

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP (MAP)  
COORDINATING COMMITTEE

MEASURE SET REVIEW

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THURSDAY  
SEPTEMBER 9, 2021

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The MAP Coordinating Committee met via Video Teleconference, at 10:00 a.m. EDT, Chip Kahn and Misty Roberts, Co-Chairs, presiding.

COMMITTEE MEMBERS PRESENT:

CHARLES (CHIP) KAHN III, MPH, Co-Chair  
MISTY ROBERTS, MSN, Co-Chair  
ARIF KAMAL, American Academy of Hospice and Palliative Medicine  
KATHERINE AST, American Academy of Hospice and Palliative Medicine  
CLARKE ROSS, American Association on Health and Disability  
SAM TIERNEY, American College of Physicians  
DAVID GIFFORD, American Health Care Association  
MARSIDA DOMI, American Health Care Association  
HEIDI BOSSLEY, American Medical Association  
KATIE BOSTON-LEARY, American Nurses Association  
ELIZABETH (LIZ) GOODMAN, America's Health Insurance Plans  
ANDREA GELZER, AmeriHealth Caritas  
CAROL PEDEN, Blue Cross Blue Shield Association  
MARGARETA BRANDT, Covered California  
KACIE KLEJA, HCA Healthcare  
DAVID BAKER, The Joint Commission  
LEAH BINDER, The Leapfrog Group

MARY BARTON, National Committee for Quality  
Assurance  
REBECCA KIRCH, National Patient Advocate  
Foundation  
LIZ CINQUEONCE, Network for Regional Healthcare  
Improvement  
LIBBY HOY, Patient & Family Centered Care  
Partners  
EMMA HOO, Purchaser Business Group on Health  
DAN CULICA, MD, PhD, Individual Subject Matter  
Expert  
JANICE TUFTE, Individual Subject Matter Expert  
RONALD WALTERS, MD, MBA, MHA, Individual Subject  
Matter Expert

NQF STAFF:

DANA GELB SAFRAN, President and CEO  
KATIE BERRYMAN, MPAP, PMP, Senior Project  
Manager  
TRICIA ELLIOT, Senior Managing Director, Quality  
Measurement  
VICTORIA FREIRE, MPH, CHES, Analyst  
IVORY HARDING, MS, Manager  
  
JOELENCIA LEFLORE, Coordinator  
  
BECKY PAYNE, MPH, Senior Analyst  
  
UDARA PERERA, DrPH, MPH, Senior Manager  
  
ASHLAN RUTH, BS IE, Project Manager  
  
SUSANNE YOUNG, MPH, Manager  
  
GUS ZIMMERMAN, MPP, Coordinator

ALSO PRESENT:

SUSANNAH BERNHEIM, Yale CORE

REENA DUSEJA, Chief Medical Officer for Quality  
Measurement

TAMYRA GARCIA, Deputy Director, Quality  
Measurement and Value-Based Incentives  
Group, CMS

TIMOTHY JACKSON, Deputy Director, Division of  
Value-Based, Incentives and Quality  
Reporting, CMS

VINITHA MEYYUR, Deputy Director, Division of  
Quality Measurement, CMS

DORIS PETER, Yale CORE

MICHELLE SCHREIBER, Deputy Director for Quality  
and Value, CMS

GRACE SNYDER, Director, Division of Value-Based,  
Incentives and Quality Reporting, CMS

ELIZABETH TRICHE, Yale CORE

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

2 10:00 a.m.

3 MS. ELLIOT: Good morning, everyone.

4 Welcome back to Day 2 of the Measure Set Review  
5 meeting. This is Tricia Elliot from NQF, and I'm  
6 going to start off with just a few housekeeping  
7 reminders.

8 Please mute your computer when not  
9 speaking. The system does allow you to mute and  
10 unmute yourself and turn your video on and off  
11 throughout the event. We encourage you to keep  
12 the video on throughout the event. Please ensure  
13 your first and last name is listed correctly in  
14 your video. That shows up, then, for the  
15 participant list in the chat as well. So, we can  
16 see names there.

17 We will do a roll call once the  
18 meeting begins. And feel free to use the chat  
19 feature to communicate with NQF staff if you're  
20 having any issues during the meeting. And we  
21 will be using a Raise Hand feature during our  
22 open discussion. Next slide, please.

1                   Once again, welcome to our Measure  
2       Applications Partnership Measure Set Review  
3       meeting.

4                   I'm going to briefly go through the  
5       agenda, and then I'll hand things over to Misty  
6       to do some highlights from day one, and then we  
7       will do the roll call.

8                   So, we'll start with the welcome and  
9       summary of day one, the roll call. Then, the  
10      topics we'll be tackling today are the Hospital  
11      Readmissions Reduction Program. We'll have a  
12      break for lunch. We'll be discussing mortality  
13      measures, and then the Hospital Inpatient Quality  
14      Review Program measures. We will, then, have a  
15      Coordinating Committee discussion. We'll have  
16      opportunities for public comment, some closing  
17      remarks, and next steps. Next slide, please.

18                  So, Misty, if I could hands things  
19      over to you for a quick summary of day one?

20                  CO-CHAIR ROBERTS: Thanks, Tricia.  
21      So, welcome back, everybody. I think that  
22      yesterday actually went really well. It went

1 quicker than planned. Of course, this is our  
2 first go-round, so we're trying to figure out  
3 timing of everything.

4 I think we had some robust discussion.  
5 We were able to get feedback as the day went on,  
6 and actually, quickly pivot and incorporate that  
7 feedback throughout the day. So, that was good,  
8 just in terms of kind of the logistics and the  
9 flow of the meeting.

10 We also got good feedback around some  
11 of the criteria that we were using on the  
12 measures. We got, specifically, around really  
13 understanding the programs themselves, as well as  
14 similar measures, so that we can better  
15 understand whether or not there are gaps if we  
16 remove a measure.

17 So, all in all, I think day one went  
18 well. We're going to have a good, robust  
19 discussion today, and we also welcome that  
20 feedback throughout the day. And then we'll  
21 probably do kind of a summary at the end of the  
22 day and get additional feedback.

1                   So, certainly, appreciate everyone  
2                   bearing with us again, as this is kind of a pilot  
3                   to test and learn. We are learning as we go.  
4                   So, appreciate everyone kind of bearing with us,  
5                   then looking forward to a good day.

6                   Chip, I don't know if you have  
7                   anything else to add from Day 1. And I may have  
8                   caught him right when he went off.

9                   CO-CHAIR-KAHN: Yes, wait, wait. I  
10                  can't get it to work.

11                 CO-CHAIR ROBERTS: There we go. So,  
12                 Tricia, should I hand it back over to you and get  
13                 started right away? Is there anything else  
14                 before we get started on the Hospital  
15                 Readmissions Reduction Program?

16                 MS. ELLIOT: I'm going to do a quick  
17                 roll call, Missy, because we have a couple of new  
18                 folks representing organizations today. So,  
19                 we'll get through that, and then I can hand it  
20                 back to you for the Hospital Readmissions  
21                 Program.

22                 CO-CHAIR ROBERTS: Great.



1 MS. ELLIOT: Okay. So, first off is  
2 the American Academy of Hospice and Palliative  
3 Care Medicine. I believe we have Katherine Ast  
4 joining us today from that organization.

5 Katherine, are you on the line?

6 MEMBER KAMAL: Actually, this is Arif  
7 Kamal. So, Katherine is going to join a bit  
8 later for a couple of hours.

9 MS. ELLIOT: Oh, okay.

10 MEMBER KAMAL: Yes.

11 MS. ELLIOT: Awesome. Thanks, Arif.  
12 Appreciate the heads-up.

13 MEMBER KAMAL: Yes. So, good morning,  
14 everybody. I'm Arif -- oh, wait, did you want me  
15 to do the --

16 MS. ELLIOT: I think we did all that  
17 yesterday. So, I think we're good. We're just  
18 doing a quick check-in.

19 MEMBER KAMAL: Okay.

20 MS. ELLIOT: I was going to call out  
21 Katherine for disclosure, since she was going to  
22 be subbing for you later. But we'll catch her

1 later. So, thank you.

2 American Association on Health and  
3 Disability, Clarke Ross?

4 MEMBER ROSS: Hi. I'm here, and 12:30  
5 to 1:45, I have another meeting.

6 MS. ELLIOT: No problem. Thanks for  
7 letting us know. American College of Physicians.  
8 I believe Sam Tierney is here today.

9 MEMBER TIERNEY: Yes.

10 MS. ELLIOT: Hi, Sam. Good morning.

11 MEMBER TIERNEY: Hi.

12 MS. ELLIOT: American Health Care  
13 Association, Marsida Domi?

14 Is she on the line yet? She's  
15 substituting for David Gifford today.

16 MEMBER DOMI: Oh, good morning. Good  
17 morning, everyone. I'm substituting for Dr.  
18 David Gifford this morning and this afternoon,  
19 although he might be able to pop in somewhere in  
20 the middle of the day, pending schedule  
21 availability.

22 MS. ELLIOT: Okay. And yesterday, we

1 did some disclosures. Do you have any conflicts  
2 of interest to share?

3 MEMBER DOMI: No conflict of interest,  
4 except for we are measure stewards on 10  
5 measures, not being discussed in the program  
6 today or yesterday, I believe, but just something  
7 to share.

8 MS. ELLIOT: Okay. Great. Thank you  
9 so much. American Medical Association, Heidi  
10 Bossley?

11 MEMBER BOSSLEY: I'm here.

12 MS. ELLIOT: Thank you. American  
13 Nurses Association, Katie Boston-Leary?

14 MEMBER BOSTON-LEARY: I'm here. Good  
15 morning.

16 MS. ELLIOT: Good morning. America's  
17 Health Insurance Plans, Liz Goodman?

18 I see Liz online, I think.

19 MEMBER GOODMAN: Yes, I'm here.

20 MS. ELLIOT: There you are. Thank  
21 you. Good morning.

22 AmeriHealth Caritas, Andrea Gelzer?

1 (No response.)

2 MS. ELLIOT: I don't see Andrea on the  
3 line yet. Blue Cross Blue Shield, Carol Peden?

4 MEMBER PEDEN: Yes. Good morning,  
5 everyone.

6 MS. ELLIOT: Good morning. Covered  
7 California, Margareta Brandt?

8 (No response.)

9 MS. ELLIOT: Okay. HCA Healthcare,  
10 Kacie Kleja?

11 MEMBER KLEJA: Good morning. I'm  
12 here, and my colleague, Laura Golden, will be  
13 stepping in for about an hour for me this  
14 morning.

15 MS. ELLIOT: Okay. Thank you.  
16 Appreciate the heads-up. Joint Commission, David  
17 Baker?

18 (No response.)

19 MS. ELLIOT: Leapfrog Group, Leah  
20 Binder?

21 MEMBER BINDER: I'm here.

22 MS. ELLIOT: Hi, Leah. Good morning.

1 MEMBER BINDER: Good morning.

2 MS. ELLIOT: National Committee for  
3 Quality Assurance, Mary Barton?

4 (No response.)

5 MS. ELLIOT: National Patient Advocate  
6 Foundation, Rebecca Kirch?

7 MEMBER KIRCH: Good morning. I'm  
8 here.

9 MS. ELLIOT: Good morning. Thank you.  
10 Network for Regional Healthcare Improvement,  
11 Julie Sonier?

12 MEMBER CINQUEONCE: Good morning.  
13 This is Liz Cinqueonce. I'm here for Julie  
14 today.

15 MS. ELLIOT: Okay. Thank you.  
16 Patient & Family Centered Health -- excuse me --  
17 Patient & Family Centered Care Partners, Libby  
18 Hoy?

19 MEMBER HOY: Good morning, everybody.

20 MS. ELLIOT: Good morning. Thank you.  
21 Purchaser Business Group on Health, Emma Hoo?

22 MEMBER HOO: Good morning. Here.

1 MS. ELLIOT: Thank you. And I'll move  
2 on to the next slide with our individual subject  
3 matter experts. Dan Culica?

4 MEMBER CULICA: I'm here. Good  
5 morning. Present.

6 MS. ELLIOT: Thank you. Janice Tufte?

7 MS. TUFTE: Good morning. I'm here.  
8 Thank you.

9 MS. ELLIOT: Thank you. Ron Walters?

10 MEMBER WALTERS: Present.

11 MS. ELLIOT: Thank you very much. And  
12 with that, next up is our federal government  
13 liaisons.

14 Michelle, did you want to give a quick  
15 update there?

16 DR. SCHREIBER: Great. Thank you.  
17 So, good morning to the group. It was a great  
18 session yesterday.

19 I just wanted to let the group know  
20 that, between 12:00 and 2:00, I had a prior  
21 engagement. And so, in my stead will be Dr.  
22 Reena Duseja, who many of you may know, served

1 for many years with the MAP from CMS. She is the  
2 Chief Medical Officer for the Quality Measures  
3 and Value Incentives Group, currently doing a  
4 detail at the White House. But she's going to  
5 sub in as well.

6 Tamyra Garcia, who is on the line now,  
7 is the Deputy of the Quality Measures and Value  
8 Incentives Group.

9 We have a number of others from CMS on  
10 the phone. I want to thank each of them for the  
11 work they do in being on, as well as our  
12 contractor, Yale CORE.

13 So, hopefully, we'll be able to answer  
14 the questions and continue the conversation. But  
15 I wanted to let people know that I'll be off from  
16 12:00 to 2:00.

17 Thank you.

18 MS. ELLIOT: Excellent. Thank you so  
19 much, Michelle. And at this point, I'm going to  
20 hand things over to Misty to kick off -- or I  
21 think, between the two of us, we'll be kicking  
22 off the Readmission Program.

1                   So, we'll move forward to slide 52.

2                   So, there's three measures in the Hospital  
3                   Readmissions Reduction Program that we're going  
4                   to be discussing today.

5                   The first one, CMIT, is 78, and this  
6                   is the Heart Failure 30-Day Readmission Rate. We  
7                   had two Committee members select this measure.

8                   The next one, Acute Myocardial  
9                   Infarction, AMI, 30-Day Readmission Rate, also  
10                  two members selected this measure.

11                  And Total Hip Arthroplasty, THA,  
12                  and/or Total Knee Arthroplasty, TKA, 30-Day  
13                  Readmission Rates, also two members.

14                  A quick overview on slide 53 of the  
15                  Hospital Readmissions Reduction Program. So,  
16                  this is a pay-for-performance and public  
17                  reporting program. The incentive structure is a  
18                  Medicare fee-for-service base operating DRG  
19                  payment. Rates are reduced for hospitals with  
20                  excess readmissions. The maximum payment  
21                  reduction in this program is 3 percent.

22                  The program goals are to reduce excess



1 readmission rates in acute care hospitals paid  
2 under the inpatient prospective payment system,  
3 which includes more than three-quarters of all  
4 hospitals, and encourage hospitals to improve  
5 communication and care coordination efforts to  
6 better engage patients and caregivers with  
7 respect to post-discharge planning.

8 A note: measures for condition-  
9 specific readmissions is a statutory requirement.  
10 And that was a note we received from our  
11 colleagues at CMS.

12 So, if we can go to --

13 CO-CHAIR ROBERTS: Oh, sorry, Tricia.  
14 I just want to clarify a few things on those.

15 So, the pay-for-performance and public  
16 reporting, is that going to apply to all measures  
17 in the program?

18 Michelle, you may be able to answer  
19 this.

20 DR. SCHREIBER: I'm sorry, I'm not  
21 sure I understand.

22 CO-CHAIR ROBERTS: So, the program

1 type, it's considered pay-for-performance and  
2 public reporting. So, all measures are going to  
3 be publicly reported and pay-for-performance, is  
4 that correct? Or, are some of them pay-for-  
5 performance, but not publicly reported?

6 DR. SCHREIBER: Yes, see, it kind of  
7 depends on what program you're talking about,  
8 Misty, and that's where it gets confusing. Okay?

9 CO-CHAIR ROBERTS: Okay.

10 DR. SCHREIBER: So, yesterday, for  
11 example, some of those, the inpatient psych, for  
12 example, they're only pay-for-reporting. So,  
13 they show up in public reporting, but in terms of  
14 being penalized or rewarded for performance, the  
15 answer is no.

16 The ones that we're talking about  
17 today, the readmissions reduction, in particular,  
18 and the mortality, are both reporting. So,  
19 they're publicly reported, as we all know. And  
20 they're tied to performance. So, they're tied to  
21 penalties or incentives, depending on which one.

22 Now, not all of them. So, when we

1 talk about the hospital programs, there are  
2 actually five hospital programs. The IQR, the  
3 Inpatient Quality Reporting Program, it's  
4 basically just pay-for-reporting, okay? And not  
5 all of those go into pay-for-performance.

6 Readmissions reduction, hospital-  
7 acquired conditions, promoting interoperability,  
8 and hospital value-based purchasing are both  
9 reporting -- they're publicly reported -- and  
10 they also are tied to performance. So, they're  
11 associated with penalties usually, but penalties  
12 and incentives in the case of hospital value-  
13 based purchasing.

14 So, the reason I had to clarify is it  
15 does get a little confusing, depending on exactly  
16 what program and exactly what measure we're  
17 talking about. For right now, readmissions  
18 reduction is definitely reporting as well as  
19 penalties.

20 CO-CHAIR ROBERTS: Okay. Thanks for  
21 that clarification. I just wanted to bring that  
22 up because I know that was a point that was

1 brought up yesterday, as people wanting to  
2 understand that better.

3 I do have a follow-up question. Where  
4 it says that, "The measures for the condition-  
5 specific readmissions is a statutory  
6 requirement," does that mean that these will not  
7 be removed because they are statutory? Or is it  
8 just, in general, you have to have measures for  
9 condition-specific readmissions?

10 DR. SCHREIBER: In general, for the  
11 Readmissions Reduction Program, we have to have  
12 condition-specific measures. It does not dictate  
13 which ones.

14 CO-CHAIR ROBERTS: Okay.

15 DR. SCHREIBER: At least by statute  
16 right now, we can't, for example, just have one  
17 single hospital-wide readmissions reduction  
18 measure. We have to have some condition-specific  
19 ones.

20 CO-CHAIR ROBERTS: Okay. Great.  
21 Thanks for that clarification.

22 Go ahead, Tricia. Sorry.

1 MS. ELLIOT: Oh, no problem. Great  
2 questions. If we can go to the next slide,  
3 please?

4 We'll discuss the first measure in  
5 this grouping, which is CMIT 78, the Heart  
6 Failure 30-Day Readmission Rate. The description  
7 is provided on the screen.

8 It is facility-level reporting. It is  
9 an endorsed measure currently. Two members  
10 selected this measure for removal. And we have  
11 the American College of Physicians, HCA, and Ron  
12 Walters who are the lead discussants on this  
13 measure.

14 And the criteria or rationale used to  
15 evaluate removal was the measure could be  
16 combined in a properly risk-adjusted overall  
17 readmission measure that is not disease-specific.

18 So, with that, Misty, I'll hand it  
19 over to you for discussion.

20 CO-CHAIR ROBERTS: Yes. So, just real  
21 quickly on that point about the overall  
22 readmission measure that's not disease-specific,

1       it sounds like Michelle says, based on statutory  
2       requirements, we would have to have condition-  
3       specific, but not necessarily this measure. So,  
4       just something we probably need to consider.

5               So, I know we talked yesterday about  
6       going through each measure individually with our  
7       lead discussants, then open it up. I do have a  
8       feeling that, because these three measures are so  
9       similar, that we may have some of the same  
10      comments, similarly to yesterday.

11              But let's open it up to our lead  
12      discussants first. How about, Ron, do you want  
13      to kick us off with your thoughts on this  
14      measure?

15              MEMBER WALTERS: Of course, I'd be  
16      glad to. And you're right, I think many of the  
17      things I'm going to say are not disease- or  
18      measure-specific. They are general terms.

19              Again, nothing against hospital  
20      readmissions reduction. Great idea. Written  
21      into the law. Let's do it. But what it did was  
22      it singled out originally three types -- in other

1 words, you look at the most common reasons for  
2 possible readmissions, and then you promulgate  
3 and support measures being developed around  
4 those. Okay? So, that's historically how it  
5 happened.

6 By the way, since then, three more  
7 measures have been added that are not up for  
8 discussion today and kind of pertinent to my  
9 point. It's that what it creates is a rework  
10 process, I would say. Now the rework in this  
11 case, worst-case scenario, is the TEP that's  
12 formed to advise them about risk adjustment, and  
13 so on.

14 But these are CMS measures, claims-  
15 based. They do the bulk of the work. And so,  
16 these have been reported. They are utilized.  
17 They are incorporated into the program, but I  
18 have more of a technical issue from a data  
19 management perspective.

20 How many diseases are going to go out  
21 and develop their own disease-specific  
22 readmission rates, usually at a society or

1 disease-specific level, because they are not a  
2 part of the CMS heart program? That happens  
3 specifically for cancer, by the way. And how  
4 much time does it snatch from the entire process  
5 to have 10 different measures or 20 different  
6 measures -- now I'm exaggerating -- versus a non-  
7 specific 30-day readmission measure that, of  
8 course, can be utilized by the relevant groups  
9 for their particular areas?

10 So, if I am interested, for example,  
11 for total knee arthroplasty readmission rates,  
12 that's just how you query the data once you have  
13 the risk adjustment in place. I get it. And  
14 heart failure, it's querying the data.

15 So, what I hope to accomplish -- and  
16 it does involve statutory change or, certainly, a  
17 discussion -- is the ability to do 30-day  
18 readmission rates on any other applicable common  
19 causes for readmission. And we can either choose  
20 to go through the process of endorsement for each  
21 one disease by disease by disease or we can  
22 develop an overall system that looks at 30-day



1 readmission rate fine-tuned to each disease.

2 Now I'm not ignorant. Will that have  
3 to be validated? Will that have to be useful to  
4 be utilized? Of course, it will, but some of the  
5 process steps involved in that probably can be  
6 significantly reduced.

7 And I think that's the theme of today.  
8 We talked about reducing burden, and there's many  
9 people who bear burden of measure reporting. In  
10 this case, it is predominantly CMS with the  
11 assistance of some TEP input, but we can make  
12 CMS's life easier. They have the systems that  
13 are capable of doing this. They just have to  
14 build the right rules in, and then you can have  
15 your disease-specific reporting for use in  
16 whatever you want to use it for, most notably,  
17 quality improvement, reduction in readmission  
18 rates, et cetera, et cetera, however you want to.

19 And I don't know what that means for  
20 the heart program. I think it extends the heart  
21 program to every 30-day readmission rate. I  
22 think it's actually a beneficial move, not a

1 restrictive move.

2 So, that's why I voted consciously to  
3 remove the measures, knowing exactly the  
4 difficulty involved.

5 Thank you.

6 CO-CHAIR ROBERTS: Thanks, Ron.

7 Kacie, what are your thoughts?

8 MEMBER KLEJA: Yes, thank you.

9 So, I will say that I was surprised,  
10 of the measures that are part of the Readmissions  
11 Reduction Program, that these are the three that  
12 kind of came to the forefront as a recommendation  
13 for removal. From a hospital perspective, I will  
14 say that we actually do receive our patient-  
15 level, condition-specific report from CMS for the  
16 hospital-wide readmissions. And so, that does  
17 allow us at the health system to go in and  
18 evaluate those patients and kind of make some of  
19 those process improvement changes that you  
20 mentioned, even if it's not necessarily available  
21 in the public eye yet.

22 I don't necessarily have any thoughts

1       about removing this specific measure or not. I  
2       think CMS does a good job of every year  
3       evaluating the technical specifications  
4       associated with the readmissions measures. They  
5       do have the Technical Expert Panels, as Ron  
6       mentioned. They are very transparent in  
7       releasing all of their risk adjustment and  
8       methodology information. So, we do appreciate  
9       that as well.

10               CO-CHAIR ROBERTS: So, Kacie, I think  
11       you said that, on the broader hospital-wide  
12       readmission report, that it does drill into the  
13       condition-specific? Is that what you said?

14               MEMBER KLEJA: It does. So,  
15       individual hospitals receive a patient-level  
16       report in advance of the data becoming publicly  
17       available, and those reports do have the cohorts  
18       that each of the patients are in, but it also  
19       provides information about their readmission  
20       date, the discharge diagnosis code on their  
21       readmission record. And so, it does allow us to  
22       dig into those data for process improvement

1 purposes.

2 CO-CHAIR ROBERTS: Sam, what are your  
3 thoughts?

4 MEMBER TIERNEY: So, thank you for not  
5 starting with me. I appreciate the mixing of the  
6 lead discussants.

7 So, the ACP does not support this  
8 measure. It does not. I have to say this was  
9 reviewed a number of years ago. So, some of the  
10 comments may have already been addressed and with  
11 newer versions of the measure.

12 There's three primary issues that were  
13 concerns for the ACP:

14 The risk adjustment model. I think  
15 there was some literature at time of review that  
16 identified a set of patient characteristics that  
17 are significantly more robust than the  
18 characteristics currently used by CMS.

19 The other issue was a concern about  
20 the 30-day timeframe. While we acknowledge that  
21 readmission rates are not entirely independent of  
22 provider control, it seems that implying a

1 measurement period of 30 days is more likely to  
2 be influenced by outside facts than a shorter  
3 interval, such as seven days.

4 And finally -- and I think maybe Ron  
5 might have touched on this -- there is a lot of  
6 burden associated with the measure in terms of  
7 the immediate financial impact of accounting for  
8 this and trying to go with it. I'm sure that's  
9 now since been addressed, given that the measure  
10 has been in the program for a number of years.

11 But those are our main concerns. And  
12 I completely understand Michelle's point about  
13 this being a statutory requirement. So, maybe  
14 there's not much movement. But we were one of  
15 the two who recommended this for removal.

16 CO-CHAIR ROBERTS: Thanks, Sam. I'm  
17 glad that you liked that I switched it up today.

18 I do want to maybe let Michelle and  
19 team comment because I am curious, if this is a  
20 statutory requirement to have condition-specific  
21 measures, without having kind of the full view of  
22 the other measures, are there other condition-

1 specific measures in the program?

2 DR. SCHREIBER: Yes. So, thanks,  
3 Misty. There are six condition-specific measures  
4 in the Hospital Readmissions Reduction Program.  
5 They're heart failure, heart attack, pneumonia,  
6 COPD, total hip and knee replacement, and open  
7 heart surgery/CABG. Stroke has been considered.

8 There is also a hospital-wide  
9 readmission measure that is included in the IQR  
10 Program, not in the Hospital Readmissions  
11 Reduction Program, but in the IQR Program. So,  
12 there is, actually, a single hospital-wide  
13 readmission measure that is in use.

14 And quite honestly, we have looked  
15 into whether or not we could substitute in the  
16 HRRP program a single measure, and as you've all  
17 subsequently heard, not without a legislative  
18 change. So, it doesn't say which ones to choose,  
19 though, but, obviously, when CMS has evaluated  
20 this, the top causes for admission and  
21 readmission are the ones that rise to anybody's  
22 top priority list of inclusion.

1 I'm actually kind of surprised that  
2 more of you haven't talked about some of the  
3 published literature that was going back and  
4 forth a couple of years ago about the heart  
5 failure readmission rate, in that there was some  
6 literature that thought that there were  
7 unintended consequences associated with this, as  
8 well as some issues around the risk adjustment  
9 that I know that Sam brought up. And there was  
10 literature, really, on both sides of that.

11 CMS didn't publish anything, but we  
12 did do an internal audit, as we do on almost all  
13 of our measures, and didn't substantiate that  
14 there was unintended consequence to the measure,  
15 and made an internal decision, actually, to  
16 continue it; that it was important.

17 So, I think the way to think about  
18 readmissions, though, is, what are we trying to  
19 do? And this gets to Sam's point about 30-day  
20 versus 7-day versus 14-day. You know, kind of  
21 what's the right timeframe?

22 These are, obviously, meant to be

1 measures of care coordination. How well was the  
2 patient prepared for discharge? Did they  
3 understand what they were supposed to do? Did  
4 they get their follow-up? Did they actually have  
5 their care coordinated post-discharge? Were they  
6 truly ready for discharge?

7 Thirty-day has been used for a long  
8 time to give enough of a window, really, to  
9 demonstrate the care coordination. So, I think  
10 that's what the thought process is.

11 But, yes, there are currently six  
12 measures in it, and we do likely have a choice,  
13 but we don't at this point have a choice not to  
14 have any.

15 The other thing that I would raise is,  
16 what's the value to patients, to the  
17 beneficiaries? Would the beneficiaries really  
18 have a better understand of what CMS posted was  
19 just an all-cause readmission rate? Or do  
20 beneficiaries have a better understanding of  
21 disease-specific rates, especially when they go  
22 to make choices for their who care? And I think



1       that many of us feel that the disease-specific  
2       rates provide more granular information to  
3       patients.

4                   CO-CHAIR-KAHN:   If I may say  
5       something, I think that there are some global  
6       problems with this program, though, that seep  
7       into this 30-day/7-day question.  And that is  
8       that almost all hospitals get penalized.

9                   DR. SCHREIBER:   Correct.

10                  CO-CHAIR-KAHN:   And the way the  
11       formula works, you're basically chasing your tail  
12       and you really can't improve.  And so, I have  
13       trouble judging the measures when -- and this  
14       gets to the legislation -- the overall premise,  
15       to me, is sort of cockeyed.  Because if you have  
16       a program in which 80 or 90 percent of the  
17       hospitals are penalized, then either all the  
18       hospitals are in trouble or there's something  
19       wrong with the measure system.  I mean, it's just  
20       there's no other way to get around it.  I mean,  
21       that's an indicator of a program that's broken.

22                  Now whether any specific measure is

1 right or wrong, it's difficult for me to say,  
2 but, clearly, the formula is leading you in a  
3 direction. Because 80 percent of the hospitals,  
4 whatever the perfect readmission rate is, 80  
5 percent of the hospitals can't be wrong.

6 DR. SCHREIBER: So, I think, Chip,  
7 obviously, what you're referring to is the  
8 structure of the program itself.

9 CO-CHAIR-KAHN: Right.

10 DR. SCHREIBER: So, should it be, for  
11 example, more of a net-neutral program? Should  
12 it be more like HVBP, where some hospitals get  
13 incentives and some hospitals get penalties?  
14 Because, obviously, you're correct that most  
15 hospitals are penalized.

16 Now, in full transparency, I think we  
17 have to face the fact that, for CMS, this is  
18 about a billion dollars a year savings to the  
19 Medicare Trust Fund. And if not from this  
20 program, it would probably have to come someplace  
21 else.

22 But you're right about the overall

1 structure of the program. I think that's a  
2 legislative issue.

3 CO-CHAIR-KAHN: Oh, no, it is. I just  
4 bring it up because --

5 DR. SCHREIBER: Yes. Yes, yes.

6 CO-CHAIR-KAHN: -- I think it gets to  
7 Ron's issue.

8 The other side of it is, being a  
9 billion dollar savings, it means it can't be  
10 fixed. And then you have this crazy -- I'll just  
11 say one more thing -- you have this crazy  
12 restriction that you can't have readmissions in  
13 value-based purchasing. Yet, you do have a 30-  
14 day cost factor in value-based purchasing, and  
15 doesn't that reflect readmissions, because  
16 readmissions is the most expensive part of the  
17 continuum of care?

18 So, this program, all I can say is --  
19 and I've written about this -- is broken. And  
20 the fact that we're held hostage to the billion  
21 dollars is, in a sense, not the hospitals'  
22 problem; it's the legislators' problem because

1       they set up a program that was bound to cause  
2       them to get savings that are totally arbitrary.  
3       I won't say anything else, but a strong letter to  
4       follow.

5                   CO-CHAIR ROBERTS: I was going to open  
6       it up now to the rest of the Committee.

7                   Andrea?

8                   MEMBER GELZER: Hi. Thanks, Misty.

9                   Michelle has already said some of the  
10       stuff I was going to say. I agree completely  
11       with her comments.

12                   I think this is a valid measure. I  
13       think it's a valid data point, but I also agree  
14       with Chip that, you know, there are problems with  
15       this system and the formulas by which we measure  
16       care. And the readmission rate should not be  
17       considered alone in the program. There have to  
18       be other valid quality metrics, you know, even  
19       from a consumer perspective, to allow a consumer  
20       to know or rate the care and which hospital they  
21       want to go to.

22                   Thank you.

1 CO-CHAIR ROBERTS: Thanks, Andrea.

2 Leah?

3 MEMBER BINDER: Just a couple of new  
4 questions, actually.

5 I like Ron's idea that we would have  
6 this global all-cause readmission rate and,  
7 ultimately, be able to drill down into it from a  
8 public perspective and look at different  
9 readmission rates for different conditions.

10 I'm just wondering, my first question  
11 would be, can we do that now? I assume we can't  
12 do that now, but why not? And is that a  
13 possibility, to bring that level of detail  
14 forward for the IQR, for instance?

15 And then, secondly, my other question  
16 is different, too. Because, yesterday, we talked  
17 about behavioral health and the gap in good  
18 measures around that. I'm wondering if we've  
19 looked a potentially getting readmission rates  
20 for behavioral health as well.

21 So, those are two totally different  
22 questions, I guess both for Michelle.

1 DR. SCHREIBER: So, I'll try to take  
2 them on.

3 You're right, Leah, within IQR, we do  
4 have the hospital-wide readmission program.  
5 Could we break that down? I don't know. I would  
6 have to go back and look. Or I may ask Susannah  
7 Bernheim in just a moment for her opinion.

8 Regarding mental health, that has come  
9 up as a subject. And I suspect that it -- you  
10 know, I can't tell you what's in the pipeline at  
11 the moment -- but I suspect that it will become a  
12 topic of conversation because mental health is,  
13 as we all know, one of the top priorities of this  
14 Administration. And I think it's a very valid  
15 question.

16 Susannah Bernheim. Susannah is from  
17 Yale CORE. They're the contractor on many of our  
18 measures that we're talking about.

19 Susannah, do you have any further  
20 comments about breaking down hospital-wide  
21 readmissions? And I'm sorry, because you didn't  
22 know I was going to call on you.

1 DR. BERNHEIM: No, problem, Michelle.  
2 Can you hear me okay?

3 DR. SCHREIBER: Yes, thanks.

4 DR. BERNHEIM: Yes, so the hospital-  
5 wide readmission measure is composed of five  
6 cohorts, and hospitals can see -- they're not  
7 publicly reported -- but the hospitals can see  
8 their performance on those five cohorts. And  
9 it's a surgical cohort -- I'm not going to  
10 remember all off the top of my head -- but a  
11 cardiorespiratory cohort, a neurology cohort.  
12 I've got other team members, if people want to  
13 know, who could do it off the top of their head.

14 And then, like the other readmission  
15 measures, there is patient-level data provided to  
16 hospitals. So, there's the ability to look in  
17 greater detail at those patients who are included  
18 in the metric.

19 MEMBER BINDER: I'm just wondering if  
20 it's possible, obviously, not at the patient  
21 level, but at the cohort level, if it's possible  
22 to make that publicly available, even on a

1 spreadsheet; just somewhere make it available  
2 publicly.

3 DR. SCHREIBER: Susannah or Jim, do we  
4 put that on the provider data catalog, or no?

5 (No response.)

6 DR. SCHREIBER: We'll go back, Leah,  
7 and check. Okay? Thanks.

8 MEMBER BINDER: Thank you.

9 CO-CHAIR ROBERTS: Heidi, I think  
10 you're next.

11 MEMBER BOSSLEY: Sure. So, I struggle  
12 with comments on these measures because I know  
13 we're stuck with the program, right? But a few  
14 things, and to you and CMS, none of these  
15 comments will be a surprise because AMA says  
16 these during comment periods.

17 But there is the ongoing concern that  
18 the reliability, the minimum reliability, score  
19 that's achieved is too low. CMS sets it at a .4  
20 right now. And there's a strong feeling that  
21 these measures really do need to demonstrate a  
22 higher reliability, not even at the average, just



1 at the minimum score, and case minimums need to  
2 be adjusted.

3 But the other thing -- and it's  
4 actually even more with the next measure we're  
5 going to talk about -- but what's interesting,  
6 looking at the NQF submissions that came through  
7 last year, there is less of a distinction and  
8 variation of performance, especially with the  
9 outliers. This measure has about 100 in worse  
10 and 100 in better. AIM is actually even -- I'll  
11 get those numbers up when we talk about that.  
12 There's small differences. And when we see the  
13 changeover years from 2016-2017 data to 2018-  
14 2019, we're talking like .1 percent absolute  
15 change.

16 And so, one of the questions that  
17 we're starting to wonder is, have we identified  
18 and kind of capped out and topped out in the  
19 readmission measures for some of these  
20 conditions, because we're not seeing any changes?  
21 And I don't know if Yale has taken a look at  
22 that, but I just would be interested to see what

1       they've found. If they've dived into it more  
2       with hospitals, are they shifting in performance?  
3       Are we still seeing them drop into lower rates or  
4       are we kind of -- have we identified where we're  
5       going to be at least for this measure?

6               CO-CHAIR ROBERTS: So, Dana or  
7       Michelle, do you all want to take that question?

8               DR. SCHREIBER: Susanna, do you have  
9       the data off the top of your head or available?  
10       I don't know the delta over the last couple of  
11       years. I can get it and bring it back.

12              DR. BERNHEIM: Yes, it's something we  
13       look at, and I don't have it handy. But, I mean,  
14       we can share that. There's both shifting among  
15       hospitals and for many years a slow decline in  
16       the readmission rates, but I don't have the most  
17       recent data.

18              DR. SCHREIBER: I mean, over time,  
19       Heidi, to your comment, there has certainly been  
20       a trend of improvement. I think part of your  
21       question is, for some of these measures, has that  
22       trend flattened? And those are measures that

1 maybe we would consider sort of topped-out.

2 MEMBER BOSSLEY: Right.

3 DR. SCHREIBER: So, we will look for  
4 the specific data around them.

5 MEMBER BOSSLEY: Okay. Thank you.

6 DR. SCHREIBER: I think they're still  
7 incrementally improving.

8 The other thing that happened in the  
9 Readmissions Reduction Program, obviously, is  
10 that we now stratify by groups according to dual  
11 eligibility. And so, that did make some  
12 difference in performance for specific hospitals.  
13 It certainly made a difference in the penalties.

14 MEMBER BOSSLEY: Okay. Having that  
15 information a little more transparent might be  
16 helpful to understand what's shifting. I mean,  
17 if we've hit our point where we know we cannot  
18 reduce readmissions anymore for this population,  
19 I think we should celebrate that, right? We've  
20 hit it and --

21 DR. SCHREIBER: Whatever that is.

22 MEMBER BOSSLEY: Right. We need to

1 rethink how you define planned versus unplanned  
2 readmissions. So, those are the questions that  
3 come forward. Is there a way to continue to  
4 improve or say we've done a good job and move on  
5 to the next thing?

6 So, just a few thoughts.

7 CO-CHAIR ROBERTS: Good points, Heidi.  
8 Did you want to say something else?

9 (No response.)

10 CO-CHAIR ROBERTS: Let's move on to  
11 Emma. I think you had your hand raised.

12 MEMBER HOO: Yes. One of the  
13 questions I have is, I find it challenging to  
14 look at these three measures without looking at  
15 the other three that aren't on the table that  
16 Michelle mentioned in terms of understanding the  
17 variability and performance of each measure.  
18 Because if these were taken off the table, it  
19 strikes me that these would be the highest volume  
20 sets of admissions, and whether retaining COPD  
21 and some of the others creates greater  
22 instability in the condition-specific measures

1       than having the group as a whole?

2               DR. SCHREIBER:  Certainly, if you were  
3       to take out these, the sort of top ones, and had  
4       a different cohort where there is potentially  
5       more room for improvement, I mean, you would see  
6       a change in distribution of performance and a  
7       changing distribution of penalties.

8               CO-CHAIR ROBERTS:  Ron, did you want  
9       to make another comment?

10              MEMBER WALTERS:  I did.  And I think  
11      this has been good continued conversation  
12      because, on the one hand, we're talking about  
13      removing measures and what's the basis for that.  
14      If we have to keep specific disease readmission  
15      rates in the program because HRRP demands it, or  
16      it would have to be changed, then, at the very  
17      least, it should be data-driven, as we just got  
18      done talking about, because, otherwise, I'm  
19      unable to explain, also, off the top of my head  
20      why we did or did not keep three in and did or  
21      did not keep another three in.  It should be  
22      based on the kind of discussion we just had, if

1 we truly need to have disease-specific.

2 At the same time, already during this  
3 last discussion, we talked about psychiatry. And  
4 I know I caught a little flack yesterday about  
5 psychiatry, but behavioral health is a very big  
6 reason. So, we have another candidate coming  
7 along, and I can probably rattle off five or six  
8 others like low back pain, and so on, after that.

9 So, I mean, we do need to look to the  
10 future and say, are we keeping -- I said 20 or  
11 30; that was probably an exaggeration -- but how  
12 many disease-specific measures are we going to  
13 end up with for 30-day readmission rate? And the  
14 intuitive answer should be the most important  
15 ones, which is exactly how this program started  
16 out, but they haven't gone through this kind of  
17 discussion when they've come up for maintenance  
18 in the past.

19 I would also -- the last thing I'll  
20 say -- I'll also remind everybody that, as an  
21 offshoot of this, we have 30-day all-cause,  
22 unplanned readmission measures, 30-day for post-

1 discharge for new patient rehab, and from long-  
2 term care hospitals. And so, you can see how  
3 this seemingly simple concept starts  
4 proliferating, for all the right reasons, but  
5 we've got to ask, is there a simpler way to do  
6 this? And I think that's the question on the  
7 table.

8 CO-CHAIR ROBERTS: Yes, I think we're  
9 recognizing the need to really look at these, as  
10 we have these discussions, to really look at  
11 these programs in more of a holistic view, so  
12 that we can make informed decisions, and  
13 recognizing that we're on this short timeline,  
14 this is a pilot project, and we've also missed  
15 this first step of the work groups that typically  
16 review probably all this stuff in more detail.  
17 But I think it's definitely an opportunity for us  
18 to learn through this.

19 Clarke, I think you've got your hand  
20 raised?

21 MEMBER ROSS: Oh, I put it in the  
22 chat, a discussion for some other time, because

1       these measures we're considering are not related  
2       to mental illness and psychiatry. But Ron keeps  
3       bringing up psychiatry.

4               So, I was the Deputy Executive  
5       Director of the State Mental Health Directors  
6       Association for over a decade and was Deputy  
7       Executive Director of NAMI, National Alliance on  
8       Mental Illness, which is the largest family  
9       organization facing mental illness whose family  
10      members have severe and persistent mental  
11      illness.

12             So, I'll take two minutes for just an  
13      overview tutorial on how complex this is. We  
14      have a cohort of people with severe and  
15      persistent mental illness who recycle in the  
16      hospitals constantly, and have not been able to  
17      figure out a way to effectively slow this  
18      recycling process.

19             Added to the complexity is we have in  
20      every state in America a statement of authority,  
21      an authority that's over 100 years old, created  
22      by states that run state psychiatric hospitals.



1 Now many of those are at capacity. And so, they  
2 contract with private hospitals, both psych  
3 hospitals and general hospitals. That's psych  
4 units at general hospitals.

5 So, trying to just track admissions  
6 and readmissions is really difficult.

7 Compounding this is Medicaid; we have the  
8 Institutions for Mental Diseases Prohibition  
9 Rule, and on the home and community-based  
10 services side, we have waiting lists because  
11 that's a waiver program and not a benefit.

12 So, I just want to present, when  
13 people make generalizations about an entire  
14 delivery system -- and I know a little bit about  
15 this in psychiatry -- this is a real complex  
16 area. We're talking about other measures. So, I  
17 wouldn't generalize into psychiatry and mental  
18 illness.

19 Thank you.

20 CO-CHAIR ROBERTS: Thanks, Clarke.

21 I do see that Doris wrote that "The  
22 cohorts for the hospital-wide readmission

1 measures are medicine, neurology, cardiovascular,  
2 surgery, and cardiorespiratory." So, it's more  
3 of that cohort level, not condition-specific, it  
4 looks like.

5 Did anybody else want to comment?

6 Rebecca, I think you had made a  
7 comment. Did you want to add onto that?

8 MEMBER KIRCH: I just appreciated  
9 where the discussion was headed around the  
10 opportunity for opening the door to more person-  
11 oriented, instead of disease-oriented, measures,  
12 where it's possible. That's an innovation that I  
13 think we all need to take seriously, as we have  
14 these discussions.

15 CO-CHAIR ROBERTS: Thanks, Rebecca.

16 Any other comments?

17 MS. TUFTE: This is Janice.

18 And I have come to the same conclusion  
19 as some others have discussed, and that was why,  
20 originally, voted them to possible removal,  
21 seeing that there could be a more generalized 30-  
22 day readmission and understanding how it has been

1       punitive against hospitals, in particular, rural  
2       hospitals and some other hospitals that might not  
3       have all the support. And we're losing rural  
4       hospitals and hospitals that take individuals  
5       with a lot of chronic conditions. So, there's a  
6       lot to this, but I do also agree with what was  
7       just stated, that taking a more person-centered  
8       approach in how perhaps more broad 30-day  
9       readmission could be added to some specific  
10      areas, right, or built into it.

11                     Thank you.

12                    CO-CHAIR ROBERTS: Michelle, did you  
13      have a comment?

14                    DR. SCHREIBER: I did. As we're  
15      discussing this, I just want to remind the  
16      Committee a little bit about how this particular  
17      program works. And that's that each one of these  
18      specific measures carries with it its own  
19      penalty. Okay? So, if you remove one of these  
20      measures, you're removing the penalty that that  
21      contributes to. So, if it's one that has a lot  
22      of readmissions, you're removing that entire

1 cohort from the penalty.

2 So, changing these measures around  
3 will mean significant changes for hospitals in  
4 their performance, as well as in the program  
5 itself. So, it's not quite as simple as just  
6 shifting in and out of some of the measures  
7 because each one is individually calculated.

8 CO-CHAIR ROBERTS: So, a question on  
9 that, Michelle. If each of them have their own  
10 penalty, it doesn't necessarily mean that the  
11 penalty -- if we remove one, will the penalty for  
12 another one increase? Or we don't know?

13 DR. SCHREIBER: We don't know,  
14 actually, because each one is really against a  
15 fixed prediction. Okay? So, if you're greater  
16 or less than the expected, that's where the  
17 penalty comes in. So, I don't know that we can  
18 predict it. We'd have to model it depending on  
19 which measure we're talking about.

20 CO-CHAIR ROBERTS: Okay.

21 DR. SCHREIBER: But it's not, Misty,  
22 like a fixed sum, you know, that we're looking at

1 a total reduction or total savings and it's like  
2 either a net-neutral or some other program where  
3 one goes up and the other one goes down. That's  
4 not exactly how this one runs.

5 CO-CHAIR ROBERTS: Okay. Any other  
6 comments from the Committee?

7 DR. SCHREIBER: My only other one --  
8 I'm sorry I keep butting in on the conversation  
9 -- but, also, just to remind the Committee that  
10 the recommendations for which conditions were  
11 chosen originally came from a MedPAC committee  
12 report. So, that's yet another group that has to  
13 be taken into consideration.

14 CO-CHAIR ROBERTS: Thanks, Michelle.

15 So, at this point, Tricia, you're  
16 going to have to remind me. I know we changed  
17 things up yesterday with getting public comment.  
18 Do we get public comment after each measure as  
19 well or are we going to do the group of measures,  
20 public comment, then vote?

21 CO-CHAIR-KAHN: Yesterday, we did the  
22 whole group, and then we did the public comment.

1 MS. ELLIOT: Correct, and then we'll  
2 vote, yes.

3 CO-CHAIR ROBERTS: Okay.

4 MS. ELLIOT: So, we just moved the  
5 public comment before the polling. So, we'll  
6 continue to the next measure to see if there's  
7 additional --

8 CO-CHAIR ROBERTS: All right.

9 MS. ELLIOT: This is a very robust  
10 conversation. So, we'll see if folks have  
11 specific comments on the next two.

12 So, slide 55 is on the screen now.  
13 And this is CMIT 80, Acute Myocardial Infarction,  
14 or AMI, 30-Day Readmission Rate. The description  
15 of the measure is there.

16 Facility-level reporting. It is an  
17 endorsed measure. Two members selected this for  
18 removal. Lead discussants: American College of  
19 Physicians, HCA, and Ron Walters.

20 The criteria and rationale for this  
21 particular measure is that "The measure should be  
22 combined in a properly risk-adjusted overall

1 readmission measure that is not disease-specific.  
2 Results are more likely to be influenced by  
3 outside factors than in a shorter interval.  
4 Question accuracy of the risk adjustment."

5 So, Misty, I'll turn it back to you.

6 CO-CHAIR ROBERTS: Yes, it sounds like  
7 a similar rationale.

8 All right, let's start with Kacie this  
9 time.

10 MEMBER KLEJA: Thanks, Misty. I  
11 actually don't have anything else to add, based  
12 on the conversation we've already had.

13 CO-CHAIR ROBERTS: Yes, I have a  
14 feeling it's going to be a lot of the same.

15 Ron, anything to add?

16 MEMBER WALTERS: I do not accept the  
17 pertinent part of the last discussion, that any  
18 decisions about this should be data-based.

19 CO-CHAIR ROBERTS: And, Sam?

20 MEMBER TIERNEY: Our comments are the  
21 same as for the last measure.

22 CO-CHAIR ROBERTS: Yes. Okay. Well,

1 I will now open it up to the Committee for any  
2 additional comments.

3 I'm not seeing any hands, and I kind  
4 of expected it to be like this.

5 Okay. So, why don't we move on to the  
6 next?

7 Oh, hold on. I'm sorry, Carol just  
8 raised her hand.

9 MEMBER PEDEN: Just going on from  
10 Ron's comment, do we have enough data on these  
11 measures to make these decisions? Do we need to  
12 see trends? Do we need to see how they're  
13 performing overall? It just concerns me a little  
14 bit that we're taking these standing alone and we  
15 need a bigger picture.

16 CO-CHAIR ROBERTS: Yes, and I think  
17 there were a few questions around the data that  
18 maybe Michelle and Susie and I were going to try  
19 to find around the incremental improvement. I  
20 don't know if that's something that you think  
21 you'll be able to get to pretty quickly or if it  
22 will take some time.



1 DR. SCHREIBER: It may take us a  
2 little bit of time. I know they're working on  
3 pulling it. It is true that there's been some  
4 flattening in some of these measures, but we're  
5 looking for the most recent reports.

6 DR. PETER: Hi. This is Doris from  
7 the developer. In a chat, I've put the heart  
8 failure data. For each measure, we'd have to  
9 give it to you. We might put it in a table or  
10 chart or something, but I put the heart failure  
11 data in there.

12 So, there is a range of performance  
13 from 16.7 to 31.2 percent and a mean of 22  
14 percent, being that one out of every five  
15 patients with heart failure returned to the  
16 hospital on average, and that the worst performer  
17 is about one out of every three patients are  
18 returning to the hospital within 30 days, just to  
19 put it in context.

20 And we can pull it out for all the  
21 other measures, too.

22 DR. SCHREIBER: Well, thanks.

1 CO-CHAIR ROBERTS: Any questions from  
2 the group, based on what Doris just discussed?  
3 And we think she's got that in the chat as well.

4 Janice?

5 MS. TUFTE: Yes, you know, those are  
6 pretty high numbers, actually, right? One in  
7 four in the average, I guess. But probably --  
8 and this is what I'll be mentioning later -- but  
9 the risk adjustment overall readmission might  
10 need to be looked at. And if we did this in a  
11 combined fashion, what that would look like, but  
12 it probably is -- you know, what always has  
13 bothered me about this, as a patient public  
14 person, is that having multiple chronic  
15 conditions, understanding how one thing can fall,  
16 but, then something else can fall, right? You  
17 might come in for heart, but, then you start  
18 having, you know, something with your diabetes or  
19 something else. And how people could be -- you  
20 know, how punitive it might be upon the facility  
21 and how hard it is to really address on an  
22 individual level.

1                   And during COVID, it's been hard to  
2                   have individuals help in the home, as well as  
3                   individuals not able to go to perhaps to some  
4                   long-term care that they maybe would go into, or  
5                   part time, which could also attribute to higher  
6                   percentages.

7                   CO-CHAIR ROBERTS: Any other comments?

8                   (No response.)

9                   CO-CHAIR ROBERTS: Okay, let's go to  
10                  the next one.

11                  MS. ELLIOT: Okay. We're now on 556,  
12                  which is CMIT 899, Total Hip Arthroplasty and/or  
13                  Total Knee Arthroplasty 30-Day Readmission Rate,  
14                  with the description on the screen.

15                  Reporting level is facility. It is  
16                  endorsed. Two Committee members selected this  
17                  measure for removal. Similarly, discussants, and  
18                  criteria and rationale appear to be similar to  
19                  the other two measures with measures should be  
20                  combined in a properly risk-adjusted overall  
21                  readmission measure that is not disease-specific.

22                  Patient population for elective

1 procedures is shifting to the outpatient setting.  
2 So, that's a new comment related to hip and knee  
3 here.

4 So, Misty, I'll had it back to you.

5 CO-CHAIR ROBERTS: Yes, that's a good  
6 observation.

7 Okay. Sam, I'm going to start with  
8 you.

9 MEMBER TIERNEY: Thanks.

10 Our Committee did not review this  
11 measure. So, cannot comment on support or do not  
12 support, although I suspect we would have the  
13 same concerns about the 30-day rate. But, again,  
14 we didn't review it. Thanks.

15 CO-CHAIR ROBERTS: Thanks. All right.  
16 Ron?

17 MEMBER WALTERS: I'm going to not  
18 duplicate a lot of things I said. I think the  
19 comment that was just made prior to this, though,  
20 about a shift in practice patterns certainly  
21 indicates the need to make a rational decision  
22 about this measure, and it may become moot. So,

1       you know, that's what we have to see.

2                   CO-CHAIR ROBERTS:   And then, Kacie?

3                   MEMBER KLEJA:   Yes, I agree.

4       Obviously, we've seen that same shift in our  
5       patient population to more of the outpatient  
6       setting for a lot of these electives.  Hip and  
7       knee procedures with, you know, very few  
8       comorbidities, limited risk.  And so, the other  
9       patients that we're still seeing, the inpatients,  
10      are those that have sort of the higher level of  
11      comorbidities and acuity.  So, definitely  
12      something to consider.

13                  CO-CHAIR ROBERTS:   And to clarify,  
14      this would be a 30-day readmission only from  
15      inpatient discharge, is that correct?  Is that  
16      how the specifications are?

17                  MS. ELLIOT:   Yes.

18                  CO-CHAIR ROBERTS:   Okay.  Okay.  
19      Janice?  We're opening it up to the Committee  
20      now.  Janice, it looks like you've got your hand  
21      raised.

22                  MS. TUFTE:   Yes, thank you.  I'm going

1 through some of this now, actually, and it would  
2 be outpatient if everything goes okay and COVID  
3 comes down. But I learned a lot from my doctor  
4 about steroid shots before, which often people  
5 do, we see, before they either have a hip or a  
6 knee replacement, right?

7                   Anyway, it's just the steroid shots  
8 can add the opportunity for infection. And so,  
9 it's something to think about. And if  
10 individuals have perhaps more comorbidities, and  
11 depending on how recently they had steroid shots  
12 or how many they've had, it could add to that 30-  
13 day readmission.

14                   CO-CHAIR ROBERTS: Katie, did you have  
15 a comment?

16                   MEMBER BOSTON-LEARY: Yes. I do want  
17 to echo the sentiments about this shift to  
18 outpatient. But the other dynamic that is  
19 playing out with some of these procedures that  
20 were typically inpatient that are shifting to  
21 outpatient is that, when there are complications,  
22 those patients are admitted to the inpatient

1 arena, which also complicates matters.

2 And even if the data-collecting side,  
3 it is shifting there, when there is a need for  
4 some adjustment or revision to the surgery, it  
5 does happen in the inpatient setting. So, how we  
6 capture that makes it even more complex. So, I  
7 just wanted to add that.

8 CO-CHAIR ROBERTS: Thanks for that.  
9 Leah?

10 MEMBER BINDER: Yes, I think the  
11 complexity that Katie (audio interference) is, I  
12 think, also a sign of one of the issues that  
13 we've had for a long time, which is that there  
14 is, because there's this split between inpatient  
15 versus outpatient quality reporting, so you can't  
16 compare them side by side, we have an issue with  
17 exactly these procedures where we're not able to  
18 assess whether, for example, an ambulatory  
19 surgery center's surgery that results in not a  
20 readmission, but somebody in the emergency room  
21 15 days later, cannot be compared side by side  
22 with a similar procedure performed at the

1       inpatient level. We should be able to do that.  
2       And so, looking in the future anyway, we should  
3       be able to assess when follow-up visits are  
4       necessitated after a procedure and be able to  
5       compare that, those rates, side by side.

6                   CO-CHAIR ROBERTS: Any other comments  
7       from the Committee?

8                   (No response.)

9                   CO-CHAIR ROBERTS: Okay. And I think  
10      that is the last measure, is that right, Tricia?

11                  MS. ELLIOT: Yes, it is, Misty.

12                  CO-CHAIR ROBERTS: Okay. Why don't we  
13      open it up for public comment? And just a  
14      reminder to limit your comments to these measures  
15      that we're discussing for the Hospital  
16      Readmissions Reduction Program and, also, limit  
17      your comments to two minutes.

18                  Any comments from the public? Amy?

19                  MS. CHIN: Hi. Can you hear me?

20                  CO-CHAIR ROBERTS: Yes, we can hear  
21      you.

22                  MS. CHIN: Okay. Okay. So, I, first,



1 want to thank everyone. This has been a really  
2 great discussion.

3 I think everyone has covered a lot of  
4 the points that my organization, the Greater New  
5 York Hospital Association, cares about, and I  
6 think they're all very relevant, especially the  
7 comments regarding how can we evaluate the  
8 measures outside the context of this program that  
9 we can't change.

10 But, aside from that, I also want to  
11 think maybe more about how we think about when  
12 we're topped-out on measures. I know that Doris  
13 has been posting kind of like the minimum and  
14 maximum rates and showing that there is  
15 variability. But I think we should have a deeper  
16 conversation on like what is the right amount of  
17 variability, right? Like even if we achieve what  
18 we consider like the ideal in quality improvement  
19 in this area, there may still be variability.  
20 So, I think there just needs to be more robust  
21 data around understanding the spread and whether  
22 we need new criteria for understanding outliers,

1       who's better/who's worse, and then taking that  
2       into context in the measures.

3                   CO-CHAIR ROBERTS:  Thanks, Amy.  Any  
4       other comments from the public?

5                   (No response.)

6                   CO-CHAIR ROBERTS:  Okay.  I know we  
7       are supposed to vote next.  I think that is the  
8       next step.  I will say I do still maybe have some  
9       concerns of whether or not we have enough  
10      information.  And as Ron said, our decision  
11      should be data-driven.  And, Doris, you did put  
12      some information in there.  I do still have some  
13      concerns about whether or not we have enough  
14      information to make some decisions.

15                  I don't know what others think.

16                  MEMBER KAMAL:  This is Arif.  I agree  
17      with that concern.  I'm just worried in terms of  
18      the direction we go.  I think disease-specific  
19      measures, not only being statutorily important,  
20      but I do think, from a consumerism perspective,  
21      it's hard to lump together a cancer readmission  
22      with a heart failure readmission from an acute

1 myocardial infarction readmission. Because, to  
2 me, the way patients may make decisions, the way  
3 hospitals may do quality improvement projects, is  
4 it's not a one-size-fits-all to how you address  
5 the problem.

6 And so, I think it's hard to lump them  
7 together because you can tie some bad care in an  
8 aggregate measure of overall readmission rate,  
9 when, in fact, you may be doing poorly in a  
10 relative small sample in a particular area.

11 I also think, in terms of choice and,  
12 again, having sort of directed QI projects in a  
13 specific area, I think, for the data we've seen  
14 so far that's been shared -- and I appreciate  
15 that -- I'm not seeing anything close to a  
16 topped-out measure. So, I worry that, if we  
17 eliminate some of these measures in anticipation  
18 of a general global measure, that we enter in a  
19 gap period where we're not focused on these  
20 issues with continued gaps being demonstrated by  
21 data, and I'd like to see more data about it,  
22 too. So, I just sort of have cause for concern

1       about all that.

2                   CO-CHAIR ROBERTS:  Thanks, Arif.

3                   Chip?

4                   CO-CHAIR-KAHN:  Yes, this goes back to  
5       my point, though.  I mean, you're making the  
6       assumption that the way this data is presented,  
7       and the way the data is collected, and then the  
8       calculation will lead to improvement.  And I  
9       think this is such a flawed program, and the  
10      questions raised by it -- I mean, particularly  
11      what we just talked about with hips and knees,  
12      for example -- I think to say that there's data  
13      here arrayed in such a way from this that would  
14      allow for decisionmaking on the part of  
15      consumers, I think is probably stretching it.

16                   And frankly -- I need to be careful  
17      how I say this -- I think because this is such a  
18      penalty program, I think there may be a  
19      disincentive here for hospitals to try to change  
20      their numbers because they're going to be  
21      penalized one way or another.  So, sort of why  
22      put the energy into it?

1                   So, I don't know, I guess I'm a little  
2 bit worried about making the assumption you're  
3 making.

4                   CO-CHAIR ROBERTS: Thanks, Chip.  
5 Heidi?

6                   MEMBER BOSSLEY: Yes, to build on that  
7 a little bit, because I do think looking at how  
8 hospitals, for example, are categorized and  
9 lumped in their worse, the-same-as-everyone-else  
10 average, and then better provides a different  
11 view than what we see in the chat.

12                   So, for example, for the AMI measure,  
13 only 17 hospitals perform better than the  
14 national average and 18 worse. And so, you may  
15 see a spread, but you're only seeing small  
16 outliers on the side and everyone's in the  
17 middle. That's another view that makes me start  
18 wondering if it might be topped-out.

19                   And so, I think that's where we need  
20 more data to understand how this measure  
21 performs, and then how it gets applied within the  
22 program, once the potential of moving one measure

1 out, putting a new one in -- all those pieces. I  
2 don't know the right answer, but that's why I  
3 start wondering, have we hit that floor for at  
4 least some of these measures and we're not going  
5 to move the needle? And what's the consequences  
6 if it stays in, stays out or goes out? I just  
7 don't know.

8 CO-CHAIR ROBERTS: Thanks. I thought  
9 I saw another hand. I'm not seeing it now.

10 Any other comments?

11 (No response.)

12 CO-CHAIR ROBERTS: Okay. So, Tricia,  
13 do you want to put up the poll?

14 MS. HARDING: Okay, everyone, polling  
15 is now open for Measure No. 78, Heart Failure 30-  
16 Day Readmission Rate, from the Hospital  
17 Readmissions Reduction Program.

18 Do you support the removal of this  
19 measure?

20 And we will show the results of the  
21 poll when we close it.

22 MEMBER WALTERS: Good move.

1 (Laughter.)

2 MS. HARDING: Okay. It looks like  
3 everyone has voted that wishes to.

4 We have 4 for yes and 15 for no. And  
5 that brings us to 21 percent.

6 Next, we will poll for Measure No. 80,  
7 Acute Myocardial Infarction 30-Day Readmission  
8 Rate from this program.

9 Do you support removal of this  
10 measure?

11 Okay. It looks like everyone has  
12 voted. We have 4 for yes and 15 for no. That  
13 brings us at 21 percent.

14 We will now look at Measure No. 899,  
15 for Total Hip Arthroplasty and/or Total Knee  
16 Arthroplasty 30-Day Readmission Rate.

17 Do you support the removal of this  
18 measure?

19 Okay, I think everyone has voted. We  
20 have 5 for yes and 11 for no. And that brings us  
21 to 31 percent.

22 MS. ELLIOT: Great. Thank you so

1 much, Ivory, for conducting the poll.

2 And before we wrap up this section, we  
3 do have a question that our CMS colleagues asked  
4 us to pose to the group.

5 So, although condition-specific  
6 measures of readmission is a statutory  
7 requirement, CMS has requested strategic input  
8 from the Committee on the value of different  
9 types of readmission measures for the Hospital  
10 Readmissions Reduction Program.

11 So, Misty, I kind of toss it back to  
12 you to see if you think we've covered this enough  
13 or if anybody wants to make any final comments.

14 CO-CHAIR-KAHN: I think it's covered.

15 MS. ELLIOT: Are we good?

16 CO-CHAIR ROBERTS: We have had a  
17 robust discussion.

18 MS. ELLIOT: That's for sure. Maybe  
19 one last call?

20 CO-CHAIR ROBERTS: Yes. I was going  
21 to say I don't know if that was something that  
22 was requested before the discussion. Probably.



1 DR. SCHREIBER: Yes.

2 CO-CHAIR ROBERTS: Okay. Good.

3 Clarke, it looks like a comment/hand  
4 raised?

5 MEMBER ROSS: Yes, thank you.

6 Just a reminder that the National  
7 Quality Forum held two summits on Hospital Star  
8 Rating, and I was quickly trying to find the  
9 report, but the opportunity is here. And I  
10 haven't found it yet.

11 But if I recall correctly, the report  
12 said there should be greater focus on units in  
13 hospitals that treat particular conditions rather  
14 than a more generic rating. So, I could have  
15 that wrong; that's my memory. And I'm an old guy  
16 now, so the memory fades. But I believe that was  
17 the National Quality Forum, two reports, two  
18 summits, to CMS; more attention on the unit  
19 treating distinct conditions, which is related to  
20 this question.

21 CO-CHAIR ROBERTS: Leah, did you have  
22 a comment?

1 MS. ELLIOT: You're on mute, if you're  
2 talking.

3 MEMBER BINDER: Sorry.

4 I was educated through this  
5 conversation to really think about readmissions  
6 beyond condition-specific because people do have  
7 complex conditions, varied conditions. So, there  
8 can be more to it than one particular condition.  
9 So, I do think it's worth thinking about how  
10 readmissions could be kind of reconsidered as  
11 patient-focused as opposed to condition-focused.  
12 I thought that was an interesting set of  
13 observations from some of the folks here.

14 MEMBER HOY: This is Libby.

15 If I could just echo Leah's comments,  
16 I think that is a valuable way to think about how  
17 consumers could use this information to really  
18 inform their decisionmaking in care, the  
19 complexity that most people arrive, even to these  
20 conditions, with. It really needs to be  
21 considered, and, yes, how we can take a more  
22 holistic approach I think is really something to

1 be considered moving forward.

2 MS. TUFTE: This is Janice. I've had  
3 my hand up.

4 Anyway, the Physician Cost Measures,  
5 Episode-Based Measures are kind of leaning into  
6 this area, where it's for the pre, and then the  
7 surgery, then the post. So, there's follow-up,  
8 and there is some notation if the readmission was  
9 specific, too. They're really concentrating on  
10 that -- if it's specific to the surgery or the  
11 treatment rather than just any 30-day, like  
12 you're mentioning, which is really, importantly,  
13 the PCMPs that are being developed.

14 MS. ELLIOT: Chip, you had a comment?

15 CO-CHAIR ROBERTS: Go ahead.

16 CO-CHAIR-KAHN: Should I go ahead?

17 MS. ELLIOT: Yes, go ahead, Chip.

18 CO-CHAIR ROBERTS: Yes, go ahead,  
19 Chip.

20 CO-CHAIR-KAHN: I mean, I am  
21 sympathetic with Clarke, but I think there's a  
22 fundamental difference between Stars and

1 readmissions. I mean, Stars are a general  
2 overall rating. And the issue of whether it told  
3 somebody whether the OB/GYN versus the cardiac  
4 unit in a hospital was or wasn't good is really a  
5 different issue, I think, than when we look at  
6 readmissions.

7 I think we have to be very sensitive  
8 about readmissions because it really depends on  
9 the conditions. Frankly, there are some  
10 hospitals that may have high readmissions, and  
11 that may be the hospital that a very high acuity  
12 patient may want to go to.

13 So, I think this is a very good  
14 measure area for improvement and accountability.  
15 I think we have to approach it -- everything is  
16 not going to work, and we should be transparent,  
17 but everything is not going to work for consumer  
18 decisionmaking. And I'm not sure this is  
19 necessarily an area that's that ripe for it. Or,  
20 at least in my view, we should have a program,  
21 which we don't have now, that really aims at  
22 improvement and accountability first, and

1 ultimately, if we can figure out the right way to  
2 display it, help consumers. But I don't think a  
3 consumer can make a decision right now based on  
4 this program. And I'm not sure that it's  
5 necessarily the right metric. But that's just my  
6 view.

7 CO-CHAIR ROBERTS: I just want to ask  
8 a quick question. So, Chip, it sounds like your  
9 concerns are really around the program itself, I  
10 mean the measures, but, also, just the program in  
11 general.

12 Michelle, how do you all get input  
13 into those specific programs?

14 DR. SCHREIBER: We get input in many  
15 different directions. As all of you know, our  
16 programs are reviewed annually and put into rule  
17 writing. So, anytime we make a change, anytime  
18 we even propose a change -- and sometimes we just  
19 seek comment through an RFI, a Request for  
20 Information -- that goes into rule writing, where  
21 we have the public who can provide and anybody  
22 who can provide comment.

1           Most of these measures have Technical  
2   Expert Panels that have been engaged to weigh in  
3   on each of these measures, both in development as  
4   well as review, and then, of course, they go  
5   through the NQF endorsement process, where  
6   there's also opportunity for review. So, we try  
7   really hard to be transparent and to make this  
8   public and to get feedback from many different  
9   stakeholders.

10           But, to Chip's point, he's right,  
11   these programs are based in legislation. And for  
12   the kind of fix of what Chip is really talking  
13   about -- and I understand your intent, Chip, and  
14   your concerns; I really do -- this won't be fixed  
15   by CMS rule writing around a specific measure.

16           This is really a legislative issue for  
17   why this program was crafted, and we think about,  
18   why was this program crafted? And that's because  
19   it was seen that lots of patients -- and we've  
20   seen the data now -- up to one out of every four,  
21   one out of every three patients are getting  
22   discharged from the hospital, and they turn

1 around in a revolving door and get readmitted.  
2 That's (a) excess cost to the whole ecosystem and  
3 (b) not great from the patient's point of view.  
4 And so, that's why this program came around and  
5 why it's still considered one of the most  
6 important programs at CMS.

7 MEMBER ROSS: I'd like to make just an  
8 observation. Twenty-five of my 50 years working  
9 have been with three national family  
10 organizations: United Cerebral Palsy, ADHD, and  
11 NAMI, National Alliance for Mental Illness. And  
12 I'm a family member for NAMI, The Arc, which is  
13 an IDDD organization, and my son participates in  
14 Special Olympics.

15 The No. 1 topic at every family  
16 gathering is, is Dr. So-and-So good or bad? Is  
17 Hospital A good or Bad? Who's the best? Who's  
18 the worst?

19 And this is an ancillary kind of  
20 thing, but that's what family members with people  
21 with significant disabilities are talking about,  
22 is word of mouth, and our impressions are all

1 different and based on all kinds of different  
2 things.

3 But just keep in mind, that's what  
4 family members talk about. I mean, Special  
5 Olympics is about athletic events, and yet, the  
6 parents sitting on the sidelines are always  
7 talking about, "I saw Dr. Smith last week and he  
8 was" X, Y, or Z. So, I just wanted to share  
9 that, as sort of a reality check on what people  
10 in family organizations are talking about.

11 Thank you.

12 DR. SCHREIBER: You're absolutely  
13 correct, and that is actually the underpinning of  
14 many of these programs, is to attempt to give  
15 information back to patients to help answer that.  
16 And while imperfect, I think it certainly does  
17 provide information back, getting to our point of  
18 disease-specific versus just sort of a general  
19 hospital-wide readmission rate.

20 CO-CHAIR ROBERTS: Carol, do you have  
21 a comment?

22 MEMBER PEDEN: Really, just going back



1 to Chip's comments, do we have a mechanism? And  
2 this may be the case and the feedback on the  
3 general discussion. When the clinical situation  
4 is changing rapidly such as it is with hip and  
5 knee replacements, that we review this regularly  
6 on the basis of the dynamic changes.

7 I mean, we're definitely going to see  
8 that the hospitals doing the patients as  
9 inpatients are selecting out the higher-risk  
10 patients. There was a paper in JAMA Surgery last  
11 week talking about bariatric patients should be  
12 done at bariatric joint centers. And so, we will  
13 probably see the readmission rates in those  
14 hospitals going up, but it doesn't mean they're  
15 doing a bad job. So, I think this is right; when  
16 it's very dynamic, we should keep it under  
17 regular review.

18 DR. SCHREIBER: And just to be clear,  
19 these are all reviewed on an annual basis. And  
20 you're right, in an ambulatory surgery center, we  
21 expect -- and we had this discussion yesterday --  
22 that there will be more measures needed. For

1 example, as hip and knee shift into the  
2 ambulatory center, what are those safety  
3 measures, including rates of ED utilization or  
4 hospitalization after those procedures have been  
5 done in an ASC?

6 MS. ELLIOT: I think we have Emma  
7 next. Did you have a comment? And then, Libby.

8 MEMBER HOO: Yes, the comment I would  
9 add, too, is that, when we think about patient-  
10 centered measures, I think our experience is that  
11 the ability to choose hospitals really depends on  
12 the lead time that an individual has with respect  
13 to an elective admission versus conditions where  
14 individuals may not necessarily have a choice,  
15 because some of these are often through the  
16 emergency room channel as opposed to self-  
17 admission.

18 I think the other piece that I'd like  
19 to raise that we're not addressing here is that I  
20 do think that some of these measures would have  
21 value from a health equity lens to understand in  
22 stratifying the population where there are

1 differences in rates of readmission overall. And  
2 sometimes it's challenging to look at the  
3 measures from either the specific methodology or  
4 the variation, and I have another committee that  
5 might be looking at it through a different lens.  
6 So, I think we need a more holistic approach in  
7 how we think about the utility of these measures.

8 DR. SCHREIBER: If I could comment  
9 there for just a moment, Emma, I think what you  
10 are going to start seeing is stratification of  
11 some of these measures. The readmissions  
12 measures are actually the first area where  
13 stratification has started to be provided back to  
14 hospitals in confidential reports, stratified  
15 generally by dual eligibility.

16 But I think most people know there's  
17 a great interest, and it was in the RFI for this  
18 year in most of our rules, about providing more  
19 information regarding equity. And that may very  
20 well start with stratification of more measures,  
21 and you may see it in this area, in particular,  
22 first.

1 MS. ELLIOT: Right. Thank you.

2 Libby, did you have a comment?

3 MEMBER HOY: Yes, and thank you for  
4 that, Michelle, and for raising that question,  
5 Emma. I think it's really important and was on  
6 my mind as well. So, definitely, with the look  
7 to equity.

8 But I just wanted to raise -- and I  
9 think somebody else just mentioned it in the chat  
10 -- there are things like referrals and other  
11 pieces of information that will influence  
12 patients and families. And I know in these  
13 conversations in our community of patients and  
14 families and the PFAnetwork, it's a bit like  
15 adding all those pieces to the puzzle. And as  
16 was mentioned before, families talk to each  
17 other. "Who's the guy who...? Why did you think  
18 so?"

19 That doesn't necessarily mean that  
20 your version of who's good is the same as mine,  
21 but it adds to it. And similarly, these measures  
22 add to our information base. And as patients and

1 families become more savvy about using data to  
2 help their decisions, I think we really just need  
3 to not expect a measure set to do all the  
4 information and provide all the information, but  
5 it is an important piece of the puzzle that I  
6 have seen growth in the patient and family  
7 community to be able to access and utilize that  
8 sort of information.

9 So, I just wanted to kind of pull back  
10 and not expect one measure, one source of  
11 information to be the end all and be all. Most  
12 of us are going to multiple sources to make these  
13 decisions.

14 MS. ELLIOT: Great. And one last hand  
15 I see raised is Rebecca.

16 MEMBER KIRCH: Thanks. I'll add just  
17 a little bit more flavor on this thread. And I  
18 appreciate, Michelle, what you said about why  
19 these programs and these measures were created,  
20 but those sidebar conversations that patients and  
21 caregivers and families have, they're looking  
22 much deeper into: did I feel supported in the

1 care transition that happened? Was there  
2 continuity of care or was it a revolving door of  
3 different doctors coming in, asking me to repeat  
4 the same history? Did I feel heard and  
5 understood? And in terms of equity, was I  
6 respected?

7 Those aren't captured in any of the  
8 measures we're talking about. And I think that's  
9 why my consistent chorus is we need room to  
10 reflect measures of today and how care and  
11 practice and quality is defined today in terms of  
12 person-centered care. So, always the opportunity  
13 for bettering ourselves by asking patients what  
14 measures we should be reporting on, instead of us  
15 presuming it with the stuff that we know we can  
16 measure that's been validated. So, just a  
17 reminder for us in terms of the future, the  
18 opportunity to think a little bit more creatively  
19 around what people would say, instead of what us,  
20 as measure developers and scientists, might  
21 think.

22 DR. SCHREIBER: Agreed.

1 MS. ELLIOT: Excellent. Thank you.  
2 I do not see any more hands raised. And we are  
3 at a point in the agenda where we have lunch next  
4 as the break. So, I just want to check in with  
5 the group, particularly Chip and Misty. Okay if  
6 we break half an hour early for lunch and  
7 reconvene at the top of the hour at 12:00 noon?

8 CO-CHAIR-KAHN: We could do that.

9 MS. ELLIOT: Because the next one,  
10 mortality, has got quite a few measures. So, I  
11 didn't know if you wanted to break that up across  
12 lunch or not.

13 CO-CHAIR-KAHN: We could. I mean, if  
14 that's okay with the group, then why don't we  
15 come back at noon and we'll proceed through?

16 MS. ELLIOT: Does that sound okay?

17 MEMBER BINDER: I actually set up a  
18 meeting for at noon, based on a 12:15 --

19 MS. ELLIOT: That was the only thing  
20 I was going to mention.

21 CO-CHAIR-KAHN: Okay. Then, I mean,  
22 I'm happy to get started.

1 MS. ELLIOT: Okay.

2 CO-CHAIR-KAHN: And then we can break  
3 at 12:00, and then let people --

4 CO-CHAIR ROBERTS: Yes, we can do  
5 that.

6 MS. ELLIOT: Okay.

7 CO-CHAIR-KAHN: So, let's get into it  
8 then. And there are quite a few measures,  
9 although I think here, too, we may find the same  
10 thing, which is that, once you've sort of done  
11 one, you've sort of gotten the comments. But why  
12 don't we start?

13 MS. ELLIOT: Okay. Sounds good. So,  
14 we are on slide 60 of our presentation, and we'll  
15 move forward to slide 61.

16 So, there are four measures that were  
17 proposed for removal in the Mortality Measure  
18 grouping. These programs fall into different  
19 aspects of IQR and value-based purchasing. So,  
20 you'll see the four CMIT IDs listed on the left-  
21 hand side, and then the program, whether it be  
22 IQR or value-based purchasing, listed in the next



1 program.

2 So, the first one is 1357, CMS Death  
3 Rate among Surgical Inpatients with Serious  
4 Treatable complications. There's four Committee  
5 members that selected that measure.

6 CMIT ID 89 is the Hospital 30-Day,  
7 All-Cause, Risk-Standardized Mortality Rate  
8 Following Heart Failure Hospitalization. Three  
9 Committee members selected that measure.

10 CMIT ID 86, Hospital 30-Day, All-  
11 Cause, Risk-Standardized Mortality Rate Following  
12 AMI Hospitalization. Two Committee members chose  
13 that one.

14 And 902, Hospital 30-Day, All-Cause,  
15 Risk-Standardized Mortality Rate Following Acute  
16 Ischemic Stroke. Two Committee members selected  
17 that.

18 Next slide, please.

19 So, for the Hospital Value-Based  
20 Purchasing Program, it is a pay-for-performance  
21 program. Incentive structure: the amount equal  
22 to 2 percent of base operating DRG is withheld

1 from the reimbursements of participating  
2 hospitals and redistributed to them as incentive  
3 payments. And the goal of the program is to  
4 improve health care quality by realigning the  
5 hospital's financial incentives and provide  
6 incentive payments to hospitals that meet or  
7 exceed performance standards.

8 And the last time, we had paused kind  
9 of at this point to ask any clarifying questions  
10 on the program. Chip, are you okay if we do that  
11 again?

12 CO-CHAIR-KAHN: Yes, please, because  
13 this program is fundamentally different from the  
14 readmissions program. And I think one of the  
15 fundamental differences is there's more  
16 flexibility on the part of the design of this  
17 program for CMS than there is in readmissions.

18 DR. SCHREIBER: And you're correct  
19 about that, Chip.

20 So, just to provide a little bit more  
21 information, the Hospital Value-Based Purchasing  
22 Program is a net-neutral program, as opposed to

1 some of the other programs. And it was  
2 specifically written that way.

3 And what that means is that, out of a  
4 pool of money -- so, all hospitals at the  
5 beginning of the year have a withhold, and then  
6 that withhold, 100 percent of that withhold is  
7 paid back, but the distribution of that withhold  
8 is according to which hospitals perform the best.  
9 So, those hospitals that perform the best can  
10 actually achieve more than 2 percent of what they  
11 withhold, and those hospitals that perform the  
12 worst will get less than that. So, you get both  
13 penalties and incentives, which is very different  
14 than many of the other programs.

15 The Hospital Value-Based Purchasing  
16 Program actually has four categories in it.

17 It has the clinical category, in which  
18 you see a lot of the mortality measures that are  
19 coming up for discussion today.

20 It also has the person and community  
21 engagement category, which is largely the HCAHPS  
22 measures. It has the safety category, which is

1 largely the hospital-acquired conditions. And it  
2 has cost and efficiencies, so Medicare spend per  
3 beneficiary. So, it has four categories.

4 The IQR Program is different. So, the  
5 IQR is the Inpatient Quality Reporting Program.  
6 It has many more measures in it. And it has  
7 other categories that aren't necessarily in  
8 there.

9 And we can send you a list of all of  
10 the measures, if you want, but these include  
11 things like the influenza vaccination. That's  
12 where COVID vaccination, for example, is going to  
13 go. PSI 04, the surgical complications mortality  
14 measure is there. There are some mortality  
15 measures. There some readmission measures.  
16 There are some payment measures, the sepsis  
17 measures. Some of the maternal measures are  
18 there. HCAHPS is also there.

19 IQR is frequently used for a place to  
20 introduce new measures. So, IQR measures are  
21 reported publicly. This does not affect payment  
22 calculations, what's in IQR. It does, however,

1 reflect what may be considered for going into the  
2 Stars Program.

3 So, Chip is absolutely correct, these  
4 are two very different measures. Each of these  
5 measures, as you've seen, is very different. The  
6 other program, the Hospital-Acquired Condition  
7 Program, again, is different, in that it has  
8 measures in it and those are penalized  
9 differently. So, each of these programs is quite  
10 different in their build and design, and each  
11 comes from a different statutory requirement.  
12 That's part of the reason they're different, but  
13 it makes it hard to keep them all straight  
14 sometimes.

15 And I'm happy to answer questions, if  
16 people have questions about the programs.

17 MEMBER BOSTON-LEARY: Yes, Michelle,  
18 this is Katie. Do you mind sharing the  
19 breakdown? Because I know, the last I looked at  
20 the different categories, HCAHPS was 50 percent.  
21 Or does it vary?

22 DR. SCHREIBER: No, it doesn't vary,

1 and I'm going to need probably Tim or Grace on  
2 the phone. I think they're 25 percent each, the  
3 four categories.

4 MS. SNYDER: Hi, Michelle. This is  
5 Grace.

6 And you're correct, in the Hospital  
7 VBP Program right now we have four domains, each  
8 of them equally weighted 25 percent.

9 MEMBER BOSTON-LEARY: Okay. Thank  
10 you. I think I'm also reflecting on my time at  
11 Maryland, where, you know, it's an all-payer  
12 state. So, they tend to have some different  
13 applications to this as well.

14 And I think this is particularly  
15 important now, especially since we're seeing an  
16 increase in hospital-acquired infections since  
17 the pandemic, with a lot of the issues that are  
18 being placed on hospitals that are, you know,  
19 multifactorial and very complex.

20 So, I appreciate the overview. Thank  
21 you.

22 DR. SCHREIBER: Yes. So, Katie,

1       you're right, the Maryland model will have some  
2       different requirements around it that other  
3       states won't. And the impact of COVID is whole  
4       other topic that we could all talk about for a  
5       long time.

6                   MEMBER BOSTON-LEARY: Absolutely.

7                   MS. ELLIOT: Dan Culica, you had a  
8       question?

9                   MEMBER CULICA: Yes. Just for the  
10       point of clarification, the entire discussion  
11       with all these programs is related to the  
12       Medicare program; it excludes the Medicaid,  
13       right?

14                   DR. SCHREIBER: So, yes and no, Dan.  
15       Okay? And I'm sorry to hedge on that one.

16                   MEMBER CULICA: No, no, no, no.  
17       It's --

18                   DR. SCHREIBER: For the most part, the  
19       penalties and the incentives that are calculated  
20       are based on the Medicare payments. They're not  
21       based on Medicaid payments. Okay?

22                   MEMBER CULICA: Right.

1 DR. SCHREIBER: However, within the  
2 measures, some of these measures also include  
3 Medicaid patients as well as Medicare patients.  
4 Okay?

5 MEMBER CULICA: Right.

6 DR. SCHREIBER: Particularly those  
7 that are collected like through eQMs that are  
8 all-payer data. So, I don't want to say that it  
9 doesn't include at all Medicaid, but the  
10 penalties, the incentives and the penalties  
11 associated are around the Medicare contribution  
12 of that, not Medicaid.

13 MEMBER CULICA: Right, right. Thank  
14 you. No, because we have several programs in the  
15 Medicaid program that have some of those  
16 components, but not all of them.

17 DR. SCHREIBER: Correct. Correct.  
18 And then, obviously, you get into different  
19 issues of what's posted on state, for example,  
20 Medicaid dashboards; what's in the Medicaid core  
21 dashboards for adults and children. So, that is,  
22 yet, another consideration. You're absolutely



1 correct about that.

2 MEMBER CULICA: Thank you, Michelle.

3 CO-CHAIR-KAHN: Okay. Are there any  
4 other technical questions regarding the program?

5 (No response.)

6 CO-CHAIR-KAHN: Okay. Tricia, why  
7 don't you take it back and we'll --

8 MS. ELLIOT: Okay, we'll go to the  
9 first measure in this grouping, CMIT 89, Hospital  
10 30-Day, All-Cause, Risk-Standardized Mortality  
11 Rate Following Heart Failure Hospitalization.  
12 The description is provided of the measure.

13 The reporting level is facility. The  
14 endorsement status is endorsed. Three Committee  
15 members selected this measure. The lead  
16 discussants are America's Health Insurance Plans,  
17 AmeriHealth Caritas, Janice Tufte and Ron  
18 Walters.

19 The criteria or rationale provided for  
20 removal: "The measures should be combined in a  
21 properly risk-adjusted, overall mortality measure  
22 that is not disease-specific. Measure requires

1 significant financial resources and risk of  
2 penalizing underresourced hospitals."

3 So, Chip, I'll hand it over to you to  
4 navigate the lead discussants.

5 CO-CHAIR-KAHN: Okay. So, I guess  
6 I'll follow the lead from Misty. Why don't we  
7 start with Ron, then, and we'll work our way  
8 back.

9 MEMBER WALTERS: Well, as strongly as  
10 I feel about readmissions, going into a hospital,  
11 dying is worse for most of the time. So, I feel  
12 even stronger about this one.

13 The concept, again, perfect, no  
14 problem with you should not be in a hospital,  
15 admitted and unexpectedly dying -- unexpectedly.  
16 And, of course, the term "unexpectedly" is a hard  
17 term to grasp. So, the way to grasp that is risk  
18 standardized, which is the best we can do with  
19 the information available.

20 But there's two problems I have. One  
21 is I can't see how this couldn't be broadened to  
22 an all-cause, properly risk-stratified mortality

1 rate, and that would be extremely broadly risk-  
2 standardized, rather than just disease-specific.  
3 Because the data is available for that, too.

4 And then, secondly is, again, I  
5 started out on the IQR and I thought there was  
6 this rather orderly sequence between moving from  
7 the IQR to the Value-Based Purchasing Programs.  
8 And I think, over the years, not as many measures  
9 have made that movement as I thought was going to  
10 at the start of the programs. I could be wrong,  
11 but that's my impression.

12 And the fact that standardized  
13 mortality rate for heart failure is such a  
14 prominent part of this value-based purchasing  
15 kind of belittles the concept I started out with:  
16 you shouldn't die from any reason from being  
17 admitted if it is totally unexpected. And I  
18 realize I threw a lot of terms in there that are  
19 tough to come by and hard to define. But,  
20 nonetheless, if anything could do that, it would  
21 be an all-disease, not disease-specific, all-  
22 cause, risk-standardized mortality rate.

1                   Now that's going to take some  
2       development I understand, and it's going to take  
3       input from an extremely broad group, rather than  
4       the narrow groups we have. But, pertinent to the  
5       previous discussions, if we want 30-day, all-  
6       cause, risk-standardized mortality rates for more  
7       diseases than we have right now during  
8       hospitalization to come through the pipeline and  
9       go into IQR, and then value-based purchasing,  
10      there's a lot that are candidates, and you  
11      already mentioned a couple of them.

12                  So, I really think, just like the last  
13      session, we need to vote what probably will be a  
14      minority opinion that you need to put some  
15      thought and work into this, and we understand the  
16      implications. And you're right, many of these  
17      are legislatively tied. But we need to improve.  
18      The concept is great.

19                  So, anyway, I'm going to hand up now.

20                  CO-CHAIR-KAHN: Okay. Thank you.

21                  DR. SCHREIBER: Can I just make a  
22      comment back to Ron to remind the Committee that

1 we do have a hybrid hospital-wide mortality  
2 measure that is set for voluntary reporting in  
3 IQR in 2024? That was just finalized.

4 MEMBER WALTERS: It makes my point  
5 even stronger.

6 DR. SCHREIBER: You won't see it  
7 probably for a year after that.

8 I'm sorry?

9 MEMBER WALTERS: It makes my point  
10 even stronger.

11 DR. SCHREIBER: Well, it does exist.  
12 You won't see publicly reported data on it,  
13 though, for a little while.

14 CO-CHAIR-KAHN: Okay. Janice?

15 MS. TUFTE: Yes, like I mentioned in  
16 the readmissions, the same here; just knowing  
17 individuals who have been very, very ill at the  
18 end of their life, for a hospital, an  
19 underresourced hospital to perhaps be penalized  
20 for it, when the patients go home, where they are  
21 also underresourced, to me, is kind of  
22 disheartening. But I understand the purpose of

1       noting this. It is important.

2                       But there's so much social determinant  
3 of health I see in this that the risk adjustment  
4 really needs to be done properly. And I am  
5 serving on the risk adjustment guidance. So, for  
6 NQF, I'm hoping that we will be able to provide  
7 some better guidance in the future in some of  
8 these areas. Thank you.

9                       CO-CHAIR-KAHN: Okay. Great.

10                      And then, finally, Andrea?

11                      MEMBER GELZER: Andrea.

12                      CO-CHAIR-KAHN: Okay, Andrea.

13                      MEMBER GELZER: Yes, so I would echo  
14 the comments that have been made. This measure  
15 bothers me because, if you look at end-stage  
16 cancer, hospitalization during the last 30 days  
17 of life with end-stage cancer, that, to me, is a  
18 good measure. I don't understand why we don't  
19 have a similar measure for congestive heart  
20 failure, because, otherwise, I think that  
21 perverse incentives exist. You penalize folks  
22 for trying to admit somebody who is really an

1 end-stage case. But I don't like this measure.  
2 I would prefer a similar measure to end-stage  
3 cancer to replace it.

4 CO-CHAIR-KAHN: Okay. Are there other  
5 comments or questions?

6 (No response.)

7 MS. ELLIOT: I do not see any other  
8 hands raised.

9 CO-CHAIR-KAHN: Okay. Well, Tricia,  
10 let's go to the next one then.

11 MS. ELLIOT: Okay. Slide 86 -- I'm  
12 sorry -- CMIT ID No. 86: Hospital 30-Day, All-  
13 Cause, Risk-Standardized Mortality Rate Following  
14 AMI Hospitalization.

15 Description is on the screen. The  
16 reporting level is facility. It is an endorsed  
17 measure. Two members selected this measure for  
18 removal. Similarly, discussants.

19 And the criteria or rationale is that  
20 "The measure should be combined in a properly  
21 risk-adjusted, overall mortality measure that is  
22 not disease-specific. Patient populations

1 requiring more care could be penalized and  
2 targeting mortality rates would require  
3 significant resources to make minimal impact."

4 I'll hand it back to you, Chip.

5 CO-CHAIR-KAHN: Okay. Andrea, why  
6 don't you go first, and then we'll go down the  
7 others.

8 MEMBER GELZER: Sure. I (audio  
9 interference) --

10 CO-CHAIR-KAHN: I'm sorry, we're  
11 missing you a little bit.

12 MEMBER GELZER: Can you hear me now?

13 CO-CHAIR-KAHN: Now we can, yes.

14 MEMBER GELZER: Hello?

15 CO-CHAIR-KAHN: Yes, we can hear you  
16 now.

17 MEMBER GELZER: Okay. Yes, and I hope  
18 I wasn't asked to be a lead discussant because I  
19 oppose this measure, because I really don't  
20 oppose this measure. I believe that it, as I  
21 said earlier, I think it's another valid data  
22 point, and if it's stratified and risk-



1       standardized, I think it makes sense to continue  
2       it.

3                   CO-CHAIR-KAHN:   Okay.   Janice?

4                   MS. TUFTE:   The same.   I voted for  
5       removal for some of these just because, as some  
6       others have commented, I would like to see a more  
7       generalized or incorporated 30-day value-based --  
8       and I'm glad Michelle mentioned what she had said  
9       that will come out in 2024.

10                   But I guess my main concern is what  
11       I've mentioned already, is that individuals may  
12       have other complex conditions, and to ensure that  
13       nobody is penalized, and then, also, that the  
14       patient has proper care at home -- so, it takes a  
15       little bit more.   You know, there's a little bit  
16       more to the measure than meets the eye, I think.

17                   Thank you.

18                   CO-CHAIR-KAHN:   Okay.   Ron, do you  
19       have anything to add?

20                   MEMBER WALTERS:   Nothing more to add.

21                   CO-CHAIR-KAHN:   Okay.   Any other  
22       comments or questions from the Committee?   Any

1 hands up?

2 MS. PERERA: You have Leah Binder.

3 CO-CHAIR-KAHN: Leah?

4 MEMBER BINDER: I guess I just want to  
5 ask those who are supporting removal of this  
6 measure and the other measure, really what  
7 criteria they're using. Are they using our  
8 measure review criteria that we've laid out or  
9 are they proposing additional criteria? I'm not  
10 really clear on what the issue is for removal.

11 CO-CHAIR-KAHN: I think we'll need to  
12 let one of them answer.

13 MEMBER WALTERS: I can answer. I did  
14 it mostly from a burden perspective. Recognizing  
15 that this is claims-based and, actually, the data  
16 is provided by Medicare, it still takes an awful  
17 lot of effort from people behind the scenes to  
18 format it, to report it, and to get the experts'  
19 opinion/input that could be repeated across 30  
20 more diseases, if it goes that direction.

21 MEMBER BINDER: Well, burden,  
22 actually, is not one of our criteria, but, I

1 mean, we could add it. We should talk about  
2 that. But it's not.

3 So, I do think we should just be  
4 really clear about that. This is a really  
5 significant measure. I mean, this is significant  
6 to a lot of people that we work with, this  
7 measure. So, a removal of the question should  
8 really be done with some really clear criterion,  
9 I guess would be my sermon. If burden is  
10 something we should consider, and we probably  
11 should, then let's consider that as part of an  
12 addition to our criteria.

13 CO-CHAIR-KAHN: Well, we will have at  
14 the end an opportunity to discuss the criteria, I  
15 think, right, Tricia?

16 MS. ELLIOT: Correct.

17 CO-CHAIR-KAHN: It's coming at the  
18 end. So, this is actually a good one. And in  
19 terms of this is a demo, there's nothing against  
20 somebody using some criteria they thought was the  
21 right criteria.

22 But, Ron, I think you really should

1 bring this up, I mean the criteria part, when we  
2 get to the discussion at the end.

3 MEMBER WALTERS: Yes, generally, it's  
4 had negative unintended consequences.

5 CO-CHAIR-KAHN: Okay. Well, we can  
6 discuss it. We can discuss that then.

7 Are there any other comments?

8 MS. ELLIOT: I think Michelle had her  
9 hand raised.

10 CO-CHAIR-KAHN: Michelle?

11 DR. SCHREIBER: Thanks. To some  
12 degree, this gets to Leah's comment of, what are  
13 the criteria for removal? We think that putting  
14 disease-specific mortality is actually very  
15 important, and largely, because (a) hospitals do  
16 quality improvement that is disease-specific,  
17 but, more importantly, we think patients,  
18 beneficiaries, caregivers really want to look at  
19 this. I mean, honestly, when you go into a  
20 hospital, what's really most important to you?  
21 That you live or die, I would think. And for  
22 patients to be able to see that, we think is

1 actually important at a disease-specific level.

2 And so, if we're going to look at  
3 criteria for removal, I'd also think that maybe  
4 we should consider what's the impact to patients  
5 and is this important information for patients.

6 MS. ELLIOT: Great. Thank you.

7 I think we have two more hands raised  
8 that we'll try to squeeze in here before lunch.

9 Dan Culica, did you have a question or  
10 a comment?

11 MEMBER CULICA: I do. I might be  
12 confused, but I think that the discussion so far  
13 was for one measure and against the other  
14 measure. And I don't see very much distinction  
15 between, from a clinical perspective, between  
16 heart failure and AMI. Maybe I'm wrong. Maybe I  
17 misunderstood the entire reflection.

18 CO-CHAIR-KAHN: Do Michelle or  
19 somebody from CMS have a comment on that? Okay.

20 DR. SCHREIBER: I mean, I don't know  
21 what to answer, Dan. This is a group of measures  
22 that are all, obviously, different for the

1 different diseases. They're calculated in a  
2 similar way. The risk standardization is a  
3 little bit different for each.

4 MEMBER CULICA: Right.

5 CO-CHAIR-KAHN: Okay. You said there  
6 was another hand?

7 MS. ELLIOT: Yes, Arif Kamal.

8 MEMBER KAMAL: Yes, actually, I was  
9 going to comment on what I see as the clinical  
10 difference between the two measures.

11 So, for me, death within a hospital  
12 within 30 days of a heart failure admission  
13 reflects likely not the index, not the first  
14 heart failure admission for a patient. You know,  
15 it's, clearly, a later one. And to me, it  
16 reflects a gap in end-of-life planning, home-  
17 based care, care coordination. So, it's really  
18 sort of a later-stage issue that I think does  
19 involve home-based palliative care, hospice, and  
20 otherwise, sort of in-home support for patients  
21 who will likely have another exacerbation, and  
22 then, can choose to manage that supportively in a

1       setting other than the hospital.

2                   For me, death within 30 days of an AMI  
3       reflects in-stent stenosis. It reflects  
4       unaddressed arrhythmia. So, this actually  
5       addresses, to me, gaps in sort of acute  
6       management and care more than it is sort of long-  
7       term care coordination.

8                   I would be against, for that reason,  
9       lumping them together, because I think they are  
10      addressing very different gaps in clinical care  
11      delivery.

12                   CO-CHAIR-KAHN: Great. Thanks.

13                   So, we're about two minutes before the  
14      hour and we have two more measures to go in this  
15      group. But I think we're close enough.

16                   I think, on the agenda, it says 12:40,  
17      and I know that some people had made plans. So,  
18      if it's okay, Tricia, why don't we take the 40  
19      minutes, because we're really, basically, at noon  
20      now.

21                   MS. ELLIOT: Right.

22                   CO-CHAIR-KAHN: And I would say we'll

1 be back at 12:40. Is that okay?

2 MS. ELLIOT: That would be fine, yes.

3 And I think we're at a good stopping point. We  
4 have a transition slide for HIQR description, but  
5 I think Michelle addressed that early on. So,  
6 we'll be able to go right into the last two  
7 measures right after lunch. So, I think we're at  
8 a good stopping point.

9 CO-CHAIR-KAHN: Great. Okay. So,  
10 we'll see everybody, then, in about 40 minutes.

11 Thank you so much.

12 (Whereupon,, the above-entitled matter  
13 went off the record at 11:59 a.m. and resumed at  
14 12:40 p.m.)

15 CO-CHAIR KAHN: Okay, we're at 12:40  
16 p.m. Marina has joined us, so let's get into the  
17 last two measures, and then any comments on that,  
18 obviously. And then we'll have an opportunity  
19 for the public to comment on these measures. And  
20 then we'll vote. Take it away, Tricia.

21 MS. ELLIOT: We'll be picking up on  
22 Slide 65. And this is just an overview of the



1 HIQR program, as the next two measures fall under  
2 this umbrella.

3 So, this program type is pay-for-  
4 reporting and public reporting. The incentive  
5 structure is hospitals that do not participate or  
6 participate but fail to meet the program  
7 requirements receive a one-fourth reduction of  
8 the applicable percentage increase in their  
9 annual payment update.

10 The program goals include progress  
11 towards paying providers based on the quality  
12 rather than the quantity of care they give  
13 patients, and to provide consumers information  
14 about hospital quality so they can make informed  
15 choices about their care.

16 We'll go to the next slide. So, the  
17 first measure we'll be talking about under this  
18 umbrella is the CMS death rate among surgical  
19 inpatients with serious, treatable conditions.

20 The description is included here on  
21 the slide. Reporting level is facility or  
22 agency. Endorsement has been removed from this

1 measure. Four Committee members recommended this  
2 for removal.

3 Lead discussants are listed there,  
4 AmeriHealth Caritas, Janice Tufte and Ron  
5 Walters, and the criteria rationale provided for  
6 removal is the NQF endorsement removal measures  
7 duplicative of other measures in the program.

8 Chip, I'll hand it over to you for  
9 comments. You're on mute, Chip, we can't hear  
10 you.

11 CO-CHAIR KAHN: Let's start with Ron  
12 and work our way over.

13 MEMBER WALTERS: Reena, I'm probably  
14 the least popular person now these last two days,  
15 but, oh well. I guess you know I voted removal  
16 on this one. Basically, of course, it was the  
17 endorsement being removed.

18 And then, secondly, as my theme has  
19 been, this is a very good targeted measure, very  
20 important, you take sick people to the surgery or  
21 not so sick people and a bad thing happens to  
22 them. So, I would have to go online and just

1 type in other measures. So, the theme of the  
2 last couple days has been we have 30 day all-  
3 cause risk standardized mortality rate so far in  
4 transcatheter valve replacement.

5 To me, my simple mind, that sounds  
6 like a serious, treatable condition. We also  
7 have one for abdominal aortic aneurism repair  
8 mortality rate. That sounds like a serious,  
9 treatable condition.

10 I did not go to the trouble of  
11 checking all the numerators and denominators for  
12 this but again, I suspect, and this is how it  
13 happens, very suddenly, that we get groups that  
14 propose measures and we skip over the piece, I  
15 think, of is there another major that does this?

16 Of course, someone will always raise  
17 their hand and say, no, this is unique, this is  
18 da-da-da and does it match the specs completely  
19 for the other major?

20 I think that's part of the job this  
21 committee is being asked to do these last days  
22 and today, to look at things like that and say,

1 can that be replaced by one that already exists?

2 Or in some cases another one. So,  
3 anyway, if I'm wrong, I've been shown to be wrong  
4 pretty good yesterday, but if I'm wrong, correct  
5 me. It sure sounds like a serious, treatable  
6 complication on a surgical inpatient.

7 CO-CHAIR KAHN: Janice, anything you  
8 want to add?

9 MEMBER TUFTE: I'm sorry, I hadn't  
10 actually read all the way through and didn't  
11 realize it was discussed until a couple days ago.

12 But I believe that some of these I  
13 thought good for removal was they were also going  
14 to be the eCQMs. I could be wrong and I think  
15 this might have been one of them but there was  
16 duplicity I believe.

17 CO-CHAIR KAHN: There's overlap, okay.  
18 Andrea, are you there? She's on mute. Anybody  
19 else have any comments or questions?

20 MS. ELLIOT: I do not see any hands  
21 raised yet.

22 MS. PERERA: Heidi?

1                   MEMBER BOSSLEY: Sorry, I raised my  
2 hand as you were saying that Tricia. This may be  
3 a question for CMS but wasn't this measure  
4 proposed to be removed in this last rule? But  
5 then there were enough comments to sway CMS to  
6 not. And I don't know the reason why but if you  
7 could maybe give us a couple bullet points on why  
8 it stayed in the program, that might be helpful.

9                   DR. DUSEJA: Thanks for that. You're  
10 absolutely correct. It was proposed for removal  
11 and based on comments we've received, we did not  
12 finalize that removal.

13                   I am going to turn to Grace Snyder and  
14 Tim Jackson, who are part of our group and speak  
15 to the comments and the decision to keeping the  
16 measure.

17                   MS. SNYDER: This is Grace Snyder.  
18 Like Reena was saying, we did receive a mixed set  
19 of public comments, certainly in support of or  
20 not in support of our proposal to remove the  
21 measure.

22                   Many of those comments go back to I

1 think our discussion from earlier today about the  
2 benefits and concerns and pros and cons of having  
3 more granular information available, whether it's  
4 disease-specific or with this particular measure,  
5 with the more serious complications versus a  
6 broader measure or an overall facility-type  
7 measure.

8 And so I think this is another example  
9 of the debate we've been having and the great  
10 conversations we've been having today about for  
11 patients and for providers, whether they want  
12 that as more granular performance information or  
13 to have a broader measure like a hospital-wide  
14 mortality measure.

15 CO-CHAIR KAHN: Why was the  
16 endorsement removed, do you know, Grace?

17 MS. SNYDER: I'll defer to other  
18 members of my team, I don't recall off the top of  
19 my head.

20 DR. DUSEJA: I think we have Patrick  
21 Romano on is my understanding. Patrick, are you  
22 on?

1 DR. ROMANO: I am, yes, can you hear  
2 me?

3 DR. DUSEJA: Yes.

4 DR. ROMANO: Great, I'm happy to join.  
5 I'm from UC Davis and the MPAC international team  
6 that supports CMS with the maintenance of PSI4.  
7 So, PSI4 started as an HRQ measure, Agency for  
8 Healthcare Research and Quality.

9 HRQ worked with NQF to get the  
10 original endorsement for PSI4. At the time of  
11 the endorsement maintenance cycle several years  
12 ago, we did bring it back to NQF for endorsement  
13 maintenance review.

14 It did go through the full process all  
15 the way actually through CSAC but then there was  
16 an appeal at the end by an NQF member  
17 organization. The appeal was sent back through  
18 the NQF process for further determination.

19 At that point, ARC made a strategic  
20 decision based on resources that it could not  
21 continue to support the cost of bringing the  
22 measure through the endorsement process.

1                   And so ARC withdrew at that point and  
2                   allowed the endorsement to be removed.

3                   CO-CHAIR KAHN: Is it duplicative of  
4                   other measures that are asked of providers here?

5                   DR. ROMANO: Currently, it overlaps  
6                   with other measures of surgical mortality. It is  
7                   a risk-adjusted surgical mortality measure.

8                   So, there are a number of other  
9                   measures in the portfolio, of course, that focus  
10                  on specific types of surgery like aortic valve  
11                  replacements, coronary bypass surgery, and so  
12                  forth.

13                  But because of the fact that PSI4 has  
14                  a broader surgical population, it allows for more  
15                  reliable estimation across a larger number of  
16                  hospitals that may not perform any of those  
17                  specialized procedures.

18                  CO-CHAIR KAHN: Are there any other  
19                  questions or points to make about it? Thank you  
20                  very much.

21                  Before we give it back to Tricia, let  
22                  me say that I think now that we're in the measure



1 transparency portion, I think we are at a  
2 different sort of level in terms of when we were  
3 in ASCs we had a paucity of measures.

4 Here, they can keep adding measures  
5 and I guess the question is at what point do we  
6 hit Ron's burden standpoint? And maybe that's a  
7 question here but we'll see how the group decides  
8 to go with it.

9 Tricia, why don't we go to the next  
10 one?

11 MS. ELLIOT: Okay, we'll move ahead to  
12 the next slide. The next slide is Slide 67,  
13 which is CMIT 902, hospital 30-day all-cause risk  
14 standardized mortality rate following acute  
15 ischemic stroke.

16 The description of the measure is on  
17 the slide, the reporting level is facility, the  
18 endorsement status is not endorsed. Two members  
19 of the Committee recommended removal and we have  
20 the lead discussants listed similar to the other  
21 measures.

22 The criteria and rationale was the

1 lack of NQF endorsement. Measure should be  
2 combined in a properly risk-adjusted overall  
3 mortality measure that is not disease-specific.

4 So, I'll hand it back to you, Chip, to  
5 lead the discussion.

6 CO-CHAIR KAHN: Ron, do you want to  
7 take it next on this?

8 MEMBER WALTERS: I'm unable to find an  
9 identical measure to this so I had to be a little  
10 more generalized and just say it was due to non-  
11 endorsement and could be combined in a properly  
12 risk-adjusted overall mortality measure that is  
13 not disease-specific.

14 So, it's kind of like you heard all  
15 day.

16 CO-CHAIR KAHN: Janice, do you have  
17 anything to add?

18 MEMBER TUFTE: I think this might end  
19 up being a little bit like what had been  
20 responded to earlier regarding heart failure  
21 versus AMI and it could be similar. But I also  
22 independently had the same idea as Ron.

1 I know a lot of patients, if they were  
2 serving on panels, they would wonder why we had  
3 so many different ones and would need some more  
4 explanation. So, thank you.

5 CO-CHAIR KAHN: Other comments or  
6 questions from the group? If there are no hands,  
7 I think this is the last one.

8 MEMBER BOSSLEY: Chip, this is Heidi,  
9 can I ask a quick question?

10 CO-CHAIR KAHN: Obviously.

11 MEMBER BOSSLEY: So, there is a hybrid  
12 measure that pulls in the stroke scale and Reena,  
13 sorry to call on you again but has it been  
14 proposed?

15 To me the risk model is very much  
16 improved by that type of measure but I don't know  
17 where it is with feasibility of implementation  
18 and everything if I remember correctly.

19 DR. DUSEJA: You're right, there has  
20 been effort to get more of that granular data  
21 that we can get through a hybrid type of measure  
22 with electronic elements.

1                   So, my understanding is that's still  
2 going through development and there is plans at a  
3 certain point to address some of the Committee's  
4 concerns around endorsement and taking these  
5 measures through endorsement as well. So, I  
6 wanted to also raise that.

7                   I know Anita goes on, I just spoke to  
8 her briefly before this call, if she wants to add  
9 anything else for this particular measure?  
10 Anita? She might not be on.

11                  MEMBER BOSSLEY: I'll just add I think  
12 the hybrid is actually endorsed which to me would  
13 be another reason why that one should be higher  
14 in the list to potentially replace that. Anita,  
15 I'm sorry, you're on.

16                  MS. MEYYUR: I was trying to get off  
17 mute, sorry. So, was the question about  
18 replacing this measure with the stroke measure?

19                  MEMBER BOSSLEY: Isn't there a hybrid  
20 if I remember correctly, a hybrid mortality that  
21 has the stroke scale? Or is that only for  
22 readmissions? I've lost track.

1 MS. MEYYUR: I think there is one,  
2 yes.

3 PARTICIPANT: There's one in  
4 development, right, Vinitha? If the team is on,  
5 they can talk to where we are in the stage of  
6 that in terms of endorsement. Doris, are you on?

7 DR. PETER: Yes, actually, I was just  
8 communicating with our colleagues about the  
9 status. So, this measure isn't the hybrid  
10 measure, there is a hybrid measure to start with  
11 and it does improve the risk adjustment, as was  
12 stated.

13 I think Heidi might have said that.  
14 And it doesn't look like it is implemented  
15 currently but the risk model was changed in order  
16 to respond to stakeholder concerns about wanting  
17 better risk adjustment.

18 So, that is why that measure was  
19 improved. I don't know about future  
20 implementation plans but if I get an indication  
21 from anyone who's on our team I will update you  
22 accordingly.

1 MS. TRICHE: This is Beth Triche, one  
2 of the Directors at CORE. I think that measure,  
3 the hybrid stroke lost endorsement because it was  
4 not used so there was no plans for  
5 implementation.

6 So, it is no longer endorsed because  
7 it wasn't used.

8 MEMBER BOSSLEY: That's helpful, thank  
9 you.

10 DR. PETER: Right, and there may be  
11 also confusion about adding the NIH stroke scale.  
12 That's the risk adjustment improvement measure  
13 and I may have been conflating the two so  
14 apologies for that.

15 MS. TRICHE: We have a measure that's  
16 currently implemented that does not adjust for  
17 the NIH stroke scale and we have one that just  
18 went through NQF and did not get endorsed because  
19 they had some concerns about it not being a  
20 functional status measure.

21 But in general, it was respecified to  
22 account for severity of stroke, just as the

1       neurological societies had asked.

2                   CO-CHAIR KAHN:   Heidi, is that  
3       satisfactory?

4                   MEMBER BOSSLEY:   Yes, I think we know  
5       there are concerns with this measure as it's  
6       written and as specified.   The sooner we can get  
7       a better specified measure in the program, I  
8       think it will address some of the concerns people  
9       have voiced.

10                  MS. TRICHE:   We do have the one that  
11       now adjusts for NIH stroke scale developed and  
12       ready to go.

13                  CO-CHAIR KAHN:   Any other questions on  
14       these or points to make on these measures?

15                  MS. PERERA:   We do have a hand raised  
16       from David Gifford.

17                  MEMBER GIFFORD:   Chip, maybe this is  
18       something for a learning experience to think  
19       about which is some of these measures I think  
20       were okay if there's another replacement measure  
21       that came in.

22                               And there are some in the works and we

1 don't know where it all is, that sort of caveat  
2 with some of the recommendations we have, it's  
3 almost like when we endorse the measure on the  
4 MUC list that isn't NQF-endorsed.

5 We want to see it get NQF-endorsed but  
6 we understand it has to go forward with that. On  
7 these measures, I'm looking at the program  
8 purpose, which is public reporting for consumer  
9 choice.

10 As we get more and more aggregate  
11 composite measures across multiple disease  
12 entities, that moves away from the purpose of the  
13 program.

14 There's good reasons for measurement  
15 and the value of these purchasing programs and  
16 other programs, putting all these into multi-  
17 scale type programs.

18 But if the programs are consumer  
19 choice, I'm trying to decide do I want to get  
20 stroke care somewhere or MI care.

21 Now, that may be a fallacy because we  
22 just go to the closest hospital where EMS takes



1 us or where doctors are, so that could be a  
2 fallacy too. But removing this measure from this  
3 program because there's composite measures raises  
4 a little bit of concern.

5 The fact that there's a more composite  
6 stroke measure that's in the works ready to come  
7 out makes me less concerned by taking this out.  
8 But I didn't hear anything about this measure  
9 should come out because of really bad -- we've  
10 learned something about its performance that  
11 makes it not worth having in anymore.

12 CO-CHAIR KAHN: Are there any comments  
13 on performance?

14 DR. DUSEJA: This is Reena, I can  
15 start and I don't have the national spread.

16 One of the things we routinely do with  
17 all our measures in our programs is to see if  
18 there still is variation across reporting, across  
19 facilities and pick one for this particular  
20 measure as we are evaluated every year in  
21 considering whether we're not really equal to  
22 move the bar any further.

1                   We've hit a particular threshold or a  
2 benchmark. So, from the last time I looked at  
3 this data, my team will correct me if I'm wrong,  
4 there's still a variation there so there's some  
5 value in being able to report it.

6                   To your point, this isn't an IQR  
7 program so there's no penalties, this is pay for  
8 reporting. So, I hope that addresses that point  
9 that you raised.

10                  CO-CHAIR KAHN: Reena, it does bring  
11 up an issue that I think David was talking about.  
12 There's been some mention that in some way this  
13 program is a way station for measures.

14                  Obviously, these measures are going  
15 the other way, not towards the other programs.

16                  But I do wonder whether being a way  
17 station or just because we have measures that  
18 we're curious about, we ought to have them out  
19 there, how that plays into the role of this  
20 particular program, which is to inform consumers.

21                  It seems to me that this  
22 experimentation with measures is a little bit

1 different than informing consumers. Also,  
2 there's so many measures in there, I don't know.

3 DR. DUSEJA: As you know, we did apply  
4 our meaningful measure framework several years  
5 ago and continue to apply it to continue to  
6 reduce those number of measures to those that we  
7 are seeing value-add for those that are consuming  
8 the information.

9 I do think there is something to say  
10 about when it gets this specific, how do  
11 consumers understand this information?

12 I know there's been a lot of work that  
13 CMS has done to translate what these measures are  
14 actually measuring for our beneficiaries, for  
15 them to understand, okay, what is this actually  
16 saying when I look at this actual metric?

17 So, there's a lot more work to be done  
18 on that so I completely agree.

19 CO-CHAIR KAHN: Any other questions or  
20 points?

21 MS. PERERA: We do have a question  
22 from Carol.

1                   MEMBER PEDEN: Could I just go back to  
2                   the surgical measure and ask for some  
3                   clarification. That could be addressing fairly at  
4                   a rescue, which is a composite measure.

5                   But how does it differ from PSI04? Is  
6                   it just a different version?

7                   DR. DUSEJA: It is PSI04 but when we  
8                   got it from ARC, we actually adjusted it, we  
9                   reevaluated it I would say.

10                  I don't know the specifics and how it  
11                  differs from PSI04. I would have to turn back to  
12                  Patrick if he can elaborate on the differences,  
13                  if any after the reevaluation.

14                  DR. ROMANO: The reevaluation that Dr.  
15                  Duseja describes is an ongoing process and so  
16                  there's a continuing process of responding to  
17                  stakeholder feedback and trying to improve the  
18                  measure.

19                  The current measure that CMS uses is  
20                  basically identical to the ARC measure that used  
21                  be called failure to rescue except that it is  
22                  applied only to CMS fee-for-service Medicare

1 patients.

2 MEMBER PEDEN: Thanks.

3 CO-CHAIR KAHN: Any other questions?

4 There is? Let's open it up to the public to see  
5 if there's anybody from the public that has a  
6 comment.

7 MS. ELLIOT: Sure, we'll check the  
8 chat and the hand-raising. So, we're open for  
9 any public comment. And those who are dialing in  
10 who we may not be able to see on the participant  
11 list, if you have any comments feel free to speak  
12 up.

13 I do not see any hands raised. Udara,  
14 can you double-check for me? Are there any hands  
15 raised or comments?

16 MS. PERERA: Leah Binder just raised  
17 her hand.

18 MS. ELLIOT: Leah? You're on mute  
19 Leah if you're speaking.

20 MEMBER BINDER: Sorry, I keep doing  
21 that. The public comment is for which measures  
22 to --

1 CO-CHAIR KAHN: The public comment is  
2 for all these measures.

3 What we've been doing is before we  
4 vote we ask for public comment so that the public  
5 comment could potentially affect the vote and  
6 influence if there's comment.

7 But I hear no comment so do you have  
8 anything else, Leah, you want to say?

9 MEMBER BINDER: I'm sorry, I came back  
10 five minutes late from my lunch.

11 CO-CHAIR KAHN: Go ahead.

12 MEMBER BINDER: The measure that's  
13 from treatable complications from surgery, that  
14 measure, is that included in this group?

15 MS. ELLIOT: I believe so, that was on  
16 the death rate among surgical inpatients with  
17 serious treatable complications, yes. I was just  
18 on Slide 66. Did you have a comment on that one,  
19 Leah?

20 MEMBER BINDER: Yes, I did have a  
21 comment. We include this measure in the hospital  
22 safety grid that we do, so we've done the safety

1 grade now for almost ten years. And we get  
2 hundreds upon thousands of press calls over time.

3 We update it every six months and we  
4 get lots and lots of calls from consumers and we  
5 deal with hospitals all the time about every  
6 single measure in our grade.

7 But of all of the measures that we use  
8 for safety, and we use about 27 right now, this  
9 is the one that gets the most attention,  
10 especially consumers and especially just the  
11 media, particularly the lay media that reaches  
12 out, such as newspaper that reaches out to  
13 consumers.

14 It's extremely important to them. A  
15 lot of people who are not in healthcare, when  
16 they think about going to a hospital they think I  
17 would go there for surgery and what's the most  
18 important thing to me? Is it going to kill me?

19 Am I going to have a complication  
20 that's going to be terrible?

21 So, it is the number-one measure we  
22 have and if we didn't a good measure of this that

1 had been tested through time and looked at by the  
2 scientists, if we didn't have a good measure of  
3 this, there are plenty of organizations that will  
4 make one.

5 There's employers who will take their  
6 claims data and make it, or somebody will take  
7 the Medicare data and make it. They'll make a  
8 measure of this, it's so important to people.

9 So, I think we definitely need to  
10 improve the measure, I'm sure we've talked about  
11 that a bit, and over time that could be done.  
12 But this measure is critically important to  
13 consumers based on our experience.

14 CO-CHAIR KAHN: Thanks for the input.  
15 Are we ready to vote then?

16 MEMBER TUFTE: A quick question, I  
17 forgot why this was NQF removed, can you share  
18 that again?

19 CO-CHAIR KAHN: I think it was a  
20 description of they were coming back for a re-up  
21 and it was taking too much time and a decision  
22 was made not to put resources into it by NQF.



1 MEMBER TUFTE: It's very low.

2 CO-CHAIR KAHN: It sounded technical  
3 in terms of the reason. Is that correct from  
4 NQF?

5 DR. DUSEJA: When it went back for re-  
6 endorsement, it was under AHRQ and yes, it had to  
7 do with resources that we heard earlier, the fact  
8 that it didn't go through the complete  
9 endorsement review.

10 MEMBER TUFTE: Thank you.

11 CO-CHAIR KAHN: So, I guess we could  
12 argue it didn't fail re-endorsement but the  
13 Agency decided not to pursue the entire pathway.  
14 I don't know what that means in terms of the  
15 conclusion, though.

16 Anything else? Why don't we go to the  
17 vote then?

18 MS. ELLIOT: Okay, if we can initiate  
19 the vote on these measures, please?

20 MS. HARDING: Okay, everyone, polling  
21 is now open for Measure 89, hospital 30-day all-  
22 cause risk standardized mortality rate following

1 heart failure, hospitalization.

2 Please provide your poll vote for if  
3 you support the removal of this measure from this  
4 program.

5 CO-CHAIR KAHN: 17, I don't know if  
6 our numbers went down any.

7 MS. HARDING: It looks like everyone  
8 has completed the poll. We have nine for yes and  
9 eight for no.

10 CO-CHAIR KAHN: Does that make the 60?

11 MS. HARDING: That gives us a  
12 percentage of 53.

13 CO-CHAIR KAHN: So, let's go to the  
14 next one then.

15 MS. HARDING: We are now on Measure  
16 86, hospital 30-day all-cause risk standardized  
17 mortality rate following AMI. Please participate  
18 in the poll to show if you support the removal of  
19 this measure.

20 It looks like everyone has  
21 participated. We have 6 for yes and 11 for no,  
22 and that puts us at 35 percent.

1                   We are now on Measure 1357, CMS death  
2 rate among surgical inpatients with serious  
3 treatable complications from the hospital  
4 inpatient quality reporting program.

5                   Please participate in this poll to  
6 show if you support removal of this measure.

7                   CO-CHAIR KAHN: I guess people got  
8 back.

9                   MS. HARDING: We have 3 for yes and 16  
10 for no. That gives us 16 percent. We are now at  
11 Measure 902, hospital 30-day all-cause risk  
12 standardized mortality rate following AMI.

13                  Please participate in the poll to show  
14 if you support removal of this measure. It looks  
15 like everyone has completed their participation.  
16 We have 8 for yes and 11 for no.

17                  And that gives us a percentage of 42.

18                  CO-CHAIR KAHN: Obviously, our  
19 conversation strongly influences the outcome  
20 there. Let's go to the next area.

21                  MS. ELLIOT: Sorry, Chip, it's Tricia.  
22 We do have this discussion point, I didn't know

1 if you wanted to just highlight this, if anybody  
2 has any other comments on mortality? CMS has  
3 requested this strategic input from the group on  
4 this.

5 CO-CHAIR KAHN: We have had a lot of  
6 discussion about this but now that we're asking  
7 the specific question, Ron or does anybody else  
8 want to make any comments?

9 MEMBER WALTERS: No, I've spoken about  
10 enough.

11 CO-CHAIR KAHN: Anybody else? Tricia,  
12 from our discussion I think --

13 MS. ELLIOT: We've covered it. We  
14 just wanted to pause just in case and I don't see  
15 any hands raised so I think we're good.

16 CO-CHAIR KAHN: I'm going to give the  
17 baton back to you then and let's go through the  
18 next set, which is also in the IQR program.

19 MS. ELLIOT: Correct, so there's two  
20 more measures that we'll be reviewing and as Chip  
21 mentioned, these are in the hospital IQR  
22 programs.

1           The first one is 1017, which is severe  
2       sepsis and septic shock, the management bundle,  
3       and is a composite measure.

4           Three members recommended this for  
5       removal. The other measures, 57, 56, also in the  
6       HIQR program, and a footnote on this one, the  
7       exclusive breast milk feeding eCQM.

8           Two members recommended removal. The  
9       measure was finalized for removal from the  
10      program in Fiscal Year 2022, beginning with the  
11      Fiscal Year 2026 payment determination. So, we  
12      just wonder if that came in after when the rule  
13      was finalized.

14          So, we'll go to the next slide. We've  
15      covered the program requirements of HIQR so we'll  
16      go right into the measures. The first one up for  
17      discussion is 1017, which is severe sepsis and  
18      septic shock, the management bundle.

19          The description is included on the  
20      screen. The reporting level is facility, it is  
21      an endorsed measure. Three members selected this  
22      for removal, the American Healthcare Association

1 and Janice Tufte have been named as the lead  
2 discussants.

3 The criteria and rationale for  
4 removal, measure is not evidence-based and is  
5 extremely difficult to collect, measure excludes  
6 clinical judgment and could lead to unintended  
7 consequence or harm by treating patients who  
8 appear to be infected but are not.

9 I'll hand it back to you, Chip. Why  
10 don't I start with David? Is David here?

11 MEMBER GIFFORD: Yes, thanks, Chip.  
12 This is an interesting measure. The IDSA and  
13 several other professional associations wrote an  
14 editorial recommending that this measure be  
15 changed.

16 Their rationale was that would drive  
17 over-antibiotic-use. There was an accompanying  
18 editorial that criticized IDSA's recommendation,  
19 saying there's no evidence that it's going to  
20 drive antibiotic overuse and it was a theoretical  
21 argument.

22 There's been a couple other articles

1 that have really raised questions about the  
2 denominator of this measure, which is based off  
3 of claims where prospective prediction of who has  
4 serious sepsis or shock is actually quite bad.

5 And it's shown that the reliability  
6 of the denominator definition here is pretty bad.  
7 And so there was some arguments for why this  
8 measure should be removed based on that  
9 performance component, which was not raised by  
10 IDSA and the other editorial, which we found kind  
11 of interesting.

12 There is data to suggest that there  
13 are good guidelines on how to manage sepsis and  
14 shock and if you follow them, you can improve  
15 some outcomes.

16 But it's unclear whether following  
17 this measure and whether people meet this measure  
18 actually do better without outcomes or not, it's  
19 sort of an ecologic type of analysis and no one's  
20 really looked at that from that standpoint.

21 So, I think there's pros and cons to  
22 keeping this measure. Clearly, severe sepsis and

1 shock is a serious illness that ties in with the  
2 purpose of this program.

3 And it's clear that there's a high  
4 mortality event, and that with the appropriate  
5 care it can be lowered. Whether this measure is  
6 accomplishing that goal or not is unclear.

7 Again, though, the purpose of this  
8 program was for public reporting and consumer  
9 choice issues. So, as far as whether it should  
10 be removed or not, I look forward to the  
11 discussion.

12 CO-CHAIR KAHN: Janice?

13 MEMBER TUFTE: Septic shock and sepsis  
14 is very interesting to me. I've experienced it  
15 and know other people that have, and there's just  
16 so much about it.

17 I appreciate that it should be treated  
18 early and that's recognized here but I do agree  
19 with what was just stated regarding what is the  
20 outcomes of this?

21 Was there better outcomes because of  
22 the following through with this management



1 bundle? Did patients have better outcomes? And  
2 the ability to of course actually fulfill the  
3 composite measure.

4 So, I think it's important and I'm not  
5 sure if there are others out there that are  
6 comparable. And as just stated, there's pros and  
7 cons I think to this.

8 CO-CHAIR KAHN: If I'd ask a question,  
9 I know we have hospital people on the line, there  
10 are two aspects here. One is that David raised,  
11 which is that I think this is a little bit more  
12 difficult in terms of collection of the  
13 information.

14 Is that an issue for you? And the  
15 second is we're in the midst of rapid development  
16 here of predictive technology for this, and is  
17 there any interaction potentially between the  
18 development of that and whether this particular  
19 approach in the measure is the best one?

20 I don't know if anybody can take that  
21 on the phone.

22 DR. DUSEJA: Is that directed to CMS

1 or is that directed to --

2 CO-CHAIR KAHN: I was sort of hoping  
3 HCA or Ameritas or somebody might but I'm happy  
4 to give it to CMS too.

5 DR. DUSEJA: First of all, I'll say  
6 thank you so much for your comments for David and  
7 Janice.

8 These are comments that we've heard  
9 from stakeholders as well and from CMS's  
10 perspective, we take all this input and really  
11 seriously look at it as we're continually  
12 evaluating the measure within the program.

13 It's true that there has been quite a  
14 concern given this is a chart-based measure in  
15 terms of abstraction burden.

16 And so we're continually looking to  
17 refine the collection of the essential elements  
18 of this composite measure and you'll see that in  
19 our updates that we do every year in terms of the  
20 specifications manual.

21 I just want to point out two things.  
22 One is we just went through re-endorsement

1 through NQF on this measure this year that  
2 addressed some of these concerns with regards to  
3 the evidence behind the measure.

4 And I think it's overwhelming showing  
5 that there's evidence behind each of these  
6 composite elements. And also, in terms of  
7 balancing this burden of collection, that was  
8 also discussed.

9 That's all public knowledge so I would  
10 suggest if it's helpful to look at that dialog,  
11 because it was a robust conversation.

12 With regards to the linkage of this  
13 process measure to outcomes, I would point you to  
14 an article that we just published last month, the  
15 stewards and some of CMS staff in CHAST.

16 And it was an analysis using  
17 propensities and we did matching to look at the  
18 effect of Step 1 on the Medicare beneficiary  
19 population.

20 And what we found was that there was  
21 actually a 5.7 percent mortality reduction for  
22 our beneficiaries over that time period.

1           So, if you think about, to your point,  
2           the magnitude of the number of sepsis cases out  
3           there per year, over 1.7 million quoted by  
4           Buckman in his paper last year, the epic Medicare  
5           paper, and there's 270,000 deaths per the CDC per  
6           year.

7           We're looking at over 15,000 lives  
8           saved per year that this measure is attributed  
9           to. To the point of the concerns of overuse of,  
10          for example, we've heard from societies like  
11          IDSA, I think that's an important thing for us to  
12          continue to monitor.

13          There has been talk, and we've had  
14          discussions with them about creating a balancing  
15          metric to help evaluate that in a rigorous way.

16          And there's also thoughts about how if  
17          there's an opportunity as we're moving to digital  
18          measures and thinking about more outcome-based  
19          measures, whether there's room in that space for  
20          sepsis in general.

21          But I want to go back to the fact that  
22          this measure in itself stands on its own based on

1 the evidence and based on that it went through  
2 the NQF endorsement process and just got re-  
3 endorsed.

4 So, I will pause to see if there are  
5 any other questions on that?

6 CO-CHAIR KAHN: Any other questions?

7 MS. PERERA: We do have a couple of  
8 hands raised.

9 CO-CHAIR KAHN: Let's go with the  
10 hands.

11 MEMBER PEDEN: Hello, I was just going  
12 to comment. I have a background in anesthesia  
13 patient safety and you mentioned is AI going to  
14 help this?

15 In detection of the problem there has  
16 to be a response loop so even if you improve  
17 detection, somebody still has to respond and part  
18 of what this metric is doing is promoting that  
19 response.

20 MEMBER BINDER: I had my hand raised  
21 also.

22 CO-CHAIR KAHN: Who is that?

1                   MEMBER BINDER: This is Leah. I  
2                   appreciate what you had to say because I was  
3                   going to mention the chest article as well that I  
4                   thought was a compelling study.

5                   But I think fundamentally, I think we  
6                   see from this the value of NQF endorsement and  
7                   the process of NQF endorsement, because there was  
8                   a robust conversation that took place about some  
9                   of these issues.

10                  And also, combined with the  
11                  information from CHAST and some of the other  
12                  research that was brought forward during the  
13                  discussion around endorsement, it's clear there's  
14                  an evidence-based measure.

15                  And it is worth saying as well this is  
16                  a very significant problem in safety and quality,  
17                  very, very significant. 1.5 million people I  
18                  think get sepsis every year, it's a huge issue.

19                  And so the combination of a very good  
20                  measure that is associated with outcomes and a  
21                  very troubling problem in healthcare I think are  
22                  strong reasons to support continuing this

1 measure.

2 CO-CHAIR KAHN: Other discussion?

3 MS. PERERA: Yes, we have Heidi?

4 CO-CHAIR KAHN: Heidi?

5 MEMBER BOSSLEY: For the AMA, and I  
6 believe this will be no surprise, there is  
7 significant concern with the evidence, as Dave  
8 mentioned, and the feasibility of this measure.

9 This measure has I think the most data  
10 elements I've ever seen in a measure in any  
11 program.

12 So, I think the one thing I would say  
13 is it's very important if the specialty societies  
14 who are the ones who are providing this care are  
15 raising these issues, I'd encourage CMS to be  
16 very thoughtful and work with the developer to be  
17 responsive, including things around the  
18 unintended consequences.

19 And the lack of information doesn't  
20 mean we aren't doing something that could harm  
21 patients.

22 And so knowing even better what there

1 could be in antibiotics overuse through the use  
2 of this measure, in all those cases we need to  
3 know that just as much as we need to know how  
4 this impacts mortality rates.

5 So, I would just encourage you to keep  
6 looking at that. Thank you.

7 CO-CHAIR KAHN: Other comments?

8 MS. PERERA: We do have a hand raised  
9 from Robert Dickerson I believe.

10 MR. DICKERSON: I work with CMS on  
11 maintaining this measure and I just wanted to  
12 comment on how the description of the denominator  
13 that was provided earlier in the conversation.

14 The denominator, it's true, the  
15 initial population is identified by ICD10 codes  
16 but the denominator is from that group of  
17 patients that is identified by codes.

18 Abstractors identify a random sample  
19 and the denominator itself is identified through  
20 doing some initial chart abstraction for the  
21 measure. So, the denominator is not defined  
22 solely based upon coding.



1           Coding casts the initial net for the  
2           initial population and then through abstraction,  
3           that group to find the denominator is refined to  
4           ensure the patients do meet criteria for having  
5           severe sepsis or septic shock, including  
6           infection, meeting service criteria, and having a  
7           sign of organ as much.

8           So, I just wanted to clarify that in  
9           terms of the denominator.

10          CO-CHAIR KAHN: Thank you. Anything  
11          else? Let's go to the next measure.

12          MS. ELLIOT: We're on Slide 72 and  
13          this is the CMIT 5756 exclusive breast milk  
14          feeding, it is an eQOM. The description is  
15          included here in the slide. The reporting level  
16          is facility.

17          Two Committee members recommended for  
18          removal. We have the two lead discussants. The  
19          criteria rationale for removal is duplicative of  
20          another measure and the intent to the measure.

21          But we also just want to remind folks  
22          that it has been finalized for removal already.

1 CO-CHAIR KAHN: I guess that makes it  
2 somewhat moot but we'll still examine it. David,  
3 do you want to start off?

4 MEMBER GIFFORD: We did not recommend  
5 this for removal so for Leah's request yesterday  
6 and the more balanced presenter of pro and con, I  
7 will take the pro here. I'm surprised it was  
8 removed.

9 I couldn't find an example of other  
10 measures that were related so it says duplicative  
11 of other measures. It wasn't clear where those  
12 would be.

13 The data on breastfeeding for kids and  
14 starting and keeping going through in the  
15 hospital is just overwhelming for short and long-  
16 term outcomes of kids, even multiple years later.

17 So, I think it's not a good thing to  
18 remove it. I understand that there's been some  
19 pushes to get what I think is it sounds like a  
20 push to get baby-friendly status for hospitals.

21 If this was bundled as part of a baby-  
22 friendly, which is a component of baby-friendly,

1       that would be fine. But I think pulling it out,  
2       it's not clear what are the other measures so I'd  
3       be interested to hear what other measure or how  
4       this fits in.

5               And I think again, with the intent of  
6       the program, it sounds like maybe yesterday  
7       Michelle mentioned that it was part of a much  
8       bigger composite-type measure.

9               And again, I think if we're doing  
10      public reporting for consumer choice,  
11      particularly a topic like this that's really hot  
12      where parents and mothers really want to know  
13      what's going on, this would be not a measure I  
14      would bury in a composite measure.

15              CO-CHAIR KAHN: Janice, do you have  
16      any comments?

17              MEMBER TUFTE: Yes, so I do know that  
18      in a few of these, when I voted for removal it  
19      was because the eQOM I thought was more  
20      beneficial to the patient.

21              I thought in this case that the eQOM  
22      was not as definitive as the other, as the

1 standard one.

2 I could be wrong on that but I think  
3 that's why I voted whichever one was for removal.  
4 One had more components in it that I thought was  
5 more effective so I'm not sure why it was  
6 removed, or maybe somebody can share about that.

7 MEMBER GIFFORD: I think it just got  
8 NQF endorsement. It's one of the few measures we  
9 have on this list that, along with the other one,  
10 has maintained NQF endorsement, we didn't lose  
11 it.

12 So, I'm surprised why it got removed  
13 too.

14 MEMBER TUFTE: I agree that it's very  
15 important for mothers to have the support they  
16 have for this and I don't know either why.

17 CO-CHAIR KAHN: CMS, could you give us  
18 insight?

19 DR. DUSEJA: Let me turn this question  
20 to Grace. Grace, could you answer that?

21 MS. SNYDER: Sure, this is Grace  
22 Snyder. I think one of the main things we saw in

1 terms of the reporting was actually very low  
2 reporting by hospitals on this measure.

3 I don't know exactly off the top of my  
4 head, I think it was maybe around 200, only about  
5 200 or so, 250 hospitals reported on this measure  
6 as one of the four eQMs that they can report on  
7 from the eQM measure set.

8 So, I think that was a big part of it.  
9 And I think separately, something we've heard  
10 anecdotally is some instances of mothers feeling  
11 some undue pressure not being able to breastfeed.

12 But I think, again, the main reason  
13 for removal was the very low reporting rates.

14 CO-CHAIR KAHN: Any other questions  
15 from the Committee, or concerns, discussion?

16 MEMBER GIFFORD: Do we even need to  
17 vote on this one, Chip? If it's already been  
18 removed and we're getting recommendations for  
19 removing --

20 CO-CHAIR KAHN: I guess it's besides  
21 the point --

22 (Simultaneous speaking.)

1 CO-CHAIR KAHN: That's true, that's a  
2 very good point. Is there an opinion from Tricia  
3 from the NQF staff?

4 MR: Yes, I was just going to ask if  
5 our vote reflects the different opinion, could it  
6 be reconsidered in the future?

7 MS. ELLIOT: And that was the point I  
8 was going to raise, Misty, so thank you. It  
9 might be interesting to vote just to see if it  
10 aligns with that decision for removal or not.

11 CO-CHAIR KAHN: So, let's stick with  
12 it I guess. Any other points to make before I  
13 open to the public?

14 MS. ELLIOT: I do not see any other  
15 hands raised, is there a comment?

16 CO-CHAIR KAHN: I don't hear any  
17 comments. I'll open it up to the public. Is  
18 there anybody from the public who has a comment  
19 on either of the measures that we just discussed?

20 MS. PERERA: We do have a hand raised  
21 from Tom.

22 MR. HEYMANN: My name is Tom Heymann,

1 I'm the President and CEO of Sepsis Alliance,  
2 we're a patient advocacy organization  
3 representing the interests and needs of the 1.7  
4 million people who are diagnosed with sepsis each  
5 year.

6 We know that denominator has a  
7 numerator of 350,000 and 1 in 3 people who die in  
8 a hospital will die of sepsis. And we know that  
9 sometimes treatment is stringent as mortality can  
10 increase as much as eight percent for every hour  
11 the treatment is delayed.

12 We've heard about the research that  
13 indicates that SEP-1 saves lives. We felt that  
14 was the truth but now we know that through solid  
15 research. And without SEP-1 we fear that many  
16 hospitals will take their eyes off of sepsis.

17 SEP-1 clearly saves lives and we  
18 cannot afford to take our eyes off of sepsis.  
19 Clearly, we'll continue to learn and modify the  
20 measure as diagnostics and intelligence improve  
21 on this response to infection.

22 But I think it is imperative that we

1 keep the heat on and keep establishing and  
2 building on the gains that we've accomplished  
3 thus far.

4 Because this does come back down to  
5 real lives and I'd like to turn it over to -- we  
6 have two patient advocates on today who would  
7 like to share their thoughts and feelings. I'll  
8 throw it to Carl Flatley first.

9 CO-CHAIR KAHN: Carl?

10 MR. FLATLEY: Hello, my name is Carl  
11 Flatley and I'm the founder of the Sepsis  
12 Alliance, which is a sepsis advocacy organization  
13 in the United States.

14 We represent 1.4 million Americans  
15 that survive sepsis yearly and the caregivers  
16 where they had 270,000 people who suffer from  
17 sepsis yearly.

18 When I started the organization in  
19 2004, there was little attention paid to this  
20 condition by either the public or hospitals in  
21 spite of the fact that sepsis is the number-one  
22 cause of death in most hospitals.



1                   In 2002 I lost my perfectly healthy  
2                   23-year-old daughter following an outpatient  
3                   hemorrhoidectomy. She developed a post-op  
4                   infection and five days later she was gone from  
5                   septic shock and medical malpractice.

6                   There were many errors committed post-  
7                   operatively. The most egregious was the fact  
8                   that they let her go over the weekend and did not  
9                   give her antibiotics.

10                  I could have written the prescription  
11                  as I'm a retired endodontist. They did this  
12                  because in deposition after the lawsuit that we  
13                  had to file was the fact that they were afraid  
14                  the antibiotics would cause diarrhea.

15                  I don't know if you know this but  
16                  since Erin died in 2002, there's been over 5  
17                  million others who have died in the United States  
18                  from sepsis and over 13 million sepsis survivors  
19                  who suffer physical and mental problems.

20                  SEP-1 is a vital measure for patients  
21                  and for families like ours. It emphasizes  
22                  decreased time to diagnosis and treatment. It

1       took days for Erin's diagnosis to be made and she  
2       had five doctors at her bedside.

3               As you know, every hour counts. Now,  
4       with SEP-1's emphasis on screening and reporting,  
5       doctors are looking out for sepsis. That level  
6       of attention saves lives.

7               A new study of patient-level data  
8       report to Medicare by 3000 hospitals show SEP-1  
9       compliance is associated with lower 30-day  
10      mortality.

11              I am speaking to you today and urging  
12      you not to remove the SEP-1 measure, not because  
13      it's perfect but because it needs to be  
14      maintained, follow the science and modify it.

15              If SEP-1 remains in place, it will  
16      make a difference for other families and it would  
17      have made a difference in mine. Thank you very  
18      much.

19              CO-CHAIR KAHN: Thank you, Dr.  
20      Flatley.

21              MR. HEYMANN: And now Katy Grainger if  
22      we may?

1 MS. GRAINGER: Good morning, my name  
2 is Katie Grainger and I am a sepsis survivor.  
3 Three years ago almost to the day I entered a  
4 hospital on the island of Kauai in Hawaii and it  
5 was a small community hospital.

6 I did not recognized the signs and  
7 symptoms of sepsis. I thought I had the flu, I  
8 was alone at the time, I was not aware that I was  
9 becoming somewhat mentally impaired.

10 I eventually called a friend in the  
11 most pain I had ever been in my life and begged  
12 her to take me to the hospital saying I felt like  
13 I was going to die.

14 By the time I got there by blood  
15 pressure was 50 over 30, I was nearly dead. I  
16 was whisked into the ICU and I was saved by  
17 doctors who recognized and had a protocol.

18 They recognized that I was in very  
19 serious shape and they immediately began  
20 delivering fluids and doing the things that are  
21 required by SEP-1.

22 I believe that because of the size of

1       this hospital, because it was such a small  
2       community hospital, that if they hadn't had to  
3       put SEP-1 into place and have these procedures, I  
4       may not be here today.

5               So, I'm speaking out for the people  
6       who are not ending up in big-city hospitals that  
7       maybe have a different procedure in place that is  
8       similar to SEP-1.

9               I'm speaking for the people who are  
10       going to hospitals that wouldn't have a major in  
11       place if it were not for SEP-1.

12              So, I also am speaking today to ask  
13       you to keep it in place. Again, it is not  
14       perfect but it is saving lives and it saved my  
15       life. Thank you.

16              CO-CHAIR KAHN: Thanks, I appreciate  
17       it. Any other public comments?

18              MS. PERERA: Grace Snyder?

19              MS. SNYDER: Thank you, also I'd like  
20       to thank patient advocates speaking about the  
21       sepsis measure. I really appreciate hearing your  
22       voice directly.

1                   My comment was related to the  
2                   exclusive breast milk feeding eCQM and I know  
3                   that measure we have finalized for removal.

4                   But I did just want to take a moment  
5                   to I think maybe step back from this specific  
6                   measure and just add to the conversation that we  
7                   are focusing on maternal health in terms of  
8                   what's been a temp area in measurement in CMS  
9                   programs, Medicare programs.

10                  And so something else that we take  
11                  into consideration is that we have some other  
12                  measures that are in development.

13                  We very recently finalized to add to  
14                  the IQR program a maternal morbidity structural  
15                  measure and there's a lot more ongoing work in  
16                  that measurement area.

17                  So, the removal of one particular  
18                  measure, please don't take it as a signal that we  
19                  don't consider it important but just to add to  
20                  the conversation that there's a lot more work  
21                  we're doing focusing on the area of maternal  
22                  health.

1 Thank you.

2 CO-CHAIR KAHN: Thanks, other  
3 comments?

4 MS. PERERA: David Gifford?

5 MEMBER GIFFORD: On the sepsis  
6 measure, I think one of the values we provide is  
7 not just the up and down votes but the  
8 recommendations and language of it.

9 I'm going to state the obvious and I  
10 know the developers probably understand this, but  
11 it's clear from reviewing that measure that the  
12 clinical ability to identify sepsis and sepsis  
13 early so you could start an effective bundle is  
14 poorly done.

15 And there aren't good criteria out  
16 there. And I think part of the reason that this  
17 measure got thrown forward is because of that  
18 challenge. I'm not sure that's adequate enough  
19 to remove it, especially given the comments we've  
20 heard today.

21 But it is clear that we need to figure  
22 out a way to identify these cases early on to do

1 a better job on the treatment of it. That  
2 factors into any measurement we have.

3 CO-CHAIR KAHN: Anybody else? I  
4 think, Tricia, we've had public comment, I  
5 appreciate the input from the patient advocates  
6 and others. I think we're ready to go to a vote.

7 MS. ELLIOT: Yes, we will initiate the  
8 vote on these two measures.

9 MS. HARDING: Polling is now open for  
10 Measure 1017 severe sepsis and septic shock,  
11 management bundle, a composite measure. Please  
12 participate in the poll to show your support for  
13 removal of this measure.

14 A few more seconds before the poll  
15 closes.

16 CO-CHAIR KAHN: I think we were up to  
17 17, we may have lost some people.

18 MS. HARDING: Okay, I'll close the  
19 poll now. We have 1 for yes and 15 for no. That  
20 puts us at 6 percent. Polling is now open for  
21 Measure 5756, exclusive breast milk feeding eCQM  
22 from this program.

1                   Please participate in the poll to show  
2                   your support for removal of this measure. The  
3                   poll will now close. We have 8 for yes and 7 for  
4                   no. This puts us at 53 percent.

5                   MS. ELLIOT: Chip, it's Tricia.  
6                   Before we move on, we had someone reach out and  
7                   want to make a comment. Emmanuel, are you still  
8                   on the line? Would you like to comment?

9                   MR. RIVERS: Yes, can you hear me  
10                  okay?

11                  CO-CHAIR KAHN: Yes, go ahead.

12                  MR. RIVERS: This is Manny Rivers, one  
13                  of the measure stewards and I wasn't sure about  
14                  Measure C. But the comment about early diagnosis  
15                  of sepsis and septic shock I think is an error.

16                  One of the great attributes of the  
17                  measure is that we now can decrease sudden  
18                  cardiovascular complications, which the mortality  
19                  are about 20 percent of the previous sepsis  
20                  patients, and recognize people much earlier lack  
21                  the screenings.

22                  One of the unrecognized things is that



1 we have now have lower mortality simply because  
2 of early recognition.

3 So, I wanted to correct and emphasize  
4 the fact that recognizing sepsis still is a  
5 challenge but this stratification now allows us  
6 to detect these people earlier.

7 That counts for almost a 20 percent  
8 mortality reduction from early screenings of  
9 lactate and blood pressure.

10 CO-CHAIR KAHN: Okay, I think we've  
11 had all the comments now and obviously, the votes  
12 reflected the commentary that we received.

13 So, I guess before we turn it back to  
14 Tricia, we have space in the existing agenda for  
15 a break and I suggest maybe we should. Do you  
16 want to take the break and we'll come back?

17 MS. ELLIOT: I leave it up to the  
18 group, we're running pretty far ahead of  
19 schedule. So, we could keep going and see how it  
20 goes or take maybe a ten-minute break? Either  
21 way.

22 CO-CHAIR KAHN: It's 1:50 p.m., why

1 don't we say let's return at 2:00 p.m. and then  
2 we'll finish up?

3 MS. ELLIOT: Okay, so a quick bio  
4 break for everybody. I saw in the comments that  
5 people are agreeing so we'll reconvene at 2:00  
6 p.m.

7 (Whereupon, the above-entitled matter  
8 went off the record at 1:51 p.m. and resumed at  
9 2:03 p.m.)

10 MS. ELLIOT: Okay, Misty, I have two  
11 minutes after the hour. Would you like to get  
12 started?

13 CO-CHAIR ROBERTS: Sure. Well,  
14 welcome back from the break, everyone. It looks  
15 like we are going to be able to end a little bit  
16 early today, so that's exciting I think for all  
17 of us.

18 I appreciate everybody's feedback  
19 today. I think what we wanted to do here at the  
20 very end though is to just do kind of a final --  
21 final round of feedback.

22 As a quick reminder, this is a pilot

1 process for us. It is a great opportunity for  
2 this committee to expand its scope. We were on a  
3 very limited timeframe and I think that we pulled  
4 together a very good process to start with, but  
5 as always, there's opportunity for improvement  
6 and we received feedback the last couple of days  
7 that we've been able to pivot very quickly and  
8 make some changes. But we want to go ahead and  
9 get additional feedback.

10 I do think in the future here, as we  
11 incorporate the work groups into this process, I  
12 do think it will make things a lot easier for the  
13 Coordinating Committee. But I think even the  
14 feedback that we receive today can be helpful for  
15 us as well.

16 So with that, let's just start with  
17 the positive. Let's start with what we feel  
18 works well during the pilot process for the  
19 measure set review. And I think we decided is  
20 that we are going to do a round robin of the  
21 committee just to make sure that we get feedback  
22 from everybody because this is going to be very

1 important to help improve our process in the  
2 future here.

3 So Tricia, are you going to help me  
4 with the round robin? I can try to pull it up on  
5 a different screen here if I need to.

6 MS. ELLIOT: No, I have it right in  
7 front of me so we can get started. We'll go in  
8 alphabetical order, the organization's name. So  
9 we'll start with American Academy of Hospice and  
10 Palliative Medicine. So either Catherine or  
11 Arif, are you on the call?

12 MEMBER AST: Hi, it's Katherine. I've  
13 been sitting in for Arif for the last hour, but I  
14 don't know enough about the project, so I don't  
15 believe I have anything to add right now.

16 MS. ELLIOT: Okay, if you're able to  
17 connect with Arif at some point, please feel free  
18 to send us any comments to our email address.

19 MEMBER AST: Perfect. Will do.

20 MS. ELLIOT: Thank you. Next up,  
21 Clarke Ross. I know he had to step away. Let's  
22 see, is he back on?

1                   Clarke, are you there?

2                   MEMBER ROSS: Yes, I'm back on.

3                   MS. ELLIOT: Okay.

4                   MEMBER ROSS: Thank you. I  
5           appreciated the opportunity to express some views  
6           of the consumer movement and the disability and  
7           mental illness movement.

8                   I really wrote down, Misty, an  
9           observation you made after my first discussion  
10          yesterday, that by eliminating measures and  
11          categories of measures, because a measure is  
12          inadequate or incomplete -- I'm paraphrasing you  
13          or I'm rephrasing it. But this is your  
14          sentiment. By eliminating measures and  
15          categories of measures because a measure is  
16          inadequate or incomplete, are we creating a  
17          measure gap?

18                  And again, I'm interested in the  
19          message that all of National Quality Forum and  
20          the MAP sends to not only stakeholders but the  
21          larger consumer movement. And I'm always asked  
22          well, why did they eliminate this area? Now

1       there's nothing. So that's a take away that I  
2       have that I thought really bodes well. Thank  
3       you.

4                   CO-CHAIR ROBERTS: Clarke, and real  
5       quickly, you mentioned at some level, that  
6       instead of going around to each person for each  
7       of these questions, do you think it would just  
8       make sense for Ben to give kind of the overall  
9       feedback on what worked well, what would help, et  
10      cetera, kind of go through all four of these  
11      questions?

12                  MS. ELLIOT: I think that would be a  
13      great approach, Misty, and then we don't have to  
14      cycle through everybody multiple times.

15                  CO-CHAIR ROBERTS: So if there's  
16      anything else, Clarke, please.

17                  MEMBER ROSS: What could work better,  
18      there's always National Quality Forum practices,  
19      preaches, and is a model for multi-stakeholder  
20      involvement. And the question is from the  
21      consumer side is there a balance? Are there  
22      enough consumer beneficiaries, patient, and their

1 family at the table? And that's a judgment and a  
2 perception thing. But it's very serious.

3 I've been involved with the Quality  
4 Forum since 2012 and it's a very serious  
5 undertaking that you all take very seriously. We  
6 appreciated it.

7 Sometimes the physician voice seems to  
8 be a little stronger and louder than some of the  
9 other voices, but that's just a personal  
10 observation. So that's all.

11 CO-CHAIR ROBERTS: And one thing just  
12 to reiterate, we really had two objectives of  
13 this meeting, there we're really two areas. One  
14 of them is on the pilot process itself and  
15 getting feedback on the process for reviewing the  
16 measure.

17 Second, that we wanted to get to also  
18 was a round of measure review criteria that we  
19 did. So I don't know if there's a way to -- did  
20 we want to put that list up there? Because I do  
21 think it's important to touch on that measure  
22 review criteria as well.

1 MS. ELLIOT: Yes, we could have that  
2 slide up. Let me just figure out. I think the  
3 team might be able to find it faster than I can.  
4 Slide 13. Oh, look at that. Perfect. So if  
5 folks can reflect on this as they make their  
6 comments, too, that would be great. Thanks,  
7 Misty.

8 So Clarke, since you were kind of our  
9 guinea pig in some of this, any comments on that  
10 measure review criteria? Then we'll move on.

11 MEMBER ROSS: Well, I think the  
12 criteria took time to develop our sound. Again,  
13 each of the stakeholders around the table will  
14 believe one criteria is stronger than others. So  
15 I tend to focus on the overall goals and  
16 objectives of the program and the context of the  
17 program in the public health of the nation. And  
18 are we making incremental improvement toward  
19 public health and the health and wellness of  
20 vulnerable people.

21 But other people, you know, focus on  
22 other criterion and that's what it's all about.



1       So I haven't thought about it, but I'm reasonably  
2       comfortable with the entire list because if I  
3       wasn't I would have made a point at some point  
4       earlier. So that's all, my two cents.

5                   CO-CHAIR ROBERTS: And I think the one  
6       comment about creating a gap, we need to figure  
7       out how to incorporate into the review and maybe  
8       it's not part of the criteria, but somehow it  
9       needs to be incorporated into the process to make  
10      sure that we're not creating any sort of measure  
11      gaps.

12                  MEMBER ROSS: Thank you.

13                  CO-CHAIR ROBERTS: Thanks, Clarke.

14                  MS. ELLIOT: Great. Thank you. Next  
15      up, American College of Physicians. I believe  
16      Sam Tierney is still on the line?

17                  MEMBER TIERNEY: Yes, thanks. You  
18      know I appreciate the opportunity to provide the  
19      pros and cons. I think it was really useful to  
20      conduct the pilot and I would say the positives  
21      from my perspective and these are more process  
22      issues, I thought it was really good to have lead

1 discussants because I've been on some of these  
2 committees where, you know, you're just sort of  
3 waiting for people to chime in and so I thought  
4 that was helpful.

5 I also thought it was helpful to group  
6 measures by program, but also by topic areas, so  
7 I feel as we discussed a lot of the issues that  
8 were raised on one measure related to other  
9 measures in the discussion. So I think that was  
10 helpful.

11 In terms of things that maybe could  
12 have been done better and I think this was sort  
13 of added, you know, like as soon as had some  
14 early discussion, but you know, I think that  
15 adding the voting option was, you know, critical  
16 because I feel like otherwise and I know Chip  
17 added this, but I think otherwise what's the  
18 point of our discussion? So that's one thing I  
19 thought worked well or was something that, you  
20 know, could have been or would have been -- was  
21 essential essentially.

22 And the other thing I would recommend

1 and I think echo Misty's comments about better  
2 understanding the measures that are in the  
3 program so that we could comment on gaps that  
4 would be like identify or promote it with the  
5 removal of these measures.

6 And lastly, I did appreciate the  
7 comments of having sort of balanced  
8 representation, pros and cons for the measure and  
9 move on, instead of maybe all of the people who  
10 recommended it be removed.

11 So that's it from my perspective.

12 Thank you.

13 CO-CHAIR ROBERTS: Yes, and just to  
14 add on to the voting, I also think we heard  
15 yesterday the option to abstain from voting. So  
16 I think we definitely want to add that in the  
17 future.

18 MEMBER BOSTON-LEARY: This is Katie  
19 from the American Nurse Association. Do you mind  
20 if I go next because I do have to run to another  
21 meeting. Is that okay?

22 MS. ELLIOT: Oh, that's totally fine.

1 Thanks for giving us a heads up. Go ahead.

2 MEMBER BOSTON-LEARY: And I'll just a  
3 mix of my thoughts, but great planning. Kudos to  
4 everyone that put all this together and planned  
5 it. It was nice to see how nimble it was where  
6 some of the bumps and suggestions that were made  
7 earlier, there was some accommodations for those  
8 and seamless.

9 I did notice also, Tricia, the voting  
10 piece went to someone else to manage which was  
11 nice for you for day two.

12 Materials, receiving them ahead of  
13 time was very helpful. Poll everywhere worked  
14 like a charm. I appreciated hiding the results  
15 just so we don't get locked into assimilating  
16 based on what we saw on the screen.

17 I appreciated the dialogue verbally  
18 and in the chat. I liked how the feedback was  
19 saved with public comments and committee and all  
20 that.

21 Also, I appreciated -- I don't want to  
22 imply that this was, you now, something that

1       wasn't appreciated, but I really appreciate you  
2       having nursing at the table. That is something  
3       that we want to make sure that we have nurses  
4       represented and just having our association  
5       represented I think is great, especially since we  
6       tend to be crowded out by physicians. So thank  
7       you for that.

8               Opportunity to improve the data to  
9       support the decisions for sure would like to see  
10      especially measures that have been in place for a  
11      while to see how it's trending, whether there are  
12      improvements or not. That will be good to have  
13      ahead of time to help with the decision making.  
14      I know we talked about that.

15             Tom mentioned voting to abstain --  
16      abstain from voting, but I don't know that we  
17      want too much of that. I think since the  
18      measures and all this, the agenda and everything  
19      is sent out ahead of time, if someone does want  
20      to abstain that should be said, mentioned ahead  
21      of time, if you will, and noted. But I don't know  
22      that we need a button for that.

1           The common theme of this measure is  
2   not good enough, but it will do for now, so  
3   what's the middle ground for measures that need  
4   to be amended or revised just so we're not  
5   throwing the baby out with the bath water.  
6   Hearing the story from the sepsis story telling  
7   or sharing of a sepsis alliance I think was very  
8   powerful. And people like us who tend to sit at  
9   the table who make decisions need that, more and  
10  more of that.

11           So thank you for the opportunity to  
12  contribute and I'll still be listening in. I  
13  just need to sign off from this medium and go to  
14  another. Thank you. Appreciate your  
15  accommodation.

16           CO-CHAIR ROBERTS: Thanks, Katie.  
17  Appreciate it.

18           MS. ELLIOT: Next up is the American  
19  Healthcare Association. I believe both David and  
20  Marsida had to step away. David gave us some  
21  comments privately in the chat that I'd like to  
22  share.

1 Overall, he thinks that the process  
2 went well. It was clear having measure  
3 developers and CMS staff acknowledged that it was  
4 very helpful to have them on the call. I think  
5 the claims for why a measure is being suggested  
6 for removal needs some fact checking, so I think  
7 that's another comment that we're hearing.

8 I also think we need -- and this is  
9 David, not Tricia speaking. I also think we also  
10 need to have more info on what are our plans.  
11 Should a measure be removed or recommendation on  
12 it such that removal is contingent on a new  
13 measure or composite measure?

14 I just wanted to share those comments  
15 that he had shared with us.

16 Next, we'll move to the American  
17 Medical Association with Heidi Bossley.

18 MEMBER BOSSLEY: Sure. Thank you. So  
19 having either participated or observed the MAP  
20 process for many, many years, this was a very  
21 well-run meeting, so kudos to NQF staff.

22 And I really appreciated having

1 comment moved up in the process and I would  
2 actually -- I went back and looked at what  
3 happened in January. Comment occurs before  
4 anyone talks. And I think that is actually  
5 extremely helpful to frame our thinking and to  
6 make sure we have all the information in front of  
7 us. Moving that up even a little bit further  
8 might be a good idea.

9 Just a few thoughts --

10 CO-CHAIR ROBERTS: Just to clarify,  
11 you're referring to public comments?

12 MEMBER BOSSLEY: Yes, sorry. Public  
13 comments.

14 CO-CHAIR ROBERTS: Even before lead  
15 discussants?

16 MEMBER BOSSLEY: Yes, even before. I  
17 think that's how it is with the --

18 CO-CHAIR ROBERTS: MUC process?

19 MEMBER BOSSLEY: Thank you, MUC, yes.  
20 And then just a few thoughts and I still don't  
21 know the answers to all of these, but regarding  
22 the criteria, just a couple of things that came



1 to mind over the last two days. The first  
2 criteria talked about whether the measure does or  
3 does not contribute to the overall goals and  
4 objectives of the program. And I'm wondering if  
5 there's a way to then also step back and not just  
6 do an individual measure evaluation, but to look  
7 at how it fits within the program and what the  
8 impact would be removing versus adding a measure,  
9 something I know that the MAP struggles with  
10 every year. But maybe tweaking that criteria or  
11 adding a new one so that you're not just looking  
12 at individual measures, but the set itself that's  
13 within a program might be useful.

14           The other thing that I don't see here  
15 and because of the number of measures that may or  
16 may not have been reviewed by NQF, I do wonder if  
17 some criteria around the scientific acceptability  
18 of the measure, either risk adjustment, how it's  
19 designed or the validity of a measure, for  
20 example. We might be able to say that comes  
21 under the negative unintended consequences, but  
22 perhaps not and so it might be worth thinking

1       about.

2                       When I started to think about what  
3       information would have been helpful during the  
4       conversation, a lot of it very similar to what  
5       staff brings for the MUC review, but gap data and  
6       I think we had quite a bit of discussion that if  
7       we had had information on disparities or sub-  
8       population and trend because we should have that  
9       information, anything that CMS or others could  
10      provide to help provide context of how a measure  
11      is performing and what information it is or is  
12      not communicating, either to the individual being  
13      measured or to the public I think would be  
14      helpful.

15                     Also, whether a measure has ever been  
16      reviewed, so not only whether it's not endorsed,  
17      has it ever come through the process or not. And  
18      if it was removed, why? I think that would be  
19      very helpful to understand.

20                     And then going back to levels of  
21      approval of yes and no and I'll stop. I do think  
22      some gradation of priority of how quickly a

1       measure might be removed or if there's something  
2       coming down the measurement development pipeline.  
3       Okay to wait, not okay to wait, sending that  
4       information would probably be useful to CMS as  
5       well. Thanks.

6                   MS. ELLIOT: Great. Thank you, Heidi.  
7       Next we have America's Health Insurance Plans. I  
8       believe Liz Goodman, are you back on the line?

9                   MEMBER GOODMAN: I don't want to  
10      repeat what others have said. I agree with all  
11      of it. I would say that in listening to the  
12      discussion, there were several questions that  
13      were raised almost every time about the history  
14      of the manager, about it lost endorsement, why?  
15      Or was it, you know, drawn? So what was the  
16      process and how did it get there? I think all of  
17      those -- the data points that are provided for  
18      the MUC list would be useful in this case.

19                   And then the thing that is the most  
20      glaring to me and what I put in the chat is this  
21      issue of how these measures intercept in a  
22      measure set. You know, I think this is

1 fundamentally a challenge both for the  
2 Coordinating Committee and for this process about  
3 looking at measures in a vacuum individually and  
4 not looking at them as part of a broader measure  
5 set. And I'm not sure how to solve that problem,  
6 but it makes it very challenging not just because  
7 we might be creating gaps in measurement, but  
8 also to really understand what's duplicative and  
9 what's not.

10 And then the last thing is the  
11 feasibility and the issues of collectability of  
12 the data. I don't think it really came out in  
13 this process as much. I think some of that was  
14 the time line that we all had when we were  
15 assigned whichever measures we were assigned and  
16 how much time we sort of had to do the homework  
17 because this was a test. But that's a really  
18 critical component of the whole process and some  
19 of these measures, not just the measures we  
20 looked at today, but measures in other sets are  
21 really profoundly difficult to implement. And  
22 that did not come out as much, I think, in this

1 discussion of the last two days.

2 MS. ELLIOT: Great. Thank you so  
3 much, Liz.

4 Next up, we have AmeriHealth Caritas.  
5 I'm not sure if Andrea Gelzer is still on the  
6 line.

7 We'll move along and circle back if  
8 Andrea rejoins.

9 Blue Cross Blue Shield Association,  
10 Carol Peden.

11 MEMBER PEDEN: Thank you. I very much  
12 enjoyed that two days. I think we had a frank  
13 and open discussion and I think it was very well  
14 organized. I think it is important that we go in  
15 with more information. Some of these measures  
16 are very important and we need not only why we  
17 should remove them, but why we should keep them  
18 and a little bit more hard data around that. And  
19 also, as others have said, the context they're  
20 in. So you know, what is part of the other suite  
21 of measures around that.

22 I would also agree that we need to

1 collect the areas where there are gaps and we  
2 took a lot of the behavioral health measures out  
3 when we recognized going forward that behavioral  
4 health is a major issue for America. So I think  
5 we need to be able to recommend why we took these  
6 measures out and what we would like to see  
7 urgently going forward from there. Thank you.

8 CO-CHAIR ROBERTS: Thank you, Carol.  
9 Next up, we have Covered California, Margareta  
10 Brandt. Are you still on the line?

11 MEMBER BRANDT: Yes. Hi, this is  
12 Margareta. I have similar feedback back to the  
13 other members, so I think I would just note that  
14 I appreciated the discussion on each measure. I  
15 thought it was really helpful to inform the  
16 voting and I appreciated the flexibility and the  
17 organization of the meeting.

18 I think, generally, as other folks  
19 mentioned that I would have appreciated more  
20 context, more data, and more time to be able to  
21 adequately feel like I could implement the  
22 criteria when reviewing the measures, so you

1 know, more information about the program and more  
2 data would have been good and helpful, along with  
3 more background or information on the evidence  
4 based.

5 And then I think again like others  
6 have mentioned would appreciate an effort to kind  
7 of identify gaps and if we are removing measures  
8 to make sure it's clear that there's an  
9 expectation that gaps will be filled over time.  
10 I think that's it. Thank you.

11 MS. ELLIOT: Thank you. Next up we  
12 have HCA with Kacie Kleja.

13 MEMBER KLEJA: Hi, thank you, yes. I  
14 have similar feedback that most of my comments  
15 have actually already been covered by other  
16 members. It's been a great couple days of  
17 meetings. The one thing that I had noted, I  
18 think we obviously see these measures and the  
19 programs go kind of hand in hand. There's some  
20 blurred lines there. I think that sometimes we  
21 focus more on the program versus the actual  
22 measures themselves, specifically thinking about

1 the readmission reduction program and some of the  
2 limitations associated with the structure of that  
3 program. So wondering if in the future it makes  
4 sense to kind of carve out time to talk about  
5 programs specifically or if we needed just to  
6 refocus to the individual measures.

7 And then I know that this was put  
8 together very quickly and I appreciate that, but  
9 it also did limit what we could pull together  
10 from -- pulling together the comprehensive  
11 stakeholders and its needs within our  
12 organization to make sure that we have the  
13 appropriate feedback in time for this meeting.

14 MS. ELLIOT: Great. Thanks so much,  
15 Kacie. I'm going to skip over The Joint  
16 Commission. I don't see any representatives from  
17 there today.

18 Leapfrog. Leah.

19 MEMBER BINDER: Just a terrific  
20 meeting. I was really, really impressed with the  
21 way you organized it. I would like to compliment  
22 the co-chairs as well because I think they did a



1 really good job in leading the meeting and  
2 Tricia, you did a great job. I thought it was  
3 really an excellent meeting and I'll tell you  
4 what I think was really different from other NQF  
5 meetings or other meetings on measurement issues  
6 that I've been involved with.

7 And I love the fact that instead of  
8 looking at well, let's look at this measure, now  
9 let's look at this measure, and now let's look at  
10 this measure. Like a lot of them are all about  
11 serial discussions about measure, measure,  
12 measure, measure, measure. Because of the  
13 structure of it and I don't think we intended  
14 this necessarily, but we forced us to step back  
15 and say all right, here's our goal for improving  
16 healthcare and is measurement contributing to it?  
17 Is the current way we're measuring within CMS  
18 contributing to that?

19 It took us -- we took more of a bird's  
20 eye view. I thought that was a really positive  
21 thing and said well, you know, is this, in fact,  
22 the kinds of measures we need to achieve the

1 purpose of our work in or of the effort to  
2 include behavioral health, for instance. It  
3 forced us to look at it. When we do that and we  
4 look at the measures in there, it's kind of  
5 disappointing to see what we have and then we  
6 begin to realize that the gaps became a robust  
7 conversation I thought on how we use measurement  
8 to achieve its purpose, not measures in and of  
9 itself which is just a piece of paper, really.  
10 This is about how do we use measurement as a tool  
11 to see improvement? And are we doing a good  
12 enough job? And what do we need to do to improve  
13 that?

14 So anyway, I thought that was and I  
15 think fundamentally I would love to see future  
16 work in this area where we're talking about  
17 removal of measures framed as that, of  
18 measurement, evaluating the effectiveness of  
19 measurement in achieving goals.

20 So I would -- because I think that's  
21 fundamentally is what we did. More than -- we  
22 talked about removal. We talked about addition,

1 but fundamentally it was take a step back and  
2 discuss whether we think we're headed in the  
3 right direction in achieving these goals.

4 And the other thing I would add is  
5 under review criteria, just -- I said this  
6 earlier, but just to formally say this at this  
7 moment, that one review criteria should be that  
8 the measure -- if the measure does not  
9 differentiate excellence from adequacy of  
10 performance, I think a measure should -- quality  
11 measure should be able to identify high quality,  
12 not just adequacy.

13 And then everything else has been  
14 said, so that's my comment.

15 MS. ELLIOT: Great. Thank you so much  
16 Leah.

17 Next up, National Committee for  
18 Quality Assurance, Mary Barton.

19 MEMBER BARTON: Thank you. I want to  
20 echo what I've heard several people say and that  
21 is I've been in a lot of MAP meetings and this  
22 one was really well done.

1                   And also, I guess, I just have a  
2                   little selfish question. If it could have been  
3                   scheduled earlier, then it would have been easier  
4                   for me to clear these other conflicts that I had  
5                   on my calendar off. So that was really  
6                   challenging for me to attend all of the meeting  
7                   because it was scheduled it seemed like two weeks  
8                   ago. But I'm sure I exaggerated that in my mind.  
9                   Anyway, thank you.

10                   MS. ELLIOT: No, Mary, you're not too  
11                   wrong on that. This was a very, very short time  
12                   line, so we appreciate and understand your  
13                   comment that it was challenging for folks to  
14                   clear their schedules and attend. So we  
15                   appreciate that you're able to attend for as much  
16                   as you could. So thank you.

17                   Next up is the National Patient  
18                   Advocate Foundation. Rebecca Kirch.

19                   MEMBER KIRCH: Hi and thank you. I'm  
20                   newer to the MAP Committee and its process, so  
21                   now my expectations are very high. Leah  
22                   commended this discussion as being special and

1       it's sort of how I would have expected it. So  
2       hats off to all of you because it was right where  
3       I would have expected it being new to the party,  
4       as it were, and I appreciated very much the  
5       flexibility, the nimbleness that staff and  
6       colleagues all brought to bear with the varied  
7       feedback you got.

8               So much has been said and I'm at the  
9       end of the alphabet, so that's fair enough, but  
10      the two points I think I'd like to highlight are  
11      a little bit more drilling down on what Leah just  
12      said about coming at this from the context of is  
13      the way that we're measuring contributing to our  
14      objective to improve accountability for quality  
15      care? And I think that's a really important  
16      context when we think about how we synthesize the  
17      information for preparing us for the discussion,  
18      but also how we approach the discussion. And I  
19      think that was what made this so successful and  
20      special.

21              But I would add to that it's not just  
22      our objective of accountability for quality care,

1 but also the representativeness around the  
2 discussant's table. And aspirationally, but  
3 achievably, I think a measure criterion specific  
4 around the diversity perspective. I heard the  
5 clarion call for nursing representation as  
6 important to embed on top of the physicians. I'd  
7 say also social workers as an important part of  
8 the field, especially because we're talking to  
9 about behavioral health in the context of these  
10 measures. And also representativeness of those  
11 who are limited resource. And that goes to the  
12 disparity and health equity points that has been  
13 an underpinning of some of the dialogue we've  
14 had.

15 A criterion, I think, that's an  
16 adjunct, but really needs to be explicit out of  
17 number eight and probably its own is how is this  
18 measure contributing to performance that  
19 diminishes disparity and promote equity in health  
20 care that we know are a rampant challenge right  
21 now? I think it's time now for that to be  
22 explicit. And thank you so much. Great two

1 days.

2 MS. ELLIOT: Great. Thank you so  
3 much. We really appreciate your feedback. The  
4 Network for Regional Healthcare Improvement.  
5 Liz.

6 MEMBER CINQUEONCE: Hi. Yes, there's  
7 a lot of comments that have been made that I  
8 completely agree with. I think overall, the  
9 process went really, really well. I did  
10 appreciate the midstream adjustments that were  
11 made and especially to allow the public input  
12 before we made the vote.

13 I also really agree with the comments  
14 that have been made about really having the work  
15 groups focus around the specific programs and  
16 make recommendations on the measure sets that are  
17 applicable to those programs. I think that's our  
18 best chance to make sure that the measures are  
19 aligned for us to identify any gaps that come  
20 along with these recommendations.

21 I think the one part that was a little  
22 bit difficult was sort of the up down nature of

1 the voting on this because throughout the  
2 discussions there were so many different nuances  
3 that came up related to each of those measures  
4 and I almost wonder if we would be better served  
5 by a matrix type of feedback that could go back  
6 to CMS where we're able to not only capture  
7 whether we're recommending removal, but really if  
8 we are saying that we're, you know, voting maybe  
9 for continuation, but that we are recommending  
10 future changes and why it might serve us well in  
11 terms of looking out a little bit further ahead  
12 than just the immediate questions about the  
13 measures that are there today.

14 But overall, really appreciated the  
15 opportunity to be part of the process and thought  
16 it was very well done. Thank you.

17 MS. ELLIOT: Thanks so much, Liz.  
18 Next up, we have Patient and Family Center Care  
19 Partners with Libby Hoy.

20 MEMBER HOY: Hi. First of all, just  
21 thank you so much for having the patient and  
22 family perspective represented in this



1 discussion. This is I don't know how many MAP  
2 meetings that I now attended, but this one is a  
3 little different. I have to agree with Leah. It  
4 felt like we were moving more towards a person-  
5 centered sort of measuring system and really  
6 looking at each of the measures in that larger  
7 picture of is it really supporting the outcomes  
8 and goals of the programs? And so I thought, you  
9 can't see, but I have marked up to infinitum the  
10 criteria that you gave us because I thought it  
11 was really, really helpful. I might suggest we  
12 put the goals on the back side, so -- I kept  
13 having to sort of make sure we were marching  
14 along to the North Star that we had -- that we  
15 had set out.

16               So I think it was, of course, NQF's  
17 team is always top shelf in meeting preparation  
18 and meeting flow, always really helpful.

19               I appreciate -- I was a little nervous  
20 on the last comment about starting earlier. I  
21 thought you meant starting earlier in the day and  
22 I was thinking oh, sweet petunias, I'm on the

1 West Coast. Seven o'clock with measure and  
2 detail. That's about all I can give you.

3 In any case, there are a lot of great  
4 discussion. I learned a lot.

5 As far as the criteria themselves, I  
6 would agree with what has been stated before. I  
7 think more context maybe on measurement, I'm  
8 sorry, on criteria number five. More contextual  
9 and historical information about where the  
10 measure sits within the larger context and how  
11 it's performed and the whys, as we've heard of.  
12 Why was it endorsed? Why was it not endorsed.  
13 You know all of that historical context is  
14 really, really helpful.

15 I would promote the addition of does  
16 it create a gap? I think that's a really, really  
17 important question and so thinking about a  
18 measure in that way.

19 Each of the criterions are really  
20 specific to the exact measure we're looking at  
21 one through eight. So I think maybe the addition  
22 of a couple of criteria that, you know, does it

1 feed the program overall? Where does it fit in  
2 the overall program? I think that encouraging  
3 that larger look.

4 And then Rebecca will not be surprised  
5 to know that I also suggested another criteria  
6 around the quality impact. I think that's a  
7 really, really important thing for all of us as  
8 we heard with the sepsis, sepsis has such a large  
9 disparity and we know that, so how does step one  
10 either support equity, promoting equity, or how  
11 does it sustain the inequities that exist today?  
12 So I think we really need to fold that into our  
13 conversations regularly.

14 As a person that comes to this work  
15 with less experience, education, and family, care  
16 giver and no experience with measure development  
17 other than where I've been able to have input, I  
18 would say that I was reflecting on how could I be  
19 a better representative of our community? And so  
20 for a couple of things, one, I think we need to  
21 increase the number of seats at the table.

22 I think we need to seek out really

1 under represented voices as we do that. I think  
2 myself, having more time to sort of get the  
3 measures as you've given them to us into a bit  
4 more of a plain language and have some  
5 conversation with patients and families in our  
6 network and really leverage the broader voices of  
7 patients and family members, that would help me  
8 to be more representative in these discussions.

9 And with that in mind, and the  
10 potential to expand the number and diversity of  
11 patient/family representatives in this process,  
12 potentially a set-aside orientation for plain  
13 language to help us get a little bit more  
14 context. So those are my thoughts. But a great  
15 meeting and again, I am just so grateful to NQF  
16 and CMS for engaging the patient/family  
17 perspective.

18 MS. ELLIOT: Excellent. Thank you so  
19 much, Libby. We really appreciate all your  
20 comments.

21 And last from the organizational  
22 representatives, Purchaser Business Group on

1 Health, Emma Hoo.

2 MEMBER HOO: Thanks. It's challenging  
3 to identify any new suggestions, given all the  
4 rich feedback that has already been provided and  
5 I agree with much of it.

6 I would also add, too, that the  
7 context and recent experience of the measures  
8 would have been very helpful in the original  
9 selection and having more time to review the  
10 information would also have been helpful in terms  
11 of better understanding some of the rationale  
12 behind the program, as well as the measure itself  
13 in the initial voting of the ten measures.

14 I would also say that during these  
15 discussions, folks referenced some of the recent  
16 recommendations that might have been made by  
17 MEDPAC or some of the journal articles speaking  
18 to some of the experience and inclusion of some  
19 of those elements in what is creating potential  
20 controversy or validation of use of the measure  
21 would have also been helpful as part of the  
22 background reading so that we were more prepared

1 for some of the discussion today. And I think  
2 some of the broader issues also include a better  
3 understanding of what might be in the pipeline  
4 for a specific program.

5 I know in the introductory session,  
6 Michelle also discussed the potential  
7 consideration of building composites among some  
8 of the measures as opposed to straight  
9 elimination and in most of the detailed measure  
10 discussion, that never came up. But I think it's  
11 something that is worth discussing and also just  
12 that broader context of understanding how the  
13 measures are used in specific quality reporting  
14 programs, public reporting or payment and also  
15 understanding that elimination of a measure in  
16 one program may affect the utility in others such  
17 as the emerging use of some of these measures in  
18 understanding health equity and stratifying that  
19 data. I feel that absent that holistic view of  
20 how some of the measures are being used or are  
21 being planned for use makes it difficult  
22 sometimes in the voting of whether we might be

1       throwing the baby out with the bath water versus  
2       truly keeping a measure that doesn't  
3       differentiate performance or may have topped of.

4               And then echoing the last comments, I  
5       do appreciate the 10 o'clock start time as a West  
6       Coast person.

7               MS. ELLIOT: Duly noted, Emma. Thank  
8       you. Next up, I'll move to our subject matter  
9       experts, Dan Culica.

10              MEMBER CULICA: This is my first MAP  
11       meeting and I just want to use the opportunity to  
12       thank Andrea again for having me on the  
13       committee. I think that it was a review, even  
14       the coordination, the education meeting that was  
15       last month because I was off two days. So I  
16       tried to learn as much from that in catching up  
17       and be prepared for the process. I think that as  
18       much as I would like to contribute to the work,  
19       like many other of my participations with the  
20       NQF, I see this as a huge learning opportunity  
21       for me.

22              And I think that probably this is what

1 I missed part of the first educational session is  
2 I think I would have liked to know more what sort  
3 of recommendation from the CMS is for each  
4 measure in the sense that I'm a firm believer of  
5 national coordination and direction in what we do  
6 at the state level. And representing a purchaser  
7 of healthcare, I'm also a huge consumer of  
8 quality measures, so again, everything that has  
9 been said it's extremely useful.

10 In terms of the process, I would say  
11 that I need to be better organized for the next  
12 meetings and now that I know how they are avoid  
13 questions like what are competing measures and  
14 why have not they've been endorsed or why they  
15 lost endorsement?

16 And then in terms of the criteria, I  
17 was thinking about criteria number eight,  
18 especially the aspect of negative unintended  
19 consequences. I thought that unintended  
20 consequences kind of hides the word negative or  
21 it is implicit. But it would be interesting if  
22 there were any positive unintended consequences.



1 But thank you very much again.

2 MS. ELLIOT: Thank you. Thank you for  
3 your comments. Next up, Janice Tufte.

4 MEMBER TUFTE: Thank you for having me  
5 here today. Let me get into -- I wrote down a  
6 few things. Basically, some of the positives  
7 were we did receive the information. It came  
8 very quickly and it was very dense for me and I  
9 kind of -- I glanced over each one, but I did it  
10 on the weekend.

11 How I decided kind of to do removal  
12 because I can find positive in almost anything,  
13 but if there was a similar measure, like if there  
14 was an E quality care measure, I tended to lean  
15 towards that, but I believe in one or two cases,  
16 it wasn't as thorough as the previous measure, so  
17 I maybe had requested the other one for removal.

18 And I think it would have helped a lot  
19 in these two days if we had some of that same  
20 information just sent again so we can see what  
21 you had originally sent where there was  
22 comparative measures, similar measures because I

1 found that very helpful. And if it would have  
2 been easier to find, I probably would have  
3 utilized it more during this last two days.

4 And I think within the measure sets,  
5 it's, you know, I think along the lines, I think  
6 as some other people. We did talk about  
7 combining or composites or bundling. And I would  
8 love to see more of that and I think a lot of  
9 patients would. I do realize it could be more  
10 burdensome, but I feel if you -- the episode-  
11 based type measurements worked. You have the  
12 pre, the whatever treatment -- treatment and the  
13 post-treatment follow-up. And it also would  
14 include the other sub-specialties or primary  
15 care. To me, just seems way more person centered  
16 if it was kind of in that area.

17 Regarding having other patients,  
18 partner, families on board, I think I may be the  
19 first patient identified as patient. And  
20 disparities, I don't have a college degree. I  
21 kind of learned as I've gone. And the more --  
22 and I'm involved with evidence, so we certainly

1       could use more individuals, you know, but I have  
2       been on Medicaid, on Medicare, you know, so I'm  
3       considered individual with disparities.

4               And the people in my community are  
5       individuals who are -- I have friends who have  
6       care and social needs, so I'm aware of a lot of  
7       their needs. Much of them aren't aware of even  
8       what a measurement is.

9               Locally, I'll just say in healthcare  
10      for the homeless, I was head of the data  
11      evaluation, so I'm the one that kind of insisted  
12      we should have patients involved with this so  
13      they're aware of it. So they learned about the  
14      core sets of measurements, right? It's just a  
15      beginning step to being aware.

16              And I like the last doctor that spoke,  
17      I had written about what impacts removals have on  
18      patients. And number eight, I thought the  
19      criteria could be refined.

20              Unintended consequences, I think are  
21      probably almost -- they come across the board,  
22      right? And I think Leah during our discussions

1 really brought out some valid points. So when  
2 we're talking about equity and disparities  
3 including having those patients and individuals  
4 present on sepsis, I think probably my guess has  
5 changed a few of our minds if we weren't  
6 necessarily -- if we would going to vote for  
7 removal. It would be wonderful if we could have  
8 more individuals. It's a lot of work getting  
9 people to really provide feedback on subject  
10 matter.

11 But as Libby and others have  
12 mentioned, I think literacy and language is a big  
13 deal. And if we include more patient, family,  
14 and communities members, I've been involved in  
15 measurement for five or six years, so I'm fairly  
16 well versed on it now and understand the process.  
17 But I believe a lot of people are disillusioned  
18 after they first get involved. They don't feel  
19 like they've contributed much. And I know we're  
20 in the process now of meaningful measures and  
21 more. So I think in the next five years, we'll  
22 be able to see more opportunities.

1                   And I think that's about it. Is this  
2 duplicate? Yes, closely compared measures. I  
3 think that's about it.

4                   So I'm honored to be here. I'm very  
5 sorry I didn't realize that I was a discussant.  
6 I didn't read through all of the materials. I  
7 didn't think I was going to be a discussant, so I  
8 saw where if you don't want to be, please let us  
9 know, but I didn't realize I was, right? So I  
10 will be a little bit more astute on that. I've  
11 just been really busy. So thank you for having  
12 me.

13                  MS. ELLIOT: No problem. Thank you so  
14 much, Janice. We appreciate your comments.

15                  Ron Walters.

16                  MEMBER WALTERS: Positive. Staff, of  
17 course, is the best staff in the world. The  
18 chair and co-chairs were excellent, as mentioned  
19 earlier, adapting the full things to the  
20 situation. And I appreciated everybody feeling  
21 free to give honest feedback. Again, that's all  
22 you can ask is to get people's honest opinions

1       about things. And I think we did a good job.

2                   As I sat -- not necessarily a comment,  
3       as I sat here I was wondering ultimately did we  
4       assist CMS or not. And obviously, this pilot  
5       program, this was our first meeting. We set out  
6       criteria as we talked about many times. If  
7       something meets all those criteria probably  
8       shouldn't be on our list. I mean it shouldn't  
9       have gotten through the process in the first  
10      place.

11                   But I was putting together in my head  
12      because I know yesterday morning the first few  
13      measures were like three to one for removal. And  
14      then we went -- we flipped, actually, the second  
15      half of them were like three to one or maybe four  
16      to one against removal. And today has probably  
17      been predominated by against removal.

18                   And so the question --- is that useful  
19      advice or not? And did we do it according to the  
20      criteria? So in my mind I was trying to stack up  
21      measure one. We gave the reasons by the  
22      reviewers, but we didn't indicate a final reason

1       for either not recommending removal or for -- for  
2       not recommending removal. We kind of talked  
3       about a lot of concepts.

4               So if you were to ask me how well, did  
5       our criteria work and did they provide useful  
6       information back to CMS about a mechanism to  
7       decide what had to be removed and/or keep, I'm  
8       not sure we have the data yet and I would love to  
9       have been tracking that all the way along more  
10      formally where we specifically said why a measure  
11      was recommended for removal or not.

12             That may become useful as time goes on  
13      and version two of this pilot or so to know how  
14      well we stick to our criteria and which ones mean  
15      more than other things.

16             The last thing I'll mention and the  
17      reason why I harped on what I was harping on so  
18      much is I'm on the front page of the NQF now and  
19      the Coordinating Committee sets the strategy for  
20      the partnership and provides direction to and  
21      ensures synchronization among the advisory work  
22      groups.

1                   Now I know that there's work being  
2                   done on the next version of this to accomplish  
3                   that. But I think what I notice is there really  
4                   is not what I would call synchronization. We saw  
5                   some examples of that. Whether you call them  
6                   duplicate measures or well, this is in this  
7                   program and it's almost like the other ones, but  
8                   not quite. It's all those sorts of things. And  
9                   I think that's what we're tasked to take care of.

10                  I wanted to tell you one more story  
11                  about cancer, just to scare you a little bit.  
12                  It's nice to talk about heart failure, diabetes,  
13                  in fact, for that matter, sepsis, like it's one  
14                  disease.

15                  A very good point was made yesterday  
16                  about behavioral health. It's many diseases.  
17                  And do we enter the era of having very disease  
18                  specific measures because that could expand very  
19                  quickly.

20                  And in cancer, I got to thinking about  
21                  the surgical one we talked today. Okay, I can do  
22                  surgical mortality for lung cancer, surgical



1 mortality for neurosurgery, surgical mortality  
2 for colon cancer, surgical mortality for pancreas  
3 cancer, et cetera, et cetera, et cetera. And  
4 that's why I keep harking on it because doctors  
5 do, there's lumpers and splitters, and doctors do  
6 like to be splitters. We need to split when it's  
7 appropriate to split. And we need to lump when  
8 it's appropriate to lump.

9           And so that's why I said a lot of the  
10 things I said because we're not at global warming  
11 yet for this, but if you plot the number of  
12 measures over time and more recently the new  
13 versus retired measures, we're warming up. And  
14 we need to be aware of that. And that's the job  
15 of this committee actually, synchronization  
16 amongst the various advisory workgroups.

17           So thank you very much for having me.  
18 I know sometimes I can be a pest and that's  
19 because I say exactly what I think and is on my  
20 mind and thanks for giving the feedback when I  
21 was wrong.

22           MS. ELLIOT: Thank you so much for

1 your comments.

2 Missy, can I hand it back to you for  
3 public comment?

4 CO-CHAIR KAHN: No, I haven't been  
5 able to comment.

6 MS. ELLIOT: Oh, okay. Go ahead,  
7 Chip.

8 CO-CHAIR KAHN: A few. Not to be  
9 disagreeable, I sort of disagree with Heidi a  
10 little bit. I think we put the public comment in  
11 the right place, but that's something that we  
12 could talk about.

13 I think it's very important and I  
14 heard it from a number of the -- a number of you  
15 that we come up with something other than just a  
16 straight binary voting. Hopefully, absentia  
17 won't be that important. It was important today  
18 in this particular instance because we had a  
19 short fuse and there were some people who were  
20 representing the organization and they hadn't had  
21 time to do analysis.

22 Hopefully, if we have a little bit

1 longer and we have the work groups, abstentions  
2 won't be an issue, although I think we should  
3 have it as an option because there may be some  
4 reason why someone needs to abstain. But I think  
5 we need some gradation. And we do have gradation  
6 in our normal process.

7           So what I'd suggest, and, obviously,  
8 it's up to the group, is that maybe the chairs  
9 work with staff on a draft of voting options and  
10 then we maybe have some communication by email  
11 with the committee over the next little while to  
12 come up with what we would like, so we're not  
13 backing into another process and saying, next  
14 year, hopefully, we'll have the opportunity to do  
15 that and saying, oh, no, now we've got to decide  
16 on the voting process, because I think it will  
17 take us some time to think it through because  
18 there were a set of options sort of put on the  
19 table today and I think we really need to think  
20 about the wording of the voting.

21           And, obviously, if you go away from  
22 binary voting and you have some options, then you

1 run into the problem that we have with the MAP,  
2 although I think we've got a formula there where  
3 you may have to have a series of votes, because  
4 you might have more than once choice. That would  
5 be my suggestion. And that we settle on a  
6 process prior to the next round, because we'd  
7 want that process to be used by the work groups  
8 as well by the Coordinating Committee itself.

9 And then, finally, I think that we've  
10 had a number of suggestions about the criteria  
11 and also the information that we think we need  
12 for our assessment. And I just wonder whether --  
13 and I know we've got a lot on the table, but I  
14 wonder whether we should follow up with anyone  
15 that feels strongly about it, even if you  
16 commented, to send a note to the staff just where  
17 you are on the criteria and where you are on what  
18 the data points are you think we need for our  
19 assessment. I think that would be useful, just  
20 so that could be memorialized and then as they  
21 think through our next process.

22 I think those are all my suggestions.

1 CO-CHAIR ROBERTS: Great. Thank you.

2 MS. ELLIOT: And Misty, before we go  
3 to public comment, we had another organization  
4 join.

5 Dr. Baker, do you have any comments  
6 about the process from yesterday or today?

7 MEMBER BAKER: No, Tricia. I don't  
8 think I have anything to add to the comments that  
9 have already been made. Thanks.

10 MS. ELLIOT: Okay. Thank you. Okay,  
11 Misty, I think we're ready to move to our public  
12 comments on the process overall, so slide 77.  
13 Thank you.

14 CO-CHAIR ROBERTS: Great. So we'll  
15 now take the opportunity to have public comment  
16 on the measure set review process, as well as the  
17 criteria that was used.

18 As a reminder, please limit your  
19 comments to two minutes and limit it to the pilot  
20 process and the criteria.

21 Let me see if we have any hands. I'm  
22 not seeing any hands. I have learned patience in

1       these processes to count to like ten before  
2       saying nobody. All right, I am not seeing any  
3       public comments.

4               MS. ELLIOT: And if I can circle back,  
5       Misty, also to our CMS partners, I believe  
6       Michelle would like to make some comments.

7               MS. SCHREIBER: Thank you, Tricia. I  
8       really appreciate it. This, I think, has been a  
9       very productive couple of days. A couple of  
10      people have asked if this is meaningful to CMS  
11      and I would say the answer is yes.

12              Some clear take-home messages is that  
13      we probably have to almost seriously rethink the  
14      in-patient psychiatry measure set and even in the  
15      context of the broader mental health measure set  
16      to be sure that it's having the impact that we  
17      want it to have.

18              The second is thinking about some of  
19      the programs and are the programs impactful and  
20      are there changes to the programs? That might  
21      not be something as simple as removing a measure,  
22      Chip, as I know you've pointed out. But all of

1 us combined, I think, have levers and have other  
2 levers that we can use and engage to bring  
3 forward changes to some of the programs.

4 In terms of the review criteria, I  
5 heard a lot of good things to put on the review  
6 criteria. There's one I didn't hear though that  
7 I'd like to just bring forward and that's are we  
8 advancing quality measures sort of writ large? In  
9 other words, are we moving to more outcome  
10 measures? Are we moving to more digital  
11 measures? Are we moving to a point where we're  
12 hearing more of the voice of patients, so patient  
13 reported outcome measures. So in other words,  
14 are we kind of moving the measure inventory used  
15 in programs to more futuristic quality measures  
16 in general?

17 But I think this has been very  
18 important. We have lessons learned of  
19 information that you would like to hear back in  
20 advance and completely agree. It changed the  
21 conversation in many parts. If that happens  
22 though, I think we also have to think of what's

1 our limit of how many measures can be discussed  
2 in a couple of days in a program like this  
3 because that kind of reporting back for every  
4 individual measure is very time intensive. And I  
5 think we just have to be very specific in  
6 thinking through are we going to look at measures  
7 comprehensively every year and pick out measures?  
8 Are we going to look at programs comprehensively?  
9 And so just some thought about that.

10 We're happy to provide all the  
11 background information, but I don't think we can  
12 do it for 550 measures which are currently in  
13 use, not at one given time at least.

14 And so also on behalf of CMS, really,  
15 I would like to thank all of you. I'd first like  
16 to thank the CMS colleagues and some of our  
17 contractors who work very hard in the background,  
18 really, to put together this information and who  
19 think about this on a daily basis; to certainly  
20 thank NQF for the work that you have done in  
21 putting this today. I think this has been one of  
22 the better meetings; to thank each and every one



1 of you who have participated and certainly  
2 finally to our co-chairs, Misty and Chip. I  
3 think you led us well. So thank you.

4 CO-CHAIR ROBERTS: Thank you. Tricia,  
5 any hands --

6 MS. ELLIOT: I did not see any hands  
7 come up for public comment. We were kind of  
8 monitoring that as Michelle was speaking. So I  
9 think we can go ahead to the next slide.

10 We'll pause here for closing remarks.  
11 Chip or Misty?

12 CO-CHAIR KAHN: I just want to thank  
13 everybody for this. I think as an experiment, we  
14 clearly were successful in showing we could go  
15 through a process. I guess I'd really like to --  
16 the one thing I guess I'd like to put emphasis on  
17 was I think Michelle at one point during our  
18 deliberations sort of asked advice about whether  
19 CMS could go to some kind of every other year  
20 process for sets of measures. And I think  
21 probably one of the things that we learned in  
22 this experiment is that we, as a group,

1 obviously, as well as all those who would help  
2 us, probably do have limited bandwidth.

3           So I think it will be probably wise  
4 for us to take all the programs over some period  
5 of time, if anything, this would work as over  
6 some period of time and split it up so that we  
7 have a manageable amount to review every year and  
8 obviously those providing us all the background  
9 information have the bandwidth to reasonably  
10 provide us the information.

11           I think it will be very important for  
12 us to have all this information. We'll have a  
13 much richer assessment. And frankly, the 500 and  
14 something is Everest to me. So I don't think  
15 it's going to be any different next year, even if  
16 we have work groups and have time for process. I  
17 think we probably should think about some way to  
18 divide it out.

19           Those are my remarks and I want to  
20 thank everybody and particularly thank the NQF  
21 staff for all the work they did in making this  
22 possible.

1 CO-CHAIR ROBERTS: Thanks, Chip. And  
2 I'll echo all of the things that Michelle and  
3 Chip laid out. NQF does a remarkable job of  
4 really getting all of the prep work done and  
5 really helping us as co-chairs to facilitate the  
6 conversations, so thank you.

7 And I appreciate CMS and team also for  
8 being here to help answer a lot of the questions  
9 that we had anticipated would come up during the  
10 discussion and then appreciate everybody's  
11 patience with us through this process and also  
12 just the robust feedback that we received.

13 And Chip said that it wasn't a  
14 success. I do think it was a success based on  
15 the ending feedback that we had, but there are  
16 still opportunities and I'm looking for  
17 incorporating these comments and feedback into  
18 future processes. So I appreciate everyone's  
19 time today.

20 Tricia, should I hand it over to you  
21 for next steps?

22 MS. ELLIOT: Yes, please. Thank you.

1 And we'll quickly go to the next slide.

2 So just to highlight where we're at in  
3 the process. We had our education meeting as  
4 most remember back on August 9th. We did our  
5 measure selection process and had a very quick  
6 due date on that which led us to today's meeting.

7 So next in the process is our  
8 September 15th Coordinating Committee's strategic  
9 meeting. And then we'll be pulling together  
10 final recommendations to share by October 1st.  
11 So there will be a lot of great information that  
12 we'll be pulling together from everything that  
13 was discussed today and future next steps.

14 I think we have one more slide to  
15 share. We just want to make sure that you please  
16 contact the team if you've not received a  
17 calendar invite for the MAP coordinating  
18 strategic meeting on the 15th for those committee  
19 members. This meeting will also kick off the MAP  
20 Coordinating Committee pre-rulemaking activities.

21 And we have our contact information  
22 there if you have any additional thoughts,

1 concerns, or questions. And with that, I think  
2 we can conclude ahead of schedule again today, so  
3 a couple hours back to everybody.

4 And thank you so much on behalf of the  
5 NQF staff. We truly appreciate all your  
6 participation and input into this very important  
7 process and very much enjoyed hearing all the  
8 perspectives. So thank you all and have a great  
9 rest of your day.

10 (Whereupon, the above-entitled matter  
11 went off the record at 3:09 p.m.)  
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