NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP COORDINATING COMMITTEE MEETING

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WEDNESDAY JANUARY 27, 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 9:15 a.m., Harold Pincus, 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
DAVID W. BAKER, MD, MPH, FACP, The Joint Commission
MARY BARTON, MD, MPP, National Committee for Quality Assurance
STEVEN BROTMAN, MD, JD, AdvaMed*
JAYNE CHAMBERS, Federation of American Hospitals
MISSY DANFORTH, The Leapfrog Group*
CHRISTOPHER 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*
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
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)
NANCY WILSON, MD, MPH, Agency for Healthcare Research and Quality (AHRQ)*
PIERRE YONG, MD, MPH, Centers for Medicare and Medicaid Services (CMS)

WORKGROUP CO-CHAIRS PRESENT
RONALD WALTERS, Hospital Workgroup*

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

ALSO PRESENT:
JOEL ANDRESS, Centers for Medicare and Medicaid Services (CMS)*
SHAWNN BITTORIE, CommPartners*
HEIDI BOSSLEY, American Medical Association
KARIN FELDMAN, American Society of Clinical Oncology
NANCY FOSTER, American Hospital Association
THOMAS GRANATIR, American Board of Medical Specialties
THOMAS JAMES, III, MD, Baptist Health Plan*
DARSHAK SANGHAVI, MD, University of Massachusetts; Centers for Medicare and Medicaid Services (CMS)

*** present by teleconference**

A-G-E-N-D-A

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

9:18 a.m.

CO-CHAIR PINCUS: Okay, so why don't we get started. We have actually substantially more people here in person, and I guess we still have a number of people who are on the phone. And I hope to take a tally on that in a couple of minutes.

So, let's talk a little bit about just to think about the experience yesterday. I think it really was an extraordinarily productive day despite all the problems with the weather and people getting here.

And I think very usefully at the outset, we were able to clarify several important points that were potentially points of confusion.

Number one is we were able to clarify the sort of distinctions in the measures under development category, I think, in terms of distinguishing among the three categories of recommending continued development, not recommending continued development, and having

insufficient information, where the insufficient information really refers to people who feel they don't have enough information to decide between the two other categories.

But more importantly, we got clarity from CMS that they're very willing to and intend to come back to us and give us feedback about measures that we recommend for continuing consideration, but are not ready for primetime.

So we're going to be developing a feedback loop about that.

And even more importantly, they emphasized the fact that what they're really looking for is less the specific recommendation and more comments that would help them to refine the specific measures.

And so the kind of commentary that we had around the table and over the airwaves really is incredibly important. And I think they were very grateful for that kind of in-depth expert advice that we were able to give them.

And that's all been sort of written

down and captured so that that can be fed back.

We also plan over the coming weeks to develop a more specific format for how we can get this feedback in an ongoing way about the performance of measures, the experience that people have had with the measures and what's been done about them.

So that we'll be able to have a fuller picture of both the further process of measure development and also what has been the impact of the measures. So I think those are all very positive kinds of things going forward.

Foster, do you want to add some more?

ACTING CO-CHAIR GESTEN: Sure. Well, first I'd be remiss if we didn't acknowledge the great job of the staff in being able to not only put this meeting together but to deal with the weather issues and folks on the phone. So I want to really shout out to everybody. NQF does an incredible job of organizing this.

I heard, in addition to what Harold mentioned, some recurrent themes that are not new

to this group and the conversations.

And they include I think a desire to have a clear sense of what alignment means, and also clarify where alignment is a good thing, and where alignment creates at least a reality of perception of this sort of double jeopardy of measures counting more than once.

I also heard I think from a lot of the comments from the workgroups a continuing struggle of trying to figure out and land on measures that were truly meaningful to patients and patient-centered.

And it includes, but it's not limited to, outcomes, like functional outcomes and others.

And then clearly payment reform is challenging and pushing on this issue of measures as they relate to shared accountability and trying to figure out what the right way of thinking about that is.

And it certainly, if for nothing else, raises lots of issues around risk adjustment and

appropriate risk adjustment, whether it's for quality measures, or we'll probably take up that conversation around payment and efficiency as well.

So, I thought it was a great, robust conversation yesterday. I look forward to today.

CO-CHAIR PINCUS: So, to kick things off I think there's a few new people that need to have the disclosure process. So, Wunmi, do you want to --

DR. BURSTIN: We went through a process yesterday of introductions and disclosures. So if anybody is new, if you're an organizational member, all I require is that you disclose if you have more than $10,000 in anything that might be associated with the work before this committee.

I think probably the new people are all organizational members.

And then if you're a subject matter expert, just give us a brief overview of what you're engaged in, in terms of work before this

committee, contracts, grants, speaker relationships, et cetera.

So, why don't we go to who's new at the table. I know we've got Jayne here today.

MS. CHAMBERS: My name's Jayne Chambers and I have nothing to disclose. I'm pressing the button.

MS. FELDMAN: Karin Feldman from the AFL-CIO. Nothing to disclose.

DR. BURSTIN: We've got Lynda Flowers in person today, but she disclosed on the phone yesterday.

Anybody new on the telephone?

DR. WILSON: Nancy Wilson, nothing to disclose. AHRQ.

DR. BURSTIN: Great. And Pierre, do you want to introduce yourself?

DR. YONG: Hi. So for folks who know Kate, I'm not Kate, obviously. So, I'm sitting in for Kate today, but I'm representing CMS, and nothing to disclose.

CO-CHAIR PINCUS: So, as people -- oh,

Lisa?

MEMBER MCGIFFERT: Can I have a question on voting? We go back and click to our original link for voting?

CO-CHAIR PINCUS: No, there's new links.

MEMBER MCGIFFERT: New link. Okay, I'll look for it.

MEMBER ANDERSON: I tried to open the new link, and I couldn't get it open. I don't know if everybody else can, but mine wouldn't open.

DR. BURSTIN: Have people been able to open the new voting link that you received today?

CO-CHAIR PINCUS: Mine worked.

DR. WILSON: Yes, mine worked too.

DR. BURSTIN: Okay. Shawnn, could you resend one to Rhonda Anderson, please?

MS. BITTORIE: Absolutely. And you should see that in a few minutes. And you may want to try a fresh browser when you receive that.

DR. BURSTIN: Great. Thank you.

CO-CHAIR PINCUS: So, as people recall, we are now doing the public comment periods before we have the discussion of measures.

So, I would like to open up the public comment period initially in the room for the hospital measures.

DR. SANGHAVI: Hi, I appreciate being here speaking to the group today. I'm just going to introduce myself.

My name is Darshak Sanghavi. My background is I'm a pediatric cardiologist at the University of Massachusetts Medical School. And I'm also the director of prevention and population health at the Innovation Center at CMS. So I'm here in my capacity also as a CMS representative.

And I just wanted to give a little bit of background to one of the hospital measures that the group is going to be discussing today.

I'm giving this as an introduction

during the public comment period just to spend a few minutes with background. I will also be here to offer technical guidance on the measure if they come up during the group discussion.

But just by way of introduction, the measure that our group has proposed is the smoking prevalence measure at the county level for inclusion in the Hospital Inpatient Quality Reporting System.

I also want to emphasize that I'm here in person, and I was here yesterday as well, unfortunately we didn't get to it, just to emphasize the critical importance of this measure and the strategy broadly at CMS and HHS. I want to telegraph that in person.

This measure has been a strategic priority both of Patrick Conway, the Deputy Administrator of CMS and former head of CCSQ, as well as Tom Frieden, the head of the Centers for Disease Control.

We have developed this concept in consultation with them, and they both strongly

have advocated for this.

I mention this by way of background because as you're no doubt aware, the use of tobacco is the leading preventable cause of misery among patients today.

We believe that with a problem this severe, it would also require interventions that are more innovative than those that have been used in the past in the hopes that they can substantially impact positively the health of Americans.

In other words, it is a big problem, and a big problem requires potentially innovative and new strategies to address it.

I also want to emphasize that the use of tobacco at the population level does introduce several complexities. But we believe this falls into a broader, strategic series of priorities at CMS.

As you are no doubt aware, we are moving from volume-based to value-based reimbursement very broadly, ultimately mirrored

in our payments systems that go from fee-for-service to accountable care to bundle payment to potentially in population-based payments.

Our payments are going in this direction, and we hope also that our quality metrics will as well.

In terms of tobacco specifically at the state level, we are currently negotiating with major large states for tracking tobacco at the state level as an adjustor in the Medicaid program broadly.

This falls into a broader series of priorities. Even in the Medicare Shared Savings Program and others, we've considered strategies as well to sort of expand the denominator.

We believe that is population health. It is caring for a broad population. And we believe this fits into our broader strategic priority of using an outcome measure.

Let me just briefly talk about why the hospital IQR and why at the county level.

First of all, we believe that in

counties, there are not currently measures that encourage cooperation and coordination.

So it is true that all hospitals in a county, by the way, most Americans live in a county that's served by an acute care hospital, do not currently have any incentive to work together, or at least even to recognize a measure that they all share in common, such as community-based smoking prevalence.

We believe that working together in some way would be incentivized by having a measure that they all have.

In addition, this is a measure that's collected by the Centers for Disease Control directly. So it can be given to hospitals and requires essentially no reporting burden on the part of hospitals. It is essentially no work at all.

Having said that again, a cooperative measure, yes, you can work together. Why again at the hospital level?

I just wanted to take a minute to say

we believe that there is a substantial and emerging body of literature and academic and scientific consensus that improved work even by hospitals can substantially and positively impact the smoking prevalence rate at the county level.

For example, according to Centers for Disease Control data, a substantial number of high-risk patients are, in fact, seen at hospitals on an annual basis. And over several years, we see a majority of patients that may be seen in a hospital.

We also currently know based on, again, CMS's broad-based strategy when looking at how we think about hospital care, we no longer just think about what happens at that encounter in the emergency department or in the four walls of the hospital.

Thirty-day readmission measures, even 30-day mortality after MI, all of those things depend on continuing coordination of care.

And there's increasing data that only when you actually touch patients after they leave

the hospital can you actually substantially reduce smoking rates.

The British Medical Journal in 2014 editorialized that the prevalence of smoking at the county level can be -- or geographic level can be substantially impacted by improved hospital care.

We also believe that hospitals have a variety of strategies at their disposal.

For example, the Cleveland Clinic in Cuyahoga County, when they actually went to a smoke-free requirement for employees actually substantially reduced their community county-based smoking rates, while other areas around the Cleveland Clinic did not, other counties.

Again, this goes into a clearly established strategy. For example, we also in the IQR have a flu vaccination measure of hospital employees.

So, this sort of -- there is a zone of expanding abilities that we have for hospitals to now impact tobacco prevalence rates.

And finally, hospitals serve their communities. Many, many hospitals as part of their mission statements clearly recognize that they do not just treat patients that show up at the door, but have a responsibility for their broader community.

In fact, many of their fund-raising efforts specifically call out their community involvement as an important part of the reason we should fund these hospitals.

Therefore we believe, again, there are substantial areas of leverage for hospitals to impact smoking rates.

I'll just conclude by saying finally that what we are proposing now is reporting only.

I think that when we propose these types of changes or these sorts of innovative strategies, it is important to do it in a deliberate fashion.

The CDC at the state level has endorsed the NQF measure, but not at the county level.

Working with CDC very carefully, we believe that the county level measure is quite robust, but that is why it is being -- you're seeing it today as a measure under development, just to explain that.

However, we will continue to work with CDC to do that.

But I'd like to then just finally just close with the fact that if we don't hold hospitals -- there is no payment against reporting only.

It is surprising and shocking in our review how often hospitals, the clinicians that work at the hospitals really have no idea of the population-based burden.

And when you don't know what you're dealing with, you can't really address it.

This substantially impacts minority and other populations as well. We believe that bringing this to hospitals' attention is critical.

And hopefully also we recognize that

this will vary. There is going to be differences across the country in what the baseline rate is.

Again, we are just looking at a prevalence rate. It puts that on your radar screen and then wherever you start at, you can start to lower that by whatever means you feel is helpful.

Again, we are not holding anybody accountable for the baseline population that currently exists. That is what we are looking to understand.

So finally, I'd respectfully submit as you can tell, we are quite interested in this measure.

We believe that this is the future of how we will be thinking about measurement in many ways with population health.

We would respectfully request that the committee here endorse the hospital MAP group's recommendation and continue development on the measure. Thank you.

MS. FOSTER: Hi, Nancy Foster from the

American Hospital Association.

This may come as something of, I don't know, a head-turning reaction after that last comment. But I wanted to get up here to emphasize to you that our member hospitals are keenly aware of the importance of working to improve not only the health of the patients that they touch every day in their hospitals but also of their communities.

However, they're struggling. They're struggling not only with the hospital measures that are already on the plate right now in the five programs that we currently have for hospitals, but also because hospitals today are more than just a building with inpatient and outpatient care. So when I said five, there's more than that programs.

We are also working with our clinicians who will be collecting, and we'll be helping them to collect, their data for MIPS or for the alternative payment models.

We are working with post-acute care.

In fact, we have many post-acute care settings. There are lots of things we're doing.

And part of the problem for our member hospitals is that right now, it doesn't make sense. There's not really this overarching strategic vision of how do we improve health in this nation. How do we improve healthcare? What role do hospitals and their clinicians and the post-acute care settings they're working with play in moving that forward?

And this deluge of measurement, to the point you all have made over the last day, the deluge of measurement causes some confusion rather than helping people see how we really move that quality performance forward in a way that truly makes a difference for patients.

That has led our members to ask us to ask you to focus attention on some high-priority opportunities to really make a difference in the health of people and to tell us explicitly what can we do as hospitals, not as public health agencies, but as hospitals to engage on that.

What can we do from our perspective as running some post-acute care settings? How do we move this ball down the road? How is that all coordinated and aligned to the word you just used?

And the discord comes when we are handed measures that seem an overreach, that seem to be not things that we truly have an effective ability to make a difference in on our own.

The smoking prevalence in the community would be one of those examples where we may have an opportunity to affect some, but we're not the major actors there.

We are happy to step up and play our role, but it has to be done in coordination and collaboration with all of the other players, including and perhaps most significantly, public health agencies, insurance, organizations that have an ability to affect it through insurance rates, and other players at the table.

And so how do you as the MAP try to think about the strategic choice of measures to

really drive healthcare forward in this country?

I know at this point in your deliberations when you're confronted with recommendations from the workgroups it's really hard to think about how you take that and get to a more strategic viewpoint.

But I hope that over the course of the next few months as the MAP prepares for the receipt of the next group of measures from CMS that you think carefully about how to get to that strategic vision and provide some requests, some guidance to CMS about what you'd like to see, and how it can be more effective in driving the entire care system towards a common, strategic point of view. Thank you.

CO-CHAIR PINCUS: Any other comments in the room? Public comments on the phone? Can we open that up?

OPERATOR: At this time if you would like to make a comment please press * then the number 1. There are no public comments at this time.

CO-CHAIR PINCUS: Thank you. So, it looks like we're going to have an interesting morning.

So, Erin, are we ready to proceed?

MS. O'ROURKE: Yes, I can kick it off on hospital.

CO-CHAIR PINCUS: Yes, well, the slides are there for clinician programs.

MS. O'ROURKE: I don't know that we want to revisit that.

CO-CHAIR PINCUS: No, we don't. Let me just remind folks on the phone in terms of getting in queue for comments to use the Raise Hand function. And welcome, all the folks we have on the phone. We very much want to have you participate. So Raise Hand or if that's not working you can interrupt, but raising hand and then you can get into the queue for questions and comments.

MS. O'ROURKE: So, we can skip to the next slide. I think you saw this a number of times yesterday.

So, I'm Erin O'Rourke, as you may remember. I'm joined by Melissa Marinelarena, another senior director here at NQF supporting the hospital workgroup.

And we are fortunate enough to have our co-chair Dr. Ron Walters on the phone. Ron, if you wanted to introduce yourself?

WORKGROUP CO-CHAIR WALTERS: Hi, I'm Ron Walters.

MS. O'ROURKE: Fair enough. So, to give you a scope of what the hospital workgroup looks at, it's quickly becoming a bit of a misnomer.

We looked at 44 measures for 8 setting-specific payment or reporting programs, including the IQR program, the hospital value-based purchasing program, the outpatient quality reporting program, the ambulatory surgery center quality reporting program, the inpatient psychiatric facility reporting program, the PPS-exempt cancer hospital quality reporting program, the HAC reduction program, and the end-stage

renal disease quality incentive program. Next slide.

So, across the conversations about the measures for all of those various programs, a few overarching themes emerged.

First, the group felt the performance measures need to foster better coordination across the care continuum. They stressed there's a need for integrated measures.

There needs to be better coordination between hospital and post-acute and long-term care as well as better EHR integration and more readily shared information to ensure that as patients go between community hospital and post-acute settings their information goes with them, and the clinicians treating them have the information they need to ensure they're giving the best possible care.

There's a need to carefully evaluate SDS adjustments to ensure that performance is captured accurately as well as there's a need to encourage holistic care from all providers,

including setting or treatment-specific settings.

The group is really focused on the need to engage patients and families as full partners in their care.

They noted a need to measure commitment to and documentation of patients' treatment goals and care preferences.

The hospital workgroup supported a balanced approach to patient accountability and to encourage relationships with patients and families and their communities.

And they stressed that measures should address outcomes that matter the most to patients.

And some examples they gave were cognitive or functional outcomes, safety, patient activation, and the patients being educated, and engaged, and able to participate fully in their care as well, as more measures that address quality of life. Next slide.

Finally, the group stressed that there's a need to drive improvement for all

patients.

Currently the measures in the program are very Medicare-focused as obviously these are Medicare programs. But the group really would like to see the populations covered to be expanded, to expand the services that are covered.

In particular, they'd like to see more measures addressing perinatal and pediatric care.

They would like to see a global measure of harm that goes beyond the HACs that are currently addressed by the different measures in the program.

And finally, they would really like to see measures assessing access to care. They noted that that's a real challenge for a number of patients and would like to see measurement drive to reduce access gaps.

So with that, Melissa is going to take you through some of the program-specific considerations.

MS. MARINELARENA: Thanks, Erin. So,

for IQR, we had 15 measures. And I think it was the most amount of measures.

So, one of the issues that we talked about was resource use versus appropriateness of care.

And the workgroup agreed that resource use was important to measure, but it is not indicative of quality of care, and it doesn't provide clear information on the appropriateness of care.

There was also a long conversation about the support. They supported the community-based measures like the smoking prevalence measure that we just heard about and I'm sure we're going to have a long conversation about.

But the workgroup had a robust conversation on the roles that hospitals played within their communities to influence health, wellness, and readmissions as well.

And, like Erin just said, the group identified gaps like perinatal and pediatric measures and obstetrics.

They also identified cost of drugs, particularly specialty drugs.

And they also discussed the need for the all-harm or global harm electronic measure. They felt that this type of measure would provide the public with more useful information about overall hospital care.

And it would also provide hospitals with more readily accessible data on their performance, rather than waiting for data from claims-based measures.

So, just quickly about the comments that we received. Again, because this was the most amount of measures that we had for all of our programs, we received quite a bit of comments.

But the majority of the comments agreed -- and I'll just go over the smoking prevalence.

So, the majority of the comments agreed with the MAP's recommendations for the smoking prevalence measure.

Although the commenters agreed that smoking is an ongoing public health issue and that hospitals may play a role in reducing smoking prevalence in their communities, but they raised several concerns.

And some of these concerns included the impact of SDS factors, attribution and factors beyond the hospital's control such as taxes, public smoking laws, access to smoking cessation medications and counseling.

There was also concerns about the development of new measures that only addresses -- this measure only addresses smoking rather than tobacco cessation, which includes smokeless products as well.

There was also concern with accurately collecting and recording EHR data for some of the measures. And some of those are the stroke measures.

There is an antimicrobial use measure that was conditionally supported.

This -- some of the commenters did not

support the inclusion of the measure in the program because it is intended for surveillance and internal quality improvement efforts.

Commenters also stated that this measure is not appropriate for accountability purposes at this time due to the limited experience with the measure.

The formerly PSI-90 received several comments as well. And this is in several different programs.

And commenters were happy to see that CMS is working to improve this measure, but they also stated that little is known about the performance of the measure after the improvements of the measure.

And another commenter urged CMS to remove the measure from the programs altogether.

Erin just mentioned measures that are more meaningful to patients. We had several mortality measures. And the workgroup discussed that mortality was not necessarily the most meaningful outcome for patients, and a lot of the

commenters agreed with that as well.

Sometimes it's functional status for a stroke patient, assessing cognitive and functional outcomes, and the commenters agreed with them.

We can move on. Okay, so now Erin will cover hospital value-based purchasing.

MS. O'ROURKE: Sure. So, for the value-based purchasing program, the hospital workgroup continued to stress a parsimonious approach to this program to reduce the burden and increase interpretability.

However, they would like to see this program expand beyond the current safety measures that are included. It currently includes PSI-90 and a number of the NSHN PAC measures.

The group stressed if the new CABG mortality measure that was on the MUC list is implemented, there'd be a need to monitor that closely for any potential unintended consequences, particularly around reduced referrals for hospice care if that care is

warranted.

The public comments we received, commenters supported MAP's parsimonious approach, in particular around the cost measures that were under consideration.

As Melissa noted, we did receive some comments expressing concerns with the new patient safety and adverse events composite, the revised PSI-90. As Melissa noted, particularly that not much is known about its performance in the real world.

And finally, commenters echoed MAP's concern about potential unintended consequences of the CABG mortality measure and would like to ensure that if that is implemented that it's closely monitored so that patients can access care that they desire if they choose hospice over continued treatment.

MEMBER MCGIFFERT: What were the unintended consequences of the mortality measure?

MS. O'ROURKE: They were concerned basically that physicians may hold off referring

patients to hospice if that's what the patient desires to avoid receiving a poor score on the measure.

So perhaps that there should be some exclusions around if the patient chooses hospice care over continued treatment. Next slide.

So, for the HAC reduction program, we had two measures under consideration. Both were updates to measures that are currently in the program.

The workgroup felt that the updated measures were significant improvements to the current version. However, these updates need to be clearly communicated to both providers and to members of the public who might be using these measures.

Again, commenters expressed similar concerns about the revised patient safety and adverse event composite, formerly PSI-90, and that more is needed to be known before it's used in a payment program.

And then the hospital outpatient

quality reporting program. The new measures, the possible admissions would fill some gaps in the program, but there's a need to consider potential need for SDS adjustment as well as risk adjustment generally, and that these needs need to be closely monitored.

The group would also like to see additional measures addressing some high-volume outpatient services.

Comments generally supported MAP's recommendation. However, some cautioned that admission measures might affect treatment decisions, particularly for cancer patients.

And commenters concurred with MAP's recommendation that risk adjustment strategies be carefully considered prior to implementation.

So I think Melissa is going to take you through the rest of the programs.

MS. MARINELARENA: Sure. So, for ambulatory surgical center quality reporting program, MAP reviewed one measure.

And this new measure addresses

surgical quality, but the group discussed that gaps still persist across other surgery types.

The comments that we received did support MAP's recommendation, noting that the measure does align with recently published professional guidelines and the potential to better understand the prevalence of TAS, or toxic anterior syndrome.

But again, there are still gaps that exist across other surgical types.

For the cancer hospital quality program, MAP discussed that there was a need for better symmetry between the cancer program and the IQR program.

And again, gaps still continue in the quality of life measures.

Some commenters indicated that they had concerns that there were a lack of detailed measure specifications on the admissions and emergency department visits for patients receiving outpatient chemotherapy measure.

And they also expressed that there was

a potential for unintended consequences if the measure is implemented without proper testing and validation, and encouraged MAP not to support the measure.

For inpatient psych, MAP supported the new substance abuse measures and the readmission measures.

And there was a discussion about measures needing to assess a connection between psychiatric care and primary care.

And again, most of the comments that we received did support MAP's conclusions. And they noted that the readmissions measure should be considered for the impact of SDS factors. And this was a theme throughout the conversation with our workgroup.

For the end-stage renal disease quality incentive program, one of the conversations that we had when we discussed gaps was that the program should consider measures from the ESRD Seamless Care Organization.

And when I took a look at these

measures they are -- I can't remember how many there are, maybe 15 or so.

They're very holistic. They take a look at the entire patient. So that was a recommendation.

And they also talked about not supporting measures that are topped out, or when there are better competing measures. And that was how some of the decisions were made as well.

So again, some of the comments that we received disagreed with the recommendation to conditionally support the readmission ratio for dialysis facilities measure.

And another set of comments expressed their concern with the quality of the studies that informed a couple of the measures, which included the measurement of phosphorus concentration measure and the avoidance of utilization of high ultrafiltration measure.

Now, I think --

WORKGROUP CO-CHAIR WALTERS: Can I say a couple of words?

MS. MARINELARENA: Oh, yes Ron, go ahead.

WORKGROUP CO-CHAIR WALTERS: Okay, sorry. As you can tell when you have excellent staff it makes the job of the co-chairs much easier.

So, the first thing I wanted to do was to say hi to Harold and the Coordinating Committee especially from Cristie Travis, co-chair, with me on the hospital workgroup who could not be there this morning. She's on a plane to San Diego, but she really wanted to be here.

This is an experienced committee. Many of the committee members have been involved since the inception.

I think we have a very collaborative environment. Everybody feels comfortable to say exactly what's on their mind, and that's very much encouraged in any committee.

A couple of enhancements I wanted to highlight from the last couple of years that we

found extremely valuable. You utilize them also.

One is the consent calendar. And even subgroupings within the consent calendar.

You experienced that yesterday with things like the drug regimens and so on, where it really helped to consolidate talking about the principles and leaving room for individual measures when required.

The other thing, as I alluded to, is co-chairs. As you all have experienced the workload can get quite intense, especially when it's 8 programs and 44 measures, and responding to requests for further discussion and/or pulling off the consent calendar.

It really is a good idea. This morning, because Cristie had to leave, really exemplifies how valuable it is to have co-chairs that can work very well together.

I want to just emphasize a couple of things that you -- I'm not going to repeat yesterday's conversation about the programs or the strategic direction.

I think you handled almost all the issues there very well yesterday, and it's something that we also wrestle with.

I did want to emphasize the interplay in the inpatient hospital world of the measures in transition. You spent some time talking about that.

And how they interact with the requirements programs, the transition from IQR and value-based purchasing, what do you do with revised measures in any continuum of tweaks, timing, more than tweaks, brand new measure that's changed significantly, how that interplays with what CMS has to do, that came out yesterday with quite a few of the measures.

And then I would say as a general rule, and you saw that in kind of our recommendations. We really do give a lot of credence to the standing committees and the endorsement process. That obviously is an important part in our considerations and influenced a lot of our decisions.

There are some issues that you've heard talked about that we still have a lot of work to do.

As we'll talk about, anything involving the words resource utilization and cost, episode-based payments, end of life, the whole handoff business, still leave an awful lot of room for continued development.

So, thank you again for taking the time to listen to eight programs and your thoughtful consideration of which ones you wanted to both discuss further and maybe even consider a change in the recommendation as given by the MAP workgroup.

So thank you again, and I'm available for any questions about any measure.

CO-CHAIR PINCUS: So, thank you very much Ron and Melissa and Erin for going through the sort of broader overview.

We have a few more things to discuss in terms of the impact of the Dual Eligibles Beneficiaries Workgroup and their input.

Melissa, are you going to --

MS. MARINELARENA: No, that's Debjani.

MS. MUKHERJEE: Hi, this is Debjani. I'm the senior director for the Duals Workgroup.

So, what I will do on this slide is quickly go over the Dual Workgroup's perspective on hospital recommendations.

We would like to share that promoting shared accountability for communication and transitions in care is something very important for our workgroup and the duals population.

And by that what we mean is not only having a transition plan, but follow-through, appropriate communication, transmission of information in a timely manner.

We would also like to support the alignment of measures across programs and settings as well as encourage the prioritization of measures within and across hospital settings, and thereby getting to parsimony, alignment, and applicability of measures within the hospital setting as well as across programs.

And that's the only slide we have for this. Thank you.

And any questions, please let me know.

CO-CHAIR PINCUS: Anything further from the committee?

(No response)

CO-CHAIR PINCUS: So, now we're going to go through the measures that have been pulled off for discussion or for voting.

And as we did yesterday I'm going to be asking the individuals who pulled the measures whether they intend for it to be for voting or for discussion, bearing in mind the strong encouragement from CMS to get the discussion and advice on the table to help inform them has been the primary priority that they have.

But if people feel that they want to re-vote, we're perfectly happy to vote on the measures as well.

But first, are there any other members of the committee that want to pull any other measures off for discussion?

(No response)

CO-CHAIR PINCUS: Okay, so let's proceed.

The first one is --

MEMBER DANFORTH: Oh, I'm sorry. Hi. This is Missy from Leapfrog. I've had my hand raised on the phone. Sorry. Can I just take one minute to just do a couple of comments?

CO-CHAIR PINCUS: Sure.

MEMBER DANFORTH: Okay. So, first -- because I think I heard Pierre say he was in the room -- I want to congratulate the committee. Their workload has just grown tremendously over the years and I think they did a very comprehensive and efficient job in reviewing measures for these programs.

But I will say in general CMS has expressed the desire over the past several years to more closely align, particularly around these hospital programs with private purchasers.

And we were a little bit discouraged to see the list of measures this year. In past

years, I think the measures have more accurately reflected the express needs of private purchasers, particularly in areas of patient safety.

But also I think I was just a little disappointed to see the lack of measures in areas that private purchasers have really been pushing on for the past several years, in areas like overuse and medication safety, misdiagnosis, patient-reported outcomes, consumer/purchaser alliance.

They've been incredibly vocal on these areas, MAP workgroups and at the Coordinating Committee level, expressing the need for these kinds of measures.

And to see a MUC list that doesn't have any of these kinds of measures was a little discouraging.

And I hope that CMS can find ways to encourage innovation among measure developers that really address some of these high-priority things.

Just going back to what Nancy said, I think it's important that we send hospitals a really clear message both from the public and the private sector on what we want them to work on, what we think is incredibly important.

And I'm not sure that this particular set of measures gets at a lot of those things.

The other thing just really quickly is that we all know so much care is moving out of the hospital and into outpatient and ambulatory settings.

And it's just incredibly important for people accessing that care because it's at a lower price to have more visibility to the quality and safety of that care.

And I think that if there's any way to accelerate the addition of measures into those two programs, the outpatient and the ambulatory, it would be fantastic. So, thank you.

CO-CHAIR PINCUS: Thank you, Missy. And I just want to mention that Missy and David Baker are going to be the initial respondents to

the discussion on the pulled measures.

So, why don't we start off with Measure 151136, Measurement of Phosphorus Concentration, pulled by Lisa.

So, Lisa, can you say: is this for voting or for discussion?

MEMBER MCGIFFERT: Just for discussion. This is another process measure. Basically, it just measures whether something was measured from what I can tell, and not necessarily connected to improvement of care.

There were some comments that questioned whether this measure would lead to any kind of improvement.

And there was another comment that was concerned about the quality of the studies that inform the measure.

It's important for us to measure what's going on in these dialysis centers, and I'm not sure if there are some other measures that are more outcome-based that would be more meaningful.

But that's what we need. We need more of that and less of this kind of measure. Thanks.

CO-CHAIR PINCUS: Missy or David, do you want to respond initially?

MEMBER BAKER: I'll just take what Lisa said and go a step further.

I think this is a really bad process measure. What we care about is really phosphorus control.

And what we've learned from -- if you're thinking about hemoglobin A1c, you know, checking A1c, checking blood pressure, checking cholesterol levels.

We know those are bad measures. They've all been retired because they're not associated with control.

So this is a measure that, again, says did you check it. It doesn't say that you did the fairly complex things that you need to do patient education, medication, dietary improvements, really to get control. So, I think

it's a bad process measure.

CO-CHAIR PINCUS: Missy, do you have any comments?

MEMBER DANFORTH: No.

CO-CHAIR PINCUS: Others in the room have any comments on this measure?

So, Lisa, you brought this up for discussion.

MEMBER MCGIFFERT: Maybe we should vote on it.

CO-CHAIR PINCUS: But I don't hear anybody speaking in support of it. And the vote of the committee was for support.

WORKGROUP CO-CHAIR WALTERS: So, this is Ron again. I guess that's my role.

So, as I mentioned earlier, all the things that have been said are true. And I use the same analogy of hemoglobin A1c. Eventually we have to get to is it under control, and then eventually what's the outcome associated with that.

This was just reviewed in 2015, having

been originally endorsed in 2007. The committee members expressed exactly a lot of the similar points, but were strongly in favor of keeping this around for now. And we took that strongly into consideration.

CO-CHAIR PINCUS: David Gifford?

MEMBER GIFFORD: I guess my question is: what are the other measures in the ESRD Quality Incentive Program?

Is there an NQF phosphorus target measure? This is the only measure that's available around phosphorus.

And where does it fit with the other measures in the portfolio of the ESRD program? The link's not working when I click through to pull up the list.

WORKGROUP CO-CHAIR WALTERS: Calcium is the other obvious one.

MEMBER GIFFORD: Is it calcium testing, or is it calcium bubble?

WORKGROUP CO-CHAIR WALTERS: Remind me about that.

MEMBER MCGIFFERT: Let me look it up.

MEMBER GIFFORD: So it's a level.

WORKGROUP CO-CHAIR WALTERS: Yes, I thought so.

MS. O'ROURKE: And that measure is topped out.

MEMBER GIFFORD: I think, you know, we're voting on whether this -- to support this for the inclusion in the ESRD program as labeled here, which is an incentive payment program.

And I'm reading sort of the program, it's silent on whether it's process or outcome measures, but clearly it's leaning towards outcome measures in the statute, in the other links.

I think I would agree with the comments here that I would vote not to support, or support it with conditions that it be quickly switched or paired to an outcome measure.

I mean, I can see why you want to progressively get there. But if you're going to pay on this, whether they're testing or not, and

it has no management, and there's no other outcome I think that that's not ready for a measure to go into rulemaking for payment.

I mean, clearly it's an NQF-endorsed measure. It's good for quality improvement and everything else.

But I think we're trying to give feedback and vote on whether the measures are ready to go into a rulemaking for a payment program for ESRD.

CO-CHAIR PINCUS: So, I want to step out of the chair role for a moment.

I'm inclined to agree with you, but it would be helpful to have two other pieces of information.

Number one is to what extent is this measure close to being topped out.

And number two, is there anything in the sort of NQF consensus development process pipeline to actually replace this measure with a level measure?

DR. BURSTIN: I thought this was in

reserve status from endorsement which means, generally reserve status is a designation we have made on the endorsement side for measures that are otherwise very good measures, but are topped out.

And we generally don't recommend those get used in programs.

MEMBER MCGIFFERT: Okay, so I'll change my proposal to have a vote on this.

DR. BURSTIN: Ron was trying to say something.

CO-CHAIR PINCUS: Ron, did you want to make a comment?

WORKGROUP CO-CHAIR WALTERS: The committee agreed to vote -- voted to recommend the measure for endorsement with reserve status.

CO-CHAIR PINCUS: So, what does that mean?

WORKGROUP CO-CHAIR WALTERS: What Helen just said.

DR. BURSTIN: It's a special status of endorsement for measures that are topped out, but

that may still be used for ongoing surveillance or something along those lines, but not necessarily the measures of first choice for programs.

CO-CHAIR PINCUS: So, Pierre, can you give a bit of a comment from the perspective of CMS?

DR. YONG: Sure. And I believe there was a robust discussion when it was under consideration for endorsement and ultimately was recommended for -- as a top-down measure.

Because I think the data did show it was topped up at the bottom end. There was still a not insignificant proportion of facilities which were not performing at the topped-out level, which is why I think it was ultimately recommended for the reserve status.

We certainly agree with a lot of the comments offered by the committee members, in that bone mineral disease is an important issue for ESRD patients.

Unfortunately, there is not a big pool

of other measures in this area. We have convened several TEPs in the past several years to look at this particular issue, and based on the literature, have not been able to identify a really promising concept for development in this area, though we are continuing to look into it.

So, I think at this point -- since we believe that the topic and the issue is of importance to this particular patient population and is important for care of these patients, given that it is a current NQF-endorsed measure though it is in reserve status -- that's why we believe it's appropriate for the program at this point.

CO-CHAIR PINCUS: I'm just curious. There's no effort around thinking of developing a control measure?

DR. YONG: I think we have looked at this issue in the past. I think our last TEP was probably a year or two ago, so we can revisit that.

But right now we don't have a current

control measure addressing this particular area because no concept surfaced that was promising at that point.

CO-CHAIR PINCUS: David and Marshall.

MEMBER GIFFORD: A couple of things. If the TEP couldn't figure out a reserve measure and struggled with it, why would we measure a process measure about whether they're getting the testing or not?

Because it doesn't sound like there's agreement on what the levels should be or anything.

And then as far as, you know, we're not supposed to bypass the NQF voting or anything so the reserve status or not it's an NQF-endorsed measure.

I would disagree with the comment that just because it's topped out doesn't mean it shouldn't be in a payment program because there are still some that are not there. And if it's a really important outcome and you want something there, you may want to still have it in a payment

program.

So, I mean I can understand why you may not for quality improvement -- and I think it's good that NQF has a topped-out status.

But again, we're voting on whether to recommend this goes into rulemaking for an incentive program for ESRD.

And I would argue it's not appropriate for rulemaking given the comments that people just said. It's a process measure with no one knowing what the outcome should be, so why would we want people to do testing, especially if they're already topped out, what that value is to doing it.

I mean, if someone said oh, we really know the phosphorus level and there's some things coming along I think we could put it support with conditions to move that level. But it just doesn't make sense to me.

CO-CHAIR PINCUS: Marshall, and then David, and then Frank.

DR. CHIN: I was just actually

surprised clinically that a measure was unable to be come up with for bone marrow metabolism. So I may want a message back to the TEP, or back to the clinical committees, you know, take another look.

I mean, the clear process measure does seem to be fairly distal, and I can't think clinically why they can't come up with an outcome measure that would be closer to the mark. So, I think it's worth a re-look.

MEMBER BAKER: I just wanted to ask whether there were also concerns that this could drive over-utilization.

Because the measure is that the phosphorus level is checked every month, and the KDOQI guidelines actually say that it should be checked every one to three months. So, that was another concern.

Is that something that was discussed?

WORKGROUP CO-CHAIR WALTERS: Yes, it was.

CO-CHAIR PINCUS: And what was the

conclusion? Or I guess the conclusion was that the measure would support it.

WORKGROUP CO-CHAIR WALTERS: That is true.

So yes, that was discussed, and yes, despite that it was supported.

CO-CHAIR PINCUS: Frank?

MEMBER OPELKA: So, this is actually a question to NQF staff and probably particularly to Helen.

My understanding of the current reserve status is it is not NQF-endorsed. And that there's endorsement and then there's reserve status, but there's not endorsed reserve status.

DR. BURSTIN: No, actually, it's a subcategory of endorsed. It remains endorsed, but it's specifically labeled "with reserve status" so that everybody knows that it's topped out.

And specifically, although to Giff's point you could certainly use it in payment programs, there is an assumption that that would

be sort of a measure not of first choice for those programs, but more for regular surveillance to make sure you kind of take your eyes off the measure. It doesn't drop in performance, but not for regular routine assessment when it's topped out.

MEMBER OPELKA: But I don't think that's -- again, I don't know all the facts around this, but having served in these committees and roles in the past when you go in reserve you're no longer maintained. That measure falls off.

It's not that a reserve measure gets updated, maintained, et cetera. It goes in reserve and it doesn't come back for endorsement use until it gets updated.

So, I beg to differ. I do not think a measure in reserve is considered an endorsed measure.

DR. BURSTIN: I'm told by the smart people in the room that it does not come back for maintenance, but it is still a subcategory at

least for what we consider endorsement.

CO-CHAIR PINCUS: Heidi?

MS. BOSSLEY: I guess it's a question again to NQF staff.

When I go on QPS, it doesn't say reserve. So, I question either there's something in the database that's wrong, or -- I think we need to clarify. Because it looks like --

DR. BURSTIN: We've gone all through this. It is clearly at a very high rate of performance, even if you look to the endorsement summary.

But it says at the end of the endorsement summary that the committee voted 22-0 to put it in reserve status. So, the labeling of QPS we've already noted as an issue.

MS. MARINELARENA: So, can I tell you what I have in the report? So this is what we wrote.

MAP agreed not to support proportion of patients with hypercalcemia, which was the other measure, because this measure was recently

reviewed by the NQF Renal Standing Committee and was recommended for reserve status because the measure has topped out.

MAP also determined that measuring hypercalcemia in this population for a pay-for-performance and public reporting program may not be as meaningful to patients because almost all dialysis patients have calcium levels before the target level.

Instead, MAP supported the inclusion of measurement of phosphorus concentration because a minimum performance rate for this measure is zero percent with a mean performance of 87 percent, suggesting that some facilities are not following the process at all. That was the reasoning.

MEMBER BAKER: I just want to point out that those ones that are not in compliance on this measure may be still following the current practice guidelines to measure it every one to three months. And they would be assigned a failing score on that. So, I just point that out

as another concern.

CO-CHAIR PINCUS: But we don't know that. So, Lisa, and then we should probably proceed to a vote.

MEMBER MCGIFFERT: Okay. Just to clarify what you just said, David, the current guidelines, if someone was following the current guidelines they would not be performing -- they would not meet this measure performance. Is that what you just said?

MEMBER BAKER: So, there may be patients -- I mean, if an organization is really conservative and they're checking the phosphorus based on the past rates, and somebody's always been in control, and they say well, we're going to back off from this to every two or three months that patient would fail the measure.

CO-CHAIR PINCUS: Is there a comment by somebody on the phone?

So, it sounds like there's differences of opinion on this. So we've moved this from discussion to voting.

And the options are to support, conditional support, or do not support.

MEMBER GIFFORD: Clarifying on the vote, I heard us talk about support or do not support.

If it's conditional support, what are the conditions? And since we have three choices, if someone votes for conditional support, I want to know what the conditions are for them to vote for that.

CO-CHAIR PINC US: Right, so that's a good question. So Lisa, you pulled it. Do you have any suggestions around conditions?

MEMBER MCGIFFERT: Yes. Someone suggested the conditional support would be that it move towards a -- let's see, support with conditions that it quickly switch to an outcome measure that tells us more about --

MEMBER GIFFORD: That's a different measure.

CO-CHAIR PINCUS: It will be a different measure.

MEMBER MCGIFFERT: Yes, it would be a different measure. So we don't --

ACTING CO-CHAIR GESTEN: Well, technically a phosphorus level is not an outcome measure, it's still a process measure.

CO-CHAIR PINCUS: Right. I mean, I'm trying to see if there is a potential recommendation or condition.

DR. RICHARDS: Well, I think at a minimum being in compliance --

CO-CHAIR PINCUS: So, it's either support or do not support.

MEMBER MCGIFFERT: So, let's just take a vote. And I recommend that we do not support this. So, how about that? Let's vote on it.

CO-CHAIR PINCUS: Okay. So, let's just take the -- before we vote make sure that folks have logged into their -- Coordinating Committee voting members are logged in through their personal ID which they got in an email this morning.

And if there's anyone who is not,

either on the phone or in the room, now is the time to speak up.

ACTING CO-CHAIR GESTEN: This is Foster. Can we have a test, a slide about the snow or something similar today? Because I've been having some significant technical issues this morning.

I do have the slide up, but I just don't know whether I have the voting capacity link yet.

MS. BITTORIE: We are going to put a test question on the screen right now.

DR. BURSTIN: And Shawnn, some people are getting in the room something saying the meeting has ended on their webinar screen.

ACTING CO-CHAIR GESTEN: That's what's called wishful thinking.

MS. BITTORIE: So, certainly we do want to make sure that if you are clicking on today's link that you have cleared your browser from yesterday. It could be holding onto yesterday's meeting.

CO-CHAIR PINCUS: While this is going on, I think both Pierre and Barry had a comment.

MEMBER NOONE: I just had a question about getting on. I have yesterday's email but not today's.

Today's email didn't -- you sent me yesterday's again.

DR. BURSTIN: Shawnn, can you just one more time send today's email to all the members?

MS. BITTORIE: Absolutely. Doing that right now.

DR. BURSTIN: Thank you.

CO-CHAIR PINCUS: Okay. Pierre? Pierre had a comment.

DR. YONG: Sorry. One of my staff members is on the phone, Joel Andress, who heads up this measure. So he just wanted to offer a clarifying comment, if that's okay.

CO-CHAIR PINCUS: Okay.

DR. YONG: Joel, are you on the line?

MR. ANDRESS: I am. Can you hear me?

DR. YONG: Yes.

MR. ANDRESS: Okay. Thank you. So, just one thing to point out. I apologize for being late to the discussion, but I think one thing that bears mention is the fact that this program for which this measure is being considered has an explicit reporting component to it.

Whereas other value-based purchasing programs are distinct from reporting programs, the QIP requires both a set of reporting measures and clinical performance measures as part of making the payment determination.

So, I think the question that I would ask the committee to consider is, if we are arguing that a reporting measure is of no value, what does that mean for a program that explicitly has a reporting component versus a clinical performance component?

I think the other issue is that there has, you know, that reporting measures of this kind of have certainly been --

CO-CHAIR PINCUS: Could you just --

let me just interrupt you for a moment. Could you explain what you mean by a reporting component as compared to a clinical performance component?

MR. ANDRESS: Sure. So, there are two types of measures that go into the QIP.

There is a clinical measure on which a facility is assessed based on performance on that measure. So, for readmissions as I'm sure you're familiar with the readmission measures, your performance relative to your peers is assessed, and your score is based upon that relative performance or improvement.

For the reporting measure there is a requirement within the QIP that reporting measures define data that must be reported to CMS, and performance or points toward the payment determination are assigned based on whether or not you meet those reporting requirements.

So, for instance, for a phosphorus reporting measure you would be assessed on whether or not you reported whether or not a

patient had received phosphorus, but not on the percentage of patients who hadn't received phosphorus, if that is at all clear.

MEMBER MCGIFFERT: Let me ask if I understand what you're saying.

There is a payment you get, an annual update if you report the certain measures that you're required to report by CMS. That's what you're distinguishing as reporting.

And then there's another piece to that that's quality that you're paid for.

And my understanding is this measure is being considered today for the quality measure, not for the reporting measure.

MR. ANDRESS: No, I think --

MEMBER MCGIFFERT: Is that wrong?

MR. ANDRESS: Well, when measures are submitted for the QIP, they have not been split up in those two camps.

In terms of looking at this as a measure, we are simply considering this measure -- which, you are right, is a reporting measure --

as a potential for use in the QIP which means it could be used potentially for either purpose.

The program itself feeds both categories into the same payment determination. There aren't two separate determinations that are made.

As an example, I think for the last payment I think 90 percent of your score is based upon your clinical performance and 10 percent is based on your meeting the reporting requirements.

CO-CHAIR PINCUS: So, what you're saying is that it has less value in terms of the overall score that you get.

So, just two quick comments from David and from Jayne.

MEMBER GIFFORD: I guess I just want to clarify because I'm reading it was submitted under the heading, and just I'm clarifying, under the CMS ESRD program which, going to the link, is a program that uses measures in performance that are tied to payment.

And if you don't submit the data you

also may have a financial penalty for not submitting the data.

And so what Joel is saying -- is Joel saying that you are proposing to use it only for submitting and not tying it to payment? Or it's going to be part of the program so it could be in the rulemaking tied to payment later on, rather than just a penalty for not reporting?

What is the vote they're asking for rulemaking on here? Are you asking to include this in rulemaking for just submitting the data, or are you asking for submitting the data as part of the QIP program?

DR. YONG: So both components make up your QIP score.

MEMBER GIFFORD: So you're asking for the whole QIP program, both penalty and also --

DR. YONG: Right. But you would only use it for one. You would not use it for both. Right. You wouldn't have the same measure in both the score calculation for the reporting as well as the performance.

CO-CHAIR PINCUS: So, it's part of the program but they're differentially scored.

DR. YONG: Right.

CO-CHAIR PINCUS: Okay? So I think that's the issue.

MEMBER MCGIFFERT: Wait a minute. I may be misunderstanding, but there are a lot of measures that hospitals have to report that are not in the quality incentive payment programs.

CO-CHAIR PINCUS: And this, apparently, the issue for us is that it is part of the program, it's scored differently. Different measures are scored differently in the ultimate payment model. And that's I think the key issue.

So, just to -- because I think we need to move ahead. And so I think we've belabored this.

So, is it okay to try the fake question?

MS. O'ROURKE: Yes, so if everyone could go and cast your vote. Is it sunny where

you are? Please let us know if you aren't seeing this screen or if you're having any voting issues.

WORKGROUP CO-CHAIR WALTERS: Are you able to tell if all of the eligible voters have voted?

MS. STERLING: Yes. And just to be sure, federal liaisons, you are not going to be voting so please exclude yourself from that.

CO-CHAIR PINCUS: Okay, what's the right number? There should be 27. We have 27. So why don't we move on. No, we have 28. It should be 28?

Okay, so let's move on to the real vote. Okay, can we move on to the real vote?

MS. STERLING: Yes. Just a second.

CO-CHAIR PINCUS: So we can vote now?

MS. STERLING: Yes. So you're voting on MUC 151136, Measurement of Phosphorus Concentration for the End-Stage Renal Disease Quality Incentive Program.

Your options are support, conditional

support, and do not support. And voting is open.

CO-CHAIR PINCUS: So, it looks like three people have not voted.

Okay, so it looks like the voting is more than 60 percent to do not support.

MS. STERLING: Right. So it's 11 percent support and 88 percent do not support. So, the workgroup recommendation does not stand and this moves to do not support.

CO-CHAIR PINCUS: And the important point here is that the commentary back to CMS is concern about this being purely a reporting measure that may not capture the full recommendations from the guidelines.

And the recommendation is strongly toward develop one that would actually measure control or performance in concert with the appropriate guidelines.

MEMBER GIFFORD: And I think, Harold, move to an outcome measure, too.

CO-CHAIR PINCUS: Right.

MEMBER BAKER: I would just add that

the workgroup raised all of these issues. So I mean, the justifications for this is all there. They just came to a different conclusion.

CO-CHAIR PINCUS: Okay. So let's move on.

Now, I understand there's some confusion about what's on the list that have been pulled.

MS. O'ROURKE: So, we had a late-breaking pull. So we'll be moving on to the influenza measure for ESRD vaccination. You'll see it on the discussion guide here, MUC 761.

And the workgroup's recommendation was do not support for this. And Pierre had pulled this.

CO-CHAIR PINCUS: Okay, so Pierre, could you give us some of your rationale?

DR. YONG: Sure. We just wanted to make sure, and to share some additional information --

CO-CHAIR PINCUS: And is this for re-voting?

DR. YONG: Yes. And so, and Ron was very familiar with the conversation. There was a pretty robust conversation at the workgroup on this particular measure.

I think the particular issues that were raised at the workgroup discussion were that there was another similar measure that is a claims-based measure, and that is in use in many facilities.

The addition that the committee thought might be a better alternative to this which is the data source of this is CROWNWeb. So, the facilities need to input the data into the ESRD data collection system.

The particular information we wanted to share with folks is that upon further examination of the claims-based measure, which is not the measure in front of you now, it systematically excludes patients who -- from the numerator who did not receive a flu vaccine during the flu season and passed away.

And so we think that's a pretty major

flaw to that measure, and that is not -- and that exclusion is not present in this particular measure that is in front of you.

So we thought that was one of the reasons we thought this was a stronger measure.

The other reason we thought this was a stronger measure potentially was because the data source for the other measure is claims. And so if we do not have access to the claims or a particular flu vaccine was not filed for that patient we won't have access to that information to calculate the rate for that, or account for that patient and the flu vaccine for the measure calculation for that facility.

CO-CHAIR PINCUS: Missy, David, do you want to respond?

MEMBER BAKER: I don't have any comments.

MEMBER DANFORTH: This is Missy. I was actually just comparing the two measures so I definitely understand what you're saying, Pierre, about not counting folks that died who didn't get

the vaccine.

But also some comments about there being no exclusions. And one of the things about the endorsed measure is that it does exclude patients who declined just based on patient choice.

So I notice that's in the workgroup's comments and seems fairly important. Do you have any comment on that?

DR. YONG: Sure. Thanks, Missy. If the facility were to -- if we were to use this measure the facility when they input the data into CROWNWeb which is our data collection system, they would be able to indicate in that, in the record whether they were offered the vaccine but declined.

CO-CHAIR PINCUS: Ron, do you want to make a comment?

WORKGROUP CO-CHAIR WALTERS: Well, Pierre summarized things pretty well.

So we have on the one hand a measure that is NQF-endorsed, claims-based, tested, fully

aligned, et cetera, et cetera.

And we have a materially different measure which is registry-based basically. It's an NHSN database, CROWNWeb.

And pertinent to Nancy's point earlier, this is not tested yet. There are workload issues.

And the committee also, in additional points raised -- discussed what is the plan for integrating those things, or are we really going to report the two measures on a going-forward basis.

And so having not heard a good, long-term solution to that decided to support the measure that exists, 226, and to not support this one.

MEMBER DANFORTH: I'm sorry, this is Missy. So, because this isn't a fully tested measure, and it sounds like the exclusion for the denominator and/or numerator aren't defined for the ones Pierre just mentioned in the measure sets, should this have gone to the other category

of voting which was, like, support direction?

I don't know, I think support continued development or whatever the long discussion was we had yesterday?

It seems like this got the type of votes that a fully specified and tested measure received. And I know we had a long conversation about this yesterday.

CO-CHAIR PINCUS: Is this on the agenda under the standing committee process?

MS. SAMPSEL: Hi Harold, this is Sarah Sampsel. I'm the senior director for the Renal Project. And we have not seen this measure on the list to be submitted for the next Renal Project.

DR. BURSTIN: And the KCQA measure I think they were discussing I'm told is not claims-based, at least from the developer. I'm just throwing that out there.

CO-CHAIR PINCUS: So, actually that raises a good question. Is there a reason why this wasn't sort of under the measures under

development rather than?

MR. AMIN: There must have been information -- I look to the staff on this and also CMS -- that this measure was tested.

Just because it's not NQF-endorsed wouldn't put it in the fully developed pathway. But CMS claims that this measure was tested which is why it went in the fully developed pathway, I assume.

CO-CHAIR PINCUS: But apparently according to some of the workgroup discussion, there are certain key elements and details that --

MR. AMIN: Missing, yes.

CO-CHAIR PINCUS: -- that are missing.

MR. AMIN: So, clarification from both staff and CMS.

MS. O'ROURKE: So, I think the key information that you see missing is why the group initially did not support this measure and instead looked to the NQF-endorsed version. So, I'd ask -- I'd turn to Pierre to clarify.

DR. YONG: Sure. Actually, I'm going to ask Joel. Can you clarify, please, for the committee?

MR. ANDRESS: I'm sorry, can you restate the question?

CO-CHAIR PINCUS: So, the question is, number one, has this measure been tested, has it been fully specified. Because the workgroup's comments included concerns about the lack of full specification.

MR. ANDRESS: So, to clarify, the measure has been specified. It has not been tested as of yet.

CO-CHAIR PINCUS: So, just should this have been under the measures under development category rather than for implementation? And therefore should we be voting on sort of a different set of conditions?

MS. O'ROURKE: From what Joel is saying, it sounds like this should have gone through the under development pathway.

CO-CHAIR PINCUS: Can we shift it over

to that pathway now?

MS. O'ROURKE: Yes, we can put that on.

MEMBER DANFORTH: Right. And it seems like it potentially would have gotten a more favorable vote. So instead of a firm do not support, it seems like there was a potential to get support continued development just based on the conversation.

CO-CHAIR PINCUS: Does CMS have an objection to doing that? Okay.

David or Jayne, do you still have comments?

MEMBER GIFFORD: Jayne and I probably can just alternate words.

CO-CHAIR PINCUS: Okay.

MEMBER GIFFORD: With what we're probably about to say, I suspect.

MS. CHAMBERS: Yes, I actually -- okay, so here it is.

I'm actually a little troubled by the process as a whole. And I respect CMS's opinion

and their explanation for why they wanted this measure to come forward.

They're advisory at this table. It's the MAP's role to determine whether we think these measures are ready for use in a payment program right now, or not ready for use in a payment program.

We are providing advice to the agency about which measures we think are ready for primetime to be used in the next rulemaking cycle in their proposed payment rules.

The discussion I'm hearing around the table right now is that this isn't ready. So, I would instead of support or not support, I think you could do conditional support, guidance with further development, and re-specification, and clearer, you know, what's going on, and NQF endorsement.

But it's our role to make that decision as to what we want that recommendation to be.

CO-CHAIR PINCUS: David?

MEMBER GIFFORD: I would completely concur. I would say in reading the statutory requirements for this program it says that measures should be NQF-endorsed save -- where due consideration is given to endorsed measures of the same specified area or medical topic.

The workgroup gave due consideration and identified that there is an NQF-endorsed measure in this area and this measure is not under development.

And I would completely agree with Jayne. Our role -- I think switching it doesn't give the correct message which is we don't support this. Well, I guess unless we change the vote. But we don't support this measure as currently constructed for rulemaking.

It may be a better measure, but we don't know, and it needs to go through further development and come back to the process.

But I think the message, regardless what the vote should be, is it's not ready for rulemaking, and you have an NQF-endorsed measure

that we do think is ready for rulemaking, and that should be the message to CMS regardless of whatever label we slap on it with the voting.

And I think this measuring under development is -- sends the wrong message to CMS and doesn't capture I think, Harold, the way you summarized it yesterday, that yes, they're under development, we want you to come back, which means -- because our role, just as Jayne said, is to advise them whether it's ready for rulemaking.

So, I would say almost any measure under development is not probably ready for rulemaking. That would be our message back to CMS.

So, if we want to switch it to under rulemaking, I'd want to make sure that labeled on there is it's not ready for rulemaking, that's why there needs to be continued development.

CO-CHAIR PINCUS: Amir?

MEMBER QASEEM: So, I absolutely agree with Jayne and David, what they just said. I'm not going to repeat what they said, but I haven't

heard any argument -- because the committee, the hospital workgroup came up with do not support.

And I think we need to have a convincing enough argument to overturn that to even conditional support.

And influenza vaccination is one of those issues. We have been talking about harmonization of the measures.

At one point in time we had 167 NQF-endorsed measures. I mean, it's craziness to have another measure.

And I understand the argument that's being presented, but I think it's just not enough and I think we need to go back to just what's already there. And if it's not serving the purpose and you need to come up with some testing data before we can overturn what the hospital workgroup has already proposed.

Because they already had that option, right? They could have given the conditions.

CO-CHAIR PINCUS: So, there are two perspectives.

One is that we should vote on the measure as it's been through the process, and whether we want to continue to support what the workgroup said or not.

Or the alternative approach is to say let's move it into this other category and vote on it that way.

So, the question is: could we take just a quick hand vote about which approach people would prefer to take?

MR. AMIN: Harold, can I just add one thing? The decision around the testing is on the MUC list that we received from CMS.

And in that forum, we got that it was fully tested and specified, which is why I brought it in this category.

We heard different information today, so if we follow the consistent rules that we have followed up to this point, we should use the information that was on the official MUC list, and therefore it should stay sort of in the current structure that it's in.

CO-CHAIR PINCUS: Okay, so that's --

MR. AMIN: So, we should just, you know --

MEMBER DANFORTH: That's helpful.

MR. AMIN: Unless there's a compelling reason for it to change the vote on the series of decisions that are available to you on this pathway we should keep it consistent.

Because this is a procedural matter. I mean, we've raised this a number of times now. But that is the decision rules that we came up with in September. That's what we've implemented.

CO-CHAIR PINCUS: My worry is that some of these other measures that have been recently pulled, we may wind up in a similar situation.

So, the intent is to be consistent with the original MUC list and how it was presented. Even though there may have been some errors in it.

Amir?

MEMBER QASEEM: One quick question was we can't really send this measure back to the hospital group and ask them to re-review or something along those lines. It doesn't work that way. Some process, right?

CO-CHAIR PINCUS: No.

MR. AMIN: We don't have the time for it?

DR. BURSTIN: And as Kate pointed out yesterday, the comments are more important. And there's plenty of comments. We should probably --

CO-CHAIR PINCUS: We've got lots of comments. So, let's move on.

So, the rule going forward is that we treat this as presented on the original MUC list. And so if we really think that it's, you know, that we disagree with the hospital workgroup's recommendations we would have to overturn that by 60 percent. Okay?

So, let's vote on -- yes, we never voted.

MS. STERLING: Okay. So, we are voting on MUC 15761, the full season influenza vaccination measure. And it's recommended for the End-Stage Renal Disease Quality Incentive Program.

And voting is now open. Your options are 1 - support, 2 - conditional support, or 3 - do not support.

CO-CHAIR PINCUS: Okay, so it looks like there is continued support for the do not support.

MR. TILLY: And the final tally is zero percent support, 7 percent conditional support, 93 percent do not support. So the recommendation is do not support.

CO-CHAIR PINCUS: So, now we're going to move towards -- and some people may have it on their discussion guide in different places.

MEMBER GIFFORD: Harold, sorry. I just wanted to -- I'd like it in the comments, even though I voted do not support, that you know, to give some hope to the family of the

person on life support that that's not a measure they should just throw the measure out.

They should keep working on it. And they should come back. And if it's really superior then they should come back through the process and do that.

Because I think it may be a superior measure, and it may be a better measure to capture other things. Because they have some concerns with the claims measure, and we might have some similar concerns.

So, I'd like the message also to be that they should continue working on these measures. It doesn't mean throw --

CO-CHAIR PINCUS: I think that was the message that people got.

MEMBER GIFFORD: I just wanted to make sure that that's on the record.

CO-CHAIR PINCUS: Okay. So, we're going to be talking next about measure 1013, Adult Local Current Smoking Prevalence.

ACTING CO-CHAIR GESTEN: The workgroup

recommendation was encourage continued development. And I think this was pulled by CMS. Rhonda, Amir, and Jayne.

CO-CHAIR PINCUS: Okay, Rhonda and Jayne.

MEMBER ANDERSON: So, I would like to just speak. This is not for a vote. This is for discussion and information.

As I think about what was said earlier from the public comment and also what all of us do in the community I want to be sure that we are not attributing things to one organization, and that they don't have a lot of control over.

And I also think that we should not be functioning in silos. And what I mean by that is hospitals already do the community health needs assessment.

In many of their communities this is one of the findings and one of their action plans.

So, I think it's important to be sure that the approach and that the measures are

meaningful to everybody that will be using them.

As we go back to some of the other comments that were made, if the public at large uses some of this information for their decision-making what are these unintended consequences also for the public at large. Because what will they really understand about this measurement.

So, I would like to make sure that we as it goes forward with the current recommendation of encourage continued development that they do take into consideration what is happening already with the community needs health assessment, how that affects hospitals and their individual communities because smoking prevalence is larger in one area than in another area, and I think all of that has to be taken into consideration.

ACTING CO-CHAIR GESTEN: So, let me just clarify, Jayne. Did you pull this measure?

MS. CHAMBERS: I supported AHA's pulling the measure. We share their comments. We share their concerns.

I think that there's -- we're not quite sure how to handle it or how to do it, how to put all the pieces in place.

And there are a number of other things on hospital's plates right now and they're learning how to work on population health within the various communities.

Each community has different resources available to it. And we're concerned that before something of this nature gets put into a payment program that we have a much better understanding about how it all works.

And at this point we don't really know how to make this measure work. Good goal, great concept, we're glad to work on it, but we're not sure how to make it work yet in a really, truly robust way.

CO-CHAIR PINCUS: So, Gail and then David.

ACTING CO-CHAIR GESTEN: Well, let me just sort of -- do you want to vote? Are we going to be voting on this because that's helpful

to know.

MS. CHAMBERS: On the list right now is conditional support. Is that right?

ACTING CO-CHAIR GESTEN: Encourage continued support.

MS. CHAMBERS: Encourage continued development is fine with me. I don't know we need to vote on it.

CO-CHAIR PINCUS: Okay, great. Gail?

MEMBER HUNT: I just wanted to know what unintended consequences you were thinking of when you mentioned that.

MEMBER ANDERSON: It has to do with the prevalence in each area. There may be a higher prevalence in one area, lower in another region, et cetera, community.

And as this is applied generically across the board I don't believe that each of those communities have the same level of need.

And so that's why I think it's important to understand the community need and not just have a measure that is attributable at

that hospital.

MEMBER HUNT: I thought it specifically addresses community-based, county-based -- it's a county-based measure so it's dealing with this is what happens in our county versus this is what happens in the next county which may be different. So that's why I don't understand unintended consequences.

MEMBER ANDERSON: I maybe misunderstood then what I read, but I thought it was being applied across the board in terms of the reporting aspect of it.

CO-CHAIR PINCUS: David?

MEMBER GIFFORD: As a former public health official I may get kicked out of the alumni association with my comments, but I haven't heard anything that talks about why the measure needs to be further developed per se. And it's going through the review process.

I understand why it falls in the category for that, but I think the comment that I'd like to underscore is this is an important

measure, an important public health measure.

You can't do these without alignment across the board. And so if CMS is just trying to put this in the hospital program and in the EHR program for physicians you need to align all the other physician groups out there, particularly when you look at the smoking rates in this country. They're in other groups that have to be there.

So, if CMS is going to go forward with this the comment I would like to make sure to get back to them is when they do it they need to do it with everyone else aligned.

You need to do the FHQCs. You need home health. You need everyone on this measure and everyone having accountability because if not then you are hanging the hospitals out on a limb to what's going on. And I think that's unfair.

CO-CHAIR PINCUS: I actually, to step out of the chair's role, I would add another issue for CMS to consider in this.

While obviously it's being measured

based upon the baseline rate of smoking in a particular county, it doesn't take into account the capacity for change in a county that may have to do with sort of the prevalence of different media exposure, the prevalence of different access to media or to other public health interventions. And that's something to consider.

The fact that it's adjusted based on baseline may not be sufficient in terms of the different types of levers and mechanisms that even collaborating hospitals or healthcare institutions can utilize.

So again, that's something to think about as one moves forward with further development.

Kevin and Lisa.

DR. LI: So, I'm going to take my government hat off for just a second and wear the hat that I was on the Vital Signs Committee for the IOM.

And for those of you not aware of that committee we were asked to kind of come up with a

set of core measures for the country.

This is really in --

CO-CHAIR PINCUS: And we're going to be talking about that later.

DR. LI: Yes. This is really in line with the kinds of discussions we had there. And we were really looking and hoping for measures that blended the kind of care delivery, population focus and encouraged joint accountability.

And so, of course I can't speak for that committee, but I can tell you that during our deliberations and in our report we were really hoping for measures like this that would help to close that gap between what has historically been a measure of sort of single accountability to a single program or a single organization and share that accountability across all of us who support healthcare.

CO-CHAIR PINCUS: Lisa?

MEMBER MCGIFFERT: I was just wanting to be clear. I understand that there's concern

that this will be used further.

But this is basically in the general reporting that hospitals are required to report certain measures in order to get the annual upgrade in the payments. Am I correct? Or is it specifically in the quality reporting?

And the other comment I guess that's kind of been said, but it seems to me that this is trying to get at the hospitals to help assess an issue that the public health community has been unable to assess because they have the patients there.

And that seems to be the purpose here is to get them to help assess how many people are smoking. But those are my questions.

CO-CHAIR PINCUS: Melissa, you want to respond?

MS. MARINELARENA: Sure. So, I can offer additional clarification around this measure.

So there is a currently endorsed measure just like this, but it's at the state and

national level. It's collected by the CDC using BRFSS, I believe.

This is the only measure in the hospital program that is under development. All other measures are fully developed, been tested.

So this one was under development. That's why the recommendation was to encourage further development because it is being respecified at the county or city level, I think.

And so it will also be collected by the CDC. So the hospitals wouldn't be required to collect the data and it would be by using BRFSS as well. So hospitals won't have to report this data. The burden won't lay on them.

It would be CDC collecting. It's a population-based survey. They call people on the telephone. That may change as the measure is developed further, but it'll be CDC doing the work.

CO-CHAIR PINCUS: So, I think we have Missy on the phone, and Jayne, and David.

MEMBER DANFORTH: Thanks so much. I

just want to go back to some of my earlier comments today about the measures that were put forward for these programs in general.

So, my understanding is that any measure that goes into the hospital IQR gets publicly reported on Hospital Compare.

I had some concerns about how consumers, patients and patient families are supposed to use information that's on a website where information is publicly reported by a hospital for a measure that's reported out I guess by county, or by city. So that's my first concern.

My second concern is, again, information -- measures that are part of the hospital IQR are supposed to go onto Hospital Compare which is supposed to be used by patients and patient families.

And as I discussed earlier this morning there's so much information that's missing from there, and there's so much education that consumer groups are trying to do to educate

consumers about what are those things that are really important when you're choosing a hospital.

And so I'm having just a really hard time philosophically seeing how this measure would fit into the IQR. Not that it's not an important measure, but specifically how it fits into the hospital IQR.

CO-CHAIR PINCUS: Thank you. Jayne, and then David.

MS. CHAMBERS: Missy, thank you for your comments. I'm right with you on that.

I mean, the IQR program is part of the entire quality metric of the five hospital payment programs where we report quality measures and we get paid on those measures.

It is important that the information that's reported on Hospital Compare be usable by the end user.

It's also important that the hospitals can use it to improve care for the patients that they're treating in their hospitals.

I think we need to look at this. If

this is a population-based measure then every healthcare entity that is involved in delivery of healthcare for patients in their community should be required to report the same measure.

Then you could get some synergy behind it and everyone would be working together to try to improve the population health. I think we're not there yet with this measure.

And I think that it's expensive to implement measures. No matter what you do there's always an infrastructure that goes with that measure to get it up and running, to review the reports, to be sure the data you're submitting is accurate. There's a cost to that.

If we're putting a measure in that's not ready for primetime there's a cost that's a wasted cost that we could be using in better ways to help patients.

CO-CHAIR PINCUS: David, and then Marshall.

MEMBER BAKER: So, I'll just say that really all the concerns that I've had have been

expressed, but I wanted to emphasize one that I think is particularly important that Rhonda started off with.

It's we want to be able to have measures that hospitals actually have the ability to control.

And if you think about the importance, the most important thing is the taxes on cigarettes.

Next thing probably laws against smoking in public places. And then availability of quit lines.

And there are so many things that are beyond the hospital's control that are just critical drivers.

So, to engage hospitals in some way to help them support all those efforts I think is great. And there have been some good examples, Cleveland Clinic being one of them, that really was engaged with the community trying to get change.

But I don't think that the measure is

really going to help organizations.

And I'll just think about Cook County as well where I think there are 37 hospitals. And imagine 10 do a great job and the others don't. And everybody gets dinged.

So, I'm just -- I don't think this is the right way to go. I don't think hospitals have enough control.

CO-CHAIR PINCUS: Marshall?

DR. CHIN: This is a question maybe for Helen, but I'm wondering like the NQF population health group. I mean, these issues must have come up. I'm just wondering what has been learned from those discussions that are relevant for what we're talking about now.

DR. BURSTIN: So, this measure was actually -- and Elisa Munthali, our VP for measurement, is on the side there. She leads this.

This measure was endorsed as part of the Population Health Committee, but at the county level.

So, I think the reason in our discussions with CMS this could only be an encourage continued development because there's a lot of work to do to think about how you really consider how that measure is then attributable to a hospital.

So, the committee has not discussed it, but it certainly could be something that the Population Health Committee can discuss going forward.

But there are lots of issues we've heard about risk adjustment and many of the issues that have already been raised.

But endorsed at the county level. The applicability to using it in a hospital program is I think where there's a thought there needs more work which is why I think the hospital workgroup landed on the idea of saying encourage continued development. Important priority area, but not necessarily ready.

CO-CHAIR PINCUS: So, just a reminder, this is for discussion, not for a vote in terms

of the people who pulled it. So, David, and then we should try to move on.

MEMBER GIFFORD: I guess I disagree a little with Jayne. This is BRFSS data. The cost is borne by the state public health agencies with funding from CDC. There is no data collection burden on any provider here.

That said, I would completely agree with Jayne and other comments, and reiterate my point, and to Dave's point, I still think you want hospitals and everything lined up.

Because while I agree the taxes and the other things are the most powerful, still, having your healthcare provider tell you to quit and reinforce it is also a really powerful message. And you need alignment.

But I agree with Missy too. Putting this on the hospital with not anywhere else, and putting it in clustered together with all the other measures for consumer choice is misleading information too.

So, I think CMS has to figure out how

to use this measure across the healthcare system, and how to use it in public reporting.

Because it's shifting in a different way, and it's trying to shift us and I would agree with that movement. But you can't use the existing vehicles necessarily to get there. And I think they really need to give some thought to that.

Because just to throw it out there actually will -- the unintended consequence is it just ticks off everyone, and no one does it, or they just do checkboxes. And then we don't really get the meaningful improvement in lowering cigarette smoking that we need to.

CO-CHAIR PINCUS: So, I think we've given the ample feedback and why don't we move on.

The next measure that's been pulled is measure 531, the NHSN antimicrobial use measure. And Rhonda, Amir, and Jayne have pulled it. So, Rhonda, do you want to comment?

MEMBER ANDERSON: Sure. This is for

discussion also.

CO-CHAIR PINCUS: It's for discussion, you said?

MEMBER ANDERSON: For discussion, from my perspective, yes.

So, as I look at this measure I think there are two things that I have concerns about.

One, it isn't a measure for appropriate use. And I think that is a focus that we've had. Going back to many of the comments over the last day and a half about outcome measures and appropriate use, et cetera, versus checking a box, and how many in this case antibiotics do you give.

I think also from an unintended consequence perspective particularly in hospitals that are tertiary in nature, and patients are with these illnesses and infections are transferred to from some of the smaller hospitals, et cetera.

The large number of antibiotics that they may be giving because of those transfers

will be in that database.

And that may be leading the public to think that they overuse, but they aren't overusing, they are actually treating patients that have been transferred to them.

And then it's my understanding that when the CDC brought this forward and NQF looked at and endorsed the measure that they said it wasn't well suited for public reporting.

And I wanted to be clear that everybody, I believe, is working toward appropriate use of antibiotics.

But what it would do potentially with public reporting when it is about amount used versus appropriate use is a real dilemma that I have as I read this.

CO-CHAIR PINCUS: Jayne?

MS. CHAMBERS: Since I've talked enough this morning I'll just say hear hear. I agree with what Rhonda said.

But we are working very much towards appropriate use of antibiotics and would welcome

a measure of appropriate use.

Quantifying the exact number of antibiotics is not necessarily telling us whether or not we're using the right antibiotics in the right setting and right amount.

CO-CHAIR PINCUS: Amir?

MEMBER QASEEM: Something very similar. I think that these antimicrobial stewardship programs haven't been in place for long enough at this point.

I think it's difficult to come up with some sort of a national benchmark, and I think we need some experience.

So, the issue is the accountability. I think this measure is not ready for accountability still. And we need some more testing data on it.

So that's why I think the conditional support makes sense.

CO-CHAIR PINCUS: Missy, David, do you want to respond?

MEMBER BAKER: So, I'll say I think

this is potentially a really good measure for the hospitals to be able to use as part of their antibiotic stewardship programs for quality improvement.

But I have real concerns about the risk adjustment methodology. Again, as what Rhonda said, penalizing tertiary care facilities, it just will be very difficult to accurately risk adjust. So, I have concerns.

CO-CHAIR PINCUS: Missy?

MEMBER DANFORTH: And this is Missy. I actually am just really supportive of the workgroup's recommendation which is conditional support pending the CDC's recommendation that the measure is ready.

I mean, I think the CDC has a lot of experience with hospital-based infection measures and how they're publicly reported, and has been really responsible and really takes seriously the feedback they get from hospitals.

So, just to reiterate for the original workgroup's recommendation.

CO-CHAIR PINCUS: Lisa and Kevin.

MEMBER MCGIFFERT: I also support what the workgroup recommended, conditional support.

I'm not crazy about this measure either, but I know that it's -- and I think it's sort of experimental at this point.

I was on the patient safety committee and I know that the agency, CDC, is -- acknowledges that they're trying to collect information. They don't have the information they need now to establish baselines. And they need more information.

They have, I don't know, a hundred, maybe a couple hundred hospitals now that are voluntarily reporting this information, but that's not really enough to get a sense of what's happening out there.

There's some evidence that as much as 50 percent of the antibiotic prescriptions in hospitals are inappropriately given.

And I do think that this is a real key part of an accountable antibiotic stewardship

program.

A lot of hospitals say they have a stewardship program, but they're kind of all over the map. And we believe that measuring their antibiotic use is a real important first step.

So, I believe that antibiotic resistance is probably the most important issue in healthcare today.

If we don't start getting a handle on it we will have a really different experience in the future for minor surgeries, and any other number of things that are going to kill people that don't kill them today.

So, I think it obviously needs more work, and I think the conditional support is an appropriate recommendation from the committee.

CO-CHAIR PINCUS: Kevin, and then Frank.

DR. LI: I just want to highlight that I think this is a really terrific step towards the Learning Health System.

This measure asks for electronic

realtime data to be sent to CDC around some key activities like medication use and antimicrobial resistance.

And much like registries have shown that when that information is readily available and easily benchmarked across institutions there's a lot of learning that happens, and there's a lot of natural improvement that can happen if that information is actionable, and live, and able to be shared.

So, I think that -- I won't comment on the merits of the measure as a measure, but the infrastructure that it is helping to create, and the sharing made possible by this I think is really fantastic, and want to make sure that people are aware that this new way of measurement is a sort of key new direction.

CO-CHAIR PINCUS: Frank, and then Chesley.

MEMBER OPELKA: So, I'm building a little bit I think on where Kevin's going, but I've kind of wavered between conditional support

and do not support.

And the reason I say that is that this is a very important issue, but it's solved very simply with efforts to create digital workflow solutions that are baked into the EHRs.

Rather than chipping data -- do another data mark to have it just report upon doesn't really put the solution right in the hands of the clinician at the point of care in realtime.

And if that's the intermediate step we have to go through, so be it, and therefore I conditionally support it.

But if I were the government and I really wanted to invest in this I would be investing in creating workflow solutions that exist in the EHR that apply antimicrobial appropriateness at the point of care in realtime, rather than something that's after the fact and being reported subsequently.

I think it's going to slow us down to do that, but if that's the only way to get there,

so bet it. We'll be slow in getting there.

CO-CHAIR PINCUS: Chesley?

DR. RICHARDS: So, I wanted to hear the other comments before I weighed in from CDC.

And I wanted to echo a comment that was said before. We do take very seriously both what the MAP says and what hospitals' concerns are.

CO-CHAIR PINCUS: A little close to the mike.

DR. RICHARDS: So, about this measure, I don't think anybody at CDC feels like it's ready as currently constituted for public reporting, for two reasons.

One, there's not enough experience with it.

The second, and it highlights some of the concerns expressed previously by Rhonda. It may need to evolve as a measure from what its current sort of form is.

The context, and I think many of you are aware of this, is that antimicrobial

resistance, particularly in hospitalized patients and in healthcare is a pressing public health urgency.

The President convened a meeting at the White House to talk about this issue and there's a large initiative within the government, at CDC, with CMS, with other agencies to address the problem.

So, to your concerns, Frank, it's not just the measurement in isolation. It's part of an entire program that's being put together that includes clinicians, EHR vendors, and state health departments.

I think in talking with the staff back and forth this morning this measure probably is two to three years, with all that said is probably two to three years to have enough experience with it to know whether it's appropriate for public reporting.

And as I said, the likelihood is that it evolves to a better measure as we learn from that.

So, if that's helpful in terms of the vote needs to be taken, I wanted to provide that context.

CO-CHAIR PINCUS: Thank you. So, I think we've given, again, sort of a full and comprehensive set of comments back to CMS and we can move on.

We have nine more measures to go through that have been pulled. I just want to remind people.

So, the next one is excess days in acute care after hospitalization for pneumonia. It's the number 391. And that was pulled by Amir.

MEMBER QASEEM: Yes, and I think it's at conditional support so I'm okay to leave it at that.

But the point that I just want to make over here is most of the data that this measure is based on is old data.

And there's a lot of new studies that have been published that have shown that actually

the ICU admission of patients actually improves survival. Actually there is no significant difference in cost. So I think we need to start looking at some of the newer data on this one.

They did all recent publications over the past two or three years and there is enough over there that I think that we need to really look into this measure again.

CO-CHAIR PINCUS: And this also among the comments was also to consider risk adjustment by sociodemographic factors as well.

David, Missy, do you have any comments on this?

MEMBER BAKER: I would just add you were talking about the risk adjustment for sociodemographic factors, but I have broader concerns about the risk adjustment methodology.

As you expand this out and you're looking at emergency department visits and other things, then that just means that all the comorbidities that the patient has are also contributing.

You know, the ratio of what proportion of all of those visits are in any way related to the patient's pneumonia decreases and decreases.

So, I think it really has to look very closely at the risk adjustment methodology for this.

CO-CHAIR PINCUS: Missy? Any comments?

MEMBER DANFORTH: Okay. I don't have any additional comments. I supported the workgroup's original recommendation.

CO-CHAIR PINCUS: Okay. David?

MEMBER GIFFORD: I would just say that as admissions to hospitals are dropping, and care for pneumonia is being more done in the outpatient or in PAC or assisted living settings the number actually may go up on the hospital side because the acuity of the people who are going there are changing.

And I just encourage CMS to think about and look at that. We've seen that in several areas for hospitals.

CO-CHAIR PINCUS: Other comments? Okay, so that's, again, we don't need to change the voting on that.

The next measure is vaginal birth after cesarean delivery rates. And that's number 22. And that was, Lisa, you pulled it?

MEMBER MCGIFFERT: I did. I'll try to make this quick.

This got a do not support from the workgroup recommendation. And I would like to ask for a vote on this.

I think this is a really important measure. I understand the reason that the committee voted to do not support because this is applying only to Medicare population.

I have no idea how many people deliver babies on Medicare, but I'm sure it's very small.

But the importance of this measure is to get it in the pipeline. And what we would like to see in the future is for this to become an all-payer measure like it is in I think 20 states. And I think Carol can talk to that.

But it seems to me that we have to -- I mean, we were kind of curious about why CMS proposed this for the Medicare population, but we also see this as a precursor to a real measure that would include all payers.

And that's why we pulled it. And so I would like to vote and recommend that it be either supported or conditionally supported to expand it. But I think we can't do that because of your new rule, Harold.

So, I'll let some of my other colleagues --

CO-CHAIR PINCUS: It's all my fault.

MEMBER MCGIFFERT: -- talk about this.

CO-CHAIR PINCUS: So, David, Missy, do you want to respond initially?

MEMBER DANFORTH: I do have comments on this. David, do you as well? I can't see you, so.

MEMBER BAKER: Okay. I'll make some comments.

My biggest concern about VBAC as a

measure is I think this is something that really is a decision that patients need to make.

I mean, there are very significant risks involved with VBAC in terms of vaginal lacerations and uterine rupture.

There's a lot of clinical situations that vary depending upon how the original cesarean section was done. The risk can vary very substantially.

So we don't know what the right rate is. So that's my biggest concern about just trying to have a measure and say, you know, we need to drive down the rate of VBAC. Well, we don't know what the right rate is.

So I agree with the committee to do not support.

CO-CHAIR PINCUS: Missy?

MEMBER DANFORTH: Yes, thanks. So, I actually disagreed with the committee's recommendation on this for a couple of reasons.

One is I read through the public comments and there were a lot of public comments

about oh, well, we don't know what the right rate is.

But as a reminder, when CMS has adopted other maternity care measures into the Inpatient Quality Reporting program and published those results, for example, early elective delivery rate on Hospital Compare they actually don't compare it to a target which was a big disappointment to us, but the decision they made.

And so, I think that there's ample opportunity to include a measure in the IQR, publicly report it, let other people, including other organizations use that data in different ways, but also the public use it without necessarily having to decide, well, what's the right rate, is it 10 percent, 15 percent, 20 percent.

There's maternity care measures now, again, that are published on Hospital Compare that aren't compared to a rate. I don't think that should necessarily stop us.

The other thing is I would really,

really, really encourage CMS -- and I know Pierre is in the room -- to really think about other ways to get this data for the all-payer population.

It looks like the Joint Commission has done a really fantastic job in certifying vendors who are able to get maternity care data on entire populations within a hospital and calculate accurate rates based on measure specifications.

My understanding is you proposed this for Medicare fee-for-service only because it's an AHRQ measure and that's how you're calculating the other AHRQ measures.

But I would really strongly encourage you to think more broadly, creatively, innovatively about opportunities to get this data from hospitals who for the most part are already using vendors who have a lot of experience in abstracting this kind of data and doing sampling potentially, and not just stop at the workgroup's recommendation and not think about even introducing that as a Medicare fee-for-service

only measure. Thanks.

CO-CHAIR PINCUS: Thank you. Carol, and then Barry.

MEMBER SAKALA: Yes. So, first of all, I'd like to thank CMS for using the MAP process to look at a population that typically is not cared for, a big Medicare population, and extending the possible benefits of this process, and also to congratulate you for really identifying a prime area in my view for quality improvement.

In 2010 there was an NIH consensus conference followed by updated guidelines from ACOG and AAFP the gist of which was nearly all women with history of cesarean would be eligible for planning a VBAC. They should be counseled and offered VBAC.

And if you cannot provide this, or your hospital cannot provide it they should be informed of where they could get this service.

Unfortunately, however, since then and in fact going back more than a decade about 9 in

10 women with a previous cesarean are having a repeat cesarean.

And I think that part of the reason for the NIH meeting was to balance the salience of catastrophic rupture which is one in thousands to actually have a rupture and have it be catastrophic against our increasing understanding of a lot of shorter- and longer-term harms of cesarean for mothers and babies.

And I would just quickly reference -- I'm happy to talk about this, but quickly reference a whole series of systematic reviews that now show increased chronic childhood disease in cesarean-born babies, and also the very serious placental problems in future cesareans and future births with prior scarring and adhesions.

So, I was really happy to see that ACOG weighed in as supporting this measure in the first open comment period.

And I think it's a prime -- it's a way that we can give a nudge here by making this

information available.

It is an all-payer measure reported by 20 states including many of the larger states in the Why Not the Best interface.

But I have to tell you how many very savvy people can't make their way through that interface. So I think it's -- even for those 20 states it's a challenge.

For consumers who need a signal about where there is the capability to provide this service and where there is the support for it as well.

And just to get back, I just want to share a little bit. On our last National Listening to Mothers survey we did adapt validated questions from the Informed Medical Decisions Foundation for this very issue.

And we saw that women were systematically kind of steered in the direction based on how much information they got about different options, based on the recommendation that their care provider gave, and based on the

kind of outcome care that they got.

So, we really feel that this is ripe for public reporting.

CO-CHAIR PINCUS: Barry?

MEMBER NOONE: I assume that the workgroup committee recommended no support because they didn't have sufficient data because of the CMS data.

My question is did that data also include Medicaid patients as well as Medicare patients. And was that volume high enough to be able to say no.

MS. CHAMBERS: It's a Medicare-only payment program.

MEMBER NOONE: Only Medicare? Because there might be enough data out there if you include Medicaid also. Thank you. Then I can't support it.

CO-CHAIR PINCUS: Other issues, other speakers want to speak about this?

Actually, Pierre, can you say something about why it's just Medicare? What's

the implications of focusing on that population?

DR. YONG: So, that's a great question. So, I think we appreciate all the comments that indicate that this is an important area because I think that's why we particularly focused on this area.

As a claims-based measure the only claims that we currently have are Medicare claims. I certainly, and I think we do have several all-payer measures in the IQR program.

The consideration we also need to make when implementing new all-payer measures is that those are usually chart-based measures. Obviously in the future hopefully we'll move to electronic clinical quality measures, so hopefully there will be less burden.

But there is an incredible burden placed on hospitals also when we implement new chart-based measures. So, that was also part of the consideration about why use a claims-based measure at this point.

But that's why it's -- since it's

claims-based only, that's the only things we have are Medicare claims.

CO-CHAIR PINCUS: It seems to me the implications of this is that it will be largely the disabled population that would be.

DR. YONG: Right. Because we looked at the numbers in the Medicare population. Not surprisingly it's exceedingly small in terms of the denominator eligible for this population. So it would be mostly a non-Medicare population of the measure.

CO-CHAIR PINCUS: Foster?

ACTING CO-CHAIR GESTEN: When you say you only have Medicare claims what are you doing with all the Medicaid claims that CMS has access to from states that we've been sending for years?

I mean, I understand that part of CMS doesn't have them, but it's not as if there's not access to Medicaid claims data from states. Or am I missing something?

DR. YONG: That's right. There's tremendous variability in the Medicaid claims and

there's a huge effort which I am not an expert on in terms of trying to standardize some of the way we can draw information out of the Medicaid claims.

So, I'm not an expert on it so I can't comment on it fully, but I know there is movement away from MSIS and there's efforts on T-MSIS which is the new system for trying to collate all the Medicaid claims and make them more similar to each other.

CO-CHAIR PINCUS: Bill?

MEMBER KRAMER: As a related question, what would be the pathway to turn this into an all-payer measure? Or at least a Medicaid plus Medicare measure.

And where I'm going with this is would it be appropriate then to conditionally support this under the condition that it be turned into an all-payer measure in some way.

But I don't know what the pathway would be and whether that's feasible, and how explicit, how quickly we could do that and how

explicit we have to be in those conditions.

CO-CHAIR PINCUS: Pierre, any thoughts?

DR. YONG: I think we'd need to do some testing of it using Medicaid claims data to make sure that we can get reliable rates using the Medicaid claims.

It would not obviously get to then all-payer using just claims data because we don't have access to all-payer claims data.

CO-CHAIR PINCUS: Rhonda? Carol, are you still up there?

MEMBER SAKALA: I just wanted to say that I reached out to Elliott Main who is the medical director of the California Maternal Quality Care Collaborative.

And he said they report it in California. It's very straightforward to collect from discharge diagnosis files.

And another important point is that it's limited to low-risk women. So I think that's a real plus for a readily and easily

collectable measure.

CO-CHAIR PINCUS: Rhonda, then Rich Antonelli, then Jayne.

MEMBER ANDERSON: I think I'm hearing that everybody agrees that this is important, but it's about where we are today.

And to reiterate is it going to give us what we need from a Medicare claims perspective. And I believe that's why the group said no.

But that there's the opportunity maybe to do that testing not with conditional, but just move forward, do the testing and come back at a later date with a true recommendation of what should go forward for all-payer.

CO-CHAIR PINCUS: Rich, and then Jayne.

DR. ANTONELLI: Yes, thank you, Harold. I'm really struggling because of the Medicare limitations.

So, dual eligibles are in this population, is that correct, Pierre?

DR. YONG: Yes, I believe they are. Because Medicare is the primary payer in Part A.

DR. ANTONELLI: Okay. So, I guess, you know, I think the spirit of this is very attractive to me.

But the fact that it's so circumscribed to this particular at-risk population, I'm concerned about the message that it may wind up sending.

So in other words, I don't think the intent of this measure is let's focus in on a high-risk population, say dual eligible pregnant women and look at VBAC. I think the intention here is to try to look at VBAC as a quality measure.

So, I am really struggling with that. I think Foster's point is well taken about if we could align this with Medicaid and put that together that would be attractive.

But I guess, unless I'm misrepresenting it, is this measure in the Medicare space because we can actually get the

data? Or were people actually thinking about the highly vulnerable dual eligible population as the genesis for the measure?

CO-CHAIR PINCUS: Jayne?

MS. CHAMBERS: Thank you. It strikes me that this would be a better all-payer measure, that we need to understand better what it is we're doing. But it could easily lend itself to be an ECQM kind of measure.

We should not be using a chart-abstracted measure done manually, or using claims for this. But if we could create it as an ECQM measure and bring it back at a later point in time that that would be a much better way to go and would move us much further down the road.

CO-CHAIR PINCUS: Bill, and then let's move to voting.

MEMBER KRAMER: Just briefly. In thinking about this, maybe this is one where it's very appropriate for us to consider voting for further development, encourage further development.

Because I'm concerned that the workgroup's recommendation do not support sounds like we don't support the idea of VBAC.

But I hear around the room that people think VBACs are important, but we need to develop the measure further by turning it into an all-payer measure.

CO-CHAIR PINCUS: I think what we agreed earlier on was that the way it came in is the way that we need to vote, rather --

MS. MARINELARENA: This is a fully developed measure. It's used by --

(Simultaneous speaking)

CO-CHAIR PINCUS: But also I think we've made clear through our comments what our intent is. Okay? So why don't we move to vote.

MS. STERLING: Great. So we are voting on the IQI 22 Vaginal Birth After Cesarean Delivery Rate Uncomplicated. And this is MUC 151093. It's recommended for the hospital inpatient quality reporting program.

Your options are 1 - support, 2 -

conditional support, or 3 - do not support. And voting is now open.

CO-CHAIR PINCUS: Bill, do you want to restate what you suggested as conditions?

MEMBER KRAMER: Well, I don't quite understand why we don't have an option for encourage further development.

DR. BURSTIN: The measure is fully developed and tested for all-payer. It's the application of the measure.

CO-CHAIR PINCUS: Yes, the condition, yes. Really, conditional support doesn't really work here because --

MEMBER KRAMER: I agree conditional support doesn't work. But why not encourage further development?

DR. BURSTIN: Encourage further development can only be for a measure that's in development. This measure is fully developed. It's an AHRQ measure, fully developed, fully tested on all-payer data. So there's nothing further to develop.

I think what people are discussing I think is the application of this measure in a Medicare-only IQR program.

Again, we have an open perinatal project with measures to be submitted. There are opportunities to bring this measure in for evaluation and endorsement. I don't believe it's ever been submitted.

So, there are further opportunities here. I just don't know what is left to do.

CO-CHAIR PINCUS: The way to think about it is that it hasn't come in, been proposed before us as a measure to be developed. It's been proposed as a measure to be applied. And so we're voting on it as a measure to be applied.

But our comments already make clear that what we're really saying is come back with a measure to be developed.

MEMBER KRAMER: Okay.

WORKGROUP CO-CHAIR WALTERS: And Harold, this is Ron again. Sorry.

This has been a very good discussion

and it mirrors a lot. I don't have anything to add to the discussion.

But this is the dilemma we found ourselves in. And it really could have gone a lot of different ways.

But the box that appeared the most appropriate to us given all that is the one that's in front of you.

So, I mean, I can't add anything to that other than that was our choice.

CO-CHAIR PINCUS: Okay, so let's continue voting.

MEMBER GIFFORD: While we're voting can I just throw out that can we make sure we have time in our next meeting, a significant chunk of time to address this issue of clear confusion of what we're voting on and what the messaging, the voting sends to CMS around rulemaking and everything else.

Because I think Bill raises a very good point and I've reiterated a number of times. We want CMS to continue developing stuff. But we

also don't think these are ready for rulemaking.

And the current voting and labeling does not adequately convey that. And I think we need to have a better way of doing that. And --

CO-CHAIR PINCUS: Well, I think part of it is --

(Simultaneous speaking)

MEMBER GIFFORD: -- discussion, to have that discussion.

CO-CHAIR PINCUS: Part of it is being clear about, you know, that CMS makes the choice about which route it's going to come under.

MEMBER GIFFORD: But you know what? There has to be a clear definition of what the meaning of that route is.

CO-CHAIR PINCUS: Right.

MEMBER GIFFORD: That if you're coming in under the encourage development you're not considering it for rulemaking because you're just asking us for feedback.

But that's not what they're doing. They're coming in with measures under development

that they are considering for rulemaking.

So when we vote for encourage further development without conditions or anything else going forward then that's sort of -- they can go out and put it out in the rulemaking.

And I think the concern -- and I was reflecting on why Bill and I were arguing the other night about whether it should be insufficient information on one of the measures AMA wanted to put forward is because we want to send a message on insufficient information.

We want to use that to say to CMS it's not ready for rulemaking. Whereas encourage development doesn't send a strong enough message.

And within encourage development there are some measures that are ready for rulemaking to go forward, and there are some that are not.

And so I think that it doesn't capture that well enough.

CO-CHAIR PINCUS: We'll come back to that. So, is the full voting done?

MS. STERLING: Actually we're still

looking for two votes.

CO-CHAIR PINCUS: Do we have it?

MR. TILLY: We do. The results are 24 percent support, 10 percent conditional support, 66 percent do not support.

CO-CHAIR PINCUS: So the recommendation of the workgroup is not overturned.

MS. O'ROURKE: And we can make sure we strengthen the comments that go along with this, that both the workgroup and the Coordinating Committee strongly support the idea of a VBAC rate. We recognize this measure has data limitations. So we will pass along all of the rich discussion.

MEMBER MCGIFFERT: Can we clearly say for either the Medicaid population or all-payer database? Thanks.

CO-CHAIR PINCUS: So, the next is INR monitoring for individuals on warfarin after hospital discharge.

And Amir, is this for discussion or

for voting?

MEMBER QASEEM: Can I start talking and then we'll go decide?

So, this is a measure that I wasn't really sure. I think the workgroup has it as, what, conditional support or something like that, right? Yes.

So, I'll just start off by saying I think the basic issue with this measure was that it's just saying that INR was done within 14 days of discharge. Or I'm not really sure that's going to lead to improvement of care, outcomes, what the intent might have been.

And then the more looking at this measure, it's a hospital accountability measure. But then I wasn't really clear on how it's going to be implemented.

So, the inpatient is going to ensure the discharge summary is sent to the primary care physician. There's a follow-up appointment that's being put in place within 14 days in all.

But then the patient population who

may not have been to their primary care for a while, or do not have a well-established relationship, how is that all going to work out?

So eventually how is this accountability going to translate into a physician level?

So, the more I start thinking about it I wasn't really clear if all this has been discussed. Because I look at the notes from the hospital workgroup and I didn't see that any of this was addressed there. So that's why I wasn't sure.

So let's see if it has been discussed and what were the responses, and then we can decide whether we're going to re-vote or not. That's the concern from my end.

CO-CHAIR PINCUS: Okay. So David, Missy, do you want to comment?

MEMBER BAKER: I'll sum up my comments in one word - phosphorus.

MEMBER QASEEM: Yes, it's the same issue.

(Laughter)

MEMBER BAKER: We need a measure of the proportion of patients who had therapeutic control of their INR within a given time period, and this is not going to help us.

Helen you just endorsed one.

CO-CHAIR PINCUS: Missy? Ron? Do you have comments?

MEMBER DANFORTH: No. I was on the patient safety committee along with Lisa who is in the room that reviewed the measure for endorsement. And we had a lot of these same conversations at that workgroup committee.

WORKGROUP CO-CHAIR WALTERS: Yes, we did, at the hospital workgroup level.

And that's why we put that please consider when perfect world arrives. This would be a great one for EHRs to subsequently report.

But right now the same discussion about what can the hospital really do about this. It's conditional support.

CO-CHAIR PINCUS: So this, I mean this

sounds almost like you're saying that you were grudgingly supportive of it, but you don't think it's ready for primetime.

But just to be clear, the condition that you put on this is more about sort of implementation through EHRs, not about some of the concerns that were voiced.

WORKGROUP CO-CHAIR WALTERS: Yes, we thought it would be more suited to a different program.

And you're right, this is kind of like the theme of the discussion we've had. Had we said do not support, which we did on the one right before this, it would have sent a wrong message about how important the safety issue is.

So, the condition was kind of figure out how to get this data in a meaningful way that the hospitals and the subsequent care pathways are supported. I know.

CO-CHAIR PINCUS: So, Frank, and then David.

MEMBER OPELKA: So, I'm going to go

back to David's comment. And I think that's really the gist of the message that we want here.

This is, to me it's far worse than phosphorus because this happens regularly and it's exceedingly dangerous that people leave the hospital and there's a missed handoff. And the next thing you know they're back with a major complication related to this medication.

So, I think David said it, said it well, what's needed. I don't think conditional support is the answer here.

To me an ECQM pathway will not solve this. To me this is do not support and it needs exactly what David had stated.

CO-CHAIR PINCUS: So, just to be clear, so what is being proposed is a re-vote, not just discussion.

And David, do you have more to say?

MEMBER BAKER: I just wanted to emphasize one point. Is there a really good care model about how to do this? And we've all, many of you have seen Coumadin clinics.

And what we need to be able to think about is how can we have a measure that will encourage that best practice or measure that best practice, right?

Because patients really, they should be seen three days after discharge by an expert who's going to go through all the dietary counseling and the monitoring.

To say, you know, at two weeks they had the blood level measured, that's not going to encourage those best care pathways.

CO-CHAIR PINCUS: Helen?

DR. BURSTIN: Just one brief comment again since you raised the phosphorus issue. At least I remember this discussion. It was a long discussion of the safety committee as Lisa and Missy know.

And I think one of the issues was the fact that although not ideal, current performance is only at 50 percent even for a did you do it, not what the actual INR was. So I think that was part.

I don't know if Missy or Lisa want to reflect on that, but I think there was a sense that there's a gap there, unlike I think what you heard earlier. So I just want to make that clarification.

CO-CHAIR PINCUS: Other comments before we vote? Jayne?

MS. CHAMBERS: So, I guess I'm curious. I mean, why is this a hospital measure? Why isn't it at least a hospital and a clinician measure together?

It seems to me that this -- I like the analogy to the phosphorus issue. I mean, I think we need to know what we're doing.

But there are multiple entities involved here. So I agree with the workgroup's recommendation. This isn't ready for primetime.

CO-CHAIR PINCUS: Well, when you say agree with the recommendation, actually what Frank has proposed is to actually change it to do not support.

MS. CHAMBERS: I agree with my

esteemed colleague.

CO-CHAIR PINCUS: So, Melissa?

MS. MARINELARENA: Sure. So, let me clarify the measure. It is not a physician-level. It is a hospital measure.

So patients that are discharged with a certain level INR, it's not therapeutic. They have to get an INR within the two weeks.

The INR is captured by the claims. And so then they match the discharge with the claims. So, it's not held back to a physician.

Ideally you would think that that patient is discharged and then goes and sees a physician, but that physician is not held accountable.

So, it's the hospital that sends, you know, it's that discharge attached to the claims. It's not physician-level.

And then the ECQM part of it came because it's an e-measure. So, the conversation was that many hospitals, the vendors probably are not capable of supporting it at this time so this

was an option. So making it the optional ECQM pathway and not requiring it at this time because many vendors aren't able to support it.

CO-CHAIR PINCUS: Other comments?

WORKGROUP CO-CHAIR WALTERS: This is Ron. I would just say, and as we frequently return to, this is another one that the Shared Savings Program might be an ideal place to park this because it would be much more of an integrated unit usually with an integrated EHR.

So, I mean, that was kind of the flavor of the discussion. It's just not -- there's nothing wrong with the concept. It's a very good measure. But where does it land.

CO-CHAIR PINCUS: Pierre, do you want to comment on sort of in relationship to the thinking of CMS?

DR. YONG: Sure. Again, appreciate the sort of discussion and the point that this is a big gap area, an important sort of safety concern.

The thinking we had was that in this

case a patient was either started or was continuing anticoagulation within the hospital, and that as part of a discharge plan that there is responsibilities of the hospital and the providers within the hospital to make sure there's adequate follow-up.

And so that's why we thought it would be appropriate. And it was developed as a hospital specified measure.

MEMBER FLOWERS: So, I have a question about whether or not there would be a care transition -- a hospital measure that gets at transitions that would support this.

Because otherwise I don't see how the hospital could -- I mean, unless there's a measure that you could align it with that related to transitions of care so that there would be some community-based follow-up to get people into primary care for that measure.

CO-CHAIR PINCUS: Pierre?

DR. YONG: So, Tara, are you on the line?

So, I believe there -- so, there are several sort of hospital discharge measures.

We have several measures in the program that talk about, or are addressing care transitions. For example, like our readmissions measures. For example, our sort of concept behind that is care transitions and coordination of care. Is that what you're?

MEMBER FLOWERS: I'm sort of looking at a community-based transition where you have the care manager following the person out into the community.

Is there any type of measure that would support that? Because I see those two as related. If there's nothing to connect the hospital to the person in the primary care setting or in the community-based setting I don't see how this works.

DR. YONG: Right. So thank you for clarifying. Yes, so we think that's obviously an important concept.

I don't think we have any measure

specifically addressing like a community care coordinator.

CO-CHAIR PINCUS: So, we're going to vote on this. The committee's recommendation was conditional support based upon it being developed as an electronic measure.

There's been a number of comments raised about this both in terms of the phosphorus issue, in terms of whether it's simply measuring whether something occurred, not whether something is under control.

Concern about the sort of appropriate accountability of the hospital as compared to more of a networked kind of accountability.

So, and I think we've had a lot of discussion about this. Now it's time to vote.

Oh, Melissa, did you want to say something?

MS. MARINELARENA: Lynda, just so you know, there's a measure, the timely transmission of a transition record. And this is for discharges from an inpatient facility to home, or

self-care, or any site of care.

And this is you -- it's patients for whom a transition record was transmitted to the facility, or primary physician, or other healthcare professional designated for follow-up care within 24 hours of discharge.

And then the INR measure, it's only for patients discharged to home. So, this would be able to catch those patients.

CO-CHAIR PINCUS: Okay. So, again, the three options are support, conditional support, or do not support.

The existing on the table measure is conditional support. And it requires 60 percent other than that to change it.

MS. STERLING: Right. So we are now voting on MUC 151015. That's INR monitoring for individuals on warfarin after hospital discharge.

This is recommended for the hospital inpatient quality reporting program. And again, it is 1 - support, 2 - conditional support, and 3 - do not support. And you are able to vote.

MEMBER FLOWERS: So, Harold, before we vote could I just say that I could see it being conditionally supported if it were used in conjunction with the transitional care measure that was just mentioned.

CO-CHAIR PINCUS: Okay, thank you. So, I think we're ready to vote. Are all the votes in?

MR. TILLY: Okay. So, we had 29 votes. Seven percent support, 34 percent conditional support, 59 percent do not support.

CO-CHAIR PINCUS: So, it is just short of overturning the workgroup's recommendation.

But we have given a considerable amount of feedback and we have confidence that they will take that under consideration.

MEMBER BAKER: Can I just make one comment that this is such an important area. We talk about gaps and this is one of the most dangerous medicines that we use. Major cause if you look at emergency department visits for adverse drug reactions.

So, I just hope this is a -- if this measure goes forward it's just a step towards others. We really need to get these better measures in place.

And Helen was looking up the measure. There is one going through the pipeline, but I really support the idea of trying to get better measures for this.

MEMBER GIFFORD: And the SNF community would encourage us having a measure on INR use in the SNF area. I know they've been excluded out of this measure. It is the leading problem in the OIG report on adverse events.

CO-CHAIR PINCUS: So, this is something that we place a high priority on sort of trying to fix this so that it actually works well for potentially a number of programs.

So the next four have all been pulled by CMS. And there may be some similarities among them. So, Pierre, can you give us an overview of what the idea is here?

DR. YONG: Yes. So, these are all the

resource use measures, correct?

So, we wanted to bring this forward to the committee and get some additional feedback because there was a robust discussion about this that Ron, you might be able to supplement at the workgroup meeting.

I think there was discussion and recognition that resource use was an important concept. However, that resource use in isolation of other information such as quality information is limited.

And so, but it ultimately was not supported by the workgroup.

And so we wanted to get some additional feedback particularly in the setting of IQR which is a public reporting program.

I think there were additional concerns about the use of the measure in a payment incentive program like hospital value-based purchasing.

But in an IQR setting where we are publicly reporting the information the use of

similar type resource use measures.

Because we have heard in prior rules as well as in conversations with stakeholders that they want additional resource use information.

These are clinically oriented episodes. We have a few resource use measures currently in IQR, but this would potentially expand that set and provide additional information.

Currently on Hospital Compare we do display the -- several resource use measures in conjunction with other related quality measures such as mortality rates so that it is paired with additional information to supplement the pure sort of payment information.

CO-CHAIR PINCUS: And to be clear, you're pulling this for further discussion, not for re-voting.

DR. YONG: We would like -- well, for vote, please.

CO-CHAIR PINCUS: Okay. So this would

require voting on each one of these.

So, why don't we discuss the whole issue of before we get into individual measures, the whole sort of concept of these episode-based payment measures.

And let's hear first from David and Missy and Ron.

WORKGROUP CO-CHAIR WALTERS: David? Missy? Pierre summarized everything.

CO-CHAIR PINCUS: Yes, if you could summarize what --

WORKGROUP CO-CHAIR WALTERS: Risk adjustment in the data. Making sure that the data is accurate. These are the kinds of things that came up.

I think there's issues beneath those, but that's the terms that they're usually couched in.

MEMBER DANFORTH: Ron, this is --

CO-CHAIR PINCUS: Missy?

MEMBER DANFORTH: Yes, sorry. Ron, I just had a couple of questions about that.

So, when you say about the accuracy of the data is there concerns that the claims are inaccurate since these are claims-extracted measures?

WORKGROUP CO-CHAIR WALTERS: That's a piece of it.

MEMBER DANFORTH: Okay. So, private purchasers have been a group of folks that have been pushing for these resource use type measures.

I will say that it is a concern when you see a resource use measure that isn't paired with a quality measure.

And at least I think for spinal fusion, cholecystectomy, and prostate resection there aren't paired quality measures. Pierre, can you confirm that?

DR. YONG: That's correct.

CO-CHAIR PINCUS: Melissa? Oh. Missy, did you have other comments?

MEMBER DANFORTH: No, I'm sorry. I don't remember seeing these on the original list

and so I'm just --

CO-CHAIR PINCUS: These were just recently pulled.

MEMBER DANFORTH: Okay.

CO-CHAIR PINCUS: So, you have to go to the most recent discussion guide from Wunmi which came out I think on --

MS. ISIJOLA: At the top it says version 3.6. So you're looking for 3.6.

MS. O'ROURKE: If they're not showing in your discussion guide, if you hit Refresh it should pull up a version that has these measures included.

We apologize. These were last-minute additions to the discussion items.

MEMBER DANFORTH: No, no, I see them, they just weren't on the list that David and I had prepared for. So, I think he might be in the same position I am which is just quickly looking at them now.

CO-CHAIR PINCUS: Okay. So, Melissa, did you have a comment on this?

MS. MARINELARENA: No. The other thing I wanted to say is that data wasn't provided on variation of these procedures, so there was also a question why these particular procedures were chosen. We didn't have that information.

CO-CHAIR PINCUS: Okay. So, I see Mary, Rhonda, and David.

MEMBER BARTON: Thanks. I would just say that when you start with a procedure for an efficiency measure you don't know -- part of the issue is who's referred for that procedure.

So, I think it's a little, you know, an organization that takes too many people for spinal fusions, for example, outside of guidelines.

They're going to have maybe great outcomes for efficiency and outcomes because they were unselective in choosing who came to this procedure.

And so that's kind of a problem in my mind with these particular kind of episode-

focused things that start with a procedure.

Because really a very efficient system will of course only refer people who are clearly indicated for a procedure.

CO-CHAIR PINCUS: Rhonda.

MEMBER ANDERSON: I'd like just a little bit more understanding of why CMS pulled this. It's a little confusing to me when a group of MUC measures go forward and then a workgroup asks either for more data, or needs some more information, or makes a recommendation.

I just don't understand the gap there in CMS's comments.

DR. YONG: I think we just wanted to get additional feedback. And so that's why we pulled these for discussion.

CO-CHAIR PINCUS: So, I mean, again, just thinking of the process.

If all you want is additional feedback do you really require re-voting on this?

DR. YONG: I mean, so I think as Kate said yesterday, I think the most important thing

is the feedback. So I think that's what we are most interested in.

CO-CHAIR PINCUS: Okay. So, Frank, and then -- excuse me, David, then Frank, then Jayne. David Gifford.

MEMBER GIFFORD: I thought you were going the other way. Sorry. I was looking at Frank. Frank is really thoughtfully thinking about his comments there.

I would support continuing with the do not support on these. I think the feedback then to CMS would be, first off, these aren't efficiency measures. These are resource measures. And I think they shouldn't be labeled as such.

Even just looking at the reports from NQF you have to pair them with outcomes.

And so I think it's really important if they want to talk about these as efficiency measures what are the outcomes they're going to match them with, and how they're going to pair them with them would be very helpful.

I also think that when these measures measure the cost for 30 days after discharge from the hospital the post-acute setting and the variability in the post-acute setting is probably one of the larger drivers.

And so the risk adjustment on functional status and support at home becomes an enormous piece of it.

What we've seen in the BPCI and others is just bypassing PAC care altogether when there's a cost measure.

And we're even starting to hear from some of the MA plans and other stuff that they're seeing adverse events from that. Higher episodes out there of worse care because of the way the measure is structured.

And so I think that that just reiterates the need to pair it with an outcome measure when they do it.

And they should be pairing it right up front because of that potential unintended consequence of that.

And then I'd say the functional measure, you know, Jayne, don't kill me, or Nancy, but I think we have to start getting functional measures from the hospital data. Whether it's the CARE tool or something else, there needs to be some measure of functional status because it's just such an important driver of resource utilization and clinical decision-making and everything else out there.

And we now have it in almost every setting but the hospitals.

CO-CHAIR PINCUS: Frank?

MEMBER OPELKA: Some of what I was going to say was just stated and much more eloquently than I can state it, so.

I think this whole set of measures is a very important focused research area that we don't know a lot about. And the potential consequences to care could be significant.

I also agree that these are not necessarily efficiency measures, but they are resource measures. And getting beyond Parts A

and B into the other components that are built into this, it would be very important to understand how those all build up and stack up.

The risk adjustment piece of this and how you actually deal with that is very, very important. Otherwise the unintended consequence is that people shy away from the patients who really need it and look at use on the low end on those who've got very low or limited costs.

And so you can get cherry-picking of patients as a potential consequence here.

So there's a lot in these measures that are very important. We do support them in the long run, but we think they need to be part of a bigger research project to sort through how we actually end up applying these because of their impact.

CO-CHAIR PINCUS: Could I just ask, Helen, where are these on the consensus process line for the standing committees?

DR. BURSTIN: Not been submitted.

CO-CHAIR PINCUS: Not yet been

submitted. Okay. Tested but not submitted.

Other issues? Anything else that people want to bring up? David Baker.

MEMBER BAKER: I just wanted to talk about how difficult it is to really develop efficiency measures.

Because if we're talking about cost per quality, now think about for these procedures your outcomes can vary from death to a whole variety of other complications.

So, if you think about how you're going to weight that and do that it's a real challenge.

I think our biggest opportunity is to be able to think about bundled payment programs where you know what your resources are. You know what is being paid, although Frank brought up the issue for risk adjustment and that's challenging.

But then you can really compare apples to apples because you can look at differences in the complication rates across providers given the same fixed set of resources.

We still need to get into the area of appropriateness though as people have brought up. So I think that that's an area that we should be thinking more about.

DR. BURSTIN: Just one brief point, Harold. So, we have endorsed other resource use measures which we have labeled as building blocks of measures to get to efficiency.

These are clearly labeled as payment measures. They're not called efficiency. If we label them as such it really is --

CO-CHAIR PINCUS: But they are.

DR. BURSTIN: Right. But the actual title is payment measures.

I just want to be fair here. We may have labeled them as efficiency, but in fact they are a building block towards efficiency.

So I think we have brought other measures like this in and endorsed them in the past. And we would look forward to seeing these come forward in the future so we can better understand the issues raised by MAP.

CO-CHAIR PINCUS: So, Pierre, is that okay in terms of additional feedback?

Okay, so we have two more measures hopefully that we can get to before we break for lunch.

So, this 30-day all-cause unplanned readmission following psychiatric hospitalization. And that was pulled by Amir. Will this be discussion?

MEMBER QASEEM: It's conditional support right now. I can probably live with that.

And the couple of issues that I just want to bring up is that -- I mean, there is definitely -- this is an important measure. There is -- my concern was that the clinical outcomes might not get better, although the readmissions might reduce.

And I wasn't really clear on this whole, the term the psychiatric admission. It's such a broad term. Because I was discussing it with other colleagues as well. It can vary from

acute psychiatric episodes to someone who may have had a suicide attempt.

So, and then of course this measure did not account for any sociodemographic variables to my understanding and I was quickly looking through this measure.

And it hasn't really been reviewed by NQF which I'm actually very strongly supportive of any measure that we move forward NQF endorsement at least should have been reviewed so we know where the details, what's their view on this.

So, if it's a conditional support, again, as I said, I'm okay with it. But some of these comments were not listed in there. So I just want to communicate these comments, that they just get added.

CO-CHAIR PINCUS: Are there comments by David, or by Ron, or by Missy?

MEMBER DANFORTH: I don't have any additional comments.

WORKGROUP CO-CHAIR WALTERS: Agree.

MEMBER BAKER: I agree with the issues that were raised. This is just such an important measure. I mean, we know about all the problems with re-hospitalization. This is another one that we know that we can actually move the needle and reduce re-hospitalization.

So I think really the challenge is the details around the risk adjustment methodology, SDS, et cetera.

CO-CHAIR PINCUS: Just to step out into my other role. I mean, as co-chair of the standing committee on behavioral health I look forward to reviewing this measure.

This is something that we've time and time again talked about trying to figure out ways to better measure the interface between behavioral health general healthcare.

In fact, for people with severe mental illness they have very high rates of comorbidity for general medical conditions. People with psychosis die 10 to 20 years earlier than the average person, typically not from things related

to their mental illness.

So, this is something that really is right at that interface. So I look forward to reviewing that with the other hat.

Other comments? Okay, let's move on to the next one which is substance use core measure set for alcohol and other drug use provided or offered at discharge.

It was pulled by Lisa and Amir.

MEMBER MCGIFFERT: I pulled it for discussion purposes and mainly because it's a process measure. It seemed like some of the discussion from the committee was wishing for more of an outcome measure.

And then I guess a lot of the issues around population screening would apply. Some of the commenters brought that up. So that was really my concern about it.

CO-CHAIR PINCUS: Amir?

MEMBER QASEEM: So, can I just make comments first and then let's see if there are any responses?

CO-CHAIR PINCUS: Sure.

MEMBER QASEEM: The issue with this measure is that -- so if a patient who's admitted for pneumonia, essentially you're going to be doing alcohol counseling, or substance abuse counseling in this patient.

I'm not really sure or aware of any evidence that says that these two better or improve outcomes.

And that's why I'm just starting out with discussion because maybe it's lack of knowledge.

And I was looking at you since it's a Joint Commission measure, of course. And maybe you can answer some of these questions.

Then of course the exclusions are extensive. But if we start looking at just exclusions some of them are incredibly complicated.

So, there is one exclusion. If you look at it it says patient ranking at unhealthy levels who does not meet the criteria for an

alcohol use disorder.

So, I'm not really sure what does unhealthy levels, how are they defining it? Some of these details are just not there.

And then finally I think the comment is that addictions treatment, many times they're not covered by individual insurances, or they might be very incredibly expensive.

And then there's the issue of accessibility. That comes up a lot. I mean, not everyone is sitting in D.C. and Philadelphia. Pretty much a lot of places in this country doesn't have access to some of these resources.

So, again, that's why I'm not -- I just want to hear from maybe even the workgroup if these items have been discussed.

Because they have this as supported and I was a little bit surprised that it's not a conditional support.

CO-CHAIR PINCUS: David?

MEMBER BAKER: So, as Amir alluded to, this is -- the Joint Commission is the steward

for this and I said that I thought I would recuse myself from the discussion.

But I will say that there is good evidence that brief physician counseling does affect particularly for alcohol use. Most of those studies are in the outpatient setting. I don't know if anything has been done in the hospital setting. But there is a solid evidence base if you think that you can generalize to the hospital setting.

CO-CHAIR PINCUS: And this is something that came before the standing committee. And it was, in fact, endorsed.

And there actually is a relatively reasonable evidence base also in terms of inpatient interventions which is included actually in what the Joint Commission submitted.

There's also clearly a gap -- oh, there's a relatively strong database in support of inpatient as well as outpatient. Not as strong on the outpatient side in primary care largely because that's where most of the studies

have been done.

But there is some data around inpatient interventions making a difference as well.

And this is part of a set of measures that include sort of screening, and brief counseling, and referral for treatment, and just sort of initiating treatment if appropriate on the inpatient setting.

One of the big gaps is, especially for substance abuse is the use of medication-assisted treatment. And that's something where there's a big gap in terms of the adoption of that.

And there's also some evidence about that being initiated in the hospital actually as being much more likely that people will engage in it afterwards.

So, for those reasons it was in fact endorsed by the standing committee. Bill?

WORKGROUP CO-CHAIR WALTERS: This is Ron.

CO-CHAIR PINCUS: Oh, Ron.

WORKGROUP CO-CHAIR WALTERS: And I agree. So again, we took the opportunity to say how there could be a better measure in the future, how there could be other things brought in in the future.

But as a stand-alone measure this has been all the way through the endorsement process and that's why we supported it.

So, everything everybody said is are there opportunities to even improve this measure. Absolutely. But the measure by itself has been vetted pretty well.

CO-CHAIR PINCUS: And if I recall correctly, and David may correct me, there was an additional element to this measure about following up at 30 days.

And the discussion in the standing committee was that while that would be appropriate for like a Medicare Shared Savings kind of program, or an ACO type program, it was probably a bridge too far for hospital accountability in terms of following up for

treatment after, 30 days after, but it's something that should be thought about for some of these other programs.

MEMBER BAKER: I'll just add in, again, there are really good models. I've seen a few hospitals that have actually set up partners with substance use programs and electronic exchange of information.

So we clearly need to be able to move towards being able to assess the proportion of patients who actually are entering treatment.

CO-CHAIR PINCUS: And it becomes --

MEMBER BAKER: But that's a ways off.

CO-CHAIR PINCUS: And it also becomes highly relevant given in the parity components of the ACA which provide for parity of insurance benefits for both mental health and substance abuse. Bill?

MEMBER KRAMER: I'll just make a -- use this particular measure to make a general comment.

Earlier in some of the public input

there was discussion about the need for parsimony in all these measure sets.

And I think the general concern I have about these kind of process measures is that they tend to crowd out other, more important, useful measures, outcome measures basically.

And the fact that this particular measure has been NQF-endorsed is great. But we're supposed to make sure we're recommending things that will be useful for public reporting and payment programs.

And I would just want to make sure that in the report to CMS that we have a strong statement not that something could be developed that's better, but something should be developed that's better and more useful to clinicians and to patients.

CO-CHAIR PINCUS: Kevin.

DR. LI: Just to point out that this, or a similar measure has been required for level 1 trauma centers for quite a while as part of level 1 trauma center certification. And so it

has experience in a number of large hospital systems. And it has for quite a while through that certification program.

CO-CHAIR PINCUS: So, I think we are done. Yesterday I was making fun of Foster saying we got through the -- you know, when I was chairing the PAC stuff it went much more quickly than the clinician one. So I have to sort of take that back.

But anyway, so I think we went through a lot of stuff. I think that we provided a lot of very useful feedback to CMS. And hopefully we have also sort of advanced the cause of further development of measures that can be more helpful, more relevant, and filling some of the gaps that we've been most concerned about.

So let's move on to lunch. And then after lunch we will take up some of the longer-term crosscutting issues.

How long for lunch?

MR. AMIN: So, we still have three sessions to go. But they will be relatively, you

know, I think they're much more forward-thinking. And hopefully this will be a different type of brain power.

So, if we could try to come back at a quarter to and do this again as a working lunch. I apologize that we've been working everybody with no breaks and working lunch for the last two days.

But you know, this will be sort of a more discussion-oriented forward-thinking time. So if we can get back in the room at 12:45 we can move on from there. Thanks.

CO-CHAIR PINCUS: Thank you.

WORKGROUP CO-CHAIR WALTERS: Thank you again for all your input and thoughtful feedback.

(Whereupon, the above-entitled matter went off the record at 12:21 p.m. and resumed at 12:41 p.m.)

ACTING CO-CHAIR GESTEN: So thanks everyone for the rich discussion this morning. We're going to, as we talked about, have a somewhat abbreviated and focused conversation in

the afternoon, picking up on some of the themes and questions and issues that we talked about this morning.

But we want to start the afternoon, before we get going, with public comment. Are we ready? Are folks ready on the phone?

MR. AMIN: Yes. Operator, do we have any public comments on the phone?

OPERATOR: If you'd like to make a public comment press star, one. Apparently no public comments.

ACTING CO-CHAIR GESTEN: And in the room? Any public comment in the room? Okay, I'm going to turn things over to Taroon.

MR. AMIN: Thank you. So just to quickly review a little bit of the agenda for this afternoon, we're going to quickly run through a number of sort of key findings that are reflective of what we've done in the last five years.

It's sort of a milestone birthday for the MAP. We are at our five year point. So we

thought it would be helpful to look back a bit into the evolution of the measures and the programs that we've evaluated over the last five years.

And then quickly just introduce this idea -- reintroduce the idea that we discussed during the September meeting around core concepts, which was an exercise that we were trying to sort of iron down, like actually define, during today's meeting. But we'll unfortunately have to wait for a future date.

But we will welcome some initial discussions or thinking about the conversation. And then we'll also move -- then we'll sort of move to the bulk of this afternoon.

We're interested in sort of reflections on sort of the role of the coordinating committee as we look across the MAP process. And then maybe do a deep dive on this issue around the voting and the voting categories and the measures under development pathway.

I just want to sort of emphasize that,

you know, we only have about an hour and a half and we want to obviously be respectful of everyone's time with travel. And so the way we'll sort of do this is present all this information out to you, and then maybe we can just an overall discussion period, all together, as a way to sort of consolidate the discussion.

And then also just reflect on the fact that staff will be taking all of the input that we receive during this conversation, and come back with some proposals for a path forward.

So the goal of today's discussion is not necessarily to come up with definitive decisions, necessarily. Given the time constraint, we don't want to force that as the ultimate outcome of today's discussion -- today's afternoon session. But more or less a reflection on what the key issues are. And if we can, come up with some general principles on a path forward. Staff will work various proposals to bring back to the coordinating committee.

At the latest, that's September. Or

potentially during an interim web meeting of this group sometime in the early summer probably.

So with that being said, I'll turn it over to my colleague, Wunmi, to run through some discussion -- or just some reflective slides here on MAP at five.

MS. ISIJOLA: Thanks, Taroon. So happy birthday MAP. We actually have cake in the back for everyone, just celebrating all of your leadership and your hard work over the past five years.

Many of you have been here for quite some time. Many of you have been around for the journey. But we appreciate all of your efforts.

One of the things that we've really noticed is really the stride to strengthening the measure sets within the federal programs. To date we've seen well over 1500 measure being considered for use in 20 different programs. And that's really attributed to all of your work in providing those recommendations to CMS.

Half of those have been process

measures. But we're really seeing a stride to really looking at more outcome-based measures. I think this year alone we've seen a substantial increase in outcome measures that are being presented to the MAP. So I think our voice speaks volumes.

So just a quick snapshot of what the percentage of measures that we've been seeing across the five years.

Many of the measures have bucketed within the clinician setting, and that may attribute to the broad spectrum of clinical and topical areas. But we also see measures within the hospital in PAC acute settings.

So as you know, we've talked about this for the past two days. But really providing upstream guidance to CMS on, not only measures that are fully developed, but also measures that are still under development.

This upstream guidance helps them to determine where their priority areas are, and where their investments should lay within

measurement testing.

We're seeing more than ever that many of the measures that are being considered are still not fully tested. And I know Kate talked about it extensively yesterday, of collaborative efforts. First to look about that feedback loop of bringing measures back once they have been tested and getting your feedback. Less and less of these measures, similarly, less than 30 percent of those are still in stage of development. So we still have some work.

I think one of the things that we're trying to do also is really integrate our work. So our MAP and CDP processes, so really looking at endorsement and how that ties into selection, and bringing that information to both committees.

This is also another representation of where we've been. A lot of the work is tied to the National Quality Strategy priority in looking at where many of the measures lie. Are we establishing alignment across the programs.

Since 2011, we've seen an increase in

communication and care coordination, which is a hot topic, but also making care affordable. So we see some changes and shifts there.

So changes in the quality programs. We're seeing the strategic shift to really looking at the nature of quality initiative programs. As you know, we're pushing more towards value-based purchasing. We're really looking at paid performance initiatives, particularly in the hospital settings.

As you know as of last year, there has been a goal of really tying traditional Medicare payments to value, by 2018. So your voices are being heard. We're really pushing the needle forward, so that's great.

Also, MACRA legislation demonstrating a change as we repealed the SGR in attempting to really tie payment to value as opposed to just -- value, as opposed to just value. But also consolidating the clinician quality initiative programs into the anticipated MIPS program.

We talked extensively about the IMPACT

Act. Really establishing standardization across post-acute care providers. But also ensuring that we have consistency across the different settings.

Next slide. And then this is just another representation of kind of where we're moving. We're seeing that we're really focusing in on payment. In the past we've really seen an increase in reporting, but we're seeing that inversely shift.

So I gave a little bit of historical context, but ultimately I wanted us to also dive into the impact and success, and, Taroon, do you want to take it away and really lead us in that?

MR. AMIN: Sure. Yes, I would just quickly summarize in terms of the two main sort of takeaways in terms of the measures and the programs, and the evolution over the last five years.

There has been a clear change in the types of measures that we've been seeing over the last five years, an increase in the number of

proposed measures that look at outcomes. There's also an increase in the number of measures that are, quote unquote, under development, which has been a major topic of discussion over the course of the last two days, and somewhere we will want to focus our discussion a little bit later in this conversation.

The second thing is that there's been a change in the programs themselves. So the evolution of these program measures for, in their intended uses, changed considerably. And I think Wunmi sort of covered those.

And so just moving on, in terms of some of the impact and successes, with the introduction of readmission measures, we've seen a reduction in the readmission rates. And MAP has supported, again, these measures, using the current in those programs.

We've also seen, in the PAC reduction, we've seen some significant reduction in rates on the next slide, a decline of 17 percent in the rates of HACs from 2011 to 2014. And

additionally, you know, the translation of these reduction HACs actually reduces significant spending in the healthcare system.

So just moving on to some of the other strategic changes here, there continues to be a lot of work related to the MAP and the consensus development process alignments to ensure that there is integration and communication between these two different processes.

Moving to the next slide. And so what you'll see here is, you know, continued effort that this group has sort of indicated and also the work that we've been undertaking with our consensus, the CSAC, the Consensus Standards Approval Committee, around how to further integrate the communication and information between the endorsement process and the measure selection process.

Some of the elements, looking forward to the next slide, that we've been working on with the NQF Board, is further consideration of how to identify measures that are at the highest

standard, meaning that meet the highest level of evidence and testing.

On the next slide. And, you know, we've -- the Board has sort of designated this as sort of an NQF plus designation which identifies measures that meet the highest level of evidence in testing. And there may be some significant influence of how this new intended use effort, within the consensus development process, may be used in the selection of measures.

So in summary, there are a lot of major activities that are happening across NQF that will influences the MAP process related to our intended use activities, and as it relates to further integration of the CDP and MAP process.

So the last thing we wanted to cover today, as it relates to sort of forward-looking efforts that are being undertaken, during our September meeting -- so moving on two or three slides actually.

So during our September meeting we discussed quite a bit the importance of a more

strategic and standard approach in which we think about gaps and alignments. And one of the elements that came out of the September meeting was encouraging us to think about the development of core concepts that is, that spanned within -- across programs, within a workgroup, and then also spanned across workgroups, so that there could be a much more aerial and strategic view in which the MAP identifies strategic areas of measurement.

And so one of the things that we worked on that we wanted to continue to work on today, was to look across these. The National Quality Strategy is obviously one of our guiding principles, and then looking across all of the different National Quality Strategy goals and identifying key areas in which we wanted to see progress.

We believe that the development -- we collectively, during the September meeting, felt that the development of the MAP core concepts would be able to identify sort of key areas we

would want to make advances.

So I'm going to actually kind of move, it's slide -- if you can move forward a little bit. We're trying to skip through some of our contents given that we don't actually have a lot of time to cover this. If you could just stop there.

One of the areas that we sort of wanted to discuss was that, if you're looking at this as an example around the NQF's priority of strengthening person and family engagements, there is several CMS objectives that sort of address this strategic priority.

For instance, promoting patient self-management. The question is, how do we want to really be able to promote patient self-management?

And so there were some example areas of focus that came in through the survey that we sent out, related to, for example, care match with the patient goals or the establishment of patient, family, caregiver goals or advanced care

planning.

So these elements represent sort of areas of focus that we might be able to continue to advance within the workgroups and then across workgroups. Clearly we won't be able to really get into the development of the core concepts during today's meeting, but this will be an activity that we will undertake during a little bit of the off-cycle work, likely in the summer.

And so with that, one of the things that we sort of -- we want to transition into, is a discussion around forward-looking areas of improvement for the MAP process. And so there appeared to be at least two different areas that emerged during our discussions over the last two days. This is not actually in the slides at all. Given that these are sort of areas of discussion that emerged from our discussion.

The first is a revisiting of the question. And this is where we really want to focus the bulk of our conversation today. The first is, again, this discussion around the role

of the coordinating committee. You know, one of the things that we've identified over the last five years, and one of the key areas of input that we got from the coordinating committee last year, was around the fact that we really did not want to have the discussion as just, you know, going through consent calendars after consent calendars and revisiting all of the workgroup deliberations.

And so one of the questions sort of posed to the group is, the role of the coordinating committee in reviewing the workgroup recommendations and how to get the coordinating committee, and specifically in what way do we want to get the coordinating committee to have a much more strategic view in the rulemaking process?

And then the second is to get some input from the coordinating committee members around this issue of the various different -- the measure under development pathway and then also the decision categories within the fully

developed measures and the measures under development pathway.

And so focusing our discussion for the last hour that we're together here before we move to public comment, we would welcome discussions across the workgroup members on key areas where the MAP can focus on improvement over the next year of pre-rulemaking.

And then second -- and thirdly, this issue around the role of the coordinating committee, and then lastly, the decision categories.

Again, we don't anticipate that this discussion will result in sort of defined decisions, but more or less key parameters for us to consider and to bring back to you during a future meeting.

So with that said, I'll turn it back to -- if there's any other comments from the staff, and if there isn't, I will turn it over to the Co-Chairs.

ACTING CO-CHAIR GESTEN: So in other

words, you want this for discussion not for vote?

(Laughter.)

MS. ISIJOLA: Yes.

MR. AMIN: Yes.

ACTING CO-CHAIR GESTEN: So in this case, feedback back to NQF and to ourselves about improving the process. So you put a couple different things on the table, clearly picking up on the last day and a half's discussion and some of the things that we struggled with. Why don't we just open it up for comments, and let me just remind folks on the phone that if you use the raise hand function then we can call on you and get your input and we'd love to have your input.

DR. WILSON: Foster, this is Nancy. My apologies, I don't have my raised hand function. But if you could put me in the queue, that would be great. I'm all set.

ACTING CO-CHAIR GESTEN: You can go first, Nancy. Go ahead.

DR. WILSON: Thank you. Thank you so much for the reference to the National Quality

Strategy and the priorities.

And one of the things that I've been thinking about, since the Affordable Care Act was passed and that we're in our -- kind of like our five year anniversary, is that the --- at the time, the National Priorities Partnership, now the National Quality Partnership, identified long-term goals for each of those priorities, and I wonder if it's time to revisit the goals, reaffirm the goals, and then really think about, okay, what we're measuring is really what we think is the best thing we can measure to get to these long-term goals.

So I just want to put that kind of flag in there for -- it's not just about coming up with a strategy with names and priorities, it's about thinking about what are the -- sort of the long-term goals.

And NQF did terrific work in identifying what those goals should be. So maybe we ought to revisit or reaffirm them.

ACTING CO-CHAIR GESTEN: Okay. Nancy,

let me just make sure that I'm understanding your comment to be that, in line with, I think, what Taroon teed up, that this is something that you think would be an important way of framing conversations going forward for the coordinating committee?

DR. WILSON: Yes.

ACTING CO-CHAIR GESTEN: Okay. Kevin?

DR. WILSON: Exactly.

ACTING CO-CHAIR GESTEN: Thanks. Kevin?

DR. LARSEN: To the earlier discussion we had, I think mostly yesterday, but it kind of came up today as well, we've articulated as the coordinating committee that we want more crosscutting measures, more integration, more kind of shared accountability. And so I think a thoughtful look at how our processes and subcommittees work -- there has been a lot of terrific work there with care coordination groups and the dual eligibles group. I think that as I see the landscape of delivery system reform

happening, there's a lot of shift in payment and accountability, that people want measures to support that.

And typically, the historical way for things to have worked, is that a new payment model exists. And then data systems start sending data out of that payment system. And then a few years downstream, we actually use that data to create measures about the new payment model.

And we're wanting to actually have those measures as part of the new payment models now, and that's part of the tension we've been talking through back and forth here today. So thinking how MAP and its set of subcommittees and the coordinating committee redo our process or continually evolve our process to keep our eyes on what's happening with these new accountabilities and this new shared cross-setting, cross-environment, cross-payment model measurement, I think would be worth some time.

ACTING CO-CHAIR GESTEN: Thanks.

David?

MEMBER GIFFORD: I think that in this evolution of time, as Taroon nicely outlined, there's a dual function in that CMS seems to want from us and I don't think we've set up for it.

One is they want early feedback on measures under development as they go forward. And then there's the -- us deciding whether a measure is appropriate for rulemaking. Those are different functions. And I think not only are those different functions, we're trying to do both of them at the same time and it's causing a lot of confusion. And CMS is trying to sometimes do both of them at the same time because of things outside of their control as well.

But I think looking at the how the process is set up to meet those two goals, because if all CMS wants is feedback on some of the measures, is the MAP the right vehicle for that or is our workgroups and other stuff, or not?

So I think that's the -- and is the

feedback about the measures or is the feedback about how it's going to be used in rulemaking to go out?

I also don't think, as this has evolved over time and as these measures evolved over time, we've not done a historical look back on how these measures have been done. You know, do they come back? What -- you know, after all of this, what happens?

You know, Kate and I were joking about what we're going to see in the PPS rule that comes out in the spring. But what's going on and how do these measures actually get used? And as they evolve over time, what's the role in giving some guidance for that?

And I would completely agree with these cross-setting measures, but dealing with the guidance for it. Because even -- while we're looking for that siloing, but still the way CMS and the programs are, they're siloed. And so how do you think about, in that siloed structure, which isn't going to change right away, how do

you use cross-setting measures? And I don't think we've had that sort of discussion and process.

And then I'd reiterate I think, just reflecting our own process, I don't think our workgroups really understand the guidance and role with it in sitting in and listening to a lot of the workgroups. Some do, and others, it depends on the chair and it depends on a lot of different factors.

I think we did our role well today, in many ways that we, and this MAP has said over time and NQF said, and we want to move to outcomes, not process. And so we did say that over time. But I think that there is some value in looking at how we do that and try to move away from voting. I still think we're talking about individual measures and doing work that really should be done elsewhere before it gets here.

I just don't think it's being done elsewhere and so that we're having to do that. And I think we need to shift it better over

there. Those are my general comments.

MR. AMIN: Foster, can I ask some questions as we go?

ACTING CO-CHAIR GESTEN: Yes.

MR. AMIN: So that we can get some --

ACTING CO-CHAIR GESTEN: Absolutely.

MR. AMIN: -- a little bit of detail. I think one of the questions, David, that you're raising, that you've raised over the course of the two days that I would like to get broad input on, is this question around whether the measure under development pathway, which was intended to solve the problem of getting early input to CMS on measures before they're fully developed, and the goal of making a decision about a measure, whether it's appropriate for rulemaking, whether those are distinctly separate goals and whether they should be handled in a separate process, quite honestly.

I mean one of the major things that we've talked about last year was we can only put so much in this three month period, especially

when we're dealing with snowstorms and vacations and all sorts of other activities. It's hard to imagine any more in here.

So are they sufficiently different that just creating a separate category is not actually achieving or -- you know, a separate categorization system, is not sufficiently addressing the problem? Or the new issue that we sort of -- that has emerged over this year's pre-rule making.

And I'd also welcome feedback from CMS as we go through this, if you have any thoughts as we go through it.

MEMBER GIFFORD: I do think it's a good point in that CMS is also going to have to put measures that are not fully developed and specified, that they're going to have to put in rulemaking. I mean, CMS has to specify our cost per beneficiary measure by October 16th. It's going to be in our rule. It has to be in our rule, otherwise they're in violation of statute.

Now, they are certainly in violation

of statute all the time but I think Burwell has made it pretty clear, they don't want to violate the statutes moving forward. And it's never good on the executive branch to violate statute and just get you called up before Congress and stuff. So I think I can understand that bind that they're in. And they're going to move forward on it.

So you're right. It's not that if you skip a step or thing, it still doesn't need it. Because they are asking for input on measures that they are having to go really fast on. I just don't think our process has figured out how to adapt that.

ACTING CO-CHAIR GESTEN: Well let me -- I know a couple people want to -- I'm not sure what's in people's heads about whether they want to comment on this or not. Because we -- what's that?

(Off-microphone comment.)

ACTING CO-CHAIR GESTEN: And I know Harold does and you do. So why don't -- Harold,

you had a specific comment around this topic?

CO-CHAIR PINCUS: Well, in some ways, you know, what we have -- and I'm not sure we need two different processes, but I think we need two different sets of criteria.

And in some ways, we need to sort of go back to the initial criteria. When we first, you know, put together the MAP, we went through and developed criteria that were not necessary measure-specific, but that were also sort of measure set-specific.

And we need to go back, I think, and I look at that, and to think about, do we need a separate set of criteria for the MUC process and a separate set of criteria for the MUD process. You know, sort of take ourselves out of the MUC and the MUD.

Because I do think that there are different criteria where we're asking like a different question, as David said. The question for the MUC is, you know, are these things ready to be put forth in rulemaking? And for the MUD

one it's the question, is it worth making an investment and is that investment likely to be realized, given the current state of information, evidence and practicality?

And so I think that they're -- so that I think we need to sort of take a step back and clarify those two distinctions.

ACTING CO-CHAIR GESTEN: So, Peter, do you want to respond to that before I get to David and others who might want to --

DR. YONG: Yes, thanks, Foster. So I actually want to address two issues that were brought up, but --- so on this first issue about sort of the MUD versus the fully developed.

So yes, I think there's a tension that David sort of identified, right, that oftentimes while we would, particularly with statutory mandated measures, we want to bring it to the MAP as fully developed, with all the specs, so you can have a chance to review it and have an understanding of what the measure is addressing.

But sometimes, because of statutory

deadlines, we are forced, in some ways to, because of the timing of the MUC and the rule, to bring things forward probably before we would normally otherwise would. And so sometimes those constraints are in place.

And sometimes we -- but we also put, sometimes, measures on the MUC list because we want feedback. I mean an example I think this year was the tobacco measure, and because it wasn't specified at that -- but it was a fully specified measure otherwise. But it's a novel measure concept for this particular program and we wanted to bring that forward, and thought it would be appropriate and important to get public feedback about that kind of measure because it's such a different sort of way to think about measures in the IQR program.

David also raised another issue, which I thought was also really important, and actually Gail and I were just talking about this. But sort of, you know, we talked a little bit about care transitions and the importance of sort of

cross-cutting measures. I think the way CMS programs are currently structured, they primarily focus on sort of settings or providers, right? We have inpatient quality reporting, we have outpatient quality reporting. We have, you know, the PAC.

So we have all these programs, but yet we recognize that cross-cutting measures are really important. And certainly we've done a lot of thinking and work to try and align measures across programs to the extent possible. I think there's still work to be done there.

But thinking forward to the future, I think it would be great to get some feedback about how we should be thinking about sort of alignment in terms of these cross-cutting measures. Because sometimes there are constraints, right? Because sometimes you need multiple providers working together to address care transition, but then what's the appropriate program to put that in given the current structure of our programs?

ACTING CO-CHAIR GESTEN: Thank you. So, David, did you want to speak to this point directly? If not, I'll go back to my order. Yes? Okay.

MEMBER BAKER: I think one of the challenges that we've had through this meeting, is we've got these different types of measures and they're all intermingled. And we're really doing very different tasks.

So one thing that we might think of is imagine if we said, well, first we're going to deal with the straightforward MUCs. Then maybe we're going to deal with any of the statutorily mandated measures, because our feedback on those, we know they're going to go forward. As David said, they have to go forward. And the feedback on that should really be around, how can we improve that, or how can CMS improve that.

And then there are others that are under development. Because again, they're very different mental tasks. And I'll use the analogy for National Institute of Health, when we're

reviewing grants we divide up the big grants from the small grants from the faculty development grants. Right? Because you're doing totally different tasks. You're viewing them with a different light. So that might be helpful for us.

ACTING CO-CHAIR GESTEN: So, let me make sure I understand. You're posing sort of three categories with the first being, you know, ones that are on the MUC list that would be evaluated in support, non-support conditions.

The second would be ones that you know are going to go forward. And so the opportunity here is to make this -- try to make it better, knowing that there's some inevitability about it.

And then the third is truly things that are under development, meaning they're on a longer course, potentially, with no mandate, and that those may be the buckets of response and/or the process or the prioritization may be different for those three.

Is that -- okay. Marla.

MEMBER WESTON: I think my comments really mirror this whole conversation about the need for cross-cutting measures and alignment and coordination. I mean when I think about what our responsibility is, it is as the coordinating committee.

And so one of the things that we need to think about how to do in the future is to look across the workgroups. And I think part of what is happening is because we look at the measures sort of structured the way they came to us, by workgroup, it causes us to drill down deeply.

And when I reflect on why many of the measures were pulled off for discussion or for vote, what was important was not that they were pulled off, but why? And the discussion about why was often around, we need to have cross-cutting measures, we need to expand the settings in which we have this measure.

So one of the things I would suggest, in terms of process, is that when things are being put off, that we capture the why ahead of

time, and that we look for patterns of how that aggregate and then give us an opportunity to have that discussion, because that's the coordination part of our work.

ACTING CO-CHAIR GESTEN: Rich? Okay, Rich Antonelli.

DR. ANTONELLI: Yes. Actually, there was a prescient of you to put me in that order. So, Marla, I agree.

What I would like to do is to maybe try to capture this notion of, we'll call it the phosphorous measure indicator. And to the degree that measure -- that there are significant measures in the pipeline that are reflective of that, that aren't really going to add value, et cetera, I think that the MAP, especially at the coordinating committee level, and then within the -- even within the standing groups, we should be able to be as proactive as possible to let folks know the kinds of measures that we're looking for.

One of the things, and I note Helen

has been extremely supportive within the standing committee and care coordination, to enable us to be a little bit more proactive with defining gaps, so one of the --- in addition to looking at measures that find their way for consideration, that encourage alignment and really get us to value, I think we should have a process in place by which we're tracking what we can do to identify gaps and then following, over time, is there activity that's now bringing measures forward in to satisfy those gaps? That would make a really cool dashboard indicator, for example, at the level of the MAP.

And then finally I think what I'd like to do is, there are some areas, like the standing committee on care coordination, but then there are care coordination measures that are being considered in the pediatrics standing group and sometimes those activities are really hard to align.

So I'd like to encourage more clarity about where those domains actually cross. Not

that they would be artificially separated, but in fact to encourage the opportunity for cross-collaboration and to possibly overuse or overemphasize the word coordinate across those various groups, especially as we start getting into the area of identifying meaningful gaps.

MR. AMIN: Rich, can I just --

ACTING CO-CHAIR GESTEN: Yes. Go ahead, Taroon.

MR. AMIN: Just to jump in here just to keep this interactive. I think the --- just to go back to the idea of core concepts that emerged from our discussion in September, from our perspective, the idea in the development of the core concepts is a vehicle from which to be able to identify the key gaps and the key areas of alignment that we want to see both within the workgroups across programs, but also across programs.

And so a step toward development of such a tool, an analytic tool by the coordinating committee, will help us to advance some of the

objectives that were just discussed.

ACTING CO-CHAIR GESTEN: Great. Heidi?

MS. BOSSLEY: Just to address a little bit more some of the angst I think that we've had over the last few days, and I've seen workgroups do this as well, looking at those measures under development. And also I think the other category, and I don't know where they fall, are the measures that are being updated in their significant changes.

But I think until we can get to a process where those measures, people know that they will either go through NQF endorsement and then the coordinating committee and the workgroups can look at it again and know that it's been evaluated, or that information is provided on how it's performing. Do you have any data on use, do you have data on reliability and validity for that program?

Until we have that, I think you will continue to see angst. Because it is, has

historically been, one and done. You see it once, we give you an idea of what we think are the issues, and then we're not sure what happens to it again.

So I think that piece, if it's a request or a new category, I don't know what it is, asking that the information come back to the coordinating committee, when it's past that development phase, and now ready for rulemaking.

ACTING CO-CHAIR GESTEN: Jayne?

MS. CHAMBERS: So it's sort of fun to sit here on the fifth anniversary and to think about where this came from, concept, and how it got put into the ACA and then has evolved to where it is now.

And the number of programs for which measures are now required, has probably -- I didn't do the exact count, but it's probably quadrupled since this started. So we have many, many more quality programs that are requiring measures with very different focus for what those are.

I like the idea -- and the statute actually requires this group to look at measures that are going to be used in rulemaking in the next year, in the upcoming year. So I think it would be fairly easy to do a separate process where you have the measures under development, where we need feedback and discussion and want input from a multistakeholder group that may have various perspectives on this, and to separate those measures from the measures that are ready for prime time and for use in a rulemaking process, and to think about how that might work.

It may come down to funding for CMS. And that's, you know, probably an issue that needs to be work through. But it strikes me that we can separate those two without having to have them in the same three month crunch time period. Frankly we wish the statute were written differently so you could get chunks of measures throughout the year, but that's not how it came out.

I do think the issue of measure

alignment and how we use cost measures or efficiency measures, you know, what all of that means, I think we need to look at that. And I think we need to focus, as the coordinating committee, on really understanding what each of the payment programs is supposed to be doing. And have a real good understanding of the effects those programs have on the entities that are being measured.

And so that may take some work for all of us around the table to really delve into programs that are not in our normal bailiwick, so that we really understand the effects of those programs, because there's a lot of interaction among them. And for entities that are measured under two or three different programs, which measures are in which program really makes a difference. So it just -- it's more complex, I think, then sometimes we give ourselves credit for looking at.

ACTING CO-CHAIR GESTEN: Thank you.

DR. BURSTIN: Just a --

ACTING CO-CHAIR GESTEN: Go ahead.

DR. BURSTIN: I just have a quick question or a comment. Jayne, that's really helpful and I know you know this stature very well, so thank you for that too.

It requires us to look at measures that will be used in rulemaking in the next year but oftentimes the rulemaking is prospective, three years ahead. So it may be the rule for 2018.

So it would be helpful to understand how much of what we're seeing of measures that are not yet quite ready are in rulemaking, but they're not going to be used for three years hence. So it would help to talk about it.

MS. CHAMBERS: I agree. Having, you know, having more information about how we think those measures are going to be used and when we think they're going to be used, would be helpful. And to the extent that it doesn't have to fall in this three month period of time, where you can do it on a more perspective period, if you're

thinking further out, you know, I think that would be helpful, too.

DR. BURSTIN: That's actually really helpful. Because we just get them lumped by the, it's the upcoming rule. But it could be three years' way. So that should cover that as well.

And I was really encouraged by Kate's comments yesterday about the idea of thinking about weaving the feedback loops in. So I think that's a really opportunity for us.

And I'm glad Kevin's here, too. That we need to really think about leaning out this process and figuring out how to get that done.

Because everybody wants feedback from the field. Many have offered it. We'd love to be able to really bring that all together and just make sense of it.

Because it's hard to do this work without knowing the performance of the measures in the field. It just continues to be the black hole for us in endorsement and that.

ACTING CO-CHAIR GESTEN: Marshall.

DR. CHIN: So I'm going to try to tie together some of the comments in a slightly different take, a slightly different complimentary angle.

And I think it's, for me, striking. I think the past couple of times I've been on MAP meetings, how the discussion, really the discussion has been very, very micro.

I mean we're talking about like individual measures and a great discussion of issues. Sometimes we talked about an issue raised at the top of this health one. Which sometimes was very successful on the issue. And very thoughtful.

But in some ways, where we don't, we haven't had much of the holistic look. So even like the setup to these slides, it's talking about like identifying gaps. Gaps in what we do. So micro gaps.

As opposed to thinking about, well, holistically the measure sets we use, are they selected to do what they're intended to do in

terms of bringing outcomes and quality of care and providing value.

I mean if you look, I think, at the public or the end users or, you know, the front line people in the healthcare, in some ways we're not directly addressing some of the concerns. So for example, we referred, like some of the health organizations today, some of the concerns involved, like feasibility and burdens. That's part of it.

But the fine line folks, there's a lot of providers that burnout is a huge issue. The concern. And the fear about like the EHR taking over patient tier as opposed to you treat it, the medical record, as opposed to the patient.

And the data collection, is it really improving value. And when we see, for example, like the op-ed, like Bob Wachter's from a couple weeks ago, in terms of like the performance measurement, is it really doing its job or is, you know, the analogy, the education, no child left behind, is really a measurement for

measurement sake.

So it's something, what Jayne just said about, thinking about, well, what are the outcomes, what we're doing? I mean are these measures, for given programs, truly leading to the improvement in quality and all that we're aiming for or not?

Or is it the same thing like, you know, the light and where we drop the keys. You know, are we really sort of improving quality of care in the things that matter to the patients or not?

And so I'm glad we're having this discussion. And I'm wondering, to what extend we can build into the working committee or some of this more holistic in other things. You know, really clearly important work.

Because otherwise we, there's endless work to do in terms of the rabbit hole of all these micro decisions, micro measures to look at. And we may just be missing the boat in terms of some of the front line people, you know, that

were saying, well, you know, what are you doing to address like overall quality of care and making sure that the work that we do, on the front lines, is meaningful.

ACTING CO-CHAIR GESTEN: So, while you used different words, I think this may be connected to the comment that Nancy made starting out. Which is --

DR. WILSON: Yes.

ACTING CO-CHAIR GESTEN: -- from her point of view, looking at what are we trying to achieve. What's our objectives. And to what degree are the measures and these initiatives really getting us to where we want to go.

Of course, all of that layered in that there actually is, that congress has spoken and there's certain things that need to be in place -- whether they necessarily line up in the way that, which we think they should, relative to objectives.

DR. LARSEN: And can I just to comment about this particular item?

ACTING CO-CHAIR GESTEN: Yes.

DR. LARSEN: So I think there's an opportunity, there's another thing that's called out by the Affordable Care Act called the National Impact Assessment of the CMS Quality Measure Reports.

I happen to serve on the federal committee that builds the plan to analyze the impact of quality reporting for CMS. And so that is a every three year report; one just came out in 2015. We're now in the process of building what the assessment will look like for the next report, which will be in 2018.

But it strikes me that we don't have a lot of back and forth conversation between the MAP and this impact analysis and impact report that this work group does. So that I think might be an opportunity here to link those two Affordable Care Act required activities and figure out where there is some cross pollination.

Where this committee can maybe review and see what that impact assessment looks like,

but maybe even give some input into how the next analysis in the report is structured.

DR. WILSON: This is Nancy. I think that is really important. And I think that what part of the cross pollination was because George Isham was part of the group. I don't know even know if that was, at some point.

But we had people in the, you know, in the measurement world who were cross pollinating. But we need to think about that more seriously. And I think that's an incredible group for figuring out what's the impact of what we've been doing.

ACTING CO-CHAIR GESTEN: Thanks. Lynda?

MEMBER FLOWERS: So, I'd like to go up about another 1,000 aerial feet and go out way in the future and suggest an answer to one of the questions that was raised today, which was: what are we trying to accomplish?

And when that question got raised the first thing I thought about was the culture of

health. And how our healthcare system is slowly but surely moving in that direction.

In the sense that its all of the piece. And that there are many things that impact health. Including your environment and all of the mediating systems that are out there, including housing, safety, access to food, et cetera. Affordable food, healthy foods.

And then, so more and more the health system is being pushed to engage in those systems. So we now have the new CMMI Accountable Health Communities Initiative. Which is saying to hospitals and other providers, here is some extra money for you to improve people's health, not only in your setting, but apart from your setting.

We now have the RWJ Initiative. Culture of Health dollars going out. For people to integrate health more broadly to address disparities and other issues.

So I'm wondering if, futuristically, there are opportunities for us to challenge the

work groups to think about the quality of these other relationships in which they engage. With CBOs, with social service agencies.

So that when we had that discussion about anticoagulation therapy, you know, so if you want the hospital to be responsible, they have to know that they're handing off to a high quality entity that can really provide, and has a track record of providing.

So I think as we think about integrating systems working across silos, there are these intermediaries that are going to be more and more brought into the picture, that are going to have an impact on the success of this payment system. And I think we should be thinking about that futuristically. Thank you.

ACTING CO-CHAIR GESTEN: Thanks. Rhonda?

MEMBER ANDERSON: A couple of things. I would like to support what was just identified. That was actually part of what I was going to request.

But then I'd like to go back to what David and Jayne and others have said about how we can separate these. And a thought came to me, when CMS removed, for discussion or brought for discussion, some of the MUC measures.

And I'm wondering if there isn't another category that would be part of that differentiation. Where if CMS has some questions, that they do what Marla was saying. Where the questions are listed out there and the why.

So that we understand their removal for discussion. And what they're really trying to get at.

Because as they bring forward all the MUCs, you know, we're all responding to those. The teams are, they work groups are, et cetera. But then at this meeting it's a little confusing unless we understand the why.

ACTING CO-CHAIR GESTEN: Thank you. Harold?

CO-CHAIR PINCUS: So I have a couple

of semi-random thoughts about what we've been discussing.

One, going back to something David mentioned in terms of making a sort of metaphorical kind of connection to reviewing NIH grants.

That one of the things that, you know, I've been involved with some aspects of, some evaluating, sort of NIH processes. And one of the thoughts that we've had on this is that whenever you fund a grant, you're essentially establishing a hypothesis that something will happen as a result of that grant.

Yet NIH, for example, never actually makes that hypothesis explicit. And if they did make it explicit, it would be much easier to evaluate their grant making process.

I think the same applies to the measures as well. That whenever you implement the measure, you're making some kind of hypothesis that something's going to happen as a result of that measure.

And it would be useful to be more explicit about that, in terms of what the expectation is. And that as a way to then follow back.

And this comes back to some of the discussions we had yesterday about what kind of feedback process we want to have. To be explicit about that. And then see whether or not in fact, you know, two, three years later, that hypothesis was in fact endorsed, or whether it wasn't.

And, you know, one can look at that both qualitatively, and to some extent, quantitatively. Here's the part of the random thinking about that.

Is that, you know, it's kind of, I was just thinking about sort of the, it also goes back something that we talked about earlier, that David brought up, about the phosphorous measure.

That, you know, when looking backwards and looking at what measures have worked and which ones haven't, you know, and I'm thinking about this in the point of view of like we're

kind of in Academy Award season. And my family actually has an annual sort of Academy Award nominations pool that we do.

That, you know, which measures, looking back on, do we think made the biggest difference? And are there ways to emulate those kinds of measures?

Like I was thinking about the discussion we had earlier about, you know, the hemoglobin A1c, its evolution in how, you know, it's made a really transformative difference in terms of, you know, how we sort of address diabetes. But, you know, the phosphorus measure doesn't do it.

And so just to think about, are there certain measures that would get that kind of, sort of Academy Award. And is there some ways, what can we learn from that. So that thing about the qualitative component of it.

Third point is, we should really give serious thought to the, really the opportunity that Kate made yesterday, about actually

systematizing and formulating a feedback process.

That we can have at, you know, the most opportune, and to figure out at the most opportune time to get that information. But also what might be the template for how the information might be presented to us.

So that it's not like a make work thing that has to be produced, but it actually is, really gets to the actual point of decision making that helps us.

And I think some of these things are, you know, some of the things people measure for us. Some of it is sort of looking prospectively at, you know, what is the plan for what measures need to get out there and when, you know, Jayne, I think you mentioned that sort of the three years out kind of thing and the, you know, and what sort of, what are the expectations going forward, and how would that actually be implemented over time?

But then also looking backwards at the, you know, the impact of the measures and

trying to identify, you know, sort of what worked and what didn't work.

ACTING CO-CHAIR GESTEN: Okay, thank you. Pierre, were you in line was that the leftover? David?

MEMBER GIFFORD: So I actually want to go back to Lynda's point. I really liked it.

And sort of, as thinking as a geriatrician with a huge group of baby boomers coming along, we need to have a better dialogue and a measurement around quality of life and function and sort of what they want out there.

Most of the measures, when you step back and look at that them, are really medicalizing a lot of things and continue to have a very medical, a very strong medical flavor to them.

And I think that -- and we've heard that from other various voices within NQF over years about how do we get more of the patient's voice and how do we get more satisfaction or quality of life measures in there. But I just,

despite asking for it we don't see it. It's still very medical.

Now some of it's because it's driven by congress and payment in some of the issues coming forward. But I think having that, the important aspect.

And being, making sure that this doesn't always go, well yes, we really want that. But it's the payment measures we have in front of us, it's Congress, either way, how do we use the power of this entity to drive that?

Then a completely unrelated one is, I think there's clearly -- and we saw some of it in the measures -- a growing sense of composite measures. And composite measures, from individual composite measures, almost sort of scale measures, to combining a series of process measures, to even combining a series of outcome measures, to now you have CMS doing a lot of Five-Star ratings.

You know, we were one of the early settings that had it, but now a lot of settings

have Five-Star. Well the Five-Star setting itself is a composite measure of how they do that.

And there's a methodology, an input and waiting and idea for that. And it's really in its infancy.

And I don't -- I think there's the potential role. And I don't know whether it's in the MAP or NQF, to look at how these star rating systems, or composite measures that are not sort of scaled within one particular clinical situation, are being constructed and done. I think some guidance would be helpful there.

And then I'll go down, back down to completely at sea level. To Dave's earlier comment.

I don't think we want parallel systems of this MUD/MUC type of discussion. It's almost you want to have two votes.

You want to have a vote, is it ready for rulemaking now? What sort of conditions or tweaks would we like to see if it goes into

rulemaking?

And then you almost want to vote a second time. And this is, sort of Bill, I think, has opened my eyes to it is, do we think this measure needs more development? Yes. We like this measure, just develop it more. Go with it.

It needs lots more development. You almost want to have two votes. Every measure, have two different sort of votes on it.

Because otherwise I think, and watching the discussion by different committees, even including the reviews that have happened in CMS about measures that come through for endorsement, there's a lot of concern that if they don't approve something, that means it's going to stop in its track. And everyone thinks the measure is really important.

So is there a way to sort of say, not stop it so in its track that it keeps going. And I'm afraid if you have two different paths, you still don't address that situation.

ACTING CO-CHAIR GESTEN: Taroon, did

you want to make a comment? Or ask a question.

MR. AMIN: Yes. This sort of, I think, related to that last train of thought. And also related to the question of the overall role of the coordinating committee.

Just reflecting on the past two years, what are the key sort of pieces of feedback that we've heard from the coordinating committee?

Particularly between last year and this year, was that procedurally to make sure that the discussion -- and this is to Marla's point as well -- around not setting up the coordinating committee process so that it's just an adjudication group that looks at all the different work group deliberations and makes a final recommendation that stamps the recommendations of the work groups.

And so it's sort of a question as it relates to, what do folks believe the role of the coordinating committee is as it relates to individual measure discussions?

To a certain extent, a lot of what

we've discussed in the past 45 minutes is the role of the coordinating committee that folks would want to see, which is related to coordination.

And obviously there was comments around potential improvements that could happen, even in the work group structure. Meaning that they're structured around settings. And that could potentially be an area that we also look at.

But even starting from where we are right now, which is an introspective look at ourselves, as you all, as the coordinating committee, what really is the role of the coordinating committee, vis-a-vis, individual measure discussions?

And clearly we've funneled the amount of discussions from significant to manageable, I think, this year. Given the snow storm issue aside, it was a manageable set.

But still, if you look at how many were actually overturned, I mean one question we

could debate is, was the bar too high to overturn? I mean we can revisit that question. We certainly debated that quite a bit last year.

But to a certain extent, we didn't overturn a significant number. And it's only to say that it's, again, we've provided a significant amount of feedback back to CMS in the discussions. So there is value there.

So it's a question I guess I would also pose to the coordinating committee around its own role, vis-a-vis, individual measures. And again, I would welcome comments from CMS as well on that.

ACTING CO-CHAIR GESTEN: Yes, I would just say, I don't know. I don't think the committee knows whether the feedback we provided was qualitatively or quantitatively different then what might have been squeezed out of the work group. Because we don't have access to all of those comments.

So I think it was a productive conversation, but I have no way of knowing if

it's the same issues that were raised in the work group. And that would be, I think, important to understand. In terms of the question about what's the added value of having a repeat of a conversation.

Because what I heard, a lot, from the work group chairs was, yes, we talked about. We mentioned that. We raised that as an issue.

So anyhow, Missy, you had a comment.

MEMBER DANFORTH: Yes. I just, I tried to get in earlier to go back on this idea around a MUD versus a MUC.

And one thing I'm wondering, if it would be possible, because it was raised as an issue yesterday and again today is, you know, there's a number of measures over the past two years about conditional support from the work group. And the coordinating committee and the conditional as NQF endorsement or NQF endorsement plus a look at the respecter adjustment.

And there was acknowledgment that, you know, nothing was ever done, you know, with

those. I'm wondering if like starting now we can actually go back maybe at least for the past two years, or even one year, and actually bring back those measures that have gotten that NQF endorsement. And have some way too so it will automatically get back on the next MUC list or some ad-hoc review of them by the committees or this committee.

But it just seems like such a waste when the developer goes through the work of putting the measures together, putting them on the MUC list, they're told that the only thing that's stopping them from being put in their program is NQF endorsement. They go through the NQF endorsement process, and they never get back on the MUC list.

I just think that that could be like really discouraging to developers. A huge waste of resources for the work groups and this committee.

So if there's a way to bring, do a retrospective look, get those measures back with

a status update, then a way to efficiently review them, I just think that would be incredibly important. And make that an ongoing process as part of this work.

CO-CHAIR PINCUS: Helen, do we know how often that is likely to happen or happens?

DR. BURSTIN: Yes. No, it's an interesting comment, Missy, and we do need to do a better job of understanding what happens to the decisions each year and, you know, having more of a retrospective view on it.

But I think part of what we're seeing is, measures are going into programs before they've hit the adjustment process. It's not as if they're stopped in their tracks because of not yet being endorsed. They're flowing in.

I think part of what we heard from Kate yesterday was also this idea of that feedback of what's happening, you know, post-hoc. The measure have then been endorsed, they've been in use, what do we know about its experience in the field.

So I think it's just a lot more to understand broadly about this issue of feedback. And I would also just love to go back to the question, you know, Kate specifically posed for yesterday of, what information do you think would be most useful to come back to the MAP?

So I think we should queue that up potentially as a discussion to follow up, perhaps on our webinar, in terms of, again, I think there's lots of opportunities.

And, you know, explicitly said to work with NQF staff to develop a feedback loop process. So I think that, to me, is one of the biggest opportunities to think about how we change this process going forward.

CO-CHAIR PINCUS: Helen, would it be useful to put together maybe a subcommittee to work with staff to develop that?

DR. BURSTIN: That would be fabulous.

CO-CHAIR PINCUS: Okay. So that's something, I think, is sort of a homework kind of process.

DR. BURSTIN: Sure.

CO-CHAIR PINCUS: So Kevin and then Heidi I think.

ACTING CO-CHAIR GESTEN: Jayne.

CO-CHAIR PINCUS: Or Jayne. No. No. And then Lynda and Bill.

MEMBER FLOWERS: Okay, so maybe you said it and I didn't hear it. But what keeps the -- why when you send it back out for endorsement, and it's endorsed, it doesn't get back onto the MUC list? What keeps it from getting back on? Which is what Missy just said.

MS. CHAMBERS: It doesn't need to be on the MUC list.

DR. BURSTIN: Yes.

MEMBER FLOWERS: Oh.

MS. CHAMBERS: I mean once it's come through and we've made a comment that it's, you know, conditionally supported --

MEMBER FLOWERS: Oh.

MS. CHAMBERS: -- after it's gone through NQF endorsement. CMS knows what our

perspective is. They can do with it what they want. And it doesn't ever need to come back.

DR. BURSTIN: So measures under consideration means they're still considering if they're in. Once they're in, they don't necessarily come back.

But I think that was part of the discussion yesterday, what would you want know about the experience of those measures, once they've hit the real world.

CO-CHAIR PINCUS: Yes. And also that whole, the whole sort of market basket of measures for each of the programs sort of has various subtle shifts that we don't necessarily see --- is also part of the feedback loop.

DR. LARSEN: So I want to follow up on Taroon's comment. In part about the, how do we become more than just the adjudication of issues that the work groups didn't handle.

And I think partly that's a process question. If we mostly just meet at the very end of this process, we're likely going to mostly

focus on those things because we're so sort of distal in the process that we don't have time and energy and analysis to do that work but, you know, to upstream.

So some of this is to think about, if we want to do coordination that's more than adjudication, we need to think about what upstream process that we continue to focus on as the coordinating committee.

We've done a number of those things, and so I'm not saying we don't. But I think it's important to think about that in this.

And a couple of suggestions for areas I think that have already come up in this meeting. One is a consistent approach to risk adjustment. We've talked and talked about this.

But we don't necessarily have guidance on what the consistent approach, that the MAP coordinating committee is going to kind of be evaluating and looking at risk adjustment as it comes through.

Another is this shared accountability

and attribution. So we really want it, we say we really want it, and then every time it comes to us we say, ugh, we don't want it like that though.

And so I think there's an opportunity for us to be proactive in this and say, yes, we really want it. And this is an example or these are the principles and criteria for how we really want that shared accountability and attribution.

CO-CHAIR PINCUS: Just a comment on that. I think part of the issue around the shared accountability and attribution sort of comes up in the context of sort of cross setting kinds of measures. And also measures that our, you know, particular program, that's not a cross setting measure, but it should be for a cross setting measure.

You know, so that's part of matching. You know, and so I think that's part of the whole picture.

So, Jayne?

MS. CHAMBERS: Yes, sort of building

on that. I guess one of the things I've been struggling with is that my vision, or what I thought the coordinating committee was supposed to do, was be wearing a very broad lens and looking at where the conflicts might be between the measures that are coming forward from the various work groups. Where those things could be setting up unintended consequences as you go through quality measurement and have a national quality measurement program from a variety of levels.

I don't think we should be looking at, you know, did we overturn our measuring, did we overturn our work groups recommendation. I think it's using the various expertise around this table to take a bigger picture look at, what does this set of measures look like for use in this program and how that might affect or relate to other programs where they have quality measures.

And it's a hard lens to wear. But I think that's part of what this group is supposed to do.

CO-CHAIR PINCUS: But also, and I just want to say, and, Pierre, I don't know if you want to comment on this, sort of on the side conversation we had during lunch, that your perspective that you perceive at least a different perspective from the work groups as compared to the coordinating committee.

DR. YONG: Yes. So thanks, Harold. I mean we were just having a conversation earlier. Because I am the CMS rep to the hospital work group. I typically have not come to, I listen to bits and pieces of prior coordinating committee conversations, but not in its entirety. Because usually Kate has been the representative or Patrick in the past.

It's been interesting for me to be here today, particularly because having sat through the hospital work group conversations, a lot of the same issues around these measures were surfacing. I think you've heard and you've observed.

But at the same time, we do get a

much, I think, a slightly different and broader sort of perspective here. Because folks that are on the hospital world group committee were chosen specifically because of their sort of interest and expertise in the hospital world as opposed to here.

You know, I was just commenting like it was great to have a mirror here and here. Have, you know, the AMA perspective here because that's not represented in the hospital work group. Yet clearly there are interests in the web measures, in those, in the IQR program, the hospital program. So that was my comment to Harold earlier.

CO-CHAIR PINCUS: Bill?

MEMBER KRAMER: Just building on a few of the earlier comments and adding a couple others.

Looking back over the five years, one thing I think we should, maybe is not recognized, we should note, is that we were initially formed as a multi-stakeholder group. And I think with

recognition that some cases there was conflict between the perspectives and the goals and what we wanted to do.

And I've been struck over -- and that's how it was in the early days; there was quite a bit of disagreement, let's say.

But I've been impressed this cycle and, you know, in the years leading up to this, about the high degree of consensus on at least some of the core principles and our approaches. It wouldn't bother there's still some differences about methodological issues and so on.

It strikes me that there's been significant progress, at least at this table and a number of other tables you sit at, you know, about things like the, while there's a role for process measures, we try to emphasize outcome measures; the desirability of composite measures.

Things like that that have sometimes gotten us -- and also issues of accountability outside the walls of the hospital or outside the walls of, you know, what's under control of a

particular provider.

And I think that's a real accomplishment. That's hard to articulate and hard to describe, but I think most people who have been involved would agree that there's been a progress in that arena.

So I think functioning as a healthy multi-stakeholder consensus group is a real accomplishment.

This cycle, I think it's worth noting that the work groups I thought were very effective. And that hasn't always been the case in the past.

And I think, at least the ones that my team participated in, particularly the hospital and clinician work groups, had strong leadership and strong participation. And I think we saw that in the materials that came to us. We ought to give them a special shout out for the good work that they did.

And finally, in terms of our role, I agree with what Jayne just said about our role

being, looking at things in a big picture. And that's more than just coordinating, which is the title. Maybe we should rethink our title.

But we ought to be taking a look across all of the measures to make sure we've got a -- that it all makes sense.

We ought to be thinking forward about what role we play and how we can be effective in helping to drive the whole measure development and consideration and recommendation loop feedback. And that whole process is very important.

So I would encourage us to look for us to live that role in this coming year. And not wait until next January to get together again.

CO-CHAIR PINCUS: Bill, thank you very much. And I completely agree. It's really been quite amazing to see the evolution of the culture here.

And I think a lot of that is attributable to the, you know, the really extraordinary competence of the NQF staff. I

think to the way in which I think Beth and George really sort of established a kind of a way -- a process by which people can feel comfortable in stating their opinion.

But, you know, really getting to the point in being able to sort of withstand, sort of questioning, but, you know, never really getting out of hand with that. And really striving to achieve what the real goals of this are, which is really to improve the quality of the healthcare for the country.

And so I think that that's really been a, you know, a remarkable evolution. And I think we're really at a good point.

I think there are things that we can do to improve things in terms of being clearer about sort of objectives, goals, definitions.

I think that putting forth a process that will be able to get us systematic information about the results of what we've recommended and what's been implemented will be enormously helpful. Because obviously we want to

drive our decision making as much on data as possible.

And I think that -- and I totally agree with your point about moving more quickly to do that. And I think, you know, putting together a small committee to think that through with the staff would be very helpful. And also involving CMS in that as well.

So I guess, Rhonda, last word. And then we would move to public comment.

MEMBER ANDERSON: So just the last piece, that I think we mentioned yesterday and I'd like to not forget, because I haven't heard it mentioned in this little round table, and that is that, yes, we know the goal, improving health, et cetera, et cetera.

But I think it was mentioned yesterday that there still might be some core concepts. And I know we didn't want -- we put that a little bit to the side. But that there are some core concepts or core principles in health improvement that cut across everything.

And I haven't -- I think it's been raised a few different times, not just this meeting but in previous meetings, and I haven't heard that there really is a response to that. That there is either some cycle that will be put in place where outside of the legal responsibilities that we have, that we really bring forward, what are those precious few outcome measures that really will make a difference to the health of the population at large?

So I just don't want to forget that. Because I do believe that that comment has come up many times, and we haven't really addressed it as a whole.

CO-CHAIR PINCUS: Thank you, Rhonda. So Taroon, did we cover what you wanted to cover?

MR. AMIN: Absolutely. And if I could just sort of highlight a few of the key themes. And there was one additional question that came up here, but I'm just going to cover it as we talk.

You know, I think one of the key themes that emerged from our conversation were really identifying the key priorities and the long-term goals. And clearly the topic that Rhonda just mentioned as well.

There's this idea around the voting and the measure categorization that David brought up. And the way that needs to be handled, which David also brought up, too --- that both David's talked about.

And then third was this idea around the feedback and the process development that needs to occur in terms of a small group, of this group, that advises.

And the need to bring in analytics in a way that can measure our performance. Both in terms of the recommendations and how they're received by CMS. And then essentially how the programs are currently structured.

So we will take all of this feedback in terms of improvements, and we will sort of work on bringing back to this group, at a later

date, some recommendations on a path forward.

So with that, I would say thank you very much to the group. Thank you very much to Harold and Foster for your leadership over these two days.

And for all of you, for especially those of you that traveled and had to travel or were trying to travel and couldn't get here with all the weather challenges, we sincerely appreciate all the time to review the volume of information that was in front of you, which is not insignificant.

So with that, I'll turn it over to Helen, if you have other comments for the rest of the staff.

CO-CHAIR PINCUS: And then public comment.

MR. AMIN: Then public comment.

DR. BURSTIN: I just want to say thank you. I think it's been an extraordinary meeting.

And thank you for, Bill, for pointing that out. Because it was definitely palatable.

This level of cooperation and willingness to hear different points of view. It's truly changed over time.

So I think that's a great accomplishment. And that's what the NQF table is all about. So I'm glad that's happening.

I just want to also say how extraordinary this last hour or so has been. So many of the issues that have surfaced are actually the ones we've been grappling with as part of our strategic planning effort that we're doing right now.

And you have raised almost every single issue, that we are prioritizing as we speak, of the strategic planning for NQF. So very prescient, thank you.

Incredibly informative and we're really looking forward to thinking about working with CMS, working with all of you. Not waiting a year, to Bill's point as well, but really seeing if we could gather some momentum and start working with CMS to think about how we can make

this process much more fruitful going forward.

And also -- again, hammering this one more time --- we can't effectively, as a nation, do out work without feedback. We've got to be able to build that into our system. So I'm so delighted that became a major theme of this work.

And special thanks to Harold and our Chair who was, you know, didn't have to serve but did. So thank you to Foster as well. And we hope Beth's family situation is improving.

ACTING CO-CHAIR GESTEN: And also Beth who's been, you know, involved in these strategies.

DR. BURSTIN: She's been so much work, but had a family situation and couldn't come. So we wish her well.

And thanks so much to all of you. And thanks to the staff who did an extraordinary amount of work, including two snow days when they were technically off. So thanks to all of them.

CO-CHAIR PINCUS: So let's open for public comment. From in the room, any public

comment?

Can we open up the line for public comment by telephone?

OPERATOR: At the tone, if you'd like to make comment, please press * then the Number 1.

CO-CHAIR PINCUS: Okay.

OPERATOR: Okay, one moment for your comment.

MS. ISIJOLA: Tom James, did you have a comment? Operator, can you open his line please?

OPERATOR: Yes, one moment please. Okay, his line is open.

MS. ISIJOLA: Tom?

DR. JAMES: Yes. Good afternoon, this is Tom James with Baptist Health Plan in Kentucky.

The question that I wanted to raise, relative to improving the MAP process, has to do with whether the kinds of measures we should be looking at also include ones involving heuristic

decision making.

That is, having less information that people tend to make good clinical judgments, both physicians and patients, and whether that might be some novel ways for future measure development. Thank you.

CO-CHAIR PINCUS: Can you say a little bit more about what you mean by that?

DR. JAMES: Yes.

CO-CHAIR PINCUS: Maybe an example.

DR. JAMES: Yes, there's, and I put into the chat box some references. But there is, I've been looking at the literature on how clinical decisions are being made in an internet era where people gather little bits of information. And from that they form, from their own experience, a view as to what is the correct answer. And they come up with that correct answer more often than one would suspect them, if they were given lots of information.

This becomes problematic for us as we've got 700 plus measures within NQF. It

becomes such a volume. And I certainly hear it, now that I'm in the Heartland of the burden of measurement.

And yet if we can come up with ways where we use fewer measures, but have people use their own cognitive capabilities, they may be able to make the right decisions. Which is what we want in the first place.

CO-CHAIR PINCUS: Well, thank you. You said you sent along some references so we can distribute that to the committee?

DR. JAMES: Yes.

CO-CHAIR PINCUS: Okay. Well, thank you. Other comments?

OPERATOR: There are no other comments at this time.

CO-CHAIR PINCUS: Thank you.

(Off record comment.)

MR. GRANATIR: This is Tom Granatir with the American Board of Medical Specialties. And I'm glad to have been here to have heard the discussion.

I also have tremendous admiration for the NQF staff and the work that the subgroups did this time. Which is really terrific.

And in some ways made me really, I was very grateful for this last conversation. Because I had felt for a while that the coordinating committee isn't doing enough strategic thinking about how measures are to be used and what programs they ought to be used for.

And if they were going to be voting about anything, it ought to be about whether these are measures -- and I would say a measure set. Because I think seeing the measures in isolation doesn't do justice to what you're actually asked to vote on.

So is this what we want to hold people and organizations accountable for through our transparency initiatives, or is that what we want to reward or not?

And I think that's what MAP was set up to do, in addition to make recommendations about measures.

But also to make recommendations about how to achieve what we want to achieve. And I think in a way that was what Dr. Sanghavi was trying to say with his defense of the smoking measure.

So I would very much like to see this group really sort of rise to a different level of conversation about the way -- not only the way the measures are used, but also what the whole basket of measures looks like that we're holding people accountable for and trying to create examples for it.

And we haven't had that kind of conversation around this table. I think we need to. Thank you.

CO-CHAIR PINCUS: Thanks. Well, seeing no further comments, I think, again, thanks to the NQF staff, thanks to all of you. Thanks to all the work groups; thanks to CMS. And look forward to getting together again soon.

(Whereupon, the above-entitled matter went off the record at 2:05 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: 01-27-16

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