensure Alan Levitt and Tara McMullen have open lines?

OPERATOR: Their lines are open.

DR. LEVITT: Yes. Now, what's the question? It's Alan Levitt.

MS. O'ROURKE: If you could explain the relationship of the falls risk composite

that's on the MUC list to the current falls measures in the home health program. Is this a roll-up of the ones that we've currently got?

DR. LEVITT: Correct. It would be a roll-up of some of the existing items that are on OASIS into a composite of those different processes.

MEMBER DANFORTH: Hi, I'm sorry. This is Missy Danforth on the phone from Leapfrog. In the measure description it says that it is NQF 0101 and, Lisa, that is the measure that was recently re-endorsed by our committee in 2015. So is it not that measure? Someone referenced a different number, 207?

MS. O'ROURKE: I think that was just the MUC list versus the NQF-endorsed number.

CO-CHAIR PINCUS: I see.

MEMBER DANFORTH: Okay. So it is the NQF-endorsed 101, just to be clear.

CO-CHAIR PINCUS: David.

MEMBER GIFFORD: Last year, there was an outcome measure for home health that was

approved and I think it was in the -- it was in the home health proposed rule this year, wasn't it, Kate? I think it was 674.

DR. GOODRICH: Alan, can you comment on that?

DR. LEVITT: Well, there is an outcome measure for falls with major injury in the falls with major injury domain, which was one of the domains of the IMPACT Act, and that is a falls outcome measure that appears to be applied in all four settings, including home health.

CO-CHAIR PINCUS: Lisa.

MEMBER McGIFFERT: Yes, I think that the problem with that is that -- well, I should have it in front of me, but I think that major injury, some major injuries are excluded from this measure, so -- still, I think the point I want to make is that we need something that actually measures whether these three steps actually prevented falls and did they have an impact on the number of falls, whether they --

DR. LEVITT: Yes, this is Alan Levitt.

We agree. We at CMS agree and that's why we brought it to the workgroup to get the idea as to which way we should go in the development of this measure, and so we certainly have taken the feedback from the workgroup that they believe very much that any process measure that we would be developing should have some type of outcome associated with it.

CO-CHAIR PINCUS: Anyone else care to comment? Rhonda?

MEMBER ANDERSON: I agree that an outcome piece is important to this. I just want to make sure, as we look at the home health piece of it, especially that the socio-demographics are in that assessment as part of it because there's a whole other set of complications that -- and challenges that happen in the home setting, as we all know, so I don't want to forget that piece.

CO-CHAIR PINCUS: Okay. Any other comments on 15207?

MR. AMIN: Can I just clarify something? There is this question that arose

whether this is an NQF-endorsed measure, Lisa, that you asked. I'd actually look to the project workgroup team on this. The measure specifications and the literature review, the rationale provided by HHS, references NQF number 0537, it just references the literature view, but that's not --

MEMBER McGIFFERT: That's what sent me there, and that measure was put on reserve because it had topped out.

MR. AMIN: Right.

MEMBER McGIFFERT: So when I first pulled it, I thought it was that, and then when I was preparing my remarks, I realized it wasn't that.

MR. AMIN: Okay.

MEMBER McGIFFERT: It was this other one. So I think that references just that the literature is in that measure and not that it is the same measure.

MR. AMIN: Right. I just want to clarify that it is not currently an NQF-endorsed

measure.

MEMBER McGIFFERT: This one is, but 0537 --

DR. BURSTIN: This one is not.

MR. AMIN: The MUC ID Number 15207 does not appear to be an NQF-endorsed measure, so I would ask clarification from the project team who was working on this, this does not appear to be an NQF-endorsed --

MEMBER McGIFFERT: Well, maybe we should ask Missy where she found that reference to this is 0101, because I know that was approved by the patient safety committee. It could have been removed in the process before it got accepted.

MR. AMIN: Can you just clarify that?

MS. O'ROURKE: Sure. So from my understanding -- Alan or Sarah, please correct me if I'm wrong, this will be developed as a composite of a number of measures that are currently NQF-endorsed that are in the home health compare program. This is -- the composite

itself is not currently endorse as a freestanding NQF measure, that it's still undergoing development.

CO-CHAIR PINCUS: Okay.

DR. LEVITT: Right. This is a composite of existing measures.

CO-CHAIR PINCUS: Okay.

MEMBER McGIFFERT: 0101 is a composite.

DR. LEVITT: The composite has not been endorsed because we're still developing the measure.

DR. BURSTIN: 0101 is an NCQA measure, so it is not for home health. That is the issue.

CO-CHAIR PINCUS: It's also being applied in a different setting.

MEMBER McGIFFERT: The other one was not -- there's one for home health and there's one for -- I think there are two of them on this list for another setting. I'm trying to remember what it was.

MEMBER DANFORTH: Helen, to my

knowledge, NCQA stores a version of 0101 in PQRS. I'm not sure how that's related to this though.

DR. BURSTIN: And this measure is for the home health program. I suspect that's why it's under continued development, to modify it to meet home health needs.

CO-CHAIR PINCUS: David?

MEMBER GIFFORD: This sounds like it might meet the criteria for insufficient information of the three categories we have to vote on here. I mean, certainly, I think everyone would encourage further development, but if we had to classify it in the three categories of either encourage further development or, I forgot the middle, but don't develop at all, or no, what's the middle one?

Return with insufficient information, it sounds like this a measure that hasn't been even specified yet because it's a composite of three existing measures and they haven't figured out how to composite them together, which is a big deal, so I'm not certain how you comment on

that.

MEMBER McGIFFERT: So 0101 is an NCQA measure not a home health, so that's what you were saying, but it's the same elements, pretty much.

DR. BURSTIN: Correct. Yes. Just pulled up that one. Missy's right, it looks a whole lot like 0101.

CO-CHAIR PINCUS: So it sounds like we've discussed this, we've augmented the comments from the earlier workgroup, CMS has heard it, so is there any further discussion? Okay. Why don't we move on to Hospice and palliative care composite process measures.

MEMBER QASEEM: Harold, before we move on, David did ask that maybe we should re-vote on this. I think he's raising a valid point.

MEMBER GIFFORD: I'm not making that motion. I just raised it as a discussion. If someone else wants to raise it.

MEMBER QASEEM: Oh, you just raised it -- oh, okay.

MEMBER GIFFORD: It sounds, actually, like there may be enough with -- I don't know enough because I didn't delve into it, but there's was a lot of confusion, but it sounds like the NCQA measure is pretty well specified and they're just going to try to apply it to a different setting. That may be enough. It going to be semantics. It goes back to, Harold, you said earlier on, oh, well, if they specify the measure then it should go forward, well, what constitutes specifying a measure.

CO-CHAIR PINCUS: Right. So let's move on to the Hospice and palliative care composite process measure. And, Lisa, you pulled it?

MEMBER McGIFFERT: I did.

CO-CHAIR PINCUS: Is this for re-vote or for discussion?

MEMBER McGIFFERT: Discussion. So this can be short. My problem with this is it's a check-the-box process measure and even the workgroup noted that in its decision and we've

had a discussion about what encouraged continued development means, so that was really the reason I pulled it.

I just felt like the workgroup noted all of the things that were concerns with this, and yet, they still encourage continued development and I'll just leave our conversation earlier today standing, because this was one of the measures that was my concern, that, you know, what we really want is for this measure to become something else that addresses all the issues that were raised rather than continuing to develop it as is as a process measure, and so that was the reason I pulled it.

It doesn't really give us the kind of information we need. It just says, you did a certain thing that may or may not be connected with an outcome. We think it's connected to an outcome, but we don't really make that connection. That's it.

MEMBER BARTON: So this is Mary Barton. I guess I'm curious about this because

do they think a composite -- I mean, it's good to retire the other seven, how many measures in this, like, six or seven, so obviously, the burden, though, doesn't change if a facility still has to report each component of a composite, so I can understand you saying composite if the underlying measures were topped out, each of them, and you wanted to push further improvement if you had a clear-cut tie between evidence and the pieces of the composite, but if you don't, then I guess I would support Lisa's question about how is this really moving things forward.

CO-CHAIR PINCUS: Gail, Carole, you want to respond?

DR. FLAMM: No, I was going to say something similar to what Mary said, so I have nothing further to add. Thanks.

MEMBER HUNT: I don't either.

CO-CHAIR PINCUS: Okay. So, Lisa, do you feel that your comments are, you know, something that will be -- are you okay with

transmitting those comments to CMS sufficiently?

MEMBER McGIFFERT: Yes.

CO-CHAIR PINCUS: Okay. So let's move on to the next one, which is MUC 15236, application of IRF functional outcomes measures changes healthcare score for medical rehabilitation patients. And, Amir? And are you asking for a re-vote or for discussion?

MEMBER QASEEM: I'm not sure, and then the reason for that is, I think the workgroup recommendation is continue to develop, and I'll be honest with you, I'm not really clear on our wrap-up over this morning's discussion of what does that mean? I mean, are we going to stick to those categories or should we be saying that you need to get this measure right before bringing it back? That's why I'm not really sure if I'm asking for discussion or a re-vote.

CO-CHAIR PINCUS: So the assumptions we're working under is that recommending continued development is that we want to make sure that we have comments about that measure as

it's being developed, and that we're expecting that it will be brought back to us for further discussion in the future.

MEMBER QASEEM: But then it does not necessarily mean it will be brought back, right? It can --

CO-CHAIR PINCUS: It's --

DR. GOODRICH: That's what I was trying to say this morning. You're right. We don't have a requirement, statutorily, to bring it back, however, we are committed to doing that and developing a process by which we can bring back all these types of measures, ones under development and ones that have actually been implemented to talk about how they're performing, et cetera.

MEMBER QASEEM: Okay.

DR. GOODRICH: So we do plan to bring these back.

MEMBER QASEEM: And meanwhile, this can get implemented in any of the federal programs while this is under continued

development though, right?

DR. GOODRICH: They could. I think for this particular category of measures, part of it, that is going to depend on our statutory requirements related to the IMPACT Act, but they certainly could.

MEMBER QASEEM: So for this one, I can live with this discussion. How about that? I'll start out nice.

CO-CHAIR PINCUS: Okay. No pressure.

MEMBER QASEEM: And the reason is some of the things have already been discussed in the workgroup; the implementation issues, the variation of patients across various skilled nursing SNFs, and as well as I think that some patients are just not going to attain the significant improvement in self-care.

And I mean those issues that we just need to keep it in mind, but again, I think this is the one that is something that we've already discussed in the past as well, those concerns are still there, so hopefully the continued

development will take some of these issues into account.

WORKGROUP CO-CHAIR RAPHAEL: No, we did spend time at the workgroup discussing the importance of understanding that for much of this population the best we could attain is stabilization and prevention of decline and that you were not necessarily going to get improvement.

CO-CHAIR PINCUS: Other comments? David.

MEMBER GIFFORD: This is the one measure in particular I was raising about. There are other NQF-endorsed measures. Particularly as the IMPACT Act moves to requiring cross-setting measures between LTAC, IRF, SNF, and home health, there are a number of NQF-endorsed measures that were developed and designed for one of those settings that is potentially applicable, with some modifications, to go to other settings.

And what we saw last year, and again this year, is CMS has picked one from one setting

to then apply to the other settings without any discussion about whether there's value in using the other measures out there, so my feedback would be, this is where I think it's important to consider that discussion of it.

In particular --

CO-CHAIR PINCUS: You mean to discuss comparative advantages in the different areas.

MEMBER GIFFORD: You know, in essence, what you're going to is almost a best-in-class measure discussion now, which didn't occur before because you could easily say, I had a SNF measure, you had a IRF measure, no best-in-class discussion would occur. Two of the measures are approved. Now, with the IMPACT Act and the shift, they can pick one measure, then go forward, then there's no more discussion of best in class.

Whereas, before, there was a process at NQF for harmonizing measures that were similar across there. So I think that that's a point I wanted to make on the measure.

The second part of this measure's a little bit in the weeds is, this and the other NQF-endorsed measures are all out there, won't work as currently specified because CMS, last year, specified Section GG in all of our post-acute assessment tools, the IRF, probably the LTAC care, the MDS and the OASIS, as required under the IMPACT Act, but this was based off of the care tool that was designed and tested before they finalized what went into the IRF-PAI and into the MDS.

So you don't have all the elements to actually calculate this measure, so I mean, I certainly would agree with encourage continued development, they need to do a lot of continued development. And as far as, like, best in class, I'm not sure whether it really matters or not which one is out there.

I mean, having done a lot of work in this, and full disclosure, we have a measure that we put in on the SNF side, I'm not sure which one's better, because actually, I don't know

because none of them's actually been tested across settings and none of them have the data for across settings. I think there's benefits from all the measures.

The last point I'd like on the discussion side is, CMS has, on our MUC list, a self-care and a mobility improvement measure and a self-care and mobility discharge score measure. I would encourage them to go back and look at whether the relative ranking differ at all, because we actually developed the same measure, they're essentially correlated at, like, 0.98, they're the same measure, so I don't -- well, conceptually, they make a lot of difference.

It's one of those circumstances where we had a bunch of clinicians and experts around the room, we thought they were two different measures, and we worked with CMS on it, and everything else, and they correlate at 0.98, so I would encourage them to go back and look at whether they need to have both of those measures and pick one of them to use, because otherwise,

it's just two sets of measures that'll add confusion out there where there's no confusion, but it will be confusion when they correlate that high.

CO-CHAIR PINCUS: Good. Any other comments. I think this is a useful discussion. Jayne.

MS. CHAMBERS: And I agree with everything that Giff just said. The comment I'd like to make is that, as these measures are developed and before they actually get rolled out, we really need to test them in the multiple different settings, and that's more than, you know, testing in 25 locations. They need robust testing across the various settings to see how they really will work.

And it's a challenge that we find on the inpatient side when measures are rolled out without testing, but to the extent that we can include comments about having testing prior to making final decisions, I think it would be important. Thanks.

CO-CHAIR PINCUS: Well, thank you. I think that was a useful discussion. Anything further? Okay. Let's move on now. There's a group of measures that are all very similar, but in different settings; the drug regime review conducted with follow-up, and Lisa and David are the people who pulled it out. Two question, is this for vote or for discussion, and secondly, can we discuss these as a group?

MEMBER McGIFFERT: My comments are for discussion and I definitely would discuss it as a group because the comments are the same for each measure.

MEMBER GIFFORD: Mine are for a vote and I would discuss them as a group because the comments are the same across them. Because actually, what you're seeing with this IMPACT Act is the measures are almost identical across all the settings.

CO-CHAIR PINCUS: Okay. So this would be for a vote.

MEMBER GIFFORD: I would move for a

vote, yes.

CO-CHAIR PINCUS: Okay.

MEMBER GIFFORD: And my move would be to change the recommendation from encourage continued development to insufficient data.

CO-CHAIR PINCUS: Okay. So do you both want to sort of --

MEMBER GIFFORD: Well, yes, because I think I'm stuck within those three categories, because at the MAP workgroup we were told we couldn't switch -- if the CMS comes in and says the measure is under consideration, then you're stuck with those three categories, if they say it's done, you're stuck with the other three categories. You can't move between the two. That's not correct?

MR. AMIN: No, that's correct.

MEMBER GIFFORD: That's correct. So the only option to change vote right now are those three categories and I would go with insufficient information.

CO-CHAIR PINCUS: Can you say a little

bit more about your rationale?

MEMBER McGIFFERT: My rationale is pretty simple. Again, it's a process measure and my understanding is the IMPACT Act does require measures of medication reconciliation and this measure is not a reconciliation measure, it is, sort of, a review measure and there were a number of comments from the public that talked about this, and it seems to me that this needs to be reworked.

In the patient safety committee there was a lot of discussion about this type of measure that just says you did a review of the medications without the obvious result being the medications were corrected or they did match, or, you know, that kind of step is missing from this, and there was a lot of concern in the endorsement process on what we're actually measuring here.

So that's, really, the point, and I kind of said, the recommendation should be no, let's wait until we have a real reconciliation measure rather than continued development.

CO-CHAIR PINCUS: David?

MEMBER GIFFORD: I have a hard time deciding what to do. I mean, clearly, I think drug regimen review is important issue, patient safety needs to be done, would encourage further development on it, but given the sequence, and what that meeting is, and everything else, I think CMS is trying to meet the deadline on IMPACT Act, and the IMPACT Act is, Lisa was saying, specifies a medication reconciliation. It doesn't say anything about drug regimen review, so the Secretary can do any measure that she wants, so it certainly can fit under IMPACT Act.

And it's a good measure in that sense, but in rushing to do this, this measure is predicated on collecting information about drug regimen review from the post-acute assessment instruments, the LTAC CARE, IRF-PAI, MDS, and OASIS, on items that have not been specified yet at all, and have not been tested.

And CMS is, right now, trying to test

a post-acute instrument that they haven't yet designed in five SNFs, five home health, five IRF, and five LTAC, so it's really early in the development. And without knowing more about how all that performs and how -- you know, I don't have any idea about the information, I think this measure really is insufficient information to determine what's going on.

I mean, I think they should keep developing it, but it's too early to put into rule and I think it's insufficient information, so that's sort of the rationale. I mean, there's also other issues that there is, under the definition, a lot of things about clinical significance and how you assess medication appropriateness in the drug regimen review. That's just sort of generic, there's no guidance on it yet, and how that guidance is, I think, will dictate whether this is a valid and reliable measure or not.

And it also, some of the definitions that seem to be in the documents that CMS put out

potentially conflict with some of the requirements and conditions of participation in those settings as well, so I think for all those reasons, I would move that we -- that these comments be certainly transmitted and that it would be insufficient for us to make a recommendation at this point.

But in those comments, it's a reasonable measure to afford, but if they're trying to comply with the IMPACT Act, I think we'd rather see them put their energy first in the med reconciliation and then a drug regimen review measure.

CO-CHAIR PINCUS: What exactly is the difference between the two?

MEMBER GIFFORD: The drug regimen review measure looks to see whether the drugs an individual is on are appropriate dose, and drug, and class for the person, and again, something else, the med reconciliation, is really just reconciling -- as these poor, frail elderly are being shuttled through the healthcare system,

that at least they're getting the drugs they're supposed to be getting and they're not, sort of, aligning.

So you see a lot of duplicate drugs or, you know, a patient will come in and the discharge summary will say, this set of drugs, the home order will be this, the last order in the hospital will be this, and they don't -- just, how do you reconcile those drugs? That would be a drug reconciliation measure, where, a drug regimen measure, which they have here, goes the next level.

And again, I would encourage development, I think, as a geriatrician clinician, it's a good thing for them to work on. It's, are the drugs appropriate, so are they on a Beers criteria of drugs and they shouldn't be taking it or not, you know, there's a drug-drug interaction, so maybe all of Dave's drugs when he comes in are appropriate and there's no confusion, but three or four of the drugs I would not give to Dave as an elderly person.

That would be the drug regimen review measure, not a med reconciliation measure.

CO-CHAIR PINCUS: So Carole, Gail, do you want to respond?

DR. FLAMM: Oh, this is Carole, I would just, this is a great discussion, add that I think there is, kind of, insufficient information with where things are right now. And very important area, but, you know, being able to clearly define and work into the specifications what are potentially significant medication issues and the, sort of, clinical judgement aspects that come along with that are incredibly important to making this work from an implementation perspective, so I think I really agree with the thrust of the discussion so far.

CO-CHAIR PINCUS: Gail?

MEMBER HUNT: Yes, and I would just note that the MAP members, to highlight some of the things that the MAP members mentioned, and one is about if you're in home health that it's typically going to be the family caregiver that's

going to be responsible for bringing -- for maintaining and creating the medication list, and then being responsible for it, and some attention ought to be paid to the expectations of time and effort that that would take, along with the issue that I think has already been raised a little bit is, how do you ensure that the older person who's in these circumstances, particularly in home healthcare, is going to be understanding what he or she needs to understand to take these medications.

So it's one thing to have the physician say, well, you got the right meds, and, you know, you're supposed to be taking them now, but there are so many issues around the accuracy and ability of the older person to be able to implement that, and to what do we hold -- how much do we hold the physician, or pharmacist, or other members of the team responsible for how that works, and just checking the box that they've gotten the medication list is maybe not enough.

CO-CHAIR PINCUS: Kate and then Rhonda.

DR. GOODRICH: Oh, I'm going to start, but Alan also, on the phone, has -- because he knows this measure far better than I do, so I think the feedback we've been hearing has been really helpful, and I will, just as a general comment, say, already, from the feedback that we've gotten from the workgroups has already started to inform a lot of these -- you know, across all three workgroups, has actually started to inform how we move forward with some of these measures, so I just wanted to say that, and this has been helpful.

But I also wanted to -- because Alan is very close to the measure development, have him say a word or two about the med rec comments.

DR. LEVITT: Thank you, Kate, and thank you all for the discussion that you're giving here. This is, affectionately call, medication reconciliation on steroids. This is a measure that includes medication reconciliation

as part of it, but goes beyond that. It really goes beyond the fact that, as David was just saying, comparing to also looking for the potential adverse effects, and also, having contact that not only are these recognized, but that they need to be brought to the attention of the prescriber.

And this just doesn't get done one time during their episode of care, or hospitalization, but that this is something that is done throughout their episode. We feel that this does fall under the domain of medication reconciliation because that is part of this med. The three items that are being used are almost verbatim three items that are on the OASIS instrument already.

They've been collected on the OASIS, they were tested when they originally came out with the OASIS, and so these are items that have been used and have been used successfully in that setting without, you know, many issues going on in terms of the ability to collect these items.

What a reconciliation measure may look like 20 years from now, when we have electronic medical records across all settings versus what we're starting out with now, where we don't have anything in post-acute care settings, it'll be a lot different. Hopefully it'll be a lot different sooner than that, but we are under statutory guidelines in terms of applying measures within this domain.

These items have been used and tested within the home health setting, and therefore, we thought that this would be a great place to start. We appreciate the workgroup, the workgroup was wonderful in terms of their discussion, both involving this type of discussion and also some of the questions we brought to the workgroup, which were not the specification for the measure, but really, what type of guidance or guidelines do we really need to give with the measure, because the guidance has been general in the home health settings.

The home health community has not

asked for any real particular guidance in terms of, well, what medications are you specifically talking about, or whatever, because there are different sorts of guidelines that may be state guidelines, or there are types of guidelines we didn't know how specific the, really, entire public wanted us to be on this, and the workgroup recommended that we be more specific than we, you know, originally decided to do.

And we've taken that back with us, but the specifications are the same, the specifications are items that have been used in OASIS, they are being tested in the other three settings, and the analysis of that testing is going on right now, and this measure that we are very comfortable with that will meet the domain as Congress has asked to do for the IMPACT Act.

CO-CHAIR PINCUS: Thank you. So, Rhonda, you put yours down. David? Okay. Any other comments about this set of measures? So it's being pulled for a vote and so we need to initiate the voting process.

ACTING CO-CHAIR GESTEN: Let me just make sure, David, is it okay if these get voted, anybody object to voting as a block versus individually? Can't do it. So one at a time. Okay.

MS. O'ROURKE: We'll vote on --

MEMBER GIFFORD: I might recommend that we vote for one after the vote of one, depending on how that vote goes, we'll see what we can do with the others.

MS. O'ROURKE: I think with that, Shawn, could you run through the voting instructions for the committee?

MS. BITTORIE: Absolutely. So what we're going to do is put a sample slide on the screen, you'll be voting directly on the informational slide for each individual measure. Right now, on your screen, you should see a question with two answer choices below, yes or no, just simply click in the box next to the answer of your choice, this would be for voting members only, and the votes will calculate in

real time.

Right now, it looks like we have about 29 voting members on the call, and in the room. And if for any reason you have any trouble clicking in the boxes next to your choice, you can refresh your session by pressing F5 on your keyboard of Command-R for a Mac. Looks like we're at about 25 right now, 26, 27, one more, bingo. We're at 28.

And I'll turn it back to you Amber and Wunmi.

CO-CHAIR PINCUS: So what's next?

MS. O'ROURKE: One more point of order, for the Federal Government liaisons, just a reminder that you are excluded from the vote, so please don't cast one.

MS. STERLING: Okay. So your choices are encourage continued development, do not encourage continued development, or insufficient information, and this is for MUC 151127, 1128, 1129, and 1130.

CO-CHAIR PINCUS: Just check.

ACTING CO-CHAIR GESTEN: I appreciate there's no chads involved in this process. I just want to say that out loud.

CO-CHAIR PINCUS: So where are we?

DR. TAVALLAEE: We have 26 votes. We just need three more. We're good.

CO-CHAIR PINCUS: So it's 16, 3, and 8.

MS. O'ROURKE: And one vote, we're having some -- one person's having technical trouble, so it's actually 17, 3, and 9.

ACTING CO-CHAIR GESTEN: And passage is 60 percent, is that right; 60 percent of what number, of 29?

MS. O'ROURKE: Of 29.

CO-CHAIR PINCUS: So 15.

MS. O'ROURKE: Technically, we do not have consensus at this time.

MS. O'ROURKE: So counting in the one vote that was cast. Okay. So to clarify the process, Taroon was just whispering in my ear, we needed 60 percent to change a vote, so we will

default to the workgroup's recommendation, so if that changes your vote. So right now, the workgroup recommendation would stand because this vote would be if you want to change from the current one to insufficient information, so we need to cross a 60 percent threshold to get to a change vote.

DR. BAKER: So what happens to do not encourage continued development? I mean, are we only voting for insufficient versus encourage?

CO-CHAIR PINCUS: No, I think what we're saying is that, there would have to be a 60 percent of people would have to vote in something other than the workgroup's original vote.

DR. BAKER: Right. That was my point, so it shouldn't just be one category.

CO-CHAIR PINCUS: Yes.

MS. BITTORIE: Amber, Wunmi, as you come to the end of voting on a particular measure, the allowable timeframe for voting, if you uncheck the box at the bottom to allow voting, it will close the poll and freeze your

results.

CO-CHAIR PINCUS: So, David?

MEMBER GIFFORD: I move the other three measures go on to the consent calendar. We don't have to vote for them.

CO-CHAIR PINCUS: Okay. Thank you.

MEMBER QASEEM: So can I ask a clarification question?

CO-CHAIR PINCUS: Sure.

MEMBER QASEEM: So there are 27 people who are voting right now, out of which 17 have -- I'm still trying to figure out the percentages over here, because the 17 out of 27 -- oh, you can't see that?

(Off mic comments)

MS. ISIJOLA: So the official percentage is 60.7 percent encourage continued development, 10.7 percent do not encourage further development, and 32 percent insufficient information, so the measure remains its default decision.

CO-CHAIR PINCUS: Okay. Is that clear

to everybody? Everybody comfortable with this?

MEMBER QASEEM: Clear, yes, comfortable is a separate issue.

DR. BURSTIN: So your lack of comfort is the percentage who still disagree with the measure.

MEMBER QASEEM: Yes.

DR. BURSTIN: I think we should capture the discomfort.

MEMBER QASEEM: Ten people are against it, right, so it's significant, so 40 percent are almost saying no, so I think that just needs to be conveyed in some way or form so that that doesn't just disappear; that number.

CO-CHAIR PINCUS: Yes.

MEMBER QASEEM: It's not 90 versus 10 percent. You're looking at almost pretty close, because your number is like 57 or 60 percent? So you're right at the cusp of it too.

CO-CHAIR PINCUS: Well, no, but don't forget, it's 60 percent to overturn.

MEMBER QASEEM: Oh.

CO-CHAIR PINCUS: Okay. Because there already is kind of an existing vote by the workgroup, so that's why it's, you know, kind of like an overriding veto kind of thing.

MS. O'ROURKE: And we can capture all of the feedback we got through the discussion here and we can, in the comments --

CO-CHAIR PINCUS: Yes, I think it was a very rich discussion, I think, that went back and forth, and I think people got it. Okay? So we now have another cluster of measures that have to do with Medicare spending per beneficiary, again, in different settings. And, David, are you pulling this for discussion or for a vote?

MEMBER GIFFORD: Vote.

CO-CHAIR PINCUS: Okay. And is it okay that we discuss them all together?

MEMBER GIFFORD: Yes.

CO-CHAIR PINCUS: Okay. So you want to give your perspective?

MEMBER GIFFORD: I would recommend that we vote insufficient information. I knew

the last one was an uphill battle on it. I think this one's a little bit clearer. Again, I want to make sure our comments are construed with not -- we support the general idea of a Medicare spend per beneficiary, we supported the IMPACT Act, you know, we support the idea of having it.

As always, you know, the devil's in the details. This measure, of all the measures that CMS has been working, has been the slowest one to come out from them, and the actual specifications in this measure were not sent out for CMS public comment until two weeks ago with the deadline for comment tomorrow at midnight after the MAP.

And so while there was a numerator/denominator definition in the information provided to the workgroup, none of the details behind any of it were provided to anyone, including the TEP that was out there. There's been a lot of disagreement by the TEP in the TEP report that CMS released just last week that have not been incorporated into the measure.

The measures, in particular, out the IMPACT Act, were to collect information for cost per beneficiary across providers for allowing comparison across providers. As specified in the specifications CMS just put out, these are with in-provider measures that they've developed. It does not allow cross-provider comparisons because they double count across providers. They do not double count with in-providers.

The other thing is that the measures have different timeframes for LTAC and SNF based on however long someone is in there, so the measure, essentially, the new specification they just put out, is the costs that occur from admission to a PAC provider, through discharge, and then 30 days after, except for home health, they're in 60-day fixed intervals, because of the way the payment issue is.

So there's different timeframes on that issue that goes out there. There's some other details about the measures that just have come out that we're still trying to wade through

on the measure issue, but I would say that what's been put before the workgroup and what's been put before us really is insufficient and the comment period hasn't even closed, so we don't know what the final specifications are.

A lot of discussion about whether this matches up the IMPACT Act or not. I think that's a semantic argument, and as you've heard, basically, CMS can do -- the Secretary can do whatever they want, because there's a close in there they can do whatever they want, so I think it fits, certainly, within that, but there are a lot of members.

I would say, since I am supposed to be an organizational member, Helen reminded me at the beginning, I did reach out. This is a position, I believe, of the home health associations I've talked to and the other nursing home associations, I've not been able to talk to the hospital associations, or a representative of IRF and LTAC on these block of measures, but we had all recommend that it be re-voted as

insufficient information.

Then I have a more general comment about risk adjustment that at some point I want to talk about all the claims measures, the potentially preventable discharge to community, and this -- that sort of cut across all of them as well. I'll bring it up now.

All the risk adjustments and all the claims measures are only claim based. In the IMPACT Act it talks about needing to align claims with the post-acute assessment instruments and the IMPACT Act requires, sort of, standardizing some of those assessments. We know that in discharge to community, re-hospitalization, and cost, the major drivers are functional status.

And functional status, you can't get from claims. Functional status is available on all the PAC instruments. You can easily link the PAC instruments to claims and do that in the risk assessment. And so we would strongly urge CMS to incorporate some of the functional status measures, cognitive status, and functional in

particular, but others, from the post-acute assessment instruments into the risk adjustment models.

And when you do that, the risk adjustment models become much more robust and much better. And so the measure that this is modeled after, the hospital cost per beneficiary measure, has been criticized for this as well, and that doesn't have functional status in it. And so I think when you add that in, it helps there, so this is why we'd argue for insufficient information at this time.

CO-CHAIR PINCUS: Gail, do you want to respond?

DR. FLAMM: This is Carole. I'll just add to the discussion. You know, this is an incredibly important area of focus. To make interpretation of these results meaningful, it feels very important to have some level of risk adjustment, risk stratification, you know, all of the kind of discussion that just went before me, so I do think that those components of the

methodology are incredibly important to sort of start to get clear as we head down this journey.

CO-CHAIR PINCUS: Gail, did you --

MEMBER HUNT: Yes. I just think I would definitely agree. I was concerned about this ability to compare across providers, which clearly is an important element and one that I don't think we're ready to have yet, and also, with regard to the home health quality reporting, I think that the issue raised by the MAP members that this could put a huge responsibility and additional burden on the family caregiver is really an important one that I hope CMS would take very seriously.

CO-CHAIR PINCUS: Jayne, I see you have your card up.

MS. CHAMBERS: I thank everyone for their comments as well and we, speaking from the hospital perspective, do have concerns about how this is going to go forward. We don't think it has appropriate risk adjustment at this point. There isn't enough specification in what we've

seen so far to be able to help us understand how the measure is going to work across settings.

I was in lengthy conversations this morning with some of our LTAC members who were trying to figure out how to respond to the comments because they keep saying, we don't have enough information. We don't really know how the measure's going to work because there's not enough detail in here for us to understand it. So I think at this point we would vote for insufficient information.

CO-CHAIR PINCUS: Are there other comments either in the room or on the phone.

ACTING CO-CHAIR GESTEN: Frank has one. Frank, on the phone.

MEMBER OPELKA: Yes. Thank you. I guess I'm a little bit confused about my options here. I hear that there's a lot of discussion about whether or not you have all the bits and pieces ready to go with this measure, and I don't disagree with what people are saying. When I looked at my options as I encourage continued

development, I don't encourage continued development, or I have insufficient information to decide whether to encourage or not encourage.

And I think we have to have these cost measures and therefore, to me, if you either encourage or don't encourage, you can always make the argument there's insufficient, but what is it insufficient for? Is it insufficient to encourage or not encourage? Do you have enough to make the decision?

To me, what I'm hearing everyone say is, we need to have this measure, but it's not ready yet. And if that is indeed the case, I'm encouraged to continue development, realizing risk adjustment deficiencies and other points that everyone has made. I'm not hearing that I have insufficient information to either encourage or not encourage.

CO-CHAIR PINCUS: So, Kate, can you help us out of this epistemologic dilemma?

DR. GOODRICH: I appreciate all the comments and, Frank, I think your clarification

of what insufficient information means is helpful. Just a couple of responses to a couple of the issues. First of all, as I'm listening to all of you what I'm hearing in the details of the comments is actually the most helpful piece, not so much the adjudication of whether we encourage or not, although that is important.

Two things on sort of the issue that does come up a lot around, sort of, the, you know, overlap, or double dinging, or whatever you want to call it, I mean, this is a situation where you have, you know, the goal is a standardized measure across all of these settings that patients transfer back and forth from all the time.

So it is actually, an alternative viewpoint might be that it's actually appropriate that you have some overlap in measuring of costs between the SNF and the home health agency, who are both responsible for certain aspects of that care, and that was something that I know has been discussed a lot in the development of this

measure, so just wanted to offer that up as well.

On the risk adjustment piece, you know, that's also come up quite a bit about the functional status being such an important predictor of a lot of different things. And as we have done with our other risk adjusted outcome measures, as we get more input and have more data, so what the law requires is that we may include standardized data in addition to claims when we have that standardized data that we could include, and do all the testing, and all those things we need to do, I think we can do that.

So just as a point of saying that for these risk-adjusted outcome measures, as with lots of other measures, they go through evolution over time as we learn and as we get better data, and I would anticipate that the same would be the case here.

CO-CHAIR PINCUS: Other comments, again, in the room or on the phone?

MEMBER GIFFORD: Since Kate opened the door for more comments on the details issue and

appreciates it, while the measure description here talks about the national median, which is appropriate, given the skewness of the data, cost data, the numerator and denominator definitions for the ratio that's multiplied by the national median is averages, and I would encourage them to at least go back and look at that. And actually, some of it actually uses averages and medians, so I'm not sure why they keep flipping between averages and medians.

And I haven't been able to delve through the details enough to understand that issue, but I think it makes more sense to probably be consistent with medians throughout than to switch between averages back and forth.

I think the other is that, you know, in the lexicon of NQF and CMS' guidance, efficiency measures really are a combination of resource and outcome. This is not an efficiency measure, though it claims to be an efficiency measure, because it just measures resource and cost, and so I would encourage CMS to be a little

bit more judicious in defining the difference between efficiency and a resource measure that goes on out there.

And I would concur with Kate that it's important to have measures across and count costs across settings, and encourage that coordination, and I think this doesn't do that the way this measure is constructed out there. And I appreciate the earlier comment, I do think that they need to keep developing a cost measure, but what we have before us, if anything, I would actually want to say they should not continue with this measure. They should start with another measure.

And if you look at the TEP comments, the TEP had a lot of comments and concerns with this measure as well. So I think a compromise, I sort of split the baby, I think this goes back to our earlier discussion in the morning, what does it mean to be encourage development? I mean, I think all of us would agree a Medicare spend per beneficiary is a good thing that we'd encourage

development, but it really is then what the measure is in front of us that we're needing to pay attention to.

And I just think that there's insufficient information to determine whether they should continue this measure or not. If we're voting that they should just continue any measure with Medicare spend per beneficiary, then I'd say the process really is not doing -- we're not meeting our statutory requirement and giving good feedback and voting on that, because it's really about the measure in front of us.

CO-CHAIR PINCUS: Thank you. Last chance. Any other comments? Okay. Why don't we proceed to vote.

MS. STERLING: Are we voting on all of these as a group?

CO-CHAIR PINCUS: Yes. Is that okay with David?

MEMBER GIFFORD: I don't know if the -- I'll defer to Erin and I wouldn't encourage people to vote one way just because they don't

want to vote and go through the process, but I suspect if we -- if the first measure of votes does not achieve the 60 percent threshold to continue with it, then I think we have to vote on each of the four measures, is that right? I mean, I'm okay with doing it as a group.

CO-CHAIR PINCUS: Everyone okay to vote as a group? Is it Kosher?

MEMBER GIFFORD: Yes, I'm okay with doing it as a group. Okay.

CO-CHAIR PINCUS: Okay.

MEMBER GIFFORD: Yes, I don't want to make us do more work.

CO-CHAIR PINCUS: Okay.

MS. STERLING: Okay. So this vote is going to be for the Medicare spending per beneficiary post-acute care, while it's going to be for MUC1134, MUC287, 289, and 291. Your options are going to be encourage continued development, do not encourage continued development, or insufficient information, and you can now vote.

So the official breakdown is 57.1 percent encourage continued development, 17.8 percent do not encourage continued development, and 25 percent insufficient information, which means we did not get to the required threshold.

CO-CHAIR PINCUS: There's not enough to overturn.

MR. AMIN: And so the recommendation remains encourage continued development.

CO-CHAIR PINCUS: With lots of comments. Yes.

MEMBER GIFFORD: I guess I'm confused. I think the last time -- I thought the threshold was 60 percent for --

CO-CHAIR PINCUS: 60 percent to change.

MEMBER GIFFORD: Oh.

CO-CHAIR PINCUS: Okay. So we have three more measures to go over under the PAC/LTC. So, Jayne, there's two measures that have to do with discharge to community post-acute care that you took off for discussion.

MS. CHAMBERS: Right. And I think most of that discussion also was around being sure that these measures are appropriately risk adjusted. We want to be sure they take account of demographic, socio-demographic, status that we felt that we needed additional information to understand better what was going on. We not opposed with them going forward for additional discussion, we just think it's important that the report provide feedback to CMS that they need to --

CO-CHAIR PINCUS: By the way, do you have your --

MS. CHAMBERS: Sorry.

CO-CHAIR PINCUS: If you could speak into the mic.

MS. CHAMBERS: Sorry. So we're not opposed to going forward with continued development of these, which is what I think the recommendation is right now. Our concern is that there be appropriate risk adjustment of the measures as they go forward and that CMS further

look at the socio-demographic adjustment and what's going on when you discharge to a community, where things are headed, so that was our concern we wanted to be sure was brought out for discussion.

CO-CHAIR PINCUS: Are there other comments either in the room or -- well, actually, first, are there any comments from Carole or Gail?

DR. FLAMM: This is Carole, I would just add, in thinking about, kind of, the risk adjustment or stratification, possibly considering, you know, sort of, where the patient came from in the pre-acute care setting as part of maybe a stratification approach, or something, in terms of the success of discharging to the community.

CO-CHAIR PINCUS: Kevin?

DR. LARSEN: A question, are you thinking of risk adjustment by the patient, or by the community, or both? So do you risk adjust that this is a community that's difficult to get

services in or is it because the patient doesn't have resources or something specific to the individual?

MS. CHAMBERS: Sorry, Kevin, I was trying to figure out where I was in the electronic version.

DR. LARSEN: I was just asking if your thinking of risk adjustment at the patient level of socio-economic status at the community level, if the community one that has less resources than another community, or are you doing both risk adjustment by the patient and by the community?

MS. CHAMBERS: I think we need to do risk adjustment both by the patient and by the community, and also the setting from which they're coming. I mean, I think it makes a difference where they have been and where they're going, and so it's both the patient and the community.

CO-CHAIR PINCUS: David?

MEMBER GIFFORD: So a couple comments. One, CMS should think about, right now, if

there's a re-hospitalization and a 30-day window after discharge, they don't count, which we support. We would encourage them to maybe add admitting to a SNF in that 30-day window as not counting either as successful discharge.

The others, to pile on to the risk adjustment, I just want to make sure the comment on functional status really is critical here. Probably the strongest predictor is your mobility, overall ADL function, to being able to go home and live independently, to need to be able to do that.

Secondly, on the -- sorry. Oh, the other issue is that -- and I've seen different versions of this measure, so I'm not sure, I just want to make sure it's on the record -- individuals who are residing in a skilled nursing facility as their permanent residence, go to the hospital, then go to LTAC, IRF, or SNF, their discharge is back to a SNF. They should be excluded from this measure because it's not reasonable to expect them to be going back to the

community at that point.

I've seen different versions where CMS has excluded and has not excluded them with that measure.

CO-CHAIR PINCUS: Any other comments either on the phone or in the room? Okay. Now, David, you also added 462 as something for discussion?

MEMBER GIFFORD: Bundle them all. I mean, I think the comments are all bundled together. All the comments that were made on the previous two are applicable to 462.

CO-CHAIR PINCUS: Okay. Good. So any further discussion about any of the recommendations around the post-acute care, long-term care workgroup? So, Rhonda?

MEMBER ANDERSON: I just wanted to add that I think we had said before, and I'd like to underscore it, because I didn't hear it now, that we'd like to see these tested as they proceed, and then be able to go forward with potential implementation, so I don't want to lose that

comment that was mentioned before.

MEMBER GIFFORD: And can I have my comment of moving towards a measure that's all payer not just fee-for-service for this as well, especially since they all have PAC assessment instruments.

CO-CHAIR PINCUS: Okay. So the question has come up, we're about to move to the clinician workgroup report, do people feel the need for a break or should we plow ahead? Plow ahead?

PARTICIPANT: Let's plow.

CO-CHAIR PINCUS: Okay. Foster?

ACTING CO-CHAIR GESTEN: So thanks. I think we're going to start by opening up for public comment, both in the room and then sequentially on the phone. And the public comment that we're inviting is for any issues or comments around the clinician measures and the program, and what we're going to be talking about shortly. So why don't we start with the room. Is there anyone in the room that wants to make a

comment, and if so, come up to the mic and introduce yourself.

MS. LEE: Theresa Lee with the Alliance for Home Health Quality and Innovation, and I want to thank this group for the time and energy it takes to look at so many different measures that are of critical importance to healthcare. I just wanted to express overall, you know, alignment with Dr. Gifford's concerns and also Jayne Chambers' concerns about some of the IMPACT Act measures.

I think that, you know, we all understand that CMS is under tremendous pressure because of legislative timeframes to pursue measures in the domains that are in the IMPACT Act. I think that we continue to be concerned about the speed that this is going forward at. We're supportive of pursuit of these measures. In the home health setting, we recognize that these are very important domains, but we also want to make sure that there is appropriate and adequate time for testing, validation, that

things like risk adjustment are addressed very appropriately because -- particularly for some of the ones that involve things like discharge to community, MSPB -- these are really critically important to make sure that we don't provide incentives that could really harm patients.

And finally, that kind of testing and validation, afterwards, it really should follow with reporting only to provider communities for at least a year so that everybody has -- all the providers have a chance to make sure that it's looking right before anything is made public. I think that's critically important because we want to make sure that we don't release misleading information to the public and do harm when we're really intending to do good, so thank you very much.

ACTING CO-CHAIR GESTEN: Great. Thank you. Any other public comments for the room. Operator, if you can review instructions for folks on the phone if people want to make public comments, again, about the clinician programs,

which we're about to, and clinician measures, talk about?

OPERATOR: Yes, sir. At this time, if you would like to make a comment, please press star, then the number 1. Okay. You do have a public comment from Sandra Robinson.

ACTING CO-CHAIR GESTEN: Go ahead, Sandra.

MS. ROBINSON: Yes, hi. I, too, would like to thank you. I've been listening in on the discussion and the shear breadth of issues that you all are dealing with is astounding, so thank you very much for your time and attention. I wanted to make a comment in support of the non-melanoma skin cancer biopsy reporting time measure.

Just a little context on these measures, they're submitted by the American Academy of Dermatology; the majority of skin biopsies are to evaluate skin cancer, and basal cell carcinoma and squamous cell carcinoma are the most common kinds of skin cancer. We

submitted two measures, one was a measure about reporting time from the clinician, reporting results to the patient.

The one that's on your agenda here is MUC216, which is reporting from the pathologist to the clinician. These measures fulfill gap areas in that there are few measures about skin cancer and there are very few measures for a pathologist to report.

In the workgroup discussion and I'm sure you're going to be talking about this, Dr. Bagley, there was quite a lot of discussion about general measures versus measures for specialty care. We think that's an incredibly important discussion that deserves a deeper dialog between CMS, the medical specialty societies, and MAP, so I'm looking forward to hearing what you all say about that.

But in essence, the Academy believes there are instances where you should have specialized measures and that this measure of the reporting time for non-melanoma skin cancer

biopsies, be careful of that, where they looked at the usual kinds of tests that are required, and the timing of the measures to accommodate that, so I look forward to hearing your discussion and encourage your support.

ACTING CO-CHAIR GESTEN: Great. Thank you. Operator, any other questions or comments from the public?

OPERATOR: There are no comments at this time.

ACTING CO-CHAIR GESTEN: Great. Thank you. Well, before I turn things over to the clinician program chair and staff, I just first want to acknowledge the group and the work that they've done over this interval and to bring forward recommendations, and Bruce Bagley and Eric Whitacre, who are the workgroup co-chairs, and Reva Winkler and Andrew Lyzenga from NQF, who are the staff.

So we've been through this once, we've been through the drill once, so now we saw one, we're going to do one, we're going to teach one

after, so you kind of get a sense of what the drill's going to be. There's going to be a set of slides that go over some of the general themes and issues that came up in the clinician program group, which Bruce and Eric will take us through.

And then following that, we have a list of, currently, nine, but we'll open it up if there are any other measures that folks that are part of the coordinating committee want to pull for discussion or vote, and we'll go through the same sort of process and ask the same questions, beginning with whether based on the conversation we had earlier whether the measure's for vote, we still want to vote or discuss, and if we want to vote, and we'll go through the same process that we just went through, which I think went reasonably well.

So why don't I turn things over to Bruce or Eric.

WORKING GROUP CO-CHAIR BAGLEY: Well, good afternoon, this is Bruce Bagley, just to say hello, and then have Eric say hello, and I think

Reva's going to lead off our presentation, and we'll be working through it together.

WORKGROUP CO-CHAIR WHITACRE: This is Eric Whitacre. Thank you very much for the opportunity.

MS. WINKLER: Okay. Thanks to Bruce and Eric. This is Reva. We want to present to you the discussion of the measures from the clinician workgroup. I think we can move ahead a couple of slides. The clinician workgroup looked at two programs this year. And most importantly, was the new program that -- the merit-based incentive payment programs -- or MIPS -- that was created as part of the MACRA legislation last year.

This new program combines parts of the existing quality programs for clinicians and aligns them into a single program that will be used to adjust physician payment. There are already almost 300 measures in the clinician measure set currently in use in federal programs. And CMS has indicated they will draw from that

existing list for the quality portion of MIPS.

And so the measures on the consideration list this year were for measures that are for MIPS because they will go into data collection a couple years before MIPS actually comes online as the formal program in 2019.

And so there were 58 measures reviewed for this MIPS program. Notably, only four of the measures were fully developed. And so the issues around measures under development was prominent and overarching for the clinician workgroup looking at measures for this program.

Now, most of the measures were focused on specialty areas that currently have few measures available for reporting. They have been submitted by medical specialty societies, generally, using registries that are developed or being developed, in often very narrow areas. We saw measures in dermatology, eye care, interventional radiology, gastroenterology, urogynecology, genetic gynecologic oncology, and so you can see that they tended to be very

specialized to fill gaps in the clinician measure set for these specialists that really don't have many measures.

Next slide, please. The other program that the clinician workgroup addressed is the Medicare shared savings program. And this is a program that's been around for a few years that facilitates coordination and cooperation among providers that are in an ACO. And so there is a strong relationship between clinicians working in ACOs with other physicians.

And so the desire to align the measures from the clinician work measure set for the Medicare shared savings program is important. So only five measures were reviewed for the MSSP this year. There were, of the five, two of the measures -- one for falls and advanced care plans -- are already in the existing clinician measure set, are now just under consideration for MSSP.

The other three are composite measures -- one an all or none composite for cardiovascular care, and two composite measures

for the PQIs --- are on the list for consideration for both the MIPS program and MSSP.

So that alignment for the clinician measures has really advanced quite considerably, particularly with the consolidation of the clinician programs into the one.

So with that introduction to the programs, I'm going to turn it over to Bruce and Eric to discuss the issues that were overarching and strategic for the clinician workgroup. Next slide, please.

WORKING GROUP CO-CHAIR BAGLEY: Okay. This is Bruce Bagley and as Reva just outlined, of course, the MIPS program, the goal, of course, is to combine and integrate and align quality measures into a unified program linking quality to payment levels. And as you're aware, the timeline is that the measures will be finalized by the end of this year, beginning in January 2017, data will be collected, and then that data will be analyzed to determine payment levels beginning January 1st of 2019. Most of you are

fully aware of that program.

At this point, we do want to thank, the clinician workgroup would like to thank, Kate Goodrich and her staff for their active participation and guidance throughout our deliberation. So it was very helpful to have them clarify many of the issues around this new program. Can I have the next slide, please?

So Reva also mentioned some of the challenges that we had to deal with because many of the measures were under development, therefore, not completely specified in some cases, and really had not been tried or tested, at least we didn't have information about that. And I think although measure developers were invited to attend the meeting or be available by phone, very few were actually available for real-time Q&A during our deliberations.

There were times when the technical details or the clinical implications of a particular measure were unclear and having developer input would have been very helpful.

More often, the MAP did not have good information about the real gap in care or opportunity for improvement, which made it difficult to weigh the impact of a measure on the quality or its effectiveness in driving systematic improvement.

So some of the measures were also -- the measures under consideration seemed to be about compliance with accepted guidelines or standardized treatment protocols. Others outlined an expected outcome from a procedure with no data about how often that outcome is currently achieved, so it seemed like these measures didn't appear to have a lot of impact because of that.

And then finally, the workgroup suggested as we continue the development process, we continue to push for patient-oriented outcome measures and composite measures that are more likely to drive systematic improvement at the point of care.

Can I have the next slide, please? This probably, this slide, brings up a much

larger issue and that is, the need for eligible providers to have NQF-endorsed or CMS-approved measures as "a condition for participation" in a CMS MIPS program has generated a plethora of narrowly-focused, mostly process-oriented measures that are unlikely to have broad impact on patients, or for that matter, on population.

So I think that that's something that we're going to have to struggle with in the future, and you'll see it reflected in some of our questions at the end of our presentation.

The other thing is that there seems to be a little bit of a disconnect between the national quality strategy six priorities, which, by the way, are very patient-centric. And the long list of provider-centric measures that we have under consideration, again, a much bigger issue than we have time to resolve this afternoon, but it continues to be an issue about how effective the measures that we endorse or approve will be in the improving quality.

So can I have the next slide, please,

and I think this is where Eric will talk about some of the specific discussions that we had.

WORKGROUP CO-CHAIR WHITACRE: Thank you, Bruce, and again, thank you for the opportunity to present. I'd like to take just a couple minutes to go over some of the more important or salient discussions we had centered around only a handful of measures on the MUC list. The first, and this was quite remarkable, had to do with non-recommended PSA screening.

In 2012, the USPSTF gave routine PSA screening as a screen for prostate cancer a Grade D recommendation. Any measure development was on the MUC list and met with just a firestorm of controversial comment and criticism. This came from multiple professional organizations and major cancer centers, and for that reason, despite, perhaps, the science -- and as a breast surgeon, I was reminded of recommendations concerning screening mammography -- we felt that the measure would not be effectively implemented, and therefore, didn't encourage further

development of this measure in its current form.

Perhaps over time, phrased differently or with appropriate risk adjustment, it could be brought back and would be more acceptable just as the mammography guidelines were a couple years later.

And the other extreme was the measure concerning potential opioid overuse. Everyone recognizes this as a serious public health problem that needs to be addressed. This has to do with the number of patients who receive more than 90 days of a 90 milligram equivalent of morphine.

The time period was thought to be important in order to take the post-operative recovery and patient out of that window, but there were concerns about the actual dosage, and this was raised by a number of members, and there was a concern from palliative care organizations during the comment period that the measure could limit appropriate end of care and palliative use, although very honestly, that is listed as an

exemption from the measure, so it would not apply.

Here again, we continued -- encourage, rather, continued development, although that was with a sense that this is really, really important and should be done. Could I have the next slide, please?

The next set of measures have to do with the potential quality indicator composites, and these were an issue -- and I'll jump down to the bottom part of the slide because these were originally developed by AHRQ for population-based measurement. And the question was whether these would be appropriate for ACOs and the Medicare shared savings program or for clinicians because these measures were being considered for both shared savings and MIPS.

And there were questions of appropriate attribution, weighting, risk assessment, socio-demographic factors, in particular, and going back to the top of the slide, there was some concern that the acute

conditions -- and just as a reminder, these concern bacterial pneumonia, dehydration, and UTI -- would lead to inappropriate use of antibiotics in order to avoid potentially being dinged for such an admission.

At the other end, the chronic conditions, which were largely complications of diabetes, COPD, asthma, and angina, would be tremendously affected by socio-demographic factors. Still, it was pointed out to us that some of these components are already in use at the clinician level. Several of these measures are being used in calculating the quality resource utilization reports -- the QRURs -- which lead directly into the value-based payment modifier.

So they're effectively being used at that level, but the workgroup felt that it was important to feel confident that population-based measures were being appropriately applied at the ACO and clinician level. Could I have the next slide, please?

The next two measures were important because one is already an NQF-endorsed measure, and that is the proportion of patients who died from cancer who were admitted to Hospice, but stayed there for less than three days. This was widely supported. The discussion here was whether or not the three-day window was appropriate, and interestingly, that discussion actually took place during the NQF endorsement and assessment.

Because this is being reviewed in the upcoming cancer project, the workgroup decided to effectively take the recommendation of the NQF review as the recommendation, although this measure was effectively supported as is. A similar condition existed for one of the vascular all-or-none outcome measures.

It seems that the NQF already has an optimal vascular care measure, which is currently undergoing review as well. The MUC measure for ischemic vascular disease all-or-none outcome was very, very similar to the existing NQF measure,

and the workgroup felt that it would be best to let the NQF make the comparison and choose the better of the two measures, with the caveat that it was extremely important to implement a composite measure.

There was a strong feeling that while it's possible to achieve optimal outcomes on one component of this composite measure, it was very important to bring the totality together, and that one of the two measures should be endorsed. Could I have the next slide, please?

Lastly, during this year's clinician workgroup meeting, we were asked to assess the presentation of public reporting information, understanding that all PTRS, MIPS, and shared savings measures are available somewhere for public reporting because Physician Compare is ramping up and there is an opportunity to make some of this information very visible when the patients and other users click on the pages.

We were asked to give some direction as to what should be prominently displayed and

readily accessible on the physician compare site compared to information that would be available in downloadable documents. And during the course of the meeting, the workgroup adhered to the principles which had previously been outlined for assessing measures for Physician Compare, and that included measures which were based on outcomes, patient-reported outcomes, composites, appropriateness, measures that were readily understood by the public, but there was a discussion which did clearly emphasize that there are times when very detailed, specific information would be of value to the user.

And this had to do with some very specific, say, ophthalmology outcomes, we discussed during the meeting some very detailed specialty specific information, and this is something that came home to me recently when a family member needed surgery for a cholesteatoma. I needed to know, what's the facial nerve, you know, outcome result? What's the result in terms of hearing and so forth?

So balancing the information displayed publicly, and yet, making the other information, essentially, readily available was also thought to be important. And I think at this point, Bruce or Reva, we're going back to a general overview?

ACTING CO-CHAIR GESTEN: The slide is regarding dual-eligible beneficiary input. Is there somebody who's going to --

MS. O'ROURKE: Yes, Debjani, are you --

MS. MUKHERJEE: Yes, can you hear me?

ACTING CO-CHAIR GESTEN: Yes. Go ahead.

MS. MUKHERJEE: This is Debjani Mukherjee. I'm the senior director for the dual-eligible beneficiaries workgroup and we thank the committee for being able to provide some perspective on the clinician recommendations. We would like to push for including a present goal of care into measurement, while recognizing that this very difficult with current measurement

science, we would like it to be more patient-centered and our duals are a very special population with multiple needs, and so we wanted to highlight that.

Secondly, we would like to recommend re-evaluating clinical practice guidelines with appropriateness for high-risk populations. And by that we mean that we would like to move away from measures of tight control of clinical values that may have unintended consequences for individuals with multiple chronic conditions, be able to sort of incorporate the patient's perspective as well as, sort of, goals when determining what kind of control a measure is to use, as well as incorporate appropriate exclusions in the current available measures.

And finally, we would like to second as well as accelerate the development of consumer-facing quality measures where the patient, sort of, has a face and, sort of, is the person to, sort of, determine which way their care goes. And thanks. I think that's the only

slide we have for this one.

ACTING CO-CHAIR GESTEN: Great. So there are three discussion questions that are teed up. Should I go through? Okay. So, first of all, thank you all for the presentations. I'm struck by the themes that keep coming up again and again with each of the workgroups, the issue of the challenge of filling gaps -- in this case, gaps for certain physicians, or conditions, and what's good -- the desire to fill the gap, the desire to fill it with something meaningful.

The issues about the appropriate entity, accountable entity, came up in the population health measures and whether it's appropriate for physicians, the value and importance of composite measures, and as well as, in the last presentation, patient-centered measures and the issue of potentially unintended consequences relative to certain guidelines and measures that spring from those.

So we have the questions that we can deliberate on that, how do we balance the issue

of wanting to have a wide number of measures applicable to a broad amount of specialty care and specialty providers, versus trying to have, you know, a parsimonious and limited number of measures that can apply to a broad population.

There are issues related to the timing of guidelines as they change, and what's appropriate in terms of integrating them, making changes in measurement efforts, and then how do we think about -- and we talked about this some this morning -- evaluating these measures, particularly ones which are very new, to sort out what the opportunity is for improvement, and I think that that's a challenge with lots of the new measures under development, so would invite any conversation both on the phone or in the room around any of these issues, or clarifying questions from the presentation.

I think I saw, David, your card up first and then Rhonda. David, no? That was old? Rhonda? Old. Okay. Harold, then Marshall.

CO-CHAIR PINCUS: A couple of times I

heard allusions to the issue of registries, and I wonder if members of the workgroup might want to comment on how those are being handled and also hearing a little bit from CMS, because I mean, registries seem like an ideal model for how to capture quality related information, you know, especially the chronic disease or for, you know, follow-up after acute incidents, but they are generally very highly specific, so it kind of goes with, you know, that first bullet.

WORKING GROUP CO-CHAIR BAGLEY: This is Bruce Bagley, maybe I could I just comment. I think that there's kind of a misunderstanding about at what level a registry might be used. I think that most of the registries record information that then is aggregated and standardized and then fed back at some later time to the clinicians.

When we're really thinking about proactively managing chronic illness, it really needs to be a point-of-care registry where the registry is available showing gaps in care during

any encounter with a patient. So I agree with you. I think that registries are a tremendously powerful tool, but we don't -- at least up until now -- have enough support from our electronics and IT to get that point of care concept, so yes, we've got a ways to go.

ACTING CO-CHAIR GESTEN: Kate, did you want to comment as well?

DR. GOODRICH: Sure. Just to remind folks how those are used in our programs, and I agree with what Bruce just said. So we have two registry recording options within the PQRS program, which will translate over very lovely into the MIPS program. One is what we call our traditional registry, so these tend to be organizations. Well, you have some that are like ACC and STS that have been around a long time, very sophisticated, lots of really good outcome measures that a high proportion of their membership uses, and those are very valuable.

We also have a lot of registries that, sort of, exist for the purpose of collecting PQRS

measures as a service for clinicians to send data in to CMS, whether those data be based upon mining claims or actual abstraction from a paper or electronic chart. All of that is out there.

And then there's something called the qualified clinical data registry, which came about as a result of the American Taxpayer Relief Act, which required CMS to develop a mechanism to allow clinicians who are submitting data to a registry for another purpose -- so their specialty society registry, their board, what have you, a local quality collaborative -- for those data to also be used for CMS payment purposes, so for PQRS value modifier, going forward, MIPS.

The MACRA legislation further emphasizes the use of these QCDRs, as we call them. We have now one year of experience with the QCDRs, as we call them. And we have ones that, again, this is the minority, that are sort of the more advanced, have been around a long time, really know what they're doing, and we have

others that are coming along that are probably more in their learning, so it's a really spectrum of what's out there right now, I would say.

I think we do -- well we definitely do see use of registries as our, probably, most rapidly growing submission mechanism, but it definitely, I would say, is in its earlier stages as, sort of, Bruce was just describing, in terms of the kind of data that are abstracted, validity of the data, the need for it to be useful at the point of care.

The other thing that MACRA does is to address the point that Bruce was making about the need to be able to use registries -- not just to collect data elements and send them to CMS, that's one thing, but to actually be able to use the registries to improve the health of the patient panel, patient population, to be able to be used as a tool for quality improvement, and that is one of the interesting things that MACRA does, it actually is very clear about us putting requirements, or the possibility anyway, in place

for incentivizing the use of registries for that purpose, through the clinical practice improvement activities piece of the new MIPS program.

So we are actively thinking about how we can tie together the four different components of the MIPS program so they actually work in concert with one another, but in particular, around qualified clinical data registries as a tool for reporting measures, but also for finding ways to incentivize their use as a tool for improvement.

ACTING CO-CHAIR GESTEN: Okay. Thank you, Kate. Marshall? Kevin, did you want to -- I know you probably want to add on to registries.

DR. LARSEN: Yes. Just some addition on the electronic component, so we know that a number of registries actually do get a live data feed from their electronic health records, and some of those are at scale, for example, the American Academy of Ophthalmology has, you know, like, almost 50 percent of ophthalmologists live

with data feeds into their registry.

What we're learning from that is that not only are those registries able to provide this level of point of care support for care gaps, they also are rapidly becoming a measure development engine in and of themselves, and I think the question for the MAP is going to be at what level should those measures stay localized within a registry and what level they should be -- where's the bar for when they get raised up as important enough or studied enough to be part of a policy program?

Because the most robust of these have really incredible data analytics expertise and they can sometimes do hundreds of little small measures that are very helpful for those practices and for managing that specific work.

And the clearer it is which of the things out of that huge analytics capability that they have should become national measures for national programs, the better chance they'll of proposing those as opposed to proposing something

else.

So to my mind, that's the kind of strategic question. For us, that work is going to happen, it should happen, it will happen. When does it get here, and when does it stay within those registries as part of quality improvement as opposed to measures in federal programs?

ACTING CO-CHAIR GESTEN: Great. Marshall?

DR. CHIN: Yes, I wanted to follow-up on the excellent comment from the dual-eligibles group about individualization of care, which they gave in the context of the multiple chronic disease group, but it applies more generally just to the geriatric group. And so especially for the CMS measurement, it's still predominantly 65 and older.

As a whole, the performance measures that NQF and CMS have used haven't really caught up to the rest of the clinical field about the individualization of the older patient, and it's

because I think somebody said this is relatively new. I mean, like -- using diabetes as an example -- 15 years ago, the clinical practice guidelines didn't mention geriatric at all, 10 years, this is central too about the geriatric issues, to like the most recent guidelines from two or three years ago are pretty specific about different risk stratification categories and who you should be aggressive with and who you shouldn't be aggressive with.

And it goes both ways that mostly, as mentioned by the development group, not wanting to be too aggressive on the frail folks where, you know, life expectancy, high glycemic control is going to be the least of the issues, and the fact localized is probably going to be the bigger issue over treatment.

And it goes the other way too of the healthy 65-year-old person where you should be aggressive, and so that you're supposed to have different clinical guidelines, but CMS and NQF, you know, we need to make sure that we are

staying up with this, because otherwise there's going to be a lot of very bad unintended consequences of providers, organizations, meeting performance measures and payment, but really not being an interest of patients.

ACTING CO-CHAIR GESTEN: Thanks. Lisa.

MEMBER McGIFFERT: I just had a question about the registries. I don't know a whole lot about them. I know some about them. They all seem to be privately controlled and I wonder, it sounds like CMS is working with them and that there can be an exchange of information, but I'm not sure what kind of assurances for quality control of the data, for revealing the data to the public at clinician level, or are we just talking about group levels?

I totally am glad to see registries building up, but the information is pretty inaccessible to the public.

ACTING CO-CHAIR GESTEN: Kate, do you want to brief?

DR. GOODRICH: Yes, I can address that. So there are actually parameters laid out in the legislation that authorize this around transparency of information. And so in terms of, you know, the measures, and the risk adjustment methodologies, and all that, we do require -- we have a number of parameters we've laid out in regulation, and sub-regulatorily, around what the QCDRs have to do to be qualified as a QCDR.

You know, there's a lot in there around transparency. Now, having said that, that means that they have to publish everything that they have in their registry, essentially, on a Web site. Can a consumer go and find that Web site? I'm sure they can Google it an find it, but it's not, like, right there in front of you, right? So that's one thing.

I would say that on the data accuracy part, we definitely had a significant learning curve, along with the registries this past year, on data validity and accuracy, and a lot of the data were not usable. We didn't use the data for

anything. It wasn't very good data -- not across the board, but for some.

But what came out of that was quite a few lessons learned; we had, like, a two-day summit with the registries and the EHR vendors on how to fix the issues that we all found that were on both sides -- both CMS and the registries -- and we think we fixed a lot of those, but it's going to be a learning curve as we go along, but I think we're in a better place than we were before.

And finally, we are required to make measure information available, publicly available, on Physician Compare. We have made clear in our regulations, we will be publicly recording the measures that come out of the QCDRs, even if they're not part of the core, sort of, PQRS/MIPS, you know, set measures, so that information will be made publicly available, you know, as we have already talked about in our regulations.

Regarding the individual level versus

group level, as you know, the way the programs have worked, and this has been a tension, is that clinicians can choose whether to report at the individual level or to report at the group level. What that means is that when a group of physicians report to us, they report as a group aggregated up.

So we do not report publicly individual clinician data when they're reporting as a group. I think it's a tension we're still trying to think about how we can work out, given those options that we currently have, because we know from the consumer and patient community they very much want individual level data, so we do understand that, so I think that's something we are still trying to think about how we can work through when they report at the group level.

That may be more information than anybody wanted, but there you have it.

ACTING CO-CHAIR GESTEN: Thanks, Kate. We're really giving you a workout today. We're getting our money's worth. Barry?

MEMBER NOONE: I'd like to ask Kate, thank you, how many of the independent organizations actually go to the Web site and enter data? That's my first question. And then because there are a tremendous amount of innumerable registries out there, medical societies, certifying boards, independent organizations that look at the quality of ambulatory surgical facilities, national organizations, such as NSQIP, which looks -- started with the VA system, but many hospitals participated in the national surgical quality insurance program.

So how does Medicare get that data? Do these groups actually use it -- use your Web site?

DR. GOODRICH: So let me be clear what I meant by posting on a Web site. What we require each registry to do is to have all of the information about their measures that are within the registry that physicians and clinicians can report on on their Web site; every detail about

the specifications, the risk adjustment, et cetera.

When the data on physician performance, or group level performance, comes in to us, what we will ultimately do -- and we haven't yet because we've only had this method for one year -- is ultimately, where we have valid and reliable data, we will post performance information on Physician Compare, which is required by law for us to do.

So the database sent us for use for the new MIPS program, so to effect to their payment, will also be the data that are used for public reporting, and that sort of gets back to the discussion that we had at the clinician workgroup, which was: what's the most useful information to have on Physician Compare that's meaningful to consumers?

Understanding, no matter what, for all valid and reliable data, we're going to put it up at least in a database that people can download, but what is actually best for consumers to be

able to go and look at to compare, you know, one provider or one group practice to another, like in the star rating format, for example. I don't know if that answers your question or not.

MEMBER NOONE: I was just wondering how many people really respond to that. Sure, you can put data in there about individual physicians in your group, or in whatever registry you're using, but does everyone respond to that?

DR. GOODRICH: When you say everyone, do you mean like consumers going to look for information?

MEMBER NOONE: No, not consumers, but medical organizations, for example, specialty societies. There are lots of them who have registries going. What is their impetus to put the data on the Medicare Web site?

DR. GOODRICH: Well, we put it on the Web site; they don't.

MEMBER NOONE: Okay.

DR. GOODRICH: So if a clinician or an ophthalmologist, you know, wants to use the IRIS

registry that AAO has to report their measure information for the purpose of PQRS, or in the future, MIPS, those data will go up on Physician Compare. We, by law, have to do that. We make that very clear in our regulations. That's, again, if it's valid and reliable. We have to do that testing to be sure that it is.

So I guess the impetus goes back a little farther than that -- what's the incentive, or impetus, for a physician to participate in a CMS-quality program? Some of that's financial, because if they don't participate, they get the maximum downward adjustment, but along with that does come public reporting, just as it does on the hospital side and for every other facility as well.

ACTING CO-CHAIR GESTEN: Right. I assume the alignment issue is around getting a two-fer -- that is, if physicians are already reporting to registry, why not use that process, right? That's the intent.

DR. GOODRICH: That is exactly right,

yes.

ACTING CO-CHAIR GESTEN: Jayne?

MS. CHAMBERS: So building on this conversation and some of Kevin's remarks earlier, one of the things, I think, from a hospital perspective that we've been concerned about is the data accuracy and validity that are in the registry, so I'm glad that that's being addressed and that, Kate, you addressed that, that the agency is looking at how you evaluate the data accuracy and validity.

And then I think the other question is -- and because I'm married to an eyeball guy, I know a little bit about the ophthalmology registry -- I question whether some of the measures that are in there, many of them are appropriate for quality improvement and for quality control within their own organizations, they're not necessarily usable for comparative purposes across entities.

And so I think that's one of the other issues we really need to struggle with as we look

at registry development.

ACTING CO-CHAIR GESTEN: Thank you. Frank, I know you've been waiting patiently.

MEMBER OPELKA: Yes, there's been a couple conversations that have piled on, so I'm going to try and hook these all together into one stream of thought, and I'm going back to the dual-eligibles, and I really applaud the comment that they made. We think that this actually goes into these clinical metrics that are being discussed in terms of registries, but we think the issue of what's happening in the clinical data ecosystem, registries represent only a small piece of that.

So first of all, we applaud a patient-centric approach rather than a payer program-centric approach, so within the domains of surgery, we would think of cholecystectomy as measurement that has to go across PCP, surgery, anesthesia, and so forth. Appendicitis would hook emergency care together with surgical care and anesthesia, and cancer care would even be

more broadly considered, that we ought to be thinking and building these MAP programs along clinical service lines that map to the patient-centric solutions that were outlined in the dual-eligibles, with goals and care plans, and things of that sort as being part of the metrics.

And we think that is a very good place to go. I realize where we started, but what makes sense to most clinicians is not the program we're in, they're very frustrated by that program and they're thinking in more clinical patient terms. In terms of these registries, they have made leaps and bounds, but they're a little bit after the fact for the most part, and I think Bruce was talking about real-time analytics -- and I think Kevin referred to this as well -- it is these new clinical applications that are emerging in the clinical data ecosystem that need to be planned and mapped out into where we go in measuring process, and outcomes, and preventable harms, and safety, and care.

And there's a part of the NQF that has

a significant role in validating those algorithms that are part of this. If we don't get started on it now, we'll never catch up to it. There's also part of the MAP that has to move to it, and I think Kevin hit it on the head, that these things are going to bubble-up relatively quickly because they're in programs.

And as they bubble-up, we need processes different than we have in the NQF today to look at how these measurement sciences map to what was said by the dual-eligible groups because that makes more sense to us as we look at this as clinicians, and I'll end there.

ACTING CO-CHAIR GESTEN: Thank you. David?

DR. BAKER: My question was for Kate, again, on the registry issue. Have you established criteria for deciding how good does the data need to be before you can use it for accountability, payment programs, and public reporting? So for example, with SDS, I talked with David, and they do a 10 percent audit to

confirm the data accuracy, and they also -- this is, I think, very impressive -- they do an assessment of the completeness by linking it to billing data. I'm not sure how they do that, but that's been a concern for us since we talked to AHA, and we heard that they do not require complete reporting for the guidelines.

So I'd be interested in hearing that and also, whether this is something that maybe MAP should weigh-in on and try and really, you know, get clear criteria from that.

DR. GOODRICH: I would welcome that, first of all. So we did have criteria for the first year, I don't think they were as rigorous as what SDS has done. Now having a year of experience under our belt, we are revising those criteria for a lot of different things, but absolutely around the data validity and accuracy. And we've definitely had conversations with the more advanced registries to understand what they're doing.

I don't know what they are off the top

of my head, but that is very much on our minds, and we'll definitely be evolving for even this next upcoming reporting period, I think. But I definitely would welcome input on that. No question.

DR. BAKER: Sorry for jumping in, because I forgot to mention, the patient reported outcomes, this is also key, because in talking with the American Joint Replacement Registry, the pilots they've done, they've had very low participation rates, as low as like 30 percent, but yet, the FORCE Registry for Joint Replacement, they say they're getting, you know, 85-90 percent, and that's the follow-up assessment as well as the pre-assessment.

So that would be another really important area to weigh-in and some methodologic challenge in dealing with, you know, the non-response parts.

ACTING CO-CHAIR GESTEN: Kevin.

DR. LARSEN: Yes, I'll just add on to that, as we've had a lot of conversations with

registries, they're really interested in being part of the solution here, and they're looking for standards and recommendations, so we just take something like risk adjustment, they are going to be figuring out risk adjustment, maybe they have figured out risk adjustment, but unless there's some recommendation about an approach and the kind of data that should be collected routinely, we will get a different risk adjustment model for each and every registry that's out there, even if they're measuring the same thing.

So we've done a little bit of work with, also, the joint registries around functional status, outcomes after knee and hip surgery, and without some careful coordination, each registry will do it their own way because the natural character of it is to build what your stakeholders and your group think makes sense.

They're very willing to coordinate, but the clearer the recommendations are and the direction to head, the better chance we have of

getting to a place I think that we want to be, which is a consistent approach for things like risk adjustment and attribution, the kind of things we mentioned earlier.

ACTING CO-CHAIR GESTEN: Okay. Well, you've managed to delay having a conversation about specific measures by having a really important and productive, and rich, conversation around both the questions that were posed here, but a whole host of other things, so thank you, everybody, the clinician workgroup for teeing them up, and for the group for having such a great conversation illuminating so many important issues.

So let me just go through the process again so that we're clear. We have nine measures that were identified for a vote, and they may change and become a discussion item, we'll see as we go through and ask the individual who pulled them. For folks who pulled measures -- and I see Sam and Amir, and Lisa, and Elizabeth -- get ready, because we're going to ask you to voice

your concern and issue soon.

That'll be followed by -- we have lead discussants in Amir and Lisa, obviously, there are measures, Amir, that you have, we'll ask for Lisa to start out the discussion, invite other folks to discuss as well, and then if we're heading towards a vote, then we'll take the votes in the way that we did in the previous section.

Let me just start, though, by asking whether any of the coordinating committee members have any additional, and I'm not asking you to do this, but just creating an opening. Measures to be pulled from the consent calendar for either vote or discussion, now's the time to mention them. Kevin?

DR. LARSEN: Yes, not to really pull it for a vote, but just a quick comment on one, the opioid measure, and the quick comment is that the Secretary's convened the states around the issue of opioid overuse, and many states are building, and already have in place, a similar measure, but each state, again, is building their

own.

And so even though that measure didn't get supported here, just to let you know that state-by-state-by-state, it's getting built, and that with a different specification state to state for looking at which providers are prescribing, potentially, too much opiates, so that's just more to highlight that as we're going to have 50 versions rather than one.

ACTING CO-CHAIR GESTEN: Okay.

MEMBER BARTON: This is Mary Barton. Kevin, I would support that, then, bringing it up for a vote.

ACTING CO-CHAIR GESTEN: So, Mary, you'd like to make a motion -- you'd like to bring that one up for a vote.

MEMBER BARTON: Well, given that information about the environment and the likelihood of there being a proliferation of measures that do not align with each other, as one of the early members of the NQF alignment workgroup, yes, I would say that's an untenable

situation, and we should, instead, do whatever we can do to encourage CMS to lay down the template and say, everybody start with this.

ACTING CO-CHAIR GESTEN: Can someone on the staff just label for us what that number is? Which measure are we talking about?

MR. AMIN: It would be helpful if who's raising it -- I mean, Amir has got four additional, 210, 211, 220, and 1082, but this additional measure, I'm actually not following what number that is myself.

MS. WINKLER: Hi. This is Reva. Foster?

ACTING CO-CHAIR GESTEN: Yes.

MS. WINKLER: Yes, it's MUC 151169, potential of opioid overuse, and the recommendation out of the workgroup was to encourage further development.

ACTING CO-CHAIR GESTEN: Thanks, Reva. That wasn't totally clear from the workgroup presentation.

DR. LARSEN: Yes, this is Kevin. I

apologize. I had thought it wasn't supported and, so I must have misread the supporting material.

ACTING CO-CHAIR GESTEN: Okay. Taroon, you mentioned that there were some others added, and I don't think I -- I have -- which ones did you mention?

MR. AMIN: So we can add them to the bottom of the list if that makes sense: 210, 211, 220, and 1082. Is that correct, Amir? Am I missing any?

ACTING CO-CHAIR GESTEN: Okay. So we have four more to the nine.

MR. AMIN: Yes, you have 13.

ACTING CO-CHAIR GESTEN: Okay. Are these all from you, Amir? Okay. That's all right.

CO-CHAIR PINCUS: Just to be clear, do we need to anymore discussion for the opioid measure or is it --

DR. LARSEN: No, I had misread it. I thought they had not supported further

development, and it sounds like they had, so I apologize.

CO-CHAIR PINCUS: I guess you already added some to the discussion.

ACTING CO-CHAIR GESTEN: Okay. So why don't we proceed, and we'll start going down the measures that I have currently on my list for a vote, and they start with the MUC 212, which is surveillance colonoscopy for dysplasia and colonic Crohn's disease, and this was pulled by Sam. First, let me just ask, Sam, do you still want to bring this up for a vote?

MEMBER LIN: Well, here's -- yes. Well, yes and no. Let me try to respond to that correctly. The discussion this morning was extremely helpful with regards to what a quality -- the definitions or limitations of the concept called encourage continued development, and that was part of our issue in trying to understand what that meant.

I mean, our interest in pulling some of these was to ensure that select, what I'll

call concerns or parameters are included in the continued development, and this is similar to, as many of you know in the association, at the House of Delegates, some of the things that are passed are tasked for referral for study, some are referral for action, but the most important part is a little clause that may or may not come up that says, and refer for study, refer for study and report, so it doesn't go into a dark hole.

And so that was our concern was that there's some issues here we thought that, you know, we support the proposed MAP recommendation, but we want to ensure that certain things are looked at in this continued development, rather than uh-huh, yes, one of those kind of things.

So that's a non-answer to your question because, you know, in some of these it's just a matter of saying, can we get certain parameters included in that continued development?

ACTING CO-CHAIR GESTEN: Sam, that is helpful, but when I look at this measure, the

workgroup recommendation was one of do not encourage further consideration.

MEMBER LIN: Yes. There are two to three that come up before --

ACTING CO-CHAIR GESTEN: Okay. I'm sorry. So we're starting with 212, and we'll take them in order, because you may have different answers to the question based on which measure it is, so starting at the top of my list is MUC212, which is the surveillance colonoscopy for dysplasia and Crohn's disease, and that workgroup recommendation was do not encourage further consideration, and you had pulled this one.

MEMBER LIN: Yes, sir, we did. And the reason for pulling that one is that, one, there aren't that many specialty metrics to start off with, so this was one that might fit into that category, so that we're not just totally into primary care or preventative medicine.

The second part was that in trying to read and understand the workgroup rationale, the

American Society for Gastrointestinal Endoscopy guidelines that are referenced recommends -- it seems like it recommends this kind of a measure, and yet, further down they sort of comment referring not about the measure, but more about the concern that this might promote utilization, and it seems to me those are, sort of, two different things.

It's utilization for whom. And then probably the overriding issue is that you've got to have baselines, and so it's important to have a baseline so that you know where you've been when you come to another point. And so with all this, it was sort of like it was a little bit confusing, so we sort of felt that rather than dropping it because of these -- I think the recommendation, proposed recommendation, is do not encourage further consideration when there's questions that are involved, and the issue of having a baseline in everybody's record.

So that was sort of the concern on this as to just dropping it completely versus the

fact that we might actually have something that's worthy of saving in this.

ACTING CO-CHAIR GESTEN: That's helpful. So your desire would be that it go forward for further development, recommend for further development.

MEMBER LIN: For continued development. Yes, sir. Absolutely.

ACTING CO-CHAIR GESTEN: Okay. Amir or Lisa, do you want to -- David, did you have a question?

MEMBER GIFFORD: I just think it's going to be helpful as we go through the voting measures if the person who's speaking can recommend what the vote they're recommending we change to, because it would be helpful to know what's in front of us. I'm not sure what they're asking us to vote to.

ACTING CO-CHAIR GESTEN: Great. Okay. You know what it is for this one. We'll try to do that for each --

MEMBER GIFFORD: Yes, now, but it's

hard to figure out what they're -- put all their comments in context as to where they're going.

ACTING CO-CHAIR GESTEN: That's helpful. Okay. We'll start with that. Amir or Lisa, either of you have any comments?

MEMBER McGIFFERT: My comment is that this is a process measure, and I think that it would be better to try to get a different kind of measure, more outcome-based.

ACTING CO-CHAIR GESTEN: Okay. Bill, you put your card down? Change your mind? You were going to say the same thing. Any other comments on this? Any comments from the staff or from anyone on the phone?

MEMBER GIFFORD: What was the vote by the workgroup? Was this a split vote or was this -- yes, no, was it, like, unanimous? They all stood up and cheered when they voted this way, or was it a split vote on it?

ACTING CO-CHAIR GESTEN: So I don't think we've gone down that path yet of getting vote counts. Do you --

WORKING GROUP CO-CHAIR BAGLEY: This is Bruce Bagley. You know, I think the major concern was that the two societies that represent the standards of care were not in favor of this measure, and it was primarily because the lack of evidence about the periodicity of the colonoscopy, so I think that we're not saying that this isn't important, but they didn't seem to be ready to use the existing evidence to put forward a measure.

MEMBER LIN: Yes, Bruce, this is Sam, I appreciate the comment. That's what I was trying to reference is the confusion because one of those societies, their guidelines, their own guidelines, recommend this kind of a baseline measurement, and then further down they sort of say, oh, we're concerned about overutilization. Those are two different topics.

If you look at the last quote in the workgroup rationale, it's from that same society that says, this might not be true, overutilization of colonoscopy, and yes, it might

or might not, but the point is, if it's patient-centric, we need a baseline, and so therefore, of the two, it would seem to me that the baseline recommendation is more critical than the concern about overutilization.

That, again, sort of dings that physicians are going to be purposely overutilizing it, which, I think, is an unfair observation.

ACTING CO-CHAIR GESTEN: So that's great. So I think that we're headed to a vote on this, and we're voting on measure 212, which is surveillance colonoscopy for dysplasia and colonic Crohn's disease. As you know, the workgroup recommendation was do not encourage further consideration. And Sam has recommended and described rationale for why he would like to see this become encourage continued development, so I think we can -- folks remember how to vote?

CO-CHAIR PINCUS: I just have one question. Sam, are you recommending encourage continued development, or is this is an example

where there's, sort of, insufficient information?

ACTING CO-CHAIR GESTEN: Encourage continued development is what he said.

MEMBER LIN: Yes, this goes back to a conversation about an hour ago where someone else was saying, trying to figure out what the outcomes are under this, and I think the most positive is that we encourage continued development on the basis that if you continue to develop it, you will come up with, hopefully, more sufficient evidence.

If you say insufficient, it's dead-ended there. At least, that statement is dead-ended to me, whereas, continued means that, yes, we're going to try to find some sort of end of the rainbow.

ACTING CO-CHAIR GESTEN: David?

MEMBER GIFFORD: Sorry. Clearly, this is going back to the confusion about what this -- I mean, I think when we developed this in the fall, we had good intentions that, clearly, have caused more confusion than probably helping the

process. Kate alluded to the fact that the IMPACT Act measures and the PAC group, CMS would be working with NQF to bring back measures considered encourage further development back to the MAP, didn't guarantee it, but is working towards it.

Is that similar for all measures and all settings or just for the PAC setting? Does that make, you know --

DR. GOODRICH: All measures and all settings. And I will say for measures such as this one where we're not the owner, we're not the steward, it was submitted to us, we would need to work with the owner to see if it's something they're still interested in and would like to bring back.

ACTING CO-CHAIR GESTEN: Any other questions before we vote? So can we go to the slide that has the vote?

MS. STERLING: The vote is now open. It's encourage continued development, do not encourage continued development, or insufficient

information. And that's for MUC15212.

ACTING CO-CHAIR GESTEN: So I'm a little unclear, is it a timeframe, or is it a number that we're looking for when we're done with this? What are we looking for?

MS. STERLING: We're looking for the number, not the timeframe.

ACTING CO-CHAIR GESTEN: And the number is?

MS. STERLING: Twenty-seven, is that correct?

ACTING CO-CHAIR GESTEN: Okay. We're there.

MS. STERLING: Twenty-eight?

ACTING CO-CHAIR GESTEN: Twenty-eight. And so my understanding of the vote is that there was not sufficient votes to overturn the recommendation of do not encourage further consideration. So why don't we move on to the next one, and, Sam, you're up again, and this one concerns biopsy reporting time by pathologists. It's MUC measure 216, and the workgroup

recommendation was do not encourage further consideration.

And, Sam, can you just, at the beginning, say what your recommendation is and then describe the rationale.

DR. LARSEN: Sure. As before, it would be encourage continued development.

ACTING CO-CHAIR GESTEN: And can you say a little bit more about rationale?

DR. LARSEN: Sure. I'm sorry. And again, it's an issue of there aren't enough metrics for specialties to start off with, but, you know, we've been making a lot of Triple Aim type of reasons for doing things, but we also have to remember the IOM STEEP principles, and this meets at least four of them in my mind: timeliness, that's self-explanatory, efficiency, that's self-explanatory, it's equitable in the sense that all clinicians caring for a patient have some equitable responsibility and ought to be held accountable, and P, patient-centered.

And the part of it that's patient-

centered is that, and this is maybe down the line, but at some point, you know, there's a lot of work going on now of something called open notes where patients have access to their records. And part of it, I would like them to be able to see that somebody actually took the time to make sure that there was timeliness, that there was efficiency, and all those wonderful things relative to their care.

The specialists in this case should be held accountable, not just the biopsying clinician who may be a primary care, who may be a dermatologist, but especially in an integrated team-based setting, everybody's got to bear full responsibility and not be able to slough off one other person.

As far as societies, there was a difference of opinion between the derms and the paths on this one; the derms in support and the pathologists not in support, so my recommendation is that there's enough of this, and it's not insufficient evidence. It's putting together the

different pieces, but I'm going to take that route and recommend that we go for encouraging continued development.

ACTING CO-CHAIR GESTEN: Thank you. Frank, you want to make a comment?

MEMBER OPELKA: No, I need to lower my hand.

ACTING CO-CHAIR GESTEN: Okay. Rich Antonelli?

DR. ANTONELLI: Yes, thank you for letting me weigh-in. So one of the things that we are spending a fair amount of time in the care coordination standing committee is this notion of, you know, measuring a one-sided handshake, and so if you look at this, it's the transmission of the information from one provider to the other, and that's partially what we're about here.

In a true patient-centered framework, the patient would be aware that the information was received and not just transmitted, so there is a little bit of a gap there. And the reason

I'm calling this out is not specifically on this measure, but I think measures like this are really emblematic with what the field is like right now around trying to really measure patient-centered care coordination.

ACTING CO-CHAIR GESTEN: Thank you. David?

MEMBER GIFFORD: Having done a year of pathology, I don't like a length measure. Regardless of the vote, just want to put on the record a comment that it really should be about percent of people who get it done within a timely time period, because by length, you start encouraging people to run reports on difficult biopsies and not get second opinions and all that stuff.

And particularly in this type of skin biopsy and other biopsies, you're going to often want second opinions, and you should notify the people why it's going on, because you're not sure what's going on, but these are something very hard to read, and just an average time could have

the unintended effect of getting quick reads out just to meet some sort of measure, unintended, so whoever the developer is, to really think about restructuring it that way and continuing to develop it fully.

ACTING CO-CHAIR GESTEN: And I don't know if you want to translate that comment into what you're recommending, these three things, but if you do want to, where does that lead in terms of what you're --

MEMBER GIFFORD: Let me ask, this was on the MUC list, Kate. Why was this put on the MUC list?

DR. GOODRICH: This was submitted to us by, I guess, AAD. It was because both dermatologists and pathologists have so few measures to choose from, and we felt this was reasonable for consideration by this body.

ACTING CO-CHAIR GESTEN: The other David.

DR. BAKER: The other David? I thought I was the David.

ACTING CO-CHAIR GESTEN: Oh, the David. You're the David. He's the other David.

DR. BAKER: I think our quality and safety problem here is with the time limits. You know, as David said, the problem is there are still errors in reading pathologic specimens and we want them to take the time that they need to get it right, so I am not in favor of this measure.

ACTING CO-CHAIR GESTEN: Our two lead respondents, either Amir or Lisa, have any comments?

MEMBER McGIFFERT: Who's the other respondent?

ACTING CO-CHAIR GESTEN: Amir.

MEMBER McGIFFERT: Oh, okay. You know, this is another process measure, and I agree with the recommendation of the workgroup, so I don't really have anything else to add. Somebody earlier said something about, I wrote it down on this measure, I'm not sure if I got it right, that there was a cancer project that was

working on this measure?

MS. STERLING: There is a cancer project, but it is not working on this measure.

ACTING CO-CHAIR GESTEN: Barry?

MEMBER NOONE: I'm a little confused about what we're looking to vote for. Is this the measure of surgical or office removal, or currettage, of non-invasive squamous cell carcinomas and/or keratoacanthoma-like cancers versus Mohs resection, is that what we're doing?

ACTING CO-CHAIR GESTEN: So as I look at the description, I don't have a clear answer. I read, like you can read, what it says, but is there anybody on the phone from that group that can clarify, or here?

MS. WINKLER: Foster, it's Reva. You might want to push the link on measure specifications and look at the numerator and denominator. That might help. The numerator says it's the number of final pathology reports diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma, to include in situ

disease, sent from the pathologist/dermapathologist to the biopsying clinician for review within five business days from the time when the tissue specimen was received by the pathologist.

MEMBER NOONE: Okay. Thank you.

ACTING CO-CHAIR GESTEN: That answer your question? Okay. Any other --

WORKING GROUP CO-CHAIR BAGLEY: Foster, I had a comment.

ACTING CO-CHAIR GESTEN: Go ahead.

WORKING GROUP CO-CHAIR BAGLEY: Yes, this is Bruce. One of the things that's not reflected in the workgroup rationale is that this is very, very specific only to these two diagnoses, and we would be very interested in seeing a measure that dealt with all pathology reports across the board be much more broadly applicable.

And, you know, the alternative is to have a measure for every last diagnosis, which is nuts. So we kind of think that we should

reconsider this in a more broad base.

ACTING CO-CHAIR GESTEN: Thanks.

MR. BRUCE: This is Sam Bruce, I would say that's a friendly amendment. Thank you.

ACTING CO-CHAIR GESTEN: So could we go to the vote? And we'll be voting, again, on the MUC216, which is biopsy reporting time, and -- or we could re-vote on colonoscopy, but that's not much fun. And the choices are encourage continued development, do not encourage continued development, or insufficient information. Just to recap, the workgroup recommendation was do not encourage further consideration.

MS. STERLING: Great. So this is MUC 15216. It's biopsy reporting time. And again, your options are encourage continued development, do not encourage continued development, or insufficient information.

ACTING CO-CHAIR GESTEN: You didn't like the way I said it, did you? All right. I'll let you say it.

DR. LARSEN: Sorry, this is Sam. I'm

not getting the right screen, so let me just cast it for the first one, encourage continued development.

ACTING CO-CHAIR GESTEN: Are you guys able to capture that? Does Sam need to refresh his screen, is that, potentially an issue? Try that, Sam.

DR. LARSEN: All right, sir. Thanks.

MS. STERLING: Okay. The official results are, 7 percent encourage continued development, 86 percent do not encourage further consideration, 7 percent insufficient information, the workgroup recommendation stands.

ACTING CO-CHAIR GESTEN: All right, Sam. Hang in there. There's more. You may have better luck going forward. We're going to give you a break, though, and go to the third one on the list, which is MUC229, Hepatitis C virus sustained virologic response, and this one was pulled by Amir. Amir, let me just ask you first, do you want to take this to a vote, conversation?

MEMBER QASEEM: It's actually a

clarification question, so probably is just a discussion item. I just want to make sure that the patients who cannot afford the treatment or patient preferences are considered, they are part of the denominator. The way it reads, it was just not clear. The way it reads right now is, all patients age 18 years and older with diagnoses of Hepatitis C who are initiating or receiving anti-viral treatment.

So the initiating part, does that mean that they have started, they are already on treatment? That part, I'm okay with, but if it includes the patient population, you know, it's an incredibly expensive medication. A lot of insurance companies don't even cover it.

ACTING CO-CHAIR GESTEN: So you're asking a question about whether the specifications account for that.

MEMBER QASEEM: Correct. So if it's -- and probably it's a question either for Bruce of Eric. You guys can answer this.

ACTING CO-CHAIR GESTEN: So the

steward here is the American Gastroenterologic Association, right, so we can't pick on Kate. Sorry, Kate. Is there anyone who can answer that clarifying question?

MEMBER QASEEM: Because if the way the measure reads right now, then I think we have a problem because you have a big chunk of population that cannot afford this treatment as well as where patient preferences are going to be. I mean, the co-payment, I was asking around for this, and I was writing notes, it's around $140 per month, the cheapest option.

MS. WINKLER: Amir, this is Reva. I think maybe the exclusion specification could help a bit. It says that the measure only needs to be reported if initiation of anti-viral treatment took place before October of the measurement year, 11 weeks before the end of the period, so I think this more clearly states that initiation is those patients who actually have begun taking the drug.

DR. BURSTIN: But just a quick

comment. I mean, either way, this is a measure still under development, so your comment will still go to the developer, even if they're not here, so they will then hear this discussion of -- and we'll emphasize that in the report as well, that there were concerns about potential patient inability to get the medicine and consider it as a potential exclusion.

Again, it's not a fully baked measure, so they clearly have some opportunity there to modify it.

ACTING CO-CHAIR GESTEN: Amir, is that responsive to your concern?

MEMBER QASEEM: Yes, I just want to make sure this comment does go back the developers.

ACTING CO-CHAIR GESTEN: But there may be some patients who, their financial status changes, and a month later they're really struggling, so I think dealing with patients, some exclusion criteria around inability to pay would be a reasonable one. Any other -- go

ahead.

MEMBER QASEEM: So the current recommendation is continued development, right?

ACTING CO-CHAIR GESTEN: Encourage continued development.

MEMBER QASEEM: Yes, I can go with that.

ACTING CO-CHAIR GESTEN: Okay. Any other conversation about this one? So we will not vote on this one. We'll move to the next one. All right, Sam, I hope you enjoyed your very brief break here. So we're moving to MUC251, which is screening endoscopy for varices in patients with cirrhosis. It was pulled by Sam. The workgroup recommendation was do not encourage further consideration.

And, Sam, two things, if you can just reiterate whether you want to move this to a vote, and then second, just describe what it is your recommendation is.

DR. LARSEN: Sure. Well, I'll first say that I'm doing much better than the

Powerball. So the recommendation here is, as before, encourage continued development. The reason being very similar to the previous one is, there's an issue of a baseline that you have to have.

Now, in this case, there's something referenced here as the AASLE, which is the American Association for Study of Liver Disease, and their guidelines recommend, et cetera, similar to the proposed metric. Towards the end, the American Society for Gastrointestinal Endoscopy comments, similar to the previous comment, and they're bringing up the concern about deterring overutilization.

Again, to me, that's two separate issues. So I think for the purpose of a baseline for good patient care, you know, you don't know where you're going until you know where you've been relative to a patient's diagnoses and data, so our recommendation is that this ought to go for continued development rather than not encouraging or just dropping it.

ACTING CO-CHAIR GESTEN: Great. Thank you. Other comments? Barry, is that a leftover or do you have a new comment? Bill.

MEMBER KRAMER: I'll just comment that this is another process screening measure, and reading the workgroup rationale, it appears there's questions about the evidence of the usefulness of this with regard to outcomes, so I don't see a compelling reason to overturn the workgroup's recommendations.

ACTING CO-CHAIR GESTEN: So comments either from lead discussants, Amir or Lisa, or from Bruce?

MEMBER McGIFFERT: I was going to say just what Bill said.

ACTING CO-CHAIR GESTEN: You guys are kind of tag-team. When you were talking last time, Bill was nodding. Bruce, did you have any comments?

WORKING GROUP CO-CHAIR BAGLEY: No, nothing further.

ACTING CO-CHAIR GESTEN: Okay. David.

DR. BAKER: I'll just go on record as, I'm in favor of process of care measures for many, many things, including screening measures, not this one though because it's Level C evidence.

MEMBER McGIFFERT: I think that -- well, my understanding is that all of these measures are for public reporting or payment programs, right? Or both. This one's for both. So I mean, I'm not saying that process measures aren't valid in some situations, but for public reporting and pay-for-performance, I think they're not good measures to use, so that's why I keep bringing it up.

I think it is good for providers to use them internally, and they're really important, and I think they're important sometimes for consumers to know what they're doing, but I don't think that they're good measures for this purpose.

ACTING CO-CHAIR GESTEN: Any further discussion? Can we bring up the slides for a

vote? We're voting on MUC251, which is screening endoscopy for varices in patients with cirrhosis. The workgroup had recommended do not encourage further consideration. It was pulled with a recommendation that this be changed to encourage continued development.

MEMBER DEZII: I had raised my hand. May I be able to comment?

ACTING CO-CHAIR GESTEN: Oh, sorry. Go ahead.

MEMBER DEZII: Not a problem. Chris Dezii, Pharma. It's late, and this is about esophageal varices, right? I swear I see something about, this measure would not deter overutilization of colonoscopy. I suspect that's a typo.

MS. WINKLER: Yes. This is Reva. I'm sure it is.

MEMBER DEZII: Okay. Thank you.

MS. WINKLER: You can blame me. That's my bad.

ACTING CO-CHAIR GESTEN: Thank you.

MEMBER DEZII: Okay. Let's rock and roll.

ACTING CO-CHAIR GESTEN: Yes. It's under workgroup rationale. It's like the third line from the bottom. Thank you for pointing that out. So the vote is up there?

MS. STERLING: Yes. We are voting on MUC15251, the screening endoscopy measure. Your options are encourage continued development, do not encourage continued development, or insufficient information. The vote is open.

All right. So the results are 3.6 percent encourage continued development, 89 percent do not encourage further consideration, and 3.5 percent insufficient information. The workgroup recommendation stands.

ACTING CO-CHAIR GESTEN: David.

MEMBER GIFFORD: General comment before I forget. I think it'd be helpful to make sure all of our comments, they go back to CMS, well, they're all going to go to CMS because this is on the MUC list, but also the other developers

out there, that what I'm hearing from these comments was clearly some confusion about what it meant for encourage further development and not -- and that some of these measures as specified, people are unhappy with, but they like the concept to be explored further.

I wouldn't want -- just like there was confusion on this, them to have the confusion at CMS or the developers end for some of these measures to say, well, we can't develop it. NQF doesn't want it, or CMS doesn't want that. I don't think we've heard that anywhere here.

You know, there's been some debate about process and outcome measure, which I think is a healthy debate to have, and when to do that, but I don't want -- I think, the endorsement of the voting here of not do it, and it looks like there seem to be different ways different committees voted on what was considered encourage further development and not, even workgroups interpret it differently, so I just wanted to make sure that that gets captured and the message

goes out.

ACTING CO-CHAIR GESTEN: Makes sense. Yes, we'll do that. Okay.

DR. LARSEN: This is Sam talking. One observation if I may, is that, about ten years ago when we were in the P-for-P, pay-for-performance, it was all about process and not outcome, and then we sort of made a transition, we think, through MIPS and things of that sort, to where we're trying to get outcomes, which is really what the patient care is about, the bottom-line, but at the same time we can't forsake the fact that if you don't have the process, if you don't have the data, if you don't have the baseline, you have no idea whether your outcome is successful or not.

And so this is -- we have to find some harmonization or balance between -- in this concept of process and the ultimate outcome that the patient needs. End of soapbox.

ACTING CO-CHAIR GESTEN: Thank you, Sam. So the next measure is MUC275. It's

ischemic vascular disease all-or-none outcome measure, and the workgroup recommendation was conditional support. It was pulled by Amir, so, Amir, again, same set of questions. Want a vote, and what's your position on the recommendation?

MEMBER QASEEM: So for this one, I think it would be worth voting, and so this is a very important topic area. I think it is valuable to have this composite measure, but I think what caught us was the coronary artery disease-like condition, that has been one of the issues, and I was just talking with David, so they have this, for example, diabetes.

So are we essentially saying we're going to give aspirin therapy to every diabetic patient? And then the blood pressure, for example, they use in this measure is 140/90, and we have discussed this to death in the journals. Now, you know it's incredibly controversial whether it's 140 or 150, what level we should be using, and the third issue with this measure is that the indications for statin use, they're

based on the outdated guideline. You already know the issue of the LDL levels versus individual risk factors as well.

So there are three issues that are concerning with this measure and if this was just limited to, maybe, coronary artery disease, it would have been okay, so I think it's the CAD risk equal and condition that really made this measure worse.

ACTING CO-CHAIR GESTEN: So I'm sorry, your recommendation is?

MEMBER QASEEM: What are my choices? To be honest with you, I'm not sure.

ACTING CO-CHAIR GESTEN: So it was conditional support. It's do not support, support, or conditional support.

MEMBER QASEEM: Do not support.

ACTING CO-CHAIR GESTEN: Okay. David?

DR. BAKER: So I may have left one out, which is the smoking part of the component, and I've had a problem with this for a long time. The current smoking rate in Utah is 10.3 percent,

and in West Virginia, it's 27.3 percent. So if you look across the states in this country, this will be a very biased measure, even in the best of hands, in the best randomized control trials, intensive therapy, behavioral therapy, pharmacologic therapy.

If you get 20 to 40 percent of your patients who smoke to quit, you're doing really well, and I'll bet you it's even much, much lower for the patients with ischemic vascular disease. So I've always had a problem with this. I think it's biased for those states that -- it's biased against those states that have a high prevalence of smoking.

ACTING CO-CHAIR GESTEN: Helen.

DR. BURSTIN: I just want to make a comment. This measure and a very similar measure are up for endorsement review, so all these issues are being debated significantly in the cardiovascular group, so I think we can certainly take some of these comments back. The smoking issue, in particular, I don't think we've talked

about yet, but it is teed up, and lots of the same discussion, as you might imagine, that you're having right here, but among a group of people for whom cardiovascular illness is something they care deeply about.

PARTICIPANT: But the other measure is not on our list, is that true?

DR. BURSTIN: That is true. This is, I believe -- Reva, help me here. I think this is a variation of the Minnesota measure from Wisconsin.

MEMBER DANFORTH: Right. This is Melissa. Yes, this is the Wisconsin measure. The Minnesota measure is up for measure review up in phase 4, and this is the updated statins guidelines, which, Minnesota, which is up for review, is reinserting the statin guideline, so they will be competing head-to-head, so that's why we deferred them from cardiovascular phase 3, so the committee can review them side-by-side, but they're basically identical measures.

MS. WINKLER: Yes. And this is Reva,

just to note that the MAP has recommended the Minnesota version of this measure in the past several times as it's gone through iterations responding to the changing guidelines, and so it has been in PQRS. It, in the most recent rule, was removed, but MAP and PQRS certainly has seen the Minnesota version of this measure previously.

ACTING CO-CHAIR GESTEN: Bill.

MEMBER KRAMER: Just to clarify, Helen, maybe it's a question for you. My understanding is that, from what you said and what I heard before, this measure is under consideration by the steering committee, and in fact, what will come out of that process will be two things, one is updates of the clinical guidelines for statins and for blood pressure control and so on, and second, looking at which one is considered the best in class.

And so the conditional support recognizes both, one, the support is important because this is a really important measure, and second, however, that because of the changes in

clinical guidelines, and the fact there are two competing measures out there which are under review, that it's only conditional support pending the results of the updating of the clinical guidelines and the selection of the best in class. Is that correct?

DR. BURSTIN: That is correct. The committee will update it based on the updated guidelines, look at the measure, consider all the issues raised here, and we'll actually go ahead and pass along whatever. Again, in our age of trying to be very linked here, we'll make sure whatever discussion was brought up here will go back to the standing committee as well as they review those measures going forward.

MEMBER KRAMER: Great. Well, I would strongly recommend that we support the workgroup's recommendation of conditional support for this.

ACTING CO-CHAIR GESTEN: David? And let me just remind, David, before you start, folks on the phone that are coordinating

committee members, that if you want to get in the queue, just raise your hand on the webinar, and we'll be happy to call on you. Go ahead, David.

MEMBER GIFFORD: I'm just curious why this measure went through on a conditional support voting, not measure under development, since it seems to be just like a lot of the other measures that go through under development. What was the rationale as to who got to pick when they went that way, and it sort of restricts the MAP on voting.

DR. BURSTIN: It's fully developed and tested.

MEMBER GIFFORD: But I'm just hearing it's not fully developed and tested because there's guideline changes, and we need to update the criteria, and we need to do a forward on it. That's no different than some of the other measures that went through on measures under development.

DR. BURSTIN: Right. Currently, right now, the measure is fully developed and tested.

Those modifications may come up as part of the upcoming evaluation process. But for right now, it's not a measure that is being developed. It's fully developed and tested, although it may change. You could say that for the majority of the measures we look at.

MEMBER GIFFORD: Right.

DR. BURSTIN: Many of them will change as the evidence changes.

MEMBER GIFFORD: So is the measure being proposed to be used as is? As is, not future changes or planned changes of the review process it's going through. It's going to go into rulemaking as is.

DR. BURSTIN: Except that it specifically -- at least the workgroup rationale specifically said, MAP conditionally supports this measure pending the outcome of the NQF evaluation by the cardiovascular committee. So it's yes. I mean, this is like many of the other -- we haven't done very many conditional supports today, but that is typical that the measure is

supported with the condition that whatever emerges out of the endorsement process will be incorporated in.

CO-CHAIR PINCUS: Incorporated. Now, are our comments being incorporated into the measure evaluation by the cardiovascular committee?

DR. BURSTIN: Yes. We will most definitely pass these comments to the CV committee as they look at this updated composite, yes, from both of them. I mean, this is what's a little difficult. Mainly changes the denominator for one to the other, not these issues of evidence from the two measures.

ACTING CO-CHAIR GESTEN: Bill.

MEMBER KRAMER: Just a process question. When we just had this recent conversation, Amir stepped out of the room for a call, and since he was the one who pulled this measure, I think, and raised the initial concerns, it might be worth recapping for his benefit in case he has any response.

DR. BURSTIN: I was saying, again, because it is fully developed and tested in its current form and going to the CV committee, if it gets conditional support, what's listed here by the workgroup as the condition is that it's conditionally supported pending the outcome of what the cardiovascular committee says.

So in some ways, you're deferring to the expertise of the CV committee, although, we will bring forward all the commentary from here to that committee, but it's not supported. It doesn't fly in. It's conditionally supported pending that evaluation.

MEMBER KRAMER: And that evaluation includes addressing the changes in the clinical guidelines that you raised in your initial concerns.

MEMBER QASEEM: And I can probably live with the conditional support, but I'll tell you, it goes back to what I started out by saying, I'm not really clear on the voting categories that we are using because half of them

we are saying, we've got a lot of these concerns, and you continue development, or it's conditional support, and I think that that's where I'm a little bit struggling, with our voting categories.

And that's why I think it went back to what I said, Harold, this will wrap it up, that we should have wrapped up that conversation from this morning because you can see we are all struggling in terms of what are we voting on.

CO-CHAIR PINCUS: So let me, like, it's kind of the way I think about it, so the measures that are under consideration are measures that have not been well-defined, that they're in development and so that they're not ready for prime time.

And the question is, do we recommend that CMS sort of invest the effort in trying to further develop them with our, you know, with our comments, or do we say it's not worth further developing.

For the measures that actually are

well-defined and well-operationalized, then it's a different set of questions. Are they ready to actually be implemented or are they not ready to be implemented, or are they almost ready to be implemented, but there's going to be another process they have to go through?

And so this is an example of something that's further along the development process, but I guess the recommendation is it's not ready to be implemented; it needs to get further input from this other process.

MEMBER QASEEM: I mean, and that's what probably I'll say. The way the measure currently reads and stands, I think it's going to do more harm than benefit. So I think I will need to see the revised measure before we can go forward with that. That's why I said that the do not approve or whatever is the recommendation.

MEMBER DANFORTH: Hi, this is Melissa again. And let me clarify that this measure is already in use in the state of Wisconsin. They provided about, I think, three quarters of data

to us. So it is in use in Wisconsin.

ACTING CO-CHAIR GESTEN: David.

MEMBER GIFFORD: So Harold, I would agree with you, and I think that was the general feeling of this group when we created the continued further development pathway, but that's not in reality how it's going to be implemented.

So I think the language you just used to put in the report back to HHS and the Secretary that those are under development, feel like they, you know, if they'd gone the other pathway they would've probably gotten not support because they weren't ready enough.

You know, I think that was earlier, Amir said that earlier, that essentially, I think that was the impression that we had. And the reason we created it was a lot of these measures were getting voted do not support because that was one of only three categories we had. It was unfair to CMS, unfair to the patients and providers out there for very good measures that needed further development, but that they weren't

ready.

Now, the twist is CMS is under a huge timeline, so they're going to forward. But they could do that anyway and it trumps it. But I think that that's then an important statement to say if that's what the classification is. And that's the way the PAC group when they met, that was the way they started out their meeting and under their impression with the measures.

CO-CHAIR PINCUS: On this measure it's a judgement that even though it's well -- and this is the judgement that the committees make, even though it is well-specified and has been in place and so forth, is it still considered under development because of all the issues that have been raised and therefore it needs to go on these as well, or is it well-enough specified that it simply needs to go through this other hoop?

MEMBER GIFFORD: Yes, but the committees don't decide that. CMS decides that on what they put on the MUC list. Committees can't change that. Taroon just said that earlier

on, right?

MEMBER GIFFORD: So how we have operationalized this to take the subjectivity out of the process -- now, whether it's subjective still is up to interpretation. Clearly, there's a lot of disagreement about that, is that CMS presents to us the level of testing that the measure has undergone. And if it's not fully tested in the settings that it's intended to be used, it goes into the measure development pathway.

That is an objective evaluation of the measure. We don't assess the extent of the testing or the results of the testing. That's really up to either the Endorsement Committee or the work groups.

In this case, this measure is tested as specified. And the question in front of the committee, as specific as it could be, is to evaluate the measure in front of you.

Now, if there are suggested changes or the measure in front of you is not a -- the

conditional support is challenging because it's -- to a certain extent, you're asking for some elements of the measure to be changed or to go through a process.

Typically, we've asked it to go to the NQF endorsement process to look at certain things. But essentially, the measure as constructed is a support.

In the case that we're discussing today, I think the question in front of the committee is is this sufficiently the measure that you would agree that should be implemented in the program or not?

If it's not, then I think Amir is proposing it's a do not support. If there are certain conditions in which you would support it, and I think there is a grey zone here. This what I think we're struggling with, which is how far do you go with the conditions? You could say develop a whole new measure.

That wasn't, I don't believe, the intent of the Coordinating Committee when we

first developed that. I'm not suggesting that's what you're saying here, but, you certainly don't want to attach so many conditions to it that it's no longer the measure that you're evaluating. So that's up to this group to make a judgment call.

MEMBER GIFFORD: I think that makes total sense. I think that makes total sense. I think the confusion is what does it mean to encourage further development. And I think what you said is that if it would have gone through the other pathway it probably would have been do not support, or it would have had a bazillion conditions put on it because it wasn't fully tested or developed yet.

DR. BURSTIN: The measure is in use. It's fully developed and tested. They're --

MEMBER GIFFORD: I'm not talking about this measure.

DR. BURSTIN: -- planning to update --

MEMBER GIFFORD: I'm just talking about --

DR. BURSTIN: Oh, you mean in general.

Okay.

MEMBER GIFFORD: -- the distinction in general.

DR. BURSTIN: Right.

MEMBER GIFFORD: No --

DR. BURSTIN: I agree.

MEMBER GIFFORD: -- I'm just saying this just raises that question again.

DR. BURSTIN: Yes.

MEMBER GIFFORD: I agree with this way this measure is. I agree with what his definition is. I'm just saying that to Amir's question to close the discussion we had in the morning, what it seems to imply as we coalesce as a group, it means that a measure that is classified, and I think it's a good criteria that you have, as being under the development pathway.

If we had not created it, there was a high likelihood, not guaranteed, that it was going to get do not support. And so I think that that message needs to be clear to CMS because these are measures under consideration for

putting in rules. And so that feedback to the Secretary, I think, is an important message for this MAP to give.

MEMBER QASEEM: So where does this measure stand in the NQF Committee? How are they reviewing it, or what's happening, and just what are they doing with it?

DR. BURSTIN: It'll come up. And I don't think it's actually there yet. I think it is -- right? Jean-Luc's not saying. Oh, it is coming forward as for full re-evaluation for both evaluation of this Wisconsin measure as well as the original Minnesota measure, which is currently endorsed.

And I know that at least the Minnesota group has -- you know, Minnesota Community Measurement, they tend to update their measure pretty commonly based on evidence. So, you know, that's the question.

We routinely do have measures that come forward where MAP has traditionally put the condition that it come through the endorsement

process and let the science play out there rather than at this table.

MEMBER QASEEM: So --

DR. BURSTIN: So that --

MEMBER QASEEM: -- Minnesota Measure is a better measure, and Wisconsin one never got a thumbs up, or you guys have given it a thumbs up?

DR. BURSTIN: We've never looked at the Wisconsin measure. They're different only in denominator. The numerators are almost identical.

MEMBER QASEEM: Okay. So is that --

DR. BURSTIN: So they'll look at them both and then make a determination of best in class.

MEMBER QASEEM: Okay.

ACTING CO-CHAIR GESTEN: Any other comments on this measure?

WORKING GROUP CO-CHAIR BAGLEY: Foster, this is Bruce. The only thing I would add that has not been discussed is the Clinician

Workgroup really felt strongly about sending a message to CMS that we do think that composite measures and maybe even all or nothing measures have value.

Because one of the reasons they dropped the Minnesota measure was because very similar individual measures were present in the Million Hearts campaign. So we're trying to send back the message that we think composite measures have a valuable place.

ACTING CO-CHAIR GESTEN: Thank you, Bruce. So I think we're ready for a vote. I don't see any other --

MEMBER QASEEM: Can I ask --

ACTING CO-CHAIR GESTEN: Go ahead.

MEMBER QASEEM: -- just one more question?

ACTING CO-CHAIR GESTEN: Yes.

MEMBER QASEEM: Bruce, this is Amir. Just clarification question, can you just tell or give us a feel for did you guys discuss these issues that we just discussed related to this

measure in your Clinician Work Group?

WORKING GROUP CO-CHAIR BAGLEY: Well, I think that both measures need to be reevaluated because of the change in the guidelines. And that's the purpose of the re-look by the NQF appropriate committee.

ACTING CO-CHAIR GESTEN: Okay. So we are voting on, this is Measure 275. It's ischemic vascular disease all or none outcome measure. The work group recommendation was conditional support, and we spent some time talking about what those conditions are just now.

This was pulled by Amir, and the recommendation was for this to be a do not support based on concerns about various elements of the measure. So, Amber, you're going to re-say what I just said.

MS. STERLING: I am. MUC15-275 ischemic vascular disease all or none outcome measure is open for vote. It's support, conditional support or do not support.

MR. TILLY: We just need a couple more

votes. I'm sorry. If you could try clicking again.

And the results of the vote are zero percent support, 89 percent conditional support, and 11 percent do not support. So the result of the vote is conditional support. The recommendation stands.

ACTING CO-CHAIR GESTEN: Great. Thank you. Let me just process and time check. We have, I don't know, I'm counting them, seven, eight, nine, something like that, more measures to go. It's about 4:30, we're supposed to close at 5:00 and we had Hospital Workgroup on today.

Clearly, we're not going to get to the Hospital Workgroup today. But we had already talked about that as being able to steal some time tomorrow based on other changes that we had made in terms of the breakout sessions and so on, so I think we do have one person who is on the line who will make a comment before we close around the hospital measures, who I guess can't be here tomorrow.

DR. BURSTIN: He's actually here in person, but we'll see if we can get --

ACTING CO-CHAIR GESTEN: Oh.

DR. BURSTIN: -- to it.

ACTING CO-CHAIR GESTEN: Okay.

DR. BURSTIN: We've got to finish this work today.

ACTING CO-CHAIR GESTEN: But we'll do this just to reassure you that we're not going to keep you until 7:00 going through hospitals. Although that might be kind of a nice threat. I don't know.

So we are back to -- we have two measures that are related to PQIs, and this is MUC 576 and 577. And I'm just guessing, and Sam and Carl you can tell me if I'm wrong, that there might be issues in common that you want to talk about relative to these.

These are prevention quality indicators out of chronic composite. Another one is acute composite. These were recommended. These were the workgroup recommendation for both

of these was encourage continued development. And they were pulled by Sam and Carl.

These are measures, just to be clear, that are both applied to MIPS and the Medicare Shared Savings Program. And so Sam and Carl, I guess the first is just clarify whether you want to bring this to a vote and then -- versus discussion, and then second, what your counter recommendation is.

MEMBER SIRIO: So I think it's going to be -- Heidi's in the room and it's going to be a little bit easier, I think, for her to do it in person, so I'm going to pass my comments, because she's got them, to Heidi.

ACTING CO-CHAIR GESTEN: Okay. And Sam, are you still on? Okay. Or Emily? So are you charged to answer those two questions as well to --

MEMBER BOSSLEY: Yes.

ACTING CO-CHAIR GESTEN: -- start out? Yes.

MEMBER BOSSLEY: Yes. Although Kate's

not in the room and we do have a question. Maybe Reva can answer it. So AMA has significant concerns with recommending these measures in both programs.

So you have them listed I think four times or they would technically be four times, so we'll handle them altogether, hopefully get us a little bit ahead of or on schedule.

But the question that we have is that these were put forward as under development, but we also see in the rationale and we know the VBPM, the payment modifier, the measure is in -- both measures are of use. So one of the questions we have is, and it goes to how the recommendation would be changed, it's either insufficient information or do not support.

And so I don't know if it's that the measures were significantly being updated and that's why they're resubmitting them as under development, but they are in use in a program right now. So I --

MS. WINKLER: Yes. Heidi, this is

Reva.

MEMBER BOSSLEY: Yes.

MS. WINKLER: Yes. The information that came to us on the MUC list stated that the specifications are undergoing significant revision and that a risk adjusted methodology was in development.

MEMBER BOSSLEY: Okay. That's helpful. Okay. So then I guess our recommendation is insufficient information. And it is in part, again, MSSP would be that the measure's being used at the ACL level and then, obviously, MIPS would be at the individual physician level.

We have not yet seen information on how this measure is specified for either level of measurement. We have concerns about whether the reliability and validity would be adequate at either level.

In large part, ACOs, again, are very different in construction. Knowing how they might work across those different types is

unclear. And then our further concern is if you take it down to the individual physician level, small sample sizes most likely will be an issue.

And these measures have been tested and in use for metropolitan or county level. So transferring it to a different level of measurement without any information is very concerning.

We also just don't know what the unintended consequences are of this type of measure until it is used. So for that reason, assuming these are under development, we would be asking for insufficient information as the recommendation.

ACTING CO-CHAIR GESTEN: Thank you. Other comments, folks on the phone?

MEMBER LIN: This is Sam and I -- yes, I agree with everything that Heidi said. Well, I guess we were again trying to be positive looking at continued development.

And one of the problems on the two that are for MSSP, using ACOs as the example, is

that it's a number. It sets a bar of 100,000. And, you know, some ACOs just aren't going to make it to 100,000 population. So there's got to be some adaptation or consideration as mentioned to that.

The other thing is there's timing. Going back to the ST thing again, timing in this is that ACOs don't receive their CMS measure except once a year and, at this point, at least six months after the year is finished. So they are put in a bind relative to being responsive until they get data. So there's additional things that we think would be helpful in the continued development.

There is a word clarification that would be helpful. In all four of these, they talk about admissions for one of the following conditions. The word admissions, is that the correct word? Because to me, if we're talking about prevention, or preventing admissions rather than admission per se, or is the appropriate word the patient presents with one of the following

conditions? We're a little confused on that.

ACTING CO-CHAIR GESTEN: Mary Barton on the phone?

MEMBER BARTON: Thanks. Yes, I think just to quickly answer Sam's question, the issue is that the admission is seen as a failure, so that the count per 100,000, you don't have to have 100,000. It's just that it's a count. You know, you average it up.

You change the numbers so that it's per 100,000 in the population. But I wanted to speak to an issue that's really more important for the Medicare Shared Savings Program than it is for MIPS.

These AHRQ measures were designed for a commercial age population 18 and older. And NCQA's actually endeavored to do a bit of work to design a measure that was relevant to the Medicare 65 and over population, which is slightly different than the way the AHRQ's set up.

The PQIs, it has it -- if you lose a

couple of conditions, it adds a couple of conditions. And for that reason I would recommend that for anything that's focused for 65 and older specifically, that they take a look at the work, at least, that NCQA has done to, you know, not have it -- to benefit from the research and the years of work that we've put into that and as well as the relevant risk adjustment.

ACTING CO-CHAIR GESTEN: Thank you, Mary. David?

MEMBER GIFFORD: I'm going to beat the dead horse. I would support insufficient -- voting for insufficient information. I think if we use the criteria that just the topic of the measure is important to further development, then there's no need to have any of the other categories.

I think we're voting for what comes before us and the information before us on this measure and insufficient information doesn't mean that whether we support and encourage development. This measure's not been specified

enough to even give appropriate guidance to CMS where to go on this measure. And I think that's an important -- so I would strongly encourage us to think about voting for insufficient information of this.

ACTING CO-CHAIR GESTEN: Thank you. Bill?

MEMBER KRAMER: I would recommend that we do support continued development. In my mind we do have information. These are established measures as they are currently specified.

What needs development is the application to other populations to make it relevant to ACOs. And that's the development work that is needed.

This is an important measure. If we were to say insufficient information we'd be saying we don't even know if this is important. We don't know if it's useful as it's currently specified.

I think we do know those things. It is important, it's useful as currently specified,

but it's not relevant, it's not useful in a Medicare Shared Savings Program because it hasn't been developed and tested in that setting.

So that's the development work that needs to be done and so I think that's the basis that I think to my understanding as to why the workgroup came up with this recommendation and why I would support that.

ACTING CO-CHAIR GESTEN: So thank you, Bill. I think we're happy to vote these two separately when we get to that, which I think we're headed towards.

But I just want to make sure before we get to that that there's not any nuanced or specific concerns that folks who raised this want to make about chronic -- the two measures, chronic versus acute.

In other words are all the comments that have been made apply equally to both or is there any more nuanced or specific consideration that you want folks to think about relative of one to the other?

MS. KHAN: So this is Rabia Khan from CMS and I just want to add some additional thought for this. So for both of the PQIs, we intend to use the specifications as AHRQ has developed them. But we are working closely with AHRQ to further develop the risk adjustment approach to also include comorbidity since the measures themselves are only risk-adjusted for age and gender.

The other piece of this that we are looking at at CMS is how to apply this measure at an ACO level. We do have two individual PQIs within the Medicare Shared Savings Program that have been specified and tested at an ACO level.

So what we're trying to do here is to replicate the process that we have for our two existing PQIs, but just at a composite level. And we're also working with the Physician Value Modifier Team who's been applying both of these composites for the value modifiers in order for us to have an aligned approach that we can use, potentially, these PQIs at an ACO level, but then

also at a clinician level for MIPs as it's already being used under the VM.

ACTING CO-CHAIR GESTEN: Thanks. Bill, is that card a residual that you have up there? Okay. No problem.

MEMBER GIFFORD: We were actually just debating -- having a very interested side debate of whether --

ACTING CO-CHAIR GESTEN: Would you like to tell us about it?

MEMBER GIFFORD: Yes, I would. Whether you would consider insufficient evidence as a vote that the measure shouldn't be considered further development or not. And both of us would agree that the measure needs to be further developed. We're just disagreeing on what the category meant, and could it be misinterpreted to not pursue further development.

I think that goes back to my earlier comment. I think all these measures, whether they do not support -- really merit further development. But if we do that, then just

everything should be further development and why are we voting on everything. So I think that's the point we were trying to debate over.

ACTING CO-CHAIR GESTEN: So I want to make sure I understand your question. Are you asking whether if something is voted as insufficient information it means it disappears from the planet or sends a signal that it should not be further developed?

MEMBER GIFFORD: I think it does not. Bill's concern was it would. And so I was throwing that out there because if people are voting concerning with Bill, if Bill's correct, I would change my vote. If Bill's not, if I'm correct, I don't know whether Bill would change his vote, but he might think differently about it.

ACTING CO-CHAIR GESTEN: So does anyone hold the truth of what happens to things that are in that category of insufficient information? I don't know if we've had much precedent for it or not, but want to take a guess

at what happens?

DR. LARSEN: This is Kevin. I'll take a guess since Kate's out of the room. I think what Kate said earlier that what's really important to CMS and HHS is this discussion and comment. And that being really clear when the discussion comes that we add narrative to what the vote has been to say this is what we think specifically about this domain. It is really important input and feedback in the measure development process.

ACTING CO-CHAIR GESTEN: Go ahead. Yes.

PARTICIPANT: Sorry I don't have a tent card.

ACTING CO-CHAIR GESTEN: Before you go, I just want to make sure it's -- we lack clarity about exactly what happens. I mean, I think your point is you describe what you would like to see happen or how you'd like to interpret it and that may resonate with others. And I take, Kevin, your comment, but there is some lack

of clarity about --

MEMBER KRAMER: Just to clarify what I'm thinking, the way I interpret that, is that there was one earlier that I voted insufficient evidence. That meant to me I don't know. I mean, I didn't even know whether to vote one, you know, did I like it or didn't like it. It's an, I don't know. It's not that a group thinks it's insufficient evidence, it's that I don't know. It's a don't know category. It's a personal kind of insufficient evidence.

So if we think that this is an important area, this topic is measuring an important thing, but the measure needs to be developed further because it's not currently specified for the uses that they applied to, then we ought to vote for needs further development.

I'm concerned if we vote for insufficient evidence it might be misinterpreted as the group thinks there's just insufficient evidence that this would be worth developing.

MS. O'ROURKE: And I'm not sure if

this clarifies, but this is a category we have not used much in the past few years. It was really an artifact from earlier days of MAP when the measures under consideration list was much less complete and CMS was sending us measures without numerators and denominators. And that is where the group really felt they did not have much information and did not want to make a decision based on a measure title.

ACTING CO-CHAIR GESTEN: So if nothing else I think an output at least of today is revisiting these categories and what they mean and articulating them and trying to be clearer about them.

I think, as David mentioned earlier in the day, these are meant to solve a particular problem which I think they did. I think they've also, like most things that are meant to solve a problem, created potentially some other ones in its wake. And some of these categories, may or may not -- they may be titles without a distinction or not meaningful, so. I'm sorry,

Rhonda.

MEMBER ANDERSON: I enjoy the conversation, but I still have difficulty understanding. We're talking about clinicians, yet I believe a lot of it is around population health management where the denominator isn't large for an individual clinician.

So I think what I think about is how does the individual clinician manage chronic illness and what are the components that would tell us, from an outcome perspective, that that clinician is managing it effectively? And from my perspective that's the real question. And that's why I believe there's insufficient evidence as to the real purpose behind this with the individual clinician.

ACTING CO-CHAIR GESTEN: Thank you. Heidi.

MEMBER BOSSLEY: So I think the only thing I would add, too, is we just heard that this measure is in use. It's being changed slightly, risk adjustment is underway. If we say

encourage continued development, we still have a measure in use. And we've already heard conversations and concerns that their measure may not be constructed adequately for either program.

So that's where I struggle with maybe you do go back to insufficient information because we're signaling to CMS we actually are concerned with how this is constructed. So I think that was part of our reasoning for this.

ACTING CO-CHAIR GESTEN: Jayne.

MS. CHAMBERS: So I want to be sure I understand sort of where we are in the measure. I think that what I heard from Kate earlier, or somebody in the room earlier, was that this measure is being critically looked at from top to bottom, that AHRQ is really sort of redoing this measure to look at for use in other populations than where it's currently specified and so it'll be undergoing substantial change.

And if that's the case are we re-looking at the risk adjustments that are in there

and how that's going to be used going forward. You know, I think --- I guess I'm starting to -- originally I was going to say conditional support, but now I'm not sure because I'm not sure we even know what the measure is we're looking at.

ACTING CO-CHAIR GESTEN: Any other comments?

MEMBER GIFFORD: The definition of harmonization is when the denominators are the same, not necessarily the numerator. I mean if your denominators are different population, then, correct me if I'm wrong, Helen, you don't have to -- it's an argument for why harmonization may not be necessary.

The numerator topic gets you into the pathway of potential harmonization, but you get out of harmonization when you say you're measuring different groups.

DR. BURSTIN: No.

MEMBER GIFFORD: No?

DR. BURSTIN: Actually, no. It's --

MEMBER GIFFORD: Okay.

DR. BURSTIN: -- either group. The reason to potentially pick a best in class is if you have both, same numerator, same denominator. You could have different denominators. You would still want to harmonize on the measure concept in the numerator. So that doesn't necessarily --

MEMBER GIFFORD: Yes, okay.

DR. BURSTIN: Yes, right.

MEMBER GIFFORD: But if you're numbers on the numerator, but they are considered then different measures. You don't vote best in class.

DR. BURSTIN: Correct.

MEMBER GIFFORD: Okay.

DR. BURSTIN: Correct.

MEMBER GIFFORD: So this is --

DR. BURSTIN: Right.

MEMBER GIFFORD: This would be a measure that's changing the denominator, not necessarily the numerator?

DR. BURSTIN: Right. And I'll just

put out, at least in the past when we've had discussions around risk adjustment, those are usually in the camp of things you would continue to work on.

I mean, I think this has come up before in other measures, just to point that out, certainly around some of the SDS issues last year and other issues.

MR. TILLY: Okay. Everybody remember how to vote? We're going to vote these one at a time. I think this is the way we do things. They'll come up. And how about if I just, Amber, just let you do this? Is that all right?

MS. STERLING: I'll do it. Great. So this is for MUC15-576. This is PQI 92, prevention of quality chronic composite measure. And this is -- is it okay if you do it both for MIPs and MSS at the same time because that's how we have our slides set up? So I don't --- just want to make sure.

MR. TILLY: Anybody have a problem if we do the two of them together, vote on them for

MIPS and for Shared Savings at the same time? I see no objection.

MS. STERLING: Okay. And the options are, encourage continued development, do not encourage continued development, or insufficient information, and voting is open.

MR. TILLY: We need some nice background music going forward. I make a motion to have something, you know, like Jeopardy music or something.

We have 28. Okay. The results of the vote are 69 percent for encourage continued development, zero percent for do not encourage further consideration, and 31 percent for insufficient information. The recommendation stands.

ACTING CO-CHAIR GESTEN: So lest folks feel disheartened about the votes and none of these being overturned, I would just point out that the conversation and the comments have been rich. And I think we've already talked about how we see them going forward and informing the

process, so take heart. So next one.

MS. STERLING: Great. We are going to move on to MUC15-577, PQI 191, prevention quality acute composite. And again, this is for both MIPs and Medicare Shared Savings.

Your options for voting are one, encourage continued development, two, do not encourage continued development, or three, insufficient information. And voting is open.

MR. TILLY: The results of the vote are 70 percent encourage continued development, zero percent do not encourage further consideration, and 29 percent insufficient information. The recommendation is encourage continued development. The MAP recommendation stands.

ACTING CO-CHAIR GESTEN: Okay. Thanks. We're going to go down to the next measure which is MUC 579. It's falls screening risk assessment plan of care to prevent future falls.

This particular measure part of MSSP.

The workgroup recommendation was to support. This was pulled by Sam and Lisa. And if you can -- you know what the two questions are, vote yes or no and I forgot the other question. Vote yes or no -- what's that?

MEMBER LIN: And why.

ACTING CO-CHAIR GESTEN: Why.

MEMBER BARTON: And what's your justification.

ACTING CO-CHAIR GESTEN: Is it like quarter to five or what? Go ahead.

MEMBER LIN: Okay. This is Sam. The recommendation here is support A and B under the three rates. But we've got a problem with Rate C which is known as planner care for falls. The whole point simply being that rather than why they're leading to improvements, this element increases the length, the complexity of currently used care plans or whether it's sometimes referred to as after-visit summaries.

And part of it is that today's care plans are still static paper trails. The lack

patient centricity, flexibility, usefulness with the patients and families. And that will not support the intent of this particular MUC. So we propose, you know, support A and B and defer the third one for maybe continued development.

ACTING CO-CHAIR GESTEN: Lisa, did you want to make a comment?

MEMBER McGIFFERT: Okay. I am looking at my notes and I have similar comments that we had with 207 that, you know, we're concerned that this doesn't complete the measure. We don't know if it had an impact on falls. We think it's important to measure this issue and our concerns are that it really isn't complete.

ACTING CO-CHAIR GESTEN: So let me make sure for you and Sam.

MEMBER McGIFFERT: It's been my understanding --

ACTING CO-CHAIR GESTEN: Is it support with modifications? Is that what you're advocating?

MEMBER McGIFFERT: It's the same --

well, we have the same concerns as we did with 207. And I just wanted to --

MEMBER LIN: Correct.

MEMBER McGIFFERT: -- voice those concerns.

ACTING CO-CHAIR GESTEN: Okay. And do you want to translate that into a recommendation for how people should vote?

MEMBER McGIFFERT: I wasn't necessarily pulling it for a vote. I did note that my understanding is that this is already being used in the physician quality reporting system, if anybody can validate that.

And if so, is there any way to look at the data that's already been collected and figure out, you know, if there actually has been a reduction in falls based on these measures. I would like to see that. I just pulled it for discussion because I feel like it's an incomplete measure.

ACTING CO-CHAIR GESTEN: Okay. Gail.

MEMBER HUNT: Yes. I would agree and

I don't think there's anything here that says that they've actually looked at --- it's all the process of doing the risk assessment and then saying does the person have a documented risk assessment in the plan of care. But it doesn't say anything about whether or not it actually made a difference in their falling -- in preventing falls, which is what the whole purpose of it is, right?

ACTING CO-CHAIR GESTEN: So, Lisa, you had said that you saw this as a discussion. I just want to check with Sam who also pulled this. Sam, I won't answer for you. Would you like us to take a vote on this?

MEMBER LIN: Well, we took a vote on 207, so I'm wondering whether we should be consistent or not.

ACTING CO-CHAIR GESTEN: What did we do with 207? Did we vote?

MEMBER LIN: Well, I thought -- gosh. Maybe I've got the wrong one. I thought the issue at that point was about implementation.

And again, this is process versus outcome, but how would you measure implementation and how do you be consistent about that? This is was sort of the same thing with the care plans. There's not consistency and a current process at this point.

If we support it we'd have to support all three parts. And I can't support the third element.

CO-CHAIR PINCUS: For the 207 we didn't vote, but we took additional comments.

MEMBER LIN: Oh.

CO-CHAIR PINCUS: Yes, sort of, you know, urging further examination of building in some kind of outcome as you're into this and looking at sort of relationship to outcome.

MEMBER LIN: Okay. And I'm struggling here because it's late in the day, but how's that different from continued development?

ACTING CO-CHAIR GESTEN: The measure's specified in use and it's NQF endorsed. That's why it's not continued development.

MEMBER LIN: Okay.

ACTING CO-CHAIR GESTEN: Lisa.

MEMBER LIN: Okay.

MEMBER McGIFFERT: I just want to clarify as I did before in 207, that we think the third measure is an important measure. We're not in agreement with the reasons that we pulled this out with Sam, yes. We want an outcome measure and we do think the third point of this composite is important.

ACTING CO-CHAIR GESTEN: Okay. Any other discussion on this? Sam, I would just want to be crystal clear. We're happy to vote if you want to take it to a vote or we cannot vote. Consistency is nice, but it's not the only value in life, so up to you.

MEMBER LIN: Yes. No, if we're going to be consistent with 207, let's move on.

ACTING CO-CHAIR GESTEN: Okay. So we would take the comments under discussion and bring those forward.

MEMBER LIN: Right. Thank you.

ACTING CO-CHAIR GESTEN: Okay. The next --

MEMBER LIN: The next part really quick, I promise.

ACTING CO-CHAIR GESTEN: I'm sorry?

MEMBER LIN: The next one is really quick, Number 11.

ACTING CO-CHAIR GESTEN: Number 11. I don't have a Number 11. I was moving on to my Number 9, which is MUC 928 which is a paired measure. Is that -- am I out of order?

PARTICIPANT: No, you're right.

ACTING CO-CHAIR GESTEN: I'm good?

PARTICIPANT: Yes.

ACTING CO-CHAIR GESTEN: All right. Sam, hang in there. It's a paired measure, depression utilization, the PHQ9, depression remission at six months, depression remission at 12 months. This one --

MEMBER LIN: Right.

ACTING CO-CHAIR GESTEN: -- was given conditional support. This is part of MIPs and it

was pulled by Elizabeth Mitchell. And Elizabeth, are you on the phone still?

MEMBER LIN: No, but this is Sam. But this is one actually I thought we had pulled and it's a quick issue. If you look, it's a typo. It keeps showing up, so we just thought we might as well say something.

Under description, fourth line says demonstrate remission, that is PHQ score of greater than five. It's less than five. That's all it is. It's just a typo, but it's been showing up all the time.

ACTING CO-CHAIR GESTEN: Well, that's --

MEMBER LIN: Because the numbers run the opposite way.

ACTING CO-CHAIR GESTEN: That's really easy. But let me just make --

MEMBER BARTON: Thanks, Sam.

ACTING CO-CHAIR GESTEN: Elizabeth, is that you? No.

MEMBER BARTON: No.

ACTING CO-CHAIR GESTEN: Okay. I'm just -- David.

DR. BAKER: So I have concerns about the numerical cutoff for this. I have seen many patients who start off with a PHQ of 14 to 17. They get down to seven. This is the best that they've felt in the last ten or 15 years.

And this measure would encourage me to actually have to start a second agent to get them down into quote remission. So I think there is significant unintended consequences from this measure.

WORKING GROUP CO-CHAIR BAGLEY: This is Bruce. I think somebody should check the measure specifications. I think that's a change of five or more as an indicator of improvement.

CO-CHAIR PINCUS: There's actually two different measures that exist out there, one is clinically significant improvement, the other is remission. So -- and this sounds like this is the remission one.

ACTING CO-CHAIR GESTEN: Well, we can

clarify, but David, I'm not sure whether you're raising this as further commentary or discussion or whether you're raising it because you think that we should vote on this?

DR. BAKER: I'd like to see a vote on this, even though I know that we'll lose. But I think that this is -- the idea of a change score is one thing, but the idea of a cutoff, you know, of less than five, I think for so many patients it's just not realistic and it's got adverse consequences. So I --

ACTING CO-CHAIR GESTEN: Okay.

DR. BAKER: I would suggest that we vote to not support it.

ACTING CO-CHAIR GESTEN: Okay. Harold and then Bill.

CO-CHAIR PINCUS: Just one issue. I'm not sure if on the overall MUC list this is paired with a clinically significant improvement measure, which is an NQF measure.

MS. WINKLER: No.

MEMBER QASEEM: Reva, do you --

MS. WINKLER: Yes. What this is is it has three components to it. Each of those three components individually is already in the clinician measure set.

What this does is bring forward an obligatory combination of the two remission measures, both at six and at 12 months where before within the clinician measure set you could choose among the three, use the PHQ9, remission at six months or remission at 12 months. What this does is bring in a measure that obligates you to use both.

CO-CHAIR PINCUS: But, Reva, isn't there also a sort of like complementary measure that also looks at six and 12 month clinically significant improvement?

MS. WINKLER: There may be, but it wasn't on the MUC list.

CO-CHAIR PINCUS: Okay.

DR. BAKER: Can I read this? So it says adult -- this is, again, it's a complicated measure, but Number 711, adults age 18 and older

with a diagnosis of major depression or dysthymia and an initial PHQ9 score greater than nine to achieve remission at six months as demonstrated by a six month plus or minus 30 day PHQ9 score of less than five. And then there's similar wording for the 12 month measure.

MEMBER GIFFORD: Dave, do the conditions that the workgroup put on there satisfy you, though, where consider target rates for different types requires and consider risk stratification to minimize adverse target rates, looking at different or --- I mean do you just want to send a signal by saying do not support to really make sure that they change this, or putting it as conditional support with your recommendation leave it as conditional support and just get the recommendation on the record?

CO-CHAIR PINCUS: I mean, I might make a recommendation to incorporate in the conditions to consider pairing it up with the clinically significant improvement measure that already is NQF approved.

DR. BAKER: That would make a lot more sense if there was another way, you know, of dealing with these patients that really have high baseline scores.

ACTING CO-CHAIR GESTEN: Bill.

MEMBER KRAMER: I wanted to raise a process question. David and others who raised issues like this around specific measures, I wonder if MAP is the right setting to debate those very specific clinical cutoffs or criteria.

It's already been through NQF endorsement where these issues, I assume, were addressed, and as well as the workgroup itself which has commissions on it. And I don't feel able to have a useful dialogue about that in this setting, so I rely a lot on the endorsement process where I know this expertise has been applied as well as a clinician workgroup.

So while I have tremendous respect for your judgment and others, it's hard in this setting to have that -- for me to enter into that conversation and decide whether it's a good idea

or not.

I will say this, from a consumer perspective, this is really, really important. I think all of us feel that depression's a very, very important measure and this is one of the few where you have really good patient-reported outcome measures.

I question whether we should actually go ahead and support this, understanding that there will be further improvements in the measure and remove the conditions for our support.

This is an important measure, a good measure. I am somewhat concerned that if we send a message of conditional support that CMS might be inclined to withdraw it from its current use, which I think would be net a mistake.

CO-CHAIR PINCUS: I think I would just say, I think this solution that we were just discussing doesn't go against a notion of the endorsement process because, you know, the initial process initially approved a measure that was focused solely on remission.

And then subsequently to sort of complement that was a measure that was added on clinically significant improvement for exactly the reasons that David suggested. So pairing them both is -- provides very limited incremental burden, but also deals with the problem David suggested.

ACTING CO-CHAIR GESTEN: Any other comments?

DR. BAKER: I just want to comment because I think the issue that Bill brings up, the broader issue about what we're able to really discuss here is an important one. But at the same time, I see this as kind of the last time that we really think about the issue of unintended consequences. And this discussion, I think, is a great one.

I mean, if we can come up with a combination or suggest that to prevent those unintended consequences, I think that's really important. Because once it goes to that next level, I'll say in our clinic at Northwestern

when I was there, the use of the PHQ9 was revolutionary.

We would all agree it dramatically improved our care, but if we all of a sudden said okay, now you have to get everybody less than five to get credit -- so, you know, 17 to seven doesn't count, then that's the level when all of a sudden we start seeing some of these unintended consequences.

So I do think it's important to discuss it. Again, not to try and get the cutoff right, but to raise issues about unintended consequences or other issues or to think creatively about how to combine them.

ACTING CO-CHAIR GESTEN: Helen.

DR. BURSTIN: Just a brief comment. Again, I don't think it's the final common step by any means. I mean, these measures are continuously evaluated on the endorsement side. In fact, your co-chair is the co-chair of the Behavioral Health Committee with Peter Briss.

So these issues are seriously

considered. And again, all this feedback will flow into endorsement. And it's exactly, I think, the reason why Minnesota Community Measurement brought forward the companion measure of percent improvement of 50 percent reduction for exactly those reasons. But all those comments will certainly be kept.

ACTING CO-CHAIR GESTEN: Seeing no raised hands or cards I'm thinking we can move to a vote. Again, we're voting on MUC 928. The workgroup recommendation was conditional support.

It was pulled and a suggestion was made to have this do not support. All right. Okay. And there was also comments that potentially a conditional support from the workgroup meeting should be moved up to support. So it'll be interesting to see how the voting goes, and -- Amber.

MS. STERLING: Great. This is MUC 15928. It is the paired measure depression utilization of the PHQ9 tool, depression remission at six months, depression remission at

12 months. Your options are one, support, two, conditional support, three, do not support. And you are open for a vote.

MEMBER QASEEM: Remind me what's the workgroup recommendation. I lost track of it.

ACTING CO-CHAIR GESTEN: Conditional --

MS. STERLING: It was conditional support.

ACTING CO-CHAIR GESTEN: -- support.

MR. TILLY: So the results are 11 percent support, 89 percent conditional support, zero percent do not support. The workgroup recommendation stands as conditional support.

ACTING CO-CHAIR GESTEN: Okay. We have three measures. Question? Yes, Kevin.

DR. LARSEN: Just a quick comment follow up from that falls question. There was a question about whether that falls measure was already in PQRS. It is already in the PQRS Program, the falls measure that we looked at a couple measures ago, and I think for

recommendation for MSSP. So it already exists in the current program.

ACTING CO-CHAIR GESTEN: So my understanding is we have three measures that currently were in -- at least on my list, were in the discussion only that potentially moved into votes. And I'm going to ask Amir to clarify that. We have 210, 211 and 220.

MEMBER QASEEM: So what are you asking me?

ACTING CO-CHAIR GESTEN: So my understanding is that on the list that I have these were for discussion, not pulled for vote. I have a note saying that these were to be pulled by you for a vote.

MEMBER QASEEM: Yes, so you know what, let's just leave it as they're all conditional support, I think, all these three, right, or four?

ACTING CO-CHAIR GESTEN: So 210 is encourage continued development. That's --

MEMBER QASEEM: Okay.

ACTING CO-CHAIR GESTEN: -- Hep A vaccination for patients with cirrhosis. 220 is Hep B vaccination for patients with chronic Hep C, was also encourage continued development.

MEMBER QASEEM: Yes.

ACTING CO-CHAIR GESTEN: And 211 is Hep B vaccination for patients with cirrhosis, encourage continued development. So they were all encourage continued development. They were identified by Sam for discussion and you --

MEMBER QASEEM: Yes.

ACTING CO-CHAIR GESTEN: -- for --

MEMBER QASEEM: So I'll keep it at discussion as well because I think the voting, I think it's just that it doesn't change anything anyways. So I'll actually combine all my comments for these three into one because I think pretty much they all fall under the same category.

Essentially, the same concerns that I think Bruce also mentioned during his presentation that the gap information is just not

provided. We don't even know what's happening in some of these population right now.

So for example, if you like to look at the Hep A vaccination for patients with cirrhosis, I don't even know how many patients are getting this vaccination are not getting the information. If this is an issue or a concern where we should even have a performance measure of what is a variation in performance measure.

And then there always going to be exceptions in certain patients as well. That was not mentioned in some of the exclusions here as well.

And if you look at some of the comments that came from like these ACP sub-specialty societies, AGA and ASGE, they all actually did not agree with these performance measures for exactly the same reasons as well.

So I'm happy to leave it as a discussion since again, the voting is going to be -- keep what workgroup is recommending anyways. But I think, again, these are the issues that

Bruce also brought up as well. I think these are incredibly important ones that are missing from many of these measures.

ACTING CO-CHAIR GESTEN: Okay, Amir. Let me turn if Sam's still on. Do you want to amplify or second or have any other additional comments that you want to make about this since you had pulled this for discussion? Anybody else who wants to make comments on any of these three measures?

MEMBER LIN: Oh, I'm sorry. This is Sam again.

ACTING CO-CHAIR GESTEN: Go ahead, Sam.

MEMBER LIN: I agree with Amir. Our only concern again was a process issue that it would help to be able to put something like the word titer in this simply because, again, it clarifies how we actually determine the capacity of this thing.

It just sort of says, you know, documented vaccination. Does that mean somebody got a needle in their arm or does that mean there

actually was titer taken to know that it took and was the right level. That's all.

ACTING CO-CHAIR GESTEN: Lisa.

MEMBER McGIFFERT: I had a note that -- I had it on 220. We're taking all these together, yes?

MEMBER LIN: Yes.

MEMBER McGIFFERT: That it sounded like the -- this is another case where the committee sounded like they were recommending something else on the conditional recommendation. They strongly considered consolidating the measure, they -- let's see, so that was one thing.

The registry was not specified and the public comments on the measure were pretty mixed with some strongly supporting and others not. It just seemed like there was not real strong agreement to encourage continued development, so I was curious about that. And then -- yes, that was mainly it.

WORKING GROUP CO-CHAIR BAGLEY: Yes,

this is Bruce. I think that these three measures really come under the category of standard of care and following protocols and things like that.

So we didn't really feel, especially without the current level information, that we could strongly support these. So we thought that encourage continued development might be the right answer and find out what the rates were.

ACTING CO-CHAIR GESTEN: Any other comments? So we have one other measure for discussion and that was -- oh, I'm sorry, David.

DR. BAKER: I just had a question --

ACTING CO-CHAIR GESTEN: Sorry about that.

DR. BAKER: -- for Bruce. Bruce, did you look at process outcome link for these? Because I just question, you know, the evidence, if this really makes a difference for outcomes.

WORKING GROUP CO-CHAIR BAGLEY: I would say the answer to that is no, we did not.

ACTING CO-CHAIR GESTEN: The last

remaining measure that we have is MUC 436 for discussion, overutilization of mesh in the posterior compartment. And this was encourage continued development and was pulled by Sam. Sam, you have the --

MEMBER LIN: And I'll be --

ACTING CO-CHAIR GESTEN: Go ahead.

MEMBER LIN: -- very quick. Thank you. Thank all of you for your patience. We agree with the MAP recommendation of continued development on this. But the reason for the discussion was, and I'm crossing the street relative to process and outcome to the outcome side, and that is there needs to be some clarification as how is the use of a mesh considered an outcome as opposed to a process. That's all.

ACTING CO-CHAIR GESTEN: Okay. Any other comments on that measure?

MEMBER McGIFFERT: I think this is a really important measure just because there has been a lot of controversy about surgical mesh and

this particular kind of mesh. And so I would just strongly encourage continued development. I mean, it's especially an issue in the Medicare population I think.

ACTING CO-CHAIR GESTEN: Okay. Well, the only thing standing between us and break is public comment. So why don't we start if there's any persevering folks left -- I need a rearview mirror, is what I need -- who want to make a comment here and then I'll let the folks on the line. Anything during day.

PARTICIPANT: Anything, but not --

ACTING CO-CHAIR GESTEN: Anything.

PARTICIPANT: -- even anticipation of this discussion.

ACTING CO-CHAIR GESTEN: No.

(Off-microphone comments.)

PARTICIPANT: Can you explain to why?

ACTING CO-CHAIR GESTEN: No, sorry. Operator, can you give folks instructions on the line if they want to make a public comment.

OPERATOR: If you would like to make a

public comment, press Star 1.

And there are no public comments.

ACTING CO-CHAIR GESTEN: So first, thanks to all the presenters and all of you for hanging in for a long day. Apologies to the folks on the Hospital Group who are really excited and ready to roll this afternoon, but believe that we're going to start with that tomorrow morning. Is that right? Any other business?

CO-CHAIR PINCUS: I just want to thank my co-conspirator here who was pulled in at the last minute and did a terrific job. And even though the --

ACTING CO-CHAIR GESTEN: It took a little longer.

CO-CHAIR PINCUS: -- post acute thing --

ACTING CO-CHAIR GESTEN: Yes.

CO-CHAIR PINCUS: -- was a lot shorter than --

ACTING CO-CHAIR GESTEN: A bit less measures.

CO-CHAIR PINCUS: But look forward to talking with everybody tomorrow.

MR. AMIN: All right. So just quickly--

MEMBER BARTON: Hi.

MR. AMIN: -- maybe we can --

MEMBER BARTON: Real quick, can you say what time we're starting tomorrow?

MR. AMIN: Yes, let's just quickly review the agenda for tomorrow. We're going to still start tomorrow at 9:00 a.m. and we'll start with the recap. But we will move directly to the hospital programs.

We'll have a public comment period, sorry, after the recap and then move to the review of the hospital programs. We'll still review the MAP at 5:00.

The breakout sessions and the MAP core concepts will likely have to wait until another time. However, we will introduce the idea of core concepts to the extent that we still have time and then have a discussion around improvement.

So we'll try to stick to as much of the schedule as possible, but obviously get through our main task of reviewing the recommendations of the workgroups. So --

DR. BURSTIN: Yes. We won't miss --

MR. AMIN: Yes.

DR. BURSTIN: -- your deadline. It will be --

MR. AMIN: No, we will definitely end to accommodate for travel for tomorrow. So again thank you all.

MS. BITTORIE: And just --

MR. AMIN: Any questions on the phone?

DR. BURSTIN: Missed question, yes.

MS. BITTORIE: Just a reminder for our committee members, you will receive a different link tonight to access tomorrow's meeting.

MEMBER LIN: Okay. Thanks.

MR. AMIN: Okay. Thank you all for your time and contributions today.

(Whereupon, the above-entitled matter went off the record at 5:12 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: NQF

Date: 01-26-16

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter