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

10:00 a.m.

MS. ELLIOT: Good morning, everyone. Welcome back to Day 2 of the Measure Set Review meeting. This is Tricia Elliot from NQF, and I'm going to start off with just a few housekeeping reminders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR ROBERTS: Great.

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

Katherine, are you on the line?

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

MS. ELLIOT: Oh, okay.

MEMBER KAMAL: Yes.

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

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

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

MEMBER KAMAL: Okay.

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

later. So, thank you.

American Association on Health and Disability, Clarke Ross?

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

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

MEMBER TIERNEY: Yes.

MS. ELLIOT: Hi, Sam. Good morning.

MEMBER TIERNEY: Hi.

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

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

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

MS. ELLIOT: Okay. And yesterday, we

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

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

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

MEMBER BOSSLEY: I'm here.

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

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

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

I see Liz online, I think.

MEMBER GOODMAN: Yes, I'm here.

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

AmeriHealth Caritas, Andrea Gelzer?

(No response.)

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

MEMBER PEDEN: Yes. Good morning, everyone.

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

(No response.)

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

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

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

(No response.)

MS. ELLIOT: Leapfrog Group, Leah Binder?

MEMBER BINDER: I'm here.

MS. ELLIOT: Hi, Leah. Good morning.

MEMBER BINDER: Good morning.

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

(No response.)

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

MEMBER KIRCH: Good morning. I'm here.

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

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

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

MEMBER HOY: Good morning, everybody.

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

MEMBER HOO: Good morning. Here.

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

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

MS. ELLIOT: Thank you. Janice Tufte?

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

MS. ELLIOT: Thank you. Ron Walters?

MEMBER WALTERS: Present.

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

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

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

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

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

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

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

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

Thank you.

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

So, we'll move forward to slide 52. So, there's three measures in the Hospital Readmissions Reduction Program that we're going to be discussing today.

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

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

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

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

The program goals are to reduce excess

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

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

So, if we can go to --

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

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

Michelle, you may be able to answer this.

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

CO-CHAIR ROBERTS: So, the program

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

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

CO-CHAIR ROBERTS: Okay.

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

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

Now, not all of them. So, when we

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

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

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

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

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

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

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

CO-CHAIR ROBERTS: Okay.

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

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

Go ahead, Tricia. Sorry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

readmission rate fine-tuned to each disease.

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

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

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

restrictive move.

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

Thank you.

CO-CHAIR ROBERTS: Thanks, Ron.

Kacie, what are your thoughts?

MEMBER KLEJA: Yes, thank you.

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

I don't necessarily have any thoughts

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

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

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

purposes.

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

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

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

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

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

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

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

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

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

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

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

specific measures in the program?

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

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

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

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

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

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

These are, obviously, meant to be

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

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

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

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

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

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

DR. SCHREIBER: Correct.

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

Now whether any specific measure is

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

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

CO-CHAIR-KAHN: Right.

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

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

But you're right about the overall

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

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

DR. SCHREIBER: Yes. Yes, yes.

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

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

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

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

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

Andrea?

MEMBER GELZER: Hi. Thanks, Misty.

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

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

Thank you.

CO-CHAIR ROBERTS: Thanks, Andrea.

Leah?

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

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

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

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

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

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

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

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

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

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

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

DR. SCHREIBER: Yes, thanks.

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

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

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

spreadsheet; just somewhere make it available publicly.

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

(No response.)

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

MEMBER BINDER: Thank you.

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

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

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

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

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

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

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

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

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

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

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

maybe we would consider sort of topped-out.

MEMBER BOSSLEY: Right.

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

MEMBER BOSSLEY: Okay. Thank you.

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

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

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

DR. SCHREIBER: Whatever that is.

MEMBER BOSSLEY: Right. We need to

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

So, just a few thoughts.

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

(No response.)

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

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

than having the group as a whole?

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

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

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

we truly need to have disease-specific.

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

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

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

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

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

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

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

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

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

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

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

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

So, trying to just track admissions and readmissions is really difficult. Compounding this is Medicaid; we have the Institutions for Mental Diseases Prohibition Rule, and on the home and community-based services side, we have waiting lists because that's a waiver program and not a benefit.

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

Thank you.

CO-CHAIR ROBERTS: Thanks, Clarke.

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

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

Did anybody else want to comment?

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

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

CO-CHAIR ROBERTS: Thanks, Rebecca.

Any other comments?

MS. TUFTE: This is Janice.

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

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

Thank you.

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

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

cohort from the penalty.

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

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

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

CO-CHAIR ROBERTS: Okay.

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

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

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

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

CO-CHAIR ROBERTS: Thanks, Michelle.

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

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

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

CO-CHAIR ROBERTS: Okay.

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

CO-CHAIR ROBERTS: All right.

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

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

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

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

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

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

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

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

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

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

Ron, anything to add?

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

CO-CHAIR ROBERTS: And, Sam?

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

CO-CHAIR ROBERTS: Yes. Okay. Well,

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

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

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

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

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

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

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

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

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

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

DR. SCHREIBER: Well, thanks.

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

Janice?

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

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

CO-CHAIR ROBERTS: Any other comments?

(No response.)

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

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

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

Patient population for elective

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

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

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

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

MEMBER TIERNEY: Thanks.

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

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

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

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

CO-CHAIR ROBERTS: And then, Kacie?

MEMBER KLEJA: Yes, I agree. Obviously, we've seen that same shift in our patient population to more of the outpatient setting for a lot of these electives. Hip and knee procedures with, you know, very few comorbidities, limited risk. And so, the other patients that we're still seeing, the inpatients, are those that have sort of the higher level of comorbidities and acuity. So, definitely something to consider.

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

MS. ELLIOT: Yes.

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

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

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

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

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

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

arena, which also complicates matters.

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

CO-CHAIR ROBERTS: Thanks for that.

Leah?

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

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

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

(No response.)

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

MS. ELLIOT: Yes, it is, Misty.

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

Any comments from the public? Amy?

MS. CHIN: Hi. Can you hear me?

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

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

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

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

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

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

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

(No response.)

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

I don't know what others think.

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

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

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

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

about all that.

CO-CHAIR ROBERTS: Thanks, Arif.

Chip?

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

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

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

CO-CHAIR ROBERTS: Thanks, Chip.

Heidi?

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

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

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

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

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

Any other comments?

(No response.)

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

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

Do you support the removal of this measure?

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

MEMBER WALTERS: Good move.

(Laughter.)

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

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

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

Do you support removal of this measure?

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

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

Do you support the removal of this measure?

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

MS. ELLIOT: Great. Thank you so

much, Ivory, for conducting the poll.

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

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

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

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

MS. ELLIOT: Are we good?

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

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

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

DR. SCHREIBER: Yes.

CO-CHAIR ROBERTS: Okay. Good.

Clarke, it looks like a comment/hand raised?

MEMBER ROSS: Yes, thank you.

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

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

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

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

MEMBER BINDER: Sorry.

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

MEMBER HOY: This is Libby.

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

be considered moving forward.

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

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

MS. ELLIOT: Chip, you had a comment?

CO-CHAIR ROBERTS: Go ahead.

CO-CHAIR-KAHN: Should I go ahead?

MS. ELLIOT: Yes, go ahead, Chip.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

different and based on all kinds of different things.

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

Thank you.

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

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

MEMBER PEDEN: Really, just going back

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

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

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

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

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

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

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

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

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

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

MS. ELLIOT: Right. Thank you.

Libby, did you have a comment?

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

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

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

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

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

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

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

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

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

DR. SCHREIBER: Agreed.

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

CO-CHAIR-KAHN: We could do that.

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

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

MS. ELLIOT: Does that sound okay?

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

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

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

MS. ELLIOT: Okay.

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

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

MS. ELLIOT: Okay.

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

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

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

program.

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, I appreciate the overview. Thank you.

DR. SCHREIBER: Yes. So, Katie,

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

MEMBER BOSTON-LEARY: Absolutely.

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

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

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

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

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

MEMBER CULICA: Right.

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

MEMBER CULICA: Right.

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

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

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

correct about that.

MEMBER CULICA: Thank you, Michelle.

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

(No response.)

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

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

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

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

significant financial resources and risk of penalizing underresourced hospitals."

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR-KAHN: Okay. Thank you.

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

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

MEMBER WALTERS: It makes my point even stronger.

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

I'm sorry?

MEMBER WALTERS: It makes my point even stronger.

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

CO-CHAIR-KAHN: Okay. Janice?

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

noting this. It is important.

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

CO-CHAIR-KAHN: Okay. Great.

And then, finally, Andrea?

MEMBER GELZER: Andrea.

CO-CHAIR-KAHN: Okay, Andrea.

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

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

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

(No response.)

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

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

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

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

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

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

I'll hand it back to you, Chip.

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

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

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

MEMBER GELZER: Can you hear me now?

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

MEMBER GELZER: Hello?

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

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

standardized, I think it makes sense to continue it.

CO-CHAIR-KAHN: Okay. Janice?

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

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

Thank you.

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

MEMBER WALTERS: Nothing more to add.

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

hands up?

MS. PERERA: You have Leah Binder.

CO-CHAIR-KAHN: Leah?

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

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

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

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

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

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

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

MS. ELLIOT: Correct.

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

But, Ron, I think you really should

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

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

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

Are there any other comments?

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

CO-CHAIR-KAHN: Michelle?

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

actually important at a disease-specific level.

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

MS. ELLIOT: Great. Thank you.

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

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

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

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

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

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

MEMBER CULICA: Right.

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

MS. ELLIOT: Yes, Arif Kamal.

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

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

setting other than the hospital.

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

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

CO-CHAIR-KAHN: Great. Thanks.

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

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

MS. ELLIOT: Right.

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

be back at 12:40. Is that okay?

MS. ELLIOT: That would be fine, yes. And I think we're at a good stopping point. We have a transition slide for HIQR description, but I think Michelle addressed that early on. So, we'll be able to go right into the last two measures right after lunch. So, I think we're at a good stopping point.

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

Thank you so much.

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

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

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

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

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

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

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

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

measure. Four Committee members recommended this for removal.

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

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

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

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

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

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

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

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

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

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

can that be replaced by one that already exists?

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

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

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

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

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

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

MS. PERERA: Heidi?

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

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

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

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

Many of those comments go back to I

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

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

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

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

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

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

DR. DUSEJA: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The criteria and rationale was the

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

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

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Obviously.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER BOSSLEY: That's helpful, thank you.

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

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

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

neurological societies had asked.

CO-CHAIR KAHN: Heidi, is that satisfactory?

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

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

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

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

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

And there are some in the works and we

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Any other questions or points?

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

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

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

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

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

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

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

patients.

MEMBER PEDEN: Thanks.

CO-CHAIR KAHN: Any other questions? There is? Let's open it up to the public to see if there's anybody from the public that has a comment.

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

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

MS. PERERA: Leah Binder just raised her hand.

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

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

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

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

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

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

CO-CHAIR KAHN: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER TUFTE: It's very low.

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

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

MEMBER TUFTE: Thank you.

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

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

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

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

heart failure, hospitalization.

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

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

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

CO-CHAIR KAHN: Does that make the 60?

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

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

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

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

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

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

CO-CHAIR KAHN: I guess people got back.

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

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

And that gives us a percentage of 42.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and Janice Tufte have been named as the lead discussants.

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

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

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

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

There's been a couple other articles

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Janice?

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

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

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

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

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

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

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

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

DR. DUSEJA: Is that directed to CMS

or is that directed to --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR KAHN: Any other questions?

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

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

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

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

MEMBER BINDER: I had my hand raised also.

CO-CHAIR KAHN: Who is that?

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

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

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

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

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

measure.

CO-CHAIR KAHN: Other discussion?

MS. PERERA: Yes, we have Heidi?

CO-CHAIR KAHN: Heidi?

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

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

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

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

And so knowing even better what there

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

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

CO-CHAIR KAHN: Other comments?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I thought in this case that the eCQM was not as definitive as the other, as the

standard one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

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

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

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

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

MR. HEYMANN: My name is Tom Heymann,

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

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

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

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

But I think it is imperative that we

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

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

CO-CHAIR KAHN: Carl?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HEYMANN: And now Katy Grainger if we may?

MS. GRAINGER: Good morning, my name is Katie Grainger and I am a sepsis survivor. Three years ago almost to the day I entered a hospital on the island of Kauai in Hawaii and it was a small community hospital.

I did not recognized the signs and symptoms of sepsis. I thought I had the flu, I was alone at the time, I was not aware that I was becoming somewhat mentally impaired.

I eventually called a friend in the most pain I had ever been in my life and begged her to take me to the hospital saying I felt like I was going to die.

By the time I got there by blood pressure was 50 over 30, I was nearly dead. I was whisked into the ICU and I was saved by doctors who recognized and had a protocol.

They recognized that I was in very serious shape and they immediately began delivering fluids and doing the things that are required by SEP-1.

I believe that because of the size of

this hospital, because it was such a small community hospital, that if they hadn't had to put SEP-1 into place and have these procedures, I may not be here today.

So, I'm speaking out for the people who are not ending up in big-city hospitals that maybe have a different procedure in place that is similar to SEP-1.

I'm speaking for the people who are going to hospitals that wouldn't have a major in place if it were not for SEP-1.

So, I also am speaking today to ask you to keep it in place. Again, it is not perfect but it is saving lives and it saved my life. Thank you.

CO-CHAIR KAHN: Thanks, I appreciate it. Any other public comments?

MS. PERERA: Grace Snyder?

MS. SNYDER: Thank you, also I'd like to thank patient advocates speaking about the sepsis measure. I really appreciate hearing your voice directly.

My comment was related to the exclusive breast milk feeding eCQM and I know that measure we have finalized for removal.

But I did just want to take a moment to I think maybe step back from this specific measure and just add to the conversation that we are focusing on maternal health in terms of what's been a temp area in measurement in CMS programs, Medicare programs.

And so something else that we take into consideration is that we have some other measures that are in development.

We very recently finalized to add to the IQR program a maternal morbidity structural measure and there's a lot more ongoing work in that measurement area.

So, the removal of one particular measure, please don't take it as a signal that we don't consider it important but just to add to the conversation that there's a lot more work we're doing focusing on the area of maternal health.

Thank you.

CO-CHAIR KAHN: Thanks, other comments?

MS. PERERA: David Gifford?

MEMBER GIFFORD: On the sepsis measure, I think one of the values we provide is not just the up and down votes but the recommendations and language of it.

I'm going to state the obvious and I know the developers probably understand this, but it's clear from reviewing that measure that the clinical ability to identify sepsis and sepsis early so you could start an effective bundle is poorly done.

And there aren't good criteria out there. And I think part of the reason that this measure got thrown forward is because of that challenge. I'm not sure that's adequate enough to remove it, especially given the comments we've heard today.

But it is clear that we need to figure out a way to identify these cases early on to do

a better job on the treatment of it. That factors into any measurement we have.

CO-CHAIR KAHN: Anybody else? I think, Tricia, we've had public comment, I appreciate the input from the patient advocates and others. I think we're ready to go to a vote.

MS. ELLIOT: Yes, we will initiate the vote on these two measures.

MS. HARDING: Polling is now open for Measure 1017 severe sepsis and septic shock, management bundle, a composite measure. Please participate in the poll to show your support for removal of this measure.

A few more seconds before the poll closes.

CO-CHAIR KAHN: I think we were up to 17, we may have lost some people.

MS. HARDING: Okay, I'll close the poll now. We have 1 for yes and 15 for no. That puts us at 6 percent. Polling is now open for Measure 5756, exclusive breast milk feeding eCQM from this program.

Please participate in the poll to show your support for removal of this measure. The poll will now close. We have 8 for yes and 7 for no. This puts us at 53 percent.

MS. ELLIOT: Chip, it's Tricia. Before we move on, we had someone reach out and want to make a comment. Emmanuel, are you still on the line? Would you like to comment?

MR. RIVERS: Yes, can you hear me okay?

CO-CHAIR KAHN: Yes, go ahead.

MR. RIVERS: This is Manny Rivers, one of the measure stewards and I wasn't sure about Measure C. But the comment about early diagnosis of sepsis and septic shock I think is an error.

One of the great attributes of the measure is that we now can decrease sudden cardiovascular complications, which the mortality are about 20 percent of the previous sepsis patients, and recognize people much earlier lack the screenings.

One of the unrecognized things is that

we have now have lower mortality simply because of early recognition.

So, I wanted to correct and emphasize the fact that recognizing sepsis still is a challenge but this stratification now allows us to detect these people earlier.

That counts for almost a 20 percent mortality reduction from early screenings of lactate and blood pressure.

CO-CHAIR KAHN: Okay, I think we've had all the comments now and obviously, the votes reflected the commentary that we received.

So, I guess before we turn it back to Tricia, we have space in the existing agenda for a break and I suggest maybe we should. Do you want to take the break and we'll come back?

MS. ELLIOT: I leave it up to the group, we're running pretty far ahead of schedule. So, we could keep going and see how it goes or take maybe a ten-minute break? Either way.

CO-CHAIR KAHN: It's 1:50 p.m., why

don't we say let's return at 2:00 p.m. and then we'll finish up?

MS. ELLIOT: Okay, so a quick bio break for everybody. I saw in the comments that people are agreeing so we'll reconvene at 2:00 p.m.

(Whereupon, the above-entitled matter went off the record at 1:51 p.m. and resumed at 2:03 p.m.)

MS. ELLIOT: Okay, Misty, I have two minutes after the hour. Would you like to get started?

CO-CHAIR ROBERTS: Sure. Well, welcome back from the break, everyone. It looks like we are going to be able to end a little bit early today, so that's exciting I think for all of us.

I appreciate everybody's feedback today. I think what we wanted to do here at the very end though is to just do kind of a final -- final round of feedback.

As a quick reminder, this is a pilot

process for us. It is a great opportunity for this committee to expand its scope. We were on a very limited timeframe and I think that we pulled together a very good process to start with, but as always, there's opportunity for improvement and we received feedback the last couple of days that we've been able to pivot very quickly and make some changes. But we want to go ahead and get additional feedback.

I do think in the future here, as we incorporate the work groups into this process, I do think it will make things a lot easier for the Coordinating Committee. But I think even the feedback that we receive today can be helpful for us as well.

So with that, let's just start with the positive. Let's start with what we feel works well during the pilot process for the measure set review. And I think we decided is that we are going to do a round robin of the committee just to make sure that we get feedback from everybody because this is going to be very

important to help improve our process in the future here.

So Tricia, are you going to help me with the round robin? I can try to pull it up on a different screen here if I need to.

MS. ELLIOT: No, I have it right in front of me so we can get started. We'll go in alphabetical order, the organization's name. So we'll start with American Academy of Hospice and Palliative Medicine. So either Catherine or Arif, are you on the call?

MEMBER AST: Hi, it's Katherine. I've been sitting in for Arif for the last hour, but I don't know enough about the project, so I don't believe I have anything to add right now.

MS. ELLIOT: Okay, if you're able to connect with Arif at some point, please feel free to send us any comments to our email address.

MEMBER AST: Perfect. Will do.

MS. ELLIOT: Thank you. Next up, Clarke Ross. I know he had to step away. Let's see, is he back on?

Clarke, are you there?

MEMBER ROSS: Yes, I'm back on.

MS. ELLIOT: Okay.

MEMBER ROSS: Thank you. I appreciated the opportunity to express some views of the consumer movement and the disability and mental illness movement.

I really wrote down, Misty, an observation you made after my first discussion yesterday, that by eliminating measures and categories of measures, because a measure is inadequate or incomplete -- I'm paraphrasing you or I'm rephrasing it. But this is your sentiment. By eliminating measures and categories of measures because a measure is inadequate or incomplete, are we creating a measure gap?

And again, I'm interested in the message that all of National Quality Forum and the MAP sends to not only stakeholders but the larger consumer movement. And I'm always asked well, why did they eliminate this area? Now

there's nothing. So that's a take away that I have that I thought really bodes well. Thank you.

CO-CHAIR ROBERTS: Clarke, and real quickly, you mentioned at some level, that instead of going around to each person for each of these questions, do you think it would just make sense for Ben to give kind of the overall feedback on what worked well, what would help, et cetera, kind of go through all four of these questions?

MS. ELLIOT: I think that would be a great approach, Misty, and then we don't have to cycle through everybody multiple times.

CO-CHAIR ROBERTS: So if there's anything else, Clarke, please.

MEMBER ROSS: What could work better, there's always National Quality Forum practices, preaches, and is a model for multi-stakeholder involvement. And the question is from the consumer side is there a balance? Are there enough consumer beneficiaries, patient, and their

family at the table? And that's a judgment and a perception thing. But it's very serious.

I've been involved with the Quality Forum since 2012 and it's a very serious undertaking that you all take very seriously. We appreciated it.

Sometimes the physician voice seems to be a little stronger and louder than some of the other voices, but that's just a personal observation. So that's all.

CO-CHAIR ROBERTS: And one thing just to reiterate, we really had two objectives of this meeting, there we're really two areas. One of them is on the pilot process itself and getting feedback on the process for reviewing the measure.

Second, that we wanted to get to also was a round of measure review criteria that we did. So I don't know if there's a way to -- did we want to put that list up there? Because I do think it's important to touch on that measure review criteria as well.

MS. ELLIOT: Yes, we could have that slide up. Let me just figure out. I think the team might be able to find it faster than I can. Slide 13. Oh, look at that. Perfect. So if folks can reflect on this as they make their comments, too, that would be great. Thanks, Misty.

So Clarke, since you were kind of our guinea pig in some of this, any comments on that measure review criteria? Then we'll move on.

MEMBER ROSS: Well, I think the criteria took time to develop our sound. Again, each of the stakeholders around the table will believe one criteria is stronger than others. So I tend to focus on the overall goals and objectives of the program and the context of the program in the public health of the nation. And are we making incremental improvement toward public health and the health and wellness of vulnerable people.

But other people, you know, focus on other criterion and that's what it's all about.

So I haven't thought about it, but I'm reasonably comfortable with the entire list because if I wasn't I would have made a point at some point earlier. So that's all, my two cents.

CO-CHAIR ROBERTS: And I think the one comment about creating a gap, we need to figure out how to incorporate into the review and maybe it's not part of the criteria, but somehow it needs to be incorporated into the process to make sure that we're not creating any sort of measure gaps.

MEMBER ROSS: Thank you.

CO-CHAIR ROBERTS: Thanks, Clarke.

MS. ELLIOT: Great. Thank you. Next up, American College of Physicians. I believe Sam Tierney is still on the line?

MEMBER TIERNEY: Yes, thanks. You know I appreciate the opportunity to provide the pros and cons. I think it was really useful to conduct the pilot and I would say the positives from my perspective and these are more process issues, I thought it was really good to have lead

discussants because I've been on some of these committees where, you know, you're just sort of waiting for people to chime in and so I thought that was helpful.

I also thought it was helpful to group measures by program, but also by topic areas, so I feel as we discussed a lot of the issues that were raised on one measure related to other measures in the discussion. So I think that was helpful.

In terms of things that maybe could have been done better and I think this was sort of added, you know, like as soon as had some early discussion, but you know, I think that adding the voting option was, you know, critical because I feel like otherwise and I know Chip added this, but I think otherwise what's the point of our discussion? So that's one thing I thought worked well or was something that, you know, could have been or would have been -- was essential essentially.

And the other thing I would recommend

and I think echo Misty's comments about better understanding the measures that are in the program so that we could comment on gaps that would be like identify or promote it with the removal of these measures.

And lastly, I did appreciate the comments of having sort of balanced representation, pros and cons for the measure and move on, instead of maybe all of the people who recommended it be removed.

So that's it from my perspective. Thank you.

CO-CHAIR ROBERTS: Yes, and just to add on to the voting, I also think we heard yesterday the option to abstain from voting. So I think we definitely want to add that in the future.

MEMBER BOSTON-LEARY: This is Katie from the American Nurse Association. Do you mind if I go next because I do have to run to another meeting. Is that okay?

MS. ELLIOT: Oh, that's totally fine.

Thanks for giving us a heads up. Go ahead.

MEMBER BOSTON-LEARY: And I'll just a mix of my thoughts, but great planning. Kudos to everyone that put all this together and planned it. It was nice to see how nimble it was where some of the bumps and suggestions that were made earlier, there was some accommodations for those and seamless.

I did notice also, Tricia, the voting piece went to someone else to manage which was nice for you for day two.

Materials, receiving them ahead of time was very helpful. Poll everywhere worked like a charm. I appreciated hiding the results just so we don't get locked into assimilating based on what we saw on the screen.

I appreciated the dialogue verbally and in the chat. I liked how the feedback was saved with public comments and committee and all that.

Also, I appreciated -- I don't want to imply that this was, you now, something that

wasn't appreciated, but I really appreciate you having nursing at the table. That is something that we want to make sure that we have nurses represented and just having our association represented I think is great, especially since we tend to be crowded out by physicians. So thank you for that.

Opportunity to improve the data to support the decisions for sure would like to see especially measures that have been in place for a while to see how it's trending, whether there are improvements or not. That will be good to have ahead of time to help with the decision making. I know we talked about that.

Tom mentioned voting to abstain -- abstain from voting, but I don't know that we want too much of that. I think since the measures and all this, the agenda and everything is sent out ahead of time, if someone does want to abstain that should be said, mentioned ahead of time, if you will, and noted. But I don't know that we need a button for that.

The common theme of this measure is not good enough, but it will do for now, so what's the middle ground for measures that need to be amended or revised just so we're not throwing the baby out with the bath water. Hearing the story from the sepsis story telling or sharing of a sepsis alliance I think was very powerful. And people like us who tend to sit at the table who make decisions need that, more and more of that.

So thank you for the opportunity to contribute and I'll still be listening in. I just need to sign off from this medium and go to another. Thank you. Appreciate your accommodation.

CO-CHAIR ROBERTS: Thanks, Katie. Appreciate it.

MS. ELLIOT: Next up is the American Healthcare Association. I believe both David and Marsida had to step away. David gave us some comments privately in the chat that I'd like to share.

Overall, he thinks that the process went well. It was clear having measure developers and CMS staff acknowledged that it was very helpful to have them on the call. I think the claims for why a measure is being suggested for removal needs some fact checking, so I think that's another comment that we're hearing.

I also think we need -- and this is David, not Tricia speaking. I also think we also need to have more info on what are our plans. Should a measure be removed or recommendation on it such that removal is contingent on a new measure or composite measure?

I just wanted to share those comments that he had shared with us.

Next, we'll move to the American Medical Association with Heidi Bossley.

MEMBER BOSSLEY: Sure. Thank you. So having either participated or observed the MAP process for many, many years, this was a very well-run meeting, so kudos to NQF staff.

And I really appreciated having

comment moved up in the process and I would actually -- I went back and looked at what happened in January. Comment occurs before anyone talks. And I think that is actually extremely helpful to frame our thinking and to make sure we have all the information in front of us. Moving that up even a little bit further might be a good idea.

Just a few thoughts --

CO-CHAIR ROBERTS: Just to clarify, you're referring to public comments?

MEMBER BOSSLEY: Yes, sorry. Public comments.

CO-CHAIR ROBERTS: Even before lead discussants?

MEMBER BOSSLEY: Yes, even before. I think that's how it is with the --

CO-CHAIR ROBERTS: MUC process?

MEMBER BOSSLEY: Thank you, MUC, yes. And then just a few thoughts and I still don't know the answers to all of these, but regarding the criteria, just a couple of things that came

to mind over the last two days. The first criteria talked about whether the measure does or does not contribute to the overall goals and objectives of the program. And I'm wondering if there's a way to then also step back and not just do an individual measure evaluation, but to look at how it fits within the program and what the impact would be removing versus adding a measure, something I know that the MAP struggles with every year. But maybe tweaking that criteria or adding a new one so that you're not just looking at individual measures, but the set itself that's within a program might be useful.

The other thing that I don't see here and because of the number of measures that may or may not have been reviewed by NQF, I do wonder if some criteria around the scientific acceptability of the measure, either risk adjustment, how it's designed or the validity of a measure, for example. We might be able to say that comes under the negative unintended consequences, but perhaps not and so it might be worth thinking

about.

When I started to think about what information would have been helpful during the conversation, a lot of it very similar to what staff brings for the MUC review, but gap data and I think we had quite a bit of discussion that if we had had information on disparities or sub-population and trend because we should have that information, anything that CMS or others could provide to help provide context of how a measure is performing and what information it is or is not communicating, either to the individual being measured or to the public I think would be helpful.

Also, whether a measure has ever been reviewed, so not only whether it's not endorsed, has it ever come through the process or not. And if it was removed, why? I think that would be very helpful to understand.

And then going back to levels of approval of yes and no and I'll stop. I do think some gradation of priority of how quickly a

measure might be removed or if there's something coming down the measurement development pipeline. Okay to wait, not okay to wait, sending that information would probably be useful to CMS as well. Thanks.

MS. ELLIOT: Great. Thank you, Heidi. Next we have America's Health Insurance Plans. I believe Liz Goodman, are you back on the line?

MEMBER GOODMAN: I don't want to repeat what others have said. I agree with all of it. I would say that in listening to the discussion, there were several questions that were raised almost every time about the history of the manager, about it lost endorsement, why? Or was it, you know, drawn? So what was the process and how did it get there? I think all of those -- the data points that are provided for the MUC list would be useful in this case.

And then the thing that is the most glaring to me and what I put in the chat is this issue of how these measures intercept in a measure set. You know, I think this is

fundamentally a challenge both for the Coordinating Committee and for this process about looking at measures in a vacuum individually and not looking at them as part of a broader measure set. And I'm not sure how to solve that problem, but it makes it very challenging not just because we might be creating gaps in measurement, but also to really understand what's duplicative and what's not.

And then the last thing is the feasibility and the issues of collectability of the data. I don't think it really came out in this process as much. I think some of that was the time line that we all had when we were assigned whichever measures we were assigned and how much time we sort of had to do the homework because this was a test. But that's a really critical component of the whole process and some of these measures, not just the measures we looked at today, but measures in other sets are really profoundly difficult to implement. And that did not come out as much, I think, in this

discussion of the last two days.

MS. ELLIOT: Great. Thank you so much, Liz.

Next up, we have AmeriHealth Caritas. I'm not sure if Andrea Gelzer is still on the line.

We'll move along and circle back if Andrea rejoins.

Blue Cross Blue Shield Association, Carol Peden.

MEMBER PEDEN: Thank you. I very much enjoyed that two days. I think we had a frank and open discussion and I think it was very well organized. I think it is important that we go in with more information. Some of these measures are very important and we need not only why we should remove them, but why we should keep them and a little bit more hard data around that. And also, as others have said, the context they're in. So you know, what is part of the other suite of measures around that.

I would also agree that we need to

collect the areas where there are gaps and we took a lot of the behavioral health measures out when we recognized going forward that behavioral health is a major issue for America. So I think we need to be able to recommend why we took these measures out and what we would like to see urgently going forward from there. Thank you.

CO-CHAIR ROBERTS: Thank you, Carol. Next up, we have Covered California, Margareta Brandt. Are you still on the line?

MEMBER BRANDT: Yes. Hi, this is Margareta. I have similar feedback back to the other members, so I think I would just note that I appreciated the discussion on each measure. I thought it was really helpful to inform the voting and I appreciated the flexibility and the organization of the meeting.

I think, generally, as other folks mentioned that I would have appreciated more context, more data, and more time to be able to adequately feel like I could implement the criteria when reviewing the measures, so you

know, more information about the program and more data would have been good and helpful, along with more background or information on the evidence based.

And then I think again like others have mentioned would appreciate an effort to kind of identify gaps and if we are removing measures to make sure it's clear that there's an expectation that gaps will be filled over time. I think that's it. Thank you.

MS. ELLIOT: Thank you. Next up we have HCA with Kacie Kleja.

MEMBER KLEJA: Hi, thank you, yes. I have similar feedback that most of my comments have actually already been covered by other members. It's been a great couple days of meetings. The one thing that I had noted, I think we obviously see these measures and the programs go kind of hand in hand. There's some blurred lines there. I think that sometimes we focus more on the program versus the actual measures themselves, specifically thinking about

the readmission reduction program and some of the limitations associated with the structure of that program. So wondering if in the future it makes sense to kind of carve out time to talk about programs specifically or if we needed just to refocus to the individual measures.

And then I know that this was put together very quickly and I appreciate that, but it also did limit what we could pull together from -- pulling together the comprehensive stakeholders and its needs within our organization to make sure that we have the appropriate feedback in time for this meeting.

MS. ELLIOT: Great. Thanks so much, Kacie. I'm going to skip over The Joint Commission. I don't see any representatives from there today.

Leapfrog. Leah.

MEMBER BINDER: Just a terrific meeting. I was really, really impressed with the way you organized it. I would like to compliment the co-chairs as well because I think they did a

really good job in leading the meeting and Tricia, you did a great job. I thought it was really an excellent meeting and I'll tell you what I think was really different from other NQF meetings or other meetings on measurement issues that I've been involved with.

And I love the fact that instead of looking at well, let's look at this measure, now let's look at this measure, and now let's look at this measure. Like a lot of them are all about serial discussions about measure, measure, measure, measure, measure. Because of the structure of it and I don't think we intended this necessarily, but we forced us to step back and say all right, here's our goal for improving healthcare and is measurement contributing to it? Is the current way we're measuring within CMS contributing to that?

It took us -- we took more of a bird's eye view. I thought that was a really positive thing and said well, you know, is this, in fact, the kinds of measures we need to achieve the

purpose of our work in or of the effort to include behavioral health, for instance. It forced us to look at it. When we do that and we look at the measures in there, it's kind of disappointing to see what we have and then we begin to realize that the gaps became a robust conversation I thought on how we use measurement to achieve its purpose, not measures in and of itself which is just a piece of paper, really. This is about how do we use measurement as a tool to see improvement? And are we doing a good enough job? And what do we need to do to improve that?

So anyway, I thought that was and I think fundamentally I would love to see future work in this area where we're talking about removal of measures framed as that, of measurement, evaluating the effectiveness of measurement in achieving goals.

So I would -- because I think that's fundamentally is what we did. More than -- we talked about removal. We talked about addition,

but fundamentally it was take a step back and discuss whether we think we're headed in the right direction in achieving these goals.

And the other thing I would add is under review criteria, just -- I said this earlier, but just to formally say this at this moment, that one review criteria should be that the measure -- if the measure does not differentiate excellence from adequacy of performance, I think a measure should -- quality measure should be able to identify high quality, not just adequacy.

And then everything else has been said, so that's my comment.

MS. ELLIOT: Great. Thank you so much Leah.

Next up, National Committee for Quality Assurance, Mary Barton.

MEMBER BARTON: Thank you. I want to echo what I've heard several people say and that is I've been in a lot of MAP meetings and this one was really well done.

And also, I guess, I just have a little selfish question. If it could have been scheduled earlier, then it would have been easier for me to clear these other conflicts that I had on my calendar off. So that was really challenging for me to attend all of the meeting because it was scheduled it seemed like two weeks ago. But I'm sure I exaggerated that in my mind. Anyway, thank you.

MS. ELLIOT: No, Mary, you're not too wrong on that. This was a very, very short time line, so we appreciate and understand your comment that it was challenging for folks to clear their schedules and attend. So we appreciate that you're able to attend for as much as you could. So thank you.

Next up is the National Patient Advocate Foundation. Rebecca Kirch.

MEMBER KIRCH: Hi and thank you. I'm newer to the MAP Committee and its process, so now my expectations are very high. Leah commended this discussion as being special and

it's sort of how I would have expected it. So hats off to all of you because it was right where I would have expected it being new to the party, as it were, and I appreciated very much the flexibility, the nimbleness that staff and colleagues all brought to bear with the varied feedback you got.

So much has been said and I'm at the end of the alphabet, so that's fair enough, but the two points I think I'd like to highlight are a little bit more drilling down on what Leah just said about coming at this from the context of is the way that we're measuring contributing to our objective to improve accountability for quality care? And I think that's a really important context when we think about how we synthesize the information for preparing us for the discussion, but also how we approach the discussion. And I think that was what made this so successful and special.

But I would add to that it's not just our objective of accountability for quality care,

but also the representativeness around the discussant's table. And aspirationally, but achievably, I think a measure criterion specific around the diversity perspective. I heard the clarion call for nursing representation as important to embed on top of the physicians. I'd say also social workers as an important part of the field, especially because we're talking to about behavioral health in the context of these measures. And also representativeness of those who are limited resource. And that goes to the disparity and health equity points that has been an underpinning of some of the dialogue we've had.

A criterion, I think, that's an adjunct, but really needs to be explicit out of number eight and probably its own is how is this measure contributing to performance that diminishes disparity and promote equity in health care that we know are a rampant challenge right now? I think it's time now for that to be explicit. And thank you so much. Great two

days.

MS. ELLIOT: Great. Thank you so much. We really appreciate your feedback. The Network for Regional Healthcare Improvement. Liz.

MEMBER CINQUEONCE: Hi. Yes, there's a lot of comments that have been made that I completely agree with. I think overall, the process went really, really well. I did appreciate the midstream adjustments that were made and especially to allow the public input before we made the vote.

I also really agree with the comments that have been made about really having the work groups focus around the specific programs and make recommendations on the measure sets that are applicable to those programs. I think that's our best chance to make sure that the measures are aligned for us to identify any gaps that come along with these recommendations.

I think the one part that was a little bit difficult was sort of the up down nature of

the voting on this because throughout the discussions there were so many different nuances that came up related to each of those measures and I almost wonder if we would be better served by a matrix type of feedback that could go back to CMS where we're able to not only capture whether we're recommending removal, but really if we are saying that we're, you know, voting maybe for continuation, but that we are recommending future changes and why it might serve us well in terms of looking out a little bit further ahead than just the immediate questions about the measures that are there today.

But overall, really appreciated the opportunity to be part of the process and thought it was very well done. Thank you.

MS. ELLIOT: Thanks so much, Liz. Next up, we have Patient and Family Center Care Partners with Libby Hoy.

MEMBER HOY: Hi. First of all, just thank you so much for having the patient and family perspective represented in this

discussion. This is I don't know how many MAP meetings that I now attended, but this one is a little different. I have to agree with Leah. It felt like we were moving more towards a person-centered sort of measuring system and really looking at each of the measures in that larger picture of is it really supporting the outcomes and goals of the programs? And so I thought, you can't see, but I have marked up to infinitum the criteria that you gave us because I thought it was really, really helpful. I might suggest we put the goals on the back side, so -- I kept having to sort of make sure we were marching along to the North Star that we had -- that we had set out.

So I think it was, of course, NQF's team is always top shelf in meeting preparation and meeting flow, always really helpful.

I appreciate -- I was a little nervous on the last comment about starting earlier. I thought you meant starting earlier in the day and I was thinking oh, sweet petunias, I'm on the

West Coast. Seven o'clock with measure and detail. That's about all I can give you.

In any case, there are a lot of great discussion. I learned a lot.

As far as the criteria themselves, I would agree with what has been stated before. I think more context maybe on measurement, I'm sorry, on criteria number five. More contextual and historical information about where the measure sits within the larger context and how it's performed and the whys, as we've heard of. Why was it endorsed? Why was it not endorsed. You know all of that historical context is really, really helpful.

I would promote the addition of does it create a gap? I think that's a really, really important question and so thinking about a measure in that way.

Each of the criterions are really specific to the exact measure we're looking at one through eight. So I think maybe the addition of a couple of criteria that, you know, does it

feed the program overall? Where does it fit in the overall program? I think that encouraging that larger look.

And then Rebecca will not be surprised to know that I also suggested another criteria around the quality impact. I think that's a really, really important thing for all of us as we heard with the sepsis, sepsis has such a large disparity and we know that, so how does step one either support equity, promoting equity, or how does it sustain the inequities that exist today? So I think we really need to fold that into our conversations regularly.

As a person that comes to this work with less experience, education, and family, care giver and no experience with measure development other than where I've been able to have input, I would say that I was reflecting on how could I be a better representative of our community? And so for a couple of things, one, I think we need to increase the number of seats at the table.

I think we need to seek out really

under represented voices as we do that. I think myself, having more time to sort of get the measures as you've given them to us into a bit more of a plain language and have some conversation with patients and families in our network and really leverage the broader voices of patients and family members, that would help me to be more representative in these discussions.

And with that in mind, and the potential to expand the number and diversity of patient/family representatives in this process, potentially a set-aside orientation for plain language to help us get a little bit more context. So those are my thoughts. But a great meeting and again, I am just so grateful to NQF and CMS for engaging the patient/family perspective.

MS. ELLIOT: Excellent. Thank you so much, Libby. We really appreciate all your comments.

And last from the organizational representatives, Purchaser Business Group on

Health, Emma Hoo.

MEMBER HOO: Thanks. It's challenging to identify any new suggestions, given all the rich feedback that has already been provided and I agree with much of it.

I would also add, too, that the context and recent experience of the measures would have been very helpful in the original selection and having more time to review the information would also have been helpful in terms of better understanding some of the rationale behind the program, as well as the measure itself in the initial voting of the ten measures.

I would also say that during these discussions, folks referenced some of the recent recommendations that might have been made by MEDPAC or some of the journal articles speaking to some of the experience and inclusion of some of those elements in what is creating potential controversy or validation of use of the measure would have also been helpful as part of the background reading so that we were more prepared

for some of the discussion today. And I think some of the broader issues also include a better understanding of what might be in the pipeline for a specific program.

I know in the introductory session, Michelle also discussed the potential consideration of building composites among some of the measures as opposed to straight elimination and in most of the detailed measure discussion, that never came up. But I think it's something that is worth discussing and also just that broader context of understanding how the measures are used in specific quality reporting programs, public reporting or payment and also understanding that elimination of a measure in one program may affect the utility in others such as the emerging use of some of these measures in understanding health equity and stratifying that data. I feel that absent that holistic view of how some of the measures are being used or are being planned for use makes it difficult sometimes in the voting of whether we might be

throwing the baby out with the bath water versus truly keeping a measure that doesn't differentiate performance or may have topped of.

And then echoing the last comments, I do appreciate the 10 o'clock start time as a West Coast person.

MS. ELLIOT: Duly noted, Emma. Thank you. Next up, I'll move to our subject matter experts, Dan Culica.

MEMBER CULICA: This is my first MAP meeting and I just want to use the opportunity to thank Andrea again for having me on the committee. I think that it was a review, even the coordination, the education meeting that was last month because I was off two days. So I tried to learn as much from that in catching up and be prepared for the process. I think that as much as I would like to contribute to the work, like many other of my participations with the NQF, I see this as a huge learning opportunity for me.

And I think that probably this is what

I missed part of the first educational session is I think I would have liked to know more what sort of recommendation from the CMS is for each measure in the sense that I'm a firm believer of national coordination and direction in what we do at the state level. And representing a purchaser of healthcare, I'm also a huge consumer of quality measures, so again, everything that has been said it's extremely useful.

In terms of the process, I would say that I need to be better organized for the next meetings and now that I know how they are avoid questions like what are competing measures and why have not they've been endorsed or why they lost endorsement?

And then in terms of the criteria, I was thinking about criteria number eight, especially the aspect of negative unintended consequences. I thought that unintended consequences kind of hides the word negative or it is implicit. But it would be interesting if there were any positive unintended consequences.

But thank you very much again.

MS. ELLIOT: Thank you. Thank you for your comments. Next up, Janice Tufte.

MEMBER TUFTE: Thank you for having me here today. Let me get into -- I wrote down a few things. Basically, some of the positives were we did receive the information. It came very quickly and it was very dense for me and I kind of -- I glanced over each one, but I did it on the weekend.

How I decided kind of to do removal because I can find positive in almost anything, but if there was a similar measure, like if there was an E quality care measure, I tended to lean towards that, but I believe in one or two cases, it wasn't as thorough as the previous measure, so I maybe had requested the other one for removal.

And I think it would have helped a lot in these two days if we had some of that same information just sent again so we can see what you had originally sent where there was comparative measures, similar measures because I

found that very helpful. And if it would have been easier to find, I probably would have utilized it more during this last two days.

And I think within the measure sets, it's, you know, I think along the lines, I think as some other people. We did talk about combining or composites or bundling. And I would love to see more of that and I think a lot of patients would. I do realize it could be more burdensome, but I feel if you -- the episode-based type measurements worked. You have the pre, the whatever treatment -- treatment and the post-treatment follow-up. And it also would include the other sub-specialties or primary care. To me, just seems way more person centered if it was kind of in that area.

Regarding having other patients, partner, families on board, I think I may be the first patient identified as patient. And disparities, I don't have a college degree. I kind of learned as I've gone. And the more -- and I'm involved with evidence, so we certainly

could use more individuals, you know, but I have been on Medicaid, on Medicare, you know, so I'm considered individual with disparities.

And the people in my community are individuals who are -- I have friends who have care and social needs, so I'm aware of a lot of their needs. Much of them aren't aware of even what a measurement is.

Locally, I'll just say in healthcare for the homeless, I was head of the data evaluation, so I'm the one that kind of insisted we should have patients involved with this so they're aware of it. So they learned about the core sets of measurements, right? It's just a beginning step to being aware.

And I like the last doctor that spoke, I had written about what impacts removals have on patients. And number eight, I thought the criteria could be refined.

Unintended consequences, I think are probably almost -- they come across the board, right? And I think Leah during our discussions

really brought out some valid points. So when we're talking about equity and disparities including having those patients and individuals present on sepsis, I think probably my guess has changed a few of our minds if we weren't necessarily -- if we would going to vote for removal. It would be wonderful if we could have more individuals. It's a lot of work getting people to really provide feedback on subject matter.

But as Libby and others have mentioned, I think literacy and language is a big deal. And if we include more patient, family, and communities members, I've been involved in measurement for five or six years, so I'm fairly well versed on it now and understand the process. But I believe a lot of people are disillusioned after they first get involved. They don't feel like they've contributed much. And I know we're in the process now of meaningful measures and more. So I think in the next five years, we'll be able to see more opportunities.

And I think that's about it. Is this duplicate? Yes, closely compared measures. I think that's about it.

So I'm honored to be here. I'm very sorry I didn't realize that I was a discussant. I didn't read through all of the materials. I didn't think I was going to be a discussant, so I saw where if you don't want to be, please let us know, but I didn't realize I was, right? So I will be a little bit more astute on that. I've just been really busy. So thank you for having me.

MS. ELLIOT: No problem. Thank you so much, Janice. We appreciate your comments.

Ron Walters.

MEMBER WALTERS: Positive. Staff, of course, is the best staff in the world. The chair and co-chairs were excellent, as mentioned earlier, adapting the full things to the situation. And I appreciated everybody feeling free to give honest feedback. Again, that's all you can ask is to get people's honest opinions

about things. And I think we did a good job.

As I sat -- not necessarily a comment, as I sat here I was wondering ultimately did we assist CMS or not. And obviously, this pilot program, this was our first meeting. We set out criteria as we talked about many times. If something meets all those criteria probably shouldn't be on our list. I mean it shouldn't have gotten through the process in the first place.

But I was putting together in my head because I know yesterday morning the first few measures were like three to one for removal. And then we went -- we flipped, actually, the second half of them were like three to one or maybe four to one against removal. And today has probably been predominated by against removal.

And so the question --- is that useful advice or not? And did we do it according to the criteria? So in my mind I was trying to stack up measure one. We gave the reasons by the reviewers, but we didn't indicate a final reason

for either not recommending removal or for -- for not recommending removal. We kind of talked about a lot of concepts.

So if you were to ask me how well, did our criteria work and did they provide useful information back to CMS about a mechanism to decide what had to be removed and/or keep, I'm not sure we have the data yet and I would love to have been tracking that all the way along more formally where we specifically said why a measure was recommended for removal or not.

That may become useful as time goes on and version two of this pilot or so to know how well we stick to our criteria and which ones mean more than other things.

The last thing I'll mention and the reason why I harped on what I was harping on so much is I'm on the front page of the NQF now and the Coordinating Committee sets the strategy for the partnership and provides direction to and ensures synchronization among the advisory work groups.

Now I know that there's work being done on the next version of this to accomplish that. But I think what I notice is there really is not what I would call synchronization. We saw some examples of that. Whether you call them duplicate measures or well, this is in this program and it's almost like the other ones, but not quite. It's all those sorts of things. And I think that's what we're tasked to take care of.

I wanted to tell you one more story about cancer, just to scare you a little bit. It's nice to talk about heart failure, diabetes, in fact, for that matter, sepsis, like it's one disease.

A very good point was made yesterday about behavioral health. It's many diseases. And do we enter the era of having very disease specific measures because that could expand very quickly.

And in cancer, I got to thinking about the surgical one we talked today. Okay, I can do surgical mortality for lung cancer, surgical

mortality for neurosurgery, surgical mortality for colon cancer, surgical mortality for pancreas cancer, et cetera, et cetera, et cetera. And that's why I keep harking on it because doctors do, there's lumpers and splitters, and doctors do like to be splitters. We need to split when it's appropriate to split. And we need to lump when it's appropriate to lump.

And so that's why I said a lot of the things I said because we're not at global warming yet for this, but if you plot the number of measures over time and more recently the new versus retired measures, we're warming up. And we need to be aware of that. And that's the job of this committee actually, synchronization amongst the various advisory workgroups.

So thank you very much for having me. I know sometimes I can be a pest and that's because I say exactly what I think and is on my mind and thanks for giving the feedback when I was wrong.

MS. ELLIOT: Thank you so much for

your comments.

Missy, can I hand it back to you for public comment?

CO-CHAIR KAHN: No, I haven't been able to comment.

MS. ELLIOT: Oh, okay. Go ahead, Chip.

CO-CHAIR KAHN: A few. Not to be disagreeable, I sort of disagree with Heidi a little bit. I think we put the public comment in the right place, but that's something that we could talk about.

I think it's very important and I heard it from a number of the -- a number of you that we come up with something other than just a straight binary voting. Hopefully, absentia won't be that important. It was important today in this particular instance because we had a short fuse and there were some people who were representing the organization and they hadn't had time to do analysis.

Hopefully, if we have a little bit

longer and we have the work groups, abstentions won't be an issue, although I think we should have it as an option because there may be some reason why someone needs to abstain. But I think we need some gradation. And we do have gradation in our normal process.

So what I'd suggest, and, obviously, it's up to the group, is that maybe the chairs work with staff on a draft of voting options and then we maybe have some communication by email with the committee over the next little while to come up with what we would like, so we're not backing into another process and saying, next year, hopefully, we'll have the opportunity to do that and saying, oh, no, now we've got to decide on the voting process, because I think it will take us some time to think it through because there were a set of options sort of put on the table today and I think we really need to think about the wording of the voting.

And, obviously, if you go away from binary voting and you have some options, then you

run into the problem that we have with the MAP, although I think we've got a formula there where you may have to have a series of votes, because you might have more than once choice. That would be my suggestion. And that we settle on a process prior to the next round, because we'd want that process to be used by the work groups as well by the Coordinating Committee itself.

And then, finally, I think that we've had a number of suggestions about the criteria and also the information that we think we need for our assessment. And I just wonder whether -- and I know we've got a lot on the table, but I wonder whether we should follow up with anyone that feels strongly about it, even if you commented, to send a note to the staff just where you are on the criteria and where you are on what the data points are you think we need for our assessment. I think that would be useful, just so that could be memorialized and then as they think through our next process.

I think those are all my suggestions.

CO-CHAIR ROBERTS: Great. Thank you.

MS. ELLIOT: And Misty, before we go to public comment, we had another organization join.

Dr. Baker, do you have any comments about the process from yesterday or today?

MEMBER BAKER: No, Tricia. I don't think I have anything to add to the comments that have already been made. Thanks.

MS. ELLIOT: Okay. Thank you. Okay, Misty, I think we're ready to move to our public comments on the process overall, so slide 77. Thank you.

CO-CHAIR ROBERTS: Great. So we'll now take the opportunity to have public comment on the measure set review process, as well as the criteria that was used.

As a reminder, please limit your comments to two minutes and limit it to the pilot process and the criteria.

Let me see if we have any hands. I'm not seeing any hands. I have learned patience in

these processes to count to like ten before saying nobody. All right, I am not seeing any public comments.

MS. ELLIOT: And if I can circle back, Misty, also to our CMS partners, I believe Michelle would like to make some comments.

MS. SCHREIBER: Thank you, Tricia. I really appreciate it. This, I think, has been a very productive couple of days. A couple of people have asked if this is meaningful to CMS and I would say the answer is yes.

Some clear take-home messages is that we probably have to almost seriously rethink the in-patient psychiatry measure set and even in the context of the broader mental health measure set to be sure that it's having the impact that we want it to have.

The second is thinking about some of the programs and are the programs impactful and are there changes to the programs? That might not be something as simple as removing a measure, Chip, as I know you've pointed out. But all of

us combined, I think, have levers and have other levers that we can use and engage to bring forward changes to some of the programs.

In terms of the review criteria, I heard a lot of good things to put on the review criteria. There's one I didn't hear though that I'd like to just bring forward and that's are we advancing quality measures sort of writ large? In other words, are we moving to more outcome measures? Are we moving to more digital measures? Are we moving to a point where we're hearing more of the voice of patients, so patient reported outcome measures. So in other words, are we kind of moving the measure inventory used in programs to more futuristic quality measures in general?

But I think this has been very important. We have lessons learned of information that you would like to hear back in advance and completely agree. It changed the conversation in many parts. If that happens though, I think we also have to think of what's

our limit of how many measures can be discussed in a couple of days in a program like this because that kind of reporting back for every individual measure is very time intensive. And I think we just have to be very specific in thinking through are we going to look at measures comprehensively every year and pick out measures? Are we going to look at programs comprehensively? And so just some thought about that.

We're happy to provide all the background information, but I don't think we can do it for 550 measures which are currently in use, not at one given time at least.

And so also on behalf of CMS, really, I would like to thank all of you. I'd first like to thank the CMS colleagues and some of our contractors who work very hard in the background, really, to put together this information and who think about this on a daily basis; to certainly thank NQF for the work that you have done in putting this today. I think this has been one of the better meetings; to thank each and every one

of you who have participated and certainly finally to our co-chairs, Misty and Chip. I think you led us well. So thank you.

CO-CHAIR ROBERTS: Thank you. Tricia, any hands --

MS. ELLIOT: I did not see any hands come up for public comment. We were kind of monitoring that as Michelle was speaking. So I think we can go ahead to the next slide.

We'll pause here for closing remarks. Chip or Misty?

CO-CHAIR KAHN: I just want to thank everybody for this. I think as an experiment, we clearly were successful in showing we could go through a process. I guess I'd really like to -- the one thing I guess I'd like to put emphasis on was I think Michelle at one point during our deliberations sort of asked advice about whether CMS could go to some kind of every other year process for sets of measures. And I think probably one of the things that we learned in this experiment is that we, as a group,

obviously, as well as all those who would help us, probably do have limited bandwidth.

So I think it will be probably wise for us to take all the programs over some period of time, if anything, this would work as over some period of time and split it up so that we have a manageable amount to review every year and obviously those providing us all the background information have the bandwidth to reasonably provide us the information.

I think it will be very important for us to have all this information. We'll have a much richer assessment. And frankly, the 500 and something is Everest to me. So I don't think it's going to be any different next year, even if we have work groups and have time for process. I think we probably should think about some way to divide it out.

Those are my remarks and I want to thank everybody and particularly thank the NQF staff for all the work they did in making this possible.

CO-CHAIR ROBERTS: Thanks, Chip. And I'll echo all of the things that Michelle and Chip laid out. NQF does a remarkable job of really getting all of the prep work done and really helping us as co-chairs to facilitate the conversations, so thank you.

And I appreciate CMS and team also for being here to help answer a lot of the questions that we had anticipated would come up during the discussion and then appreciate everybody's patience with us through this process and also just the robust feedback that we received.

And Chip said that it wasn't a success. I do think it was a success based on the ending feedback that we had, but there are still opportunities and I'm looking for incorporating these comments and feedback into future processes. So I appreciate everyone's time today.

Tricia, should I hand it over to you for next steps?

MS. ELLIOT: Yes, please. Thank you.

And we'll quickly go to the next slide.

So just to highlight where we're at in the process. We had our education meeting as most remember back on August 9th. We did our measure selection process and had a very quick due date on that which led us to today's meeting.

So next in the process is our September 15th Coordinating Committee's strategic meeting. And then we'll be pulling together final recommendations to share by October 1st. So there will be a lot of great information that we'll be pulling together from everything that was discussed today and future next steps.

I think we have one more slide to share. We just want to make sure that you please contact the team if you've not received a calendar invite for the MAP coordinating strategic meeting on the 15th for those committee members. This meeting will also kick off the MAP Coordinating Committee pre-rulemaking activities.

And we have our contact information there if you have any additional thoughts,

concerns, or questions. And with that, I think we can conclude ahead of schedule again today, so a couple hours back to everybody.

And thank you so much on behalf of the NQF staff. We truly appreciate all your participation and input into this very important process and very much enjoyed hearing all the perspectives. So thank you all and have a great rest of your day.

(Whereupon, the above-entitled matter went off the record at 3:09 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Set Review

Before: NQF

Date: 09-09-21

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

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Court Reporter