NATIONAL QUALITY FORUM

Moderator: MAP Hospital Workgroup
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OPERATOR: This is Conference #: 6174490

Hello, and welcome to the Measure Applications Partnership Hospital Workgroup Web Meeting.

Please note that today's call is being recorded and all public lines will be muted during this broadcast. Workgroup members, please note your lines will be open for the duration of today's call, so please be sure to use your mute button when you're not speaking or presenting. Please keep your computer speakers turned all the way down or off if you've joined us by phone. And please do not place the call on hold at anytime.

If you need assistance at anytime today and you've joined by phone, please press star zero, and an operator will assist you. For technical support with the web portion of today's program, please send an e-mail to nqf@commpartners.com. That e-mail address is currently displayed in the chat box area and will remain there throughout today's program.

Today's meeting will include specific question and comment periods, however, you can submit a question at anytime by using the chat box. To do so, simply type your question in the chat box on the lower left corner of your screen. Please be sure to click the send button located next to the box to submit your questions.

During the designated public comment period, you will also have the opportunity to ask live questions over the phone by pressing star one. These instructions will be repeated later in the program.

I would also like to draw your attention to the links area located to the side of the slide window. You'll find resource information relative to (inaudible). Simply click on the link on of your choice and it will open in a separate web browser window from which you can print or save the file. It will provide notes (inaudible) to the meeting as it will open in its own web browser window.

And now, it is my pleasure to welcome Cristie Travis to the program. Cristie, let's get started.

Cristie Upshaw Travis: Thank you so much.

Well, I'm going to add my welcome to everyone for the MAP Hospital Workgroup Web Meeting. I'm Cristie Upshaw Travis, and I'm the CEO of the Memphis Business Group on Health. And I am one of the co-chairs for the MAP Hospital Workgroup.

Before I pass it on, I do want to thank all of you for your commitment to this process and for your thoughtful participation on today's call. We have a very packed agenda as you will learn more about. And so we really thank you for thinking about the issues that have been raised in advance. And we will be getting through this agenda, all of us together.

Also, looking forward to our in-person meeting, which we'll learn more about at the in-depth of this session.

So I'm going to turn it over to Ron Walters now who is our other co-chair. Ron?

Ronald Walters: Hi. This is Ron Walters. I'm a medical oncologist at MD Anderson in Texas. And thank you again, as Cristie said, for your time and effort over the years and your dedication to this process. I know we're kind of like almost like a

family now, some of us have been on this for a while, we've got to know each other and it really is appreciated.

I also want to thank my co-chair, Cristie, this year. I hope that we meet your needs. And are able to deliver a valuable product to – or CMS, a – our constituents of the National Quality Forum members, patients, providers, et cetera. And most importantly, I hope we can make every person on the committee who has put in a lot of time and effort feel valued, because we really do appreciate your efforts.

So, we're going to take a roll call right – Jean-Luc is going to take a roll call right now. And see who's present on the line.

Jean-Luc Tilly: Good afternoon, everyone. When I call your name, please just introduce yourself and your organization.

Ronald Walters?

Ronald Walters: I am here.

Jean-Luc Tilly: Cristie Travis?

Cristie Upshaw Travis: I'm here.

Jean-Luc Tilly: Kelly Trautner? Nancy Foster?

Nancy Foster: Here. I'm Nancy Foster with the American Hospital Association.

Jean-Luc Tilly: David Engler?

David Engler: Hi. It's David Engler with America's Essential Hospitals.

Jean-Luc Tilly: Donna Slosburg?

Donna Slosburg: Good morning. Donna Slosburg with the ASC Quality Collaboration.

Jean-Luc Tilly: Wei Ying?

Wei Ying: Yes, Wei Ying from Blue Cross Blue Shield of Mass.

Jean-Luc Tilly: Andrea Benin? Heather Lewis? Allen Nissenson?

Allen Nissenson: Hi. I'm Allen Nissenson. I'm a nephrologist with Kidney Care Partners.

Jean-Luc Tilly: Great. Gregory Alexander?

Gregory Alexander: Yes. Hi, I'm Greg Alexander with University of Missouri School of Nursing.

Jean-Luc Tilly: Right. Floyd Fowler Jr.?

Floyd Fowler Jr.: Hi. I'm Jack Fowler. I'm with the Informed Medical Decisions Foundation.

Jean-Luc Tilly: Mitchell Levy?

Mitchell Levy: Hi. It's Mitchell Levy. I'm with Brown University in Providence. I'm an intensivist.

Jean-Luc Tilly: Sean Morrison? Dolores Mitchell?

Dolores Mitchell: I'm Dolores Mitchell. I'm the executive director of the Group Insurance Commission of the Commonwealth of Massachusetts.

Jean-Luc Tilly: Michael Phelan? Ann Marie Sullivan?

Ann Marie Sullivan: Hi, Ann Sullivan. I'm the commissioner of the New York State Office of Mental Health.

Jean-Luc Tilly: Brock Slabach? Shekhar Mehta?

Shekhar Mehta: Oh, yes, I'm Shekhar Mehta. I'm representing the Pharmacy Quality Alliance.

Jean-Luc Tilly: Richard Bankowitz?

Richard Bankowitz: Yes, hello. I'm Richard Bankowitz. I'm the chief medical officer for the Premier Health Care Alliance, an alliance of 2,800 hospitals across the U.S.

Jean-Luc Tilly: Martin Hatlie? Jamie Brooks Robertson? (Mary Jo Condon)? Jeff Jacobs?

Jeff Jacobs: Hi, I'm Jeff Jacobs. I'm representing the Society of Thoracic Surgeons. Thank you.

Jean-Luc Tilly: All right. Helen Haskell? Shelley Fuld Nasso?

Shelley Fuld Nasso: Hi, I'm Shelley Fuld Nasso. I'm a patient advocator and CEO of the National Coalition for Cancer Survivorship.

Jean-Luc Tilly: Oh, great. And Thomas Lutzow? Pamela Owens?

Pamela Owens: Yes, this is Pam Owens from the Agency for Healthcare Research and Quality.

Jean-Luc Tilly: Daniel Pollock?

Daniel Pollock: I'm here, Dan Pollock, Centers for Disease Control and medical epidemiologist.

Jean-Luc Tilly: And Pierre Yong?

Pierre Yong: Hi, Pierre Yong, CMS Medicare.

Zehra Shahab: And Kelly Trautner, I saw that you sent us a message on the webinar, if you could dial in as well.

Kelly Trautner: I just did.

Zehra Shahab: Oh, did you want to introduce yourself?

Kelly Trautner: Hi, I'm Kelly Trautner from AFT Nurses and Health Professionals.

Zehra Shahab: Hi, Kelly.

Kelly Trautner: Hi.

Zehra Shahab: OK.

Jean-Luc Tilly: OK, great. So I'm Jean-Luc Tilly, I'm a project analyst here at NQF. And we're going to do a staff introduction.

Zehra Shahab: Hi, I'm Zehra Shahab. I'm the project manager for the – supporting the MAP Hospital Workgroup. I've been at NQF for about two years now, and has supported readmissions and population health, care coordination, a variety of projects. This is my first time on the MAP Hospital Workgroup and I'm looking forward to working with you all.

Erin O'Rourke: Hi, this is Erin O'Rourke. I'm a senior project manager here at NQF, supporting the Hospital Workgroup. I also work with the PAC/LTC Workgroup and the Coordinating Committee. I should hopefully be familiar to most of you, this, I think, will be my fifth pre-rulemaking cycle like a number of you. So, I'm looking forward to continuing our work together.

Melissa Mariñelarena: Hi, this is Melissa Mariñelarena. I'm a senior director here at NQF. I recently came back to NQF. I was here back in 2008. So, MAP is new to me. This is my first time on MAP and I also work on the CDP side. So I'm looking forward to working with all of you.

Female: Thanks, Melissa.

Now, we can turn it over to Ron to review the meeting objectives.

Ronald Walters: So, I agree. Although it may seem routine to some people on the call, we do want to give you an orientation to the 2015 version of the pre-rulemaking approach. For those of you that are new members, it'll all make sense very quickly as you dive into the work. So, please feel free to ask any questions you have as we work our way through this.

We will go through each of the workgroup programs individually. And sequentially, much as we do in the in-person meeting with a focus for this call on the high-priority domains and whether or not people like the high-priority domains or have additions or comments about them. And then, also, input on potential measure gaps associated with each program. And try to keep at relatively confined as there is a lot of material to proceed through.

We gave you the spreadsheet that has the current measures, the existing measures under the various programs. We are specifically not asked as part of

the MAP program to comment on those, but the framework is there so that you can help formulate your ideas about gaps that need to be addressed.

So with that, I think I'll turn it back over to Erin again to go through the pre-rulemaking approach and thank you again for your time and attention.

Erin O'Rourke: Thanks, Ron.

So, today, we want to provide a high-level look at how the workgroup will be making its recommendations on the measures under consideration (come) December.

So, in September, the Coordinating Committee met to review and update the process that staff will use to develop the preliminary analyses that will form these pieces of our December meeting. In particular, the Coordinating Committee focused on defining what MAP means when we talk about impacts, gap and alignments.

Today, we'll be providing you with background information on the programs that the Hospital Workgroup might be considering measures for (come) December.

As Ron noted, we – this year, an enhancement we made was to provide you with a spreadsheet that includes the current measures for each program. We've listened to your concerns that this was information you needed to review the measures under consideration so we want to say get this to you early so that you could start to familiarize yourself with both the structure of the program and the measures that are currently in it.

We also added what we call a framework for each program. It's really just a fancy way of saying we organized it for you to hopefully make it a little more understandable. We used the National Quality Strategy priorities and the NQF list of condition/topics to organize those measures for you.

So then we'll be meeting in person (come) December to go – to do the bulk of our pre-rulemaking work. We'll have the list of measures under consideration

then and we'll give an – give the recommendation of support, conditional support or do not support for each measure on that list.

And then, in January, the Coordinating Committee will meet again to examine the key cross-cutting issues that arose from the workgroup meetings.

So if you take a look on this slide, we wanted to show the approach in a little more detail and call your attention to some key next steps. As you'll see, we are getting ready for the release of the measures under consideration list by December 1st. That will kick off initial public comment period where stakeholders will have the chance to weigh in on the measures under consideration before you all meet, so you'll have the benefit of some early public comments when making your recommendations.

We'll then be convening in December to actually make our recommendations. I also did want to note, it's not included in this timeline but we'll be having an All-MAP web meeting on November 13th, where we'll be really going through this approach in more detail. That's when we'll walk you through some of the key things, like what the preliminary analysis algorithm looks like, what are all the steps in the process, how we'll be running the meeting, train you a little bit on how we'll be doing the voting, those kind of meeting management thing. So if you are available, we'd strongly encourage you to attend that All-MAP web meeting, all five workgroups will be getting together to hear about the process simultaneously.

So, on the next slide, you will see the programs where the Hospital Workgroup might be considering measures for. Most of these should be familiar to you by now, but I did want to note that this year, the Hospital Workgroup will be considering measures or potentially considering measures for the End-Stage Renal Disease Quality Incentive Program. This – it's not a new program but it had been previously discussed by the Post-Acute Care and Long-Term Care Workgroup. However, now, under the domain of the Hospital Workgroup, so I did want to draw your attention there and hope that everyone could spend a little extra time familiarizing themselves with that program. And I also did want to give a special welcome to Allen Nissenson

from Kidney Care Partners as our new workgroup member joining us from the PAC/LTC group.

So, on the next slide, I just wanted to quickly review our goals for today's meeting. So will review the structure of each program and the measures that have been finalized for that program. As I noted, we developed a – what we call a framework to show you what measures are currently in that program. And I did want to just quickly walk you through that document. We're going to just share that with you quickly if you could bear with me.

This is also attached to the material that I sent out, it was the Excel document and you can access it through the links on the side of the webinar platform that Jean was mentioning at the top of our call.

OK. So this is an Excel document, obviously, there is a tab for each program that you can see on the bottom. It's sortable, it's filterable to let you play around and really see what measures are in there. Again, this includes the current measures for each program and how we would map them to the different NQF's priorities and the NQF conditions. So I won't belabor this but did want to draw your attention and give you a quick tutorial about how you can use this document.

The second document I wanted to draw your attention to was the CMS needs and priorities document. This is what we used to develop the list of measure gaps that we'll be asking you to provide input on later on in the program. So, that is also on the links that we'd again, ask you to take some time to read that document and familiarize yourself.

So with that, I think I will pause …

Andrea Benin: I'm sorry. It's Andrea Benin. I just joined, sorry.

Erin O'Rourke: Oh, hi, Andrea.

Cristie Upshaw Travis: Thanks, Andrea. Welcome.

Erin O'Rourke: So I think with that, I will pause and see if there's any questions or any items for a discussion here, and then we can start our review of the programs.

Nancy Foster: Erin, it's Nancy Foster. Excuse me, I have a …

Erin O'Rourke: Hi, Nancy.

Nancy Foster: … bit of a throaty thing going on here. I apologize, everyone.

I'm just curious, as I sent you a note yesterday, the Institute of Medicine's report on vital signs, which really laid out a concrete and empowering framework for measurement going forward that would really draw together a wide variety of providers in – and public health officials and others in trying to make impressive improvement on important issues for the public, where will that enter into our conversation?

Erin O'Rourke: So, we definitely agree with you that that is a very important piece of work and we strongly encourage all the workgroup members to take a look at that.

We are actually going to discuss that at the Coordinating Committee level. At their September 18th meeting, they – one of the key outputs was an idea that MAP should develop what they're calling a set of core concepts and they are anticipating that vital signs would be a key input to that. However, I – from your note, I know that there might be interest in this workgroup also discussing it, so we were thinking if we get through the material we need to cover at the end, we'd love to get input from the Hospital Workgroup members to bring back to the Coordinating Committee about how MAP could potentially best utilize the vital signs report.

Nancy Foster: Thank you. I appreciate that.

And one other quick question, which is, I don't see on our list of programs to look at things like ACO's bundled payments and other programs that CMS has launched. Are – is that the territory of some other workgroup or are they just not being discussed?

Erin O'Rourke: So, the Clinician Workgroup is discussing the Medicare Shared Savings Program. I believe that's the only ACO program that we're considering at MAP.

Nancy Foster: Thanks. I guess that would be a further conversation with CMS, so probably bringing those programs and to this group as well for input. But, thank you.

Erin O'Rourke: OK.

Richard Bankowitz: And hi, it's Richard Bankowitz. And I want to also say, as I read this, I thought that was an omission as well. I've referenced to the IOM. Many of our premier hospitals are starting to use this as a guide post for measure – a measurement in the performance improvement area and if we could use that in any way to guide our discussions, I think it would be excellent.

Erin O'Rourke: Thanks, Richard.

So I think with that, we can start our review of each of the programs. I'm going to kick it off with a quick review of the Inpatient Psychiatric Facilities Quality Reporting Program. So this is a pay for reporting program. Inpatient psychiatric hospitals or units that do not report data on the required measures will receive a 2 percent reduction in their annual payment update.

The goals of this program are to provide consumers with information to help their – to help inform their decisions, to improve their quality of care in psychiatric facilities by ensuring that providers are aware of and reporting on best practices, and to establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units.

Next slide.

So this next slide, this gives a very quick overview of the measures that are currently in the program. You'll see that there are 16 measures in this program as of the last rulemaking cycle. They address the NQF domains of care coordination, health and well-being and person and family centered care.

Next slide.

So in this slide, you'll see the high-priority domain for future measure consideration that CMS identified in the needs and priorities document. These are also organized by NQF's priorities. So they've really noted a number of gaps in this program, including experience of care, treatment and quality of care for geriatric and pediatric populations, readmissions, access to care and efficiency.

So I think with that, I'll turn it over to Cristie to see if the workgroup would have any suggestions for a refinement or additional topics that should be considered for a future measure development.

Cristie Upshaw Travis: Thank you, Erin.

Well, this is our first opportunity to give some feedback, so we'll see how this time goes. We have about five to 10 minutes to focus our comments. And as I was thinking about this, I kind of put it into three buckets. One is, you know, are the right categories and sub-categories are measures identified that Erin just went through. Are there priorities which are not on the list that you would suggest? And then if it at all possible, of the categories and measures that we want on the list, which ones of those are the highest priority for us?

So, I will turn it over to the workgroup now to see if you all have comments or suggestions about this list of high priorities for future measure development.

Dolores Mitchell: This is Dolores Mitchell. And I just have a question which – to which I expect the answer is going to be not now, but we're looking at it. But, I was struck by there being no mention in the psychiatric area about the opioid crisis and what treatments – what treatment modality should be enacted.

Now, as I say, I know that it's not consistent with the procedural norms of this organization, you know, to jump at matters where there hasn't been a lot of previous work and thought and deliberation, but somehow or rather it seems to me that unless people disagree that there is an opioid crisis that somewhere some reference to what needs to be looked at, maybe it needs to be put in as a gap measure, I don't know.

But I think some mentioned of it somewhere is appropriate.

Cristie Upshaw Travis: Thank you, Dolores. Certainly, I think effective prevention and treatment is a category under which something like that could fall. So thank you so much for bringing that up.

Nancy Foster: So …

Female: Now, this is …

Nancy Foster: … this is Nancy. Sorry, I just wanted to agree with Dolores. And mark that as the first, but of many occasions this year, we will be agreeing with each other, that is critically important issue. HHS broadly has declared it has a major area of emphasis and yet it is surprising that nothing on here addresses that. And it is one of the IOM vital sign areas as well. They specifically call out addictive behavior, drug dependence and illicit use.

So, I think there's a lot of reason to think about that, and I would support Dolores's urging that we take that one on.

Michael Phelan: This is Mike Phelan speaking. I think one of the challenges is, this medical community management of opioid addiction is an outpatient problem and it's not typically an inpatient issue.

So, other than measures that would address how hospitals (route) patients to the appropriate outpatient resources is going to be pretty slim in picking on what kind of measures you would have if the vast majority of the care of this type of population is done as an outpatient.

Ann Marie Sullivan: Yes, this is Ann Sullivan. I agree a little bit with that, but these measures are amongst screening and even on alcohol use, et cetera. So, I think that you should have drug use as part of the screening that goes on in the same way that you have alcohol and probably all drug use, you know, putting us off into categories of this one or that one, I don't think, really solves the problem, people get into cocaine, there's now K2, there's all kinds of things out there.

So I think the concept, I agree with you, a screening and then getting people into treatment as we know that up to 60 percent to 70 percent of individuals

were admitted to psych units have some kind of substance use abuse. So, working with them and on what – showing that you screen for that and that you then connected them to after care is critical. But it should be for any kind of substance use.

And then the only other thought I had on looking at this is I think a couple of things. One, I think one of the things to think of is whether or not are people connected to a primary care doctor. It's important to be able to screen for the metabolic and I think these are in here. But I think it's the same thing as looking for connection for after care. So think about the concept of our psych patients because when we have looked at it, often very few of them are actually connected to primary care physicians. And that's something that can be done again while they're an inpatient in terms of emphasizing the need for their overall medical care. Again, not just isolating it to have them in screen for diabetes or something else, but are they kind of connected to care.

And then the other is when you talk about best practices and healthy living to think a little bit about putting some thoughts in there about the recovery approach, you know, I think even while most psychiatric hospitalizations nowadays are kind of short, it's still important that people incorporate into those hospitalizations what we consider recovery, which is looking at the positive strengths of individuals and what their future can be so that at least that's incorporated in some way and that some degree of the after care when you're making an after care plan that that's to some extent included. So those are kinds of my thoughts about these.

Cristie Upshaw Travis: Thank you, Ann.

Richard Bankowitz: This is Richard Bankowitz and I think the comment about the outpatient nature of opioids really points out another gap, which is that these measures in general are not well coordinated across the continuum of care. We continue to measure things in silos that are rapidly starting to fall apart and yet we have no big picture measures of IOM suggest. And instead, what we have are these micro measures of things like hours of restraint, used hours of seclusion. These are important but they're micro measures.

So, I think the gap is the lack of a big picture view and the focus on micro management in my mind.

Cristie Upshaw Travis: Thank you, Richard.

Male: Thanks, Ann and Richard. One more thing is the issues of violence with what's been going on in the country recently and the issue of gun violence, I just don't see anything addressing that particular topic, if it's, even possible.

I don't know even know what measures will be out there but I definitely see it as a gap if there's issues of violence, gun violence, domestic violence. But, it seems like there's no place to put that, that category and it may be some place that we can at least identify as a gap in the inpatient psychiatric side that maybe it can carry over like the opioid issue for that outpatient side. And I agree 100 percent with that siloing, because that's what's happening here is you're going to have silo of increasing care but it's not going to translate over to outpatient or E.D. care.

Thomas Lutzow: Excuse me, this is Tom Lutzow in iCare. I'm a – I was invited to participate from the dual's MAP group into this group.

I would like to add to this idea of, you know, moving away from isolation to a collective impact. And I know it's difficult because you're talking about adding to the inpatient load maybe measures that they don't have direct controls, that environment does not have a direct control of, but some kind of a step-down strategy from inpatient to maybe a community observation, maybe a crisis resource center, a residential crisis resource center as a step-down strategy could be something encouraged or, you know, some kind of referral measure or MOU structure.

The other service that should be looked at is some kind of mobile crisis response capability that is home focused. And now, you're starting to see a connectivity between the inpatient environment to a transitional environment and maybe even a mobile crisis response capability in the home so they never, you know, the crisis never reaches the point where inpatient care is required. Some kind of flow like that is, you know, broader, maybe more difficult, expanding control is going to be a problem, but that is where the value lies.

Cristie Upshaw Travis: Thank you so much for bringing that altogether for us.

We're about at the end of our time for this program and I thought I would just see if there was any last comment or suggestion that someone would like to make.

Michael Phelan: Sorry, it's Mike Phelan again. Under communication and care coordination, I recall brining up this topic a few years ago sometime in emergency medicine position the idea of lengths of stay that psychiatric patients will sometimes spend in the emergency departments of being transferred either to a psychiatric facility or elsewhere.

I see the readmissions and re-hospitalizations, but E.D. length of care, I can see that actually tying in a little bit with patient's experience of care.

Cristie Upshaw Travis: Thank you so much, Mike.

Martin Hatlie: Cristie, this is Martin. If I could just quickly say too that I think this is a really great area from a patient point of view as well. I don't know (Richard) if you were really thinking about the burden on hospitals and the kind of what the (silo-ization), but I think patients are looking for some kind of integrated measure or set of measures that they can use for an overall picture. So, I think it's a sweet spot for this group. And there needs to be some sense making because the report cards, the – you know, the collective measures are out there. They're inconsistent from place to place and I think it's confusing for consumer's use of care. And I fully support this approach.

Cristie Upshaw Travis: Well, thank you, (Marty). And I thank all of you for your thoughtful comments and suggestions on this.

I did have one question for Erin. Are there psychiatric measures being considered by any of the other workgroups so that we could kind of begin to understand perhaps the opportunity to connect across any of the other workgroups?

Erin O'Rourke: Sure. So I would – I'm not certain what's currently in this Physician Quality Reporting Program, but I would imagine there would be measures of psychiatric care there so we can connect with our colleagues in the clinician workgroup and see if there's something we can look to in that measure set to, perhaps, suggest to be re-specified at the facility level to start to fill some of these gaps.

Cristie Upshaw Travis: Or at least for us to be able to understand how the two – how we may be aligned, you know, if some of these issues that have been brought up today are being addressed in the clinician workgroup, I think that would be helpful for us to be aware of that.

And you know, I think there was a lot of emphasis on integration and being sure that we're looking at the entire continuum, so that we really understand how the inpatient measures are fitting into a bigger picture.

So, you know, we can maybe follow up on that in between meetings, Erin, I think that could be helpful.

Erin O'Rourke: Yes, that's a great suggestion. We can see what's currently in the outpatient programs and see if there's a way we can bring that back to the group to show you if there's a transition from inpatient to outpatient and what's the measures …

Cristie Upshaw Travis: OK. Well, thank you so much.

Male: There was – I just wanted to say quickly that the – maybe the LTPAC group or the group that's working with long-term care might have an antipsychotic type of approach, so that maybe a good point to look.

Cristie Upshaw Travis: OK. And I heard one last comment and then we're going to need to move onto the next program.

Andrea Benin: Sure, Cristie, it's Andrea Benin.

I would just – and I'm not seeing on the list here the need – if there's something about gap in access to care, and I'm not sure whether that really

goes in the inpatient thing or we just want to kind of, you know, be able to say that some – in somewhere, there needs to be metrics still around how we access mental health care.

I just would want to get that captured somewhere or somehow as a gap. Thanks.

Cristie Upshaw Travis: Great, thank you, Andrea.

Well, thank you all so much. I'm going to turn it back over to Erin to talk about the Hospital Value-Based Purchasing Program.

Erin O'Rourke: Thanks, Cristie.

So, the Hospital Value-Based Purchasing Program or as we refer to it, the VBP Program, is the pay for performance program. A portion of reimbursements are withheld and use to fund a pool of incentive payments that hospitals can earn back overtime.

Hospitals are scored either on their performance relative to other hospitals or on their performance overtime, and the higher of the two scores is used.

The goals of this program are to improve quality by realigning financial incentives and to provide incentive payments to hospitals that meet or exceed performance standards.

So, on the next slide, you'll see the measures that are in the fiscal year 2018 measure set. You'll notice for this one, we tagged them to the domains that CMS uses to score the program rather than NQF priority just to be consistent with how people are really thinking about the measures for this program.

There are 15 measures in the set, they address topics like patient experience, care coordination, mortality, complication, health care associated conditions, early elective delivery and spending per beneficiary.

The next slide, you'll see the – that CMS has noted that person and family engagement, best practices for healthy living and making care affordable are high priority domain for this program.

And on the following slide, you'll see specifically the topics that they've called out as high priority for a future measure consideration.

This includes adverse drug events, behavioral health, cancer, care transitions, palliative and end of life care, and medication reconciliation.

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

Ronald Walters: Thank you very much.

There was certainly a lot of feedback during the last program discussion we hope to continue. I also noticed that we didn't get one program in without not directly referencing the core major set in the IOM report but darn well and you're talking about in a lot of ways.

And I think you're going to see that in a lot of things as we go forward, it's really the framework and the terms that are used rather than the specific items that are discussed. And so there's a great deal of overlap anyway that goes on.

So, these are the high-priority domains and the measurement gaps. I would open at this time for any discussion and comments about anything they don't see on there and needs to be highlighted. So, thank you.

Dolores Mitchell: This is Dolores again. And I don't have one to add unless you think that all I care about is addiction, that is not – let me hasten to say that's not the case.

The language on this – the very first bullet about adverse drug reactions, I think, needs to be clarified to make sure that you're talking about adverse medical reactions, not the reactions to overdoses and the like. It's just a way of – it's just phraseology. I won't attempt to do it in a conference call, but just call it to your attention that you might want to clean up that language a little bit.

Male: OK.

Thomas Lutzow: Yes, this is Tom Lutzow. And I'd like to, again, from the MAP – from the dual's MAP, I happen to be president of independent care health plan, it's an HMO in Wisconsin.

Similar to a question Dolores asked on the last set, it's a question of scope I hope somebody is paying attention to this. But if they're not, you know, it's a concern. We're observing in our claims record a discrepancy between the coding that hospitals deliver to us and what's actually in the patient record. So, somebody is, other than the doctor, is reading that patient record and deciding, for instance, I'm going to code for diabetes because there's language in there that suggest diabetes when in fact diabetes is not the case.

And so, hospitals are being penalized, perhaps, because – and rates are being set and five-star quality programs are being decided by patients who are in the wrong denominator.

They don't need to be in the denominator, they don't need to have – be in pneumonia denominator because they're – they don't have it, and yet the coder who isn't a physician is maybe an associate degree qualified person is basically distorting the claims stream record. And so, that would be purchasing suffers, five star staffers – suffers, rates sending suffers and so how do we get a quality measure on accuracy of information and if this isn't within the NQF realm, whose realm is this in because it's affecting our judgment about hospital performance.

Ronald Walters: Thank you. I don't think that has come up in the five years of our discussions actually. And you're right, there's a fine line between quality and compliance. And I think you just outlined one that no one else asked.

Nancy Foster: So Ron, it's Nancy. Not to disagree with you or anything, but I think this is an issue we've talked a lot about in terms of whether measure is derived from claims information have the veracity to be used in a way they're being used, or sometimes were proposed to be used.

Claims are built for one purpose in trying to modify them to make them appropriate for quality improvement has been a challenge recognized for at least as long as I've been in health care. And no one has come up with a

particular solution for that. But I think it is why, in part, a lot of people are very interested in deriving measures from electronic health records data rather than from claims information, both that and the fact that individual claims may, in many cases, be disappearing as we move into other forms of payment.

But, claims are built for specific reason and that's a billing purpose. And they're very specific rules about when you can code something and how you code it and that is the domain of the coding clinic, which is in part of collaborative between CMS and the AHA and a few other partners, but I think not the domain of this quality measurement group.

And I'm happy to put anybody in touch with folks in the coding clinic if you like.

(Mary Jo Condon): Hi, this is (Mary Jo Condon).

Ronald Walters: Sorry.

(Mary Jo Condon): No, I would just say …

Ronald Walters: Go ahead.

(Mary Jo Condon): … that I think although claims are originally built, of course, just for payment, I think that the problem that was described a few moments ago is actually in part because we are now using claims for quality improvement. And we're seeing an effort by some providers to make sure that patients are risk adjusted in the most generous of ways.

And so, I think that what you might be seeing there is also an attempt to make sure that as much risk if possible of being captured on that claim, and that might be backfiring in the sense then because a patient is not been receiving the clinical care associated with the conditions that are being documented on the claim.

So I don't know that moving to a clinical record would necessarily address that problem completely because I don't know that the clinical records then wouldn't change to better reflect risk in the same way.

Ronald Walters: Yes, and that's what I was going to say too, is what was brought up was not necessarily the claims per se but the reconciliation process between the claim and what is documented in the clinical record. And I don't know that that has been – I mean, in compliance world, obviously, that occurs all the time. But, as far as any sort of measured discussion, yes, the deficiency that Nancy and others have brought up is there. No question about it. But the measure that reflects that is going to be an interesting measure.

What other comments do people have about any other gaps or the domains that have been – high-priority domains that have been identified?

(Crosstalk)

Cristie Upshaw Travis: This is Cristie. I guess one of the questions that I do have is, you know, as these programs, such as this one, have more and more measures that potentially get into the program, then the influence of each individual measure, you know, kind of gets diluted to a certain point.

And you know, kind of to Nancy and Richard's points earlier today, I just think it would be interesting and important to have a better understanding of, you know, the importance and the strategic importance, the clinical importance, the balance of what's important to clinicians as well as purchasers and patients, but not to have so many measure – I guess I get concerned with having so many measures in each of these programs that their importance or their impact on the whole gets diluted to the point that we may not really be anticipating.

So that – oh, that's probably more of a comment than a question, but I just think having an understanding of strategically where this type of a program wants to go, so that we can be sure the most important measures are the ones that are in the program and if they receive the weight that they need, to receive or should be receiving in order to get the results we're looking for, I just think, is very important.

Ronald Walters: Yes.

OK. Let's move onto IQR and meaningful use. Hello?

Melissa Mariñelarena: Hello. Hi, this is Melissa.

So, the Hospital Inpatient Quality Recording Program or IQR as everyone knows it, is it pay-for-recording and public reporting program, that requires hospitals paid under the inpatient perspective payment or IT'S, to report on various types of measures including process, structure, outcomes, efficiency, health of care and patient perspective.

So, for list of the measures of these measures is then publicly recorded on the CMS Compare website, which is designed to provide consumer's information about hospital quality so that they can make informed choices about their care.

The hospital could choose not to participate in the program, receive a two percent reduction in their annual Medicare payment update.

The Medicare and Medicare EHR Incentive Program or the EHR Incentive Program authorizes incentive payments for eligible hospitals, critical access hospitals and other eligible professionals to promote adoption and meaningful use of certified EHRs.

And through this program, eligible hospitals and critical access hospitals are required to report on electronic clinical quality measures using the certified EHR to be able to qualify for their incentive payments. As of this year, in 2015, eligible hospitals that do not demonstrate meaningful use will be subject to Medicare payment reductions.

And some of the goals for this program include improving quality, safety, efficiency and reducing the health disparities, engaging patients and their families, improving care coordination and population and public health and, of course, maintaining the privacy and security of patient health information. And then hopefully, we can get to what we were just talking about the goal in the conversation previously.

So, this program has the largest number of measures. And as you can see here, the majority of the measures are patient safety related measures and then affordable care measures.

The patient safety measures include the readmission measures for AMI CHF, pneumonia and stroke in the overall readmission measure. And it also includes all of the VTE measures, mortality measures and the CLABSI, URSA, CAUTI and CDF measures and that's just an example of what's in there.

Example of the affordable care measures include the hospital level risk standardized payment measure for AMI, hospital level days in acute care after hospitalization for AMI, hospital level days in acute care in the 30 days following hospitalization for AMI and heart failure, and there's others.

And some of the effective communication measures that are the E.D. measures are the E.D. measures and the discharge measures for stroke. In the family – the person and family centered care measure is the patient survey or age gaps.

So, the next slide is just a pie chart that shows – it's just a visual of all the different types of measure. And as you can see, there's either the different categories and this includes your core measures with COPD, CHF, AMI, VTE, your general surgical measures, and the registry participation, because those are some of like the cross-cutting areas, the registry participation, cost and resource use. There's some pediatric measures in there including the HEENT and pediatric asthma, there's a kidney and UTI, and mortality measures, infectious disease, which were the CAUTI, CLABSI, all of those measures. So that just gives you a snapshot of all of the measures that are in this program.

OK. So, high-priority domains that CMS has identified include patient and family engagement, best practices of healthy living and making care affordable.

And if we go to the next slide, this shows – again, these are the topics that CMS has identified as high priority for future measure consideration. Adverse drug events and this is the same topic that we can offer a clarification, behavioral health, cancer, care transitions, palliative and end of life care, and medication reconciliation.

And now, I'll turn it over to Cristie.

Cristie Upshaw Travis: Sure. Thank you very much.

I just want to ask a clarifying question and Melissa, I'm sorry, I didn't think about this earlier, but we're really kind of covering two programs here, right, IQR and meaningful use?

Melissa Mariñelarena: Yes.

Cristie Upshaw Travis: OK.

So, when you make your comments, just be sure that you help us stay organized by letting us know if you're addressing – your comment is addressing IQR or whether it's addressing meaningful use and that'll just help us to be sure we capture the comments correctly.

So, I'll be glad to turn it over to the group for about 10 minutes of discussion on these two programs.

(Crosstalk)

Dolores Mitchell: Hi, it's Dolores, it's me again.

I think I'm going to ignore your last comment about identify which program, because I don't care where it gets put.

(Crosstalk)

Dolores Mitchell: Because affordable care is in that list but nowhere do I see anything about cost of drugs particularly specialty drugs.

Martin Hatlie: And this is (Marty). I've got a similar kind of just question, I guess, we have the high-priority domains and yet when we get, you know, when we shift to the high-priority domain, which includes patient and family engagements, which I care very much about, to the measurement gaps, you know, I don't see anything in the measurement gaps listed, addressing sort of those particulars

of the high-quality domains, I think it's the affordable care that Dolores has raised.

So, how we integrate, you know, the connection between what's the measure is identifying as high priorities and then measurement gaps. So, are we trying to see those priorities reflected at the measurement gaps?

Ann Marie Sullivan: So I – this is Ann. I can try to clarify that.

So I think, yes, if you could help us drill down on these domains and what sort of topic, a – we could look for measures for that would address them and help us to address that domain more robustly. And that – hopefully, that clarifies a little bit.

So, what measures we could really add that would track with these domains?

Male: But of course, I don't mean to negate the point you are making, it is just to distract from it, but there are five metrics now that CMS is pushing through all of the transformation work in patient and family engagement.

So, we – and 75 percent of the hospitals in the country have a goal in the next year to adopt those that they're participating in the Partnership for Patient's campaign. And we see the same measure is being reflected in the QIO work and now and probably in the transform of clinical practice initiative.

So, they are being disseminated and pushed by CMS in other ways and it seems like they would be sensemaking to see them reflected here, and they're distributed across a framework that seems pretty reasonable and pretty (excessful). I'm happy to happy to share those and I'd like to see them reflected in kind of the measurement gaps as we go forward. I mean, it's really kind of tossing back the ball back to CMS, saying you're – you've decided to (inaudible) elsewhere, maybe we should see them in our NQF work.

And again, it goes back to the point that I think Richard (read) in the phone call, but several agreed with, a matter of just sensemaking across different measurement activities CMS is sponsoring or supporting or incentivizing.

Thomas Lutzow: Tom Lutzow again from iCare.

You know, I've complained to CMS about this, so I don't think there's enough emphasis on interconnectivity between health care provider system, so nursing home's hospitals or nursing home's home health agencies, nursing home's health plans, hospital's health plans and so on.

And especially when you're dealing with performance sensitive information, if hospitals get judged about readmission, they should have some information and interconnectivity into the minimum data set and what's going on in nursing homes because what happens there affects what happens at the hospital on the readmit side.

There is not enough emphasis, I don't think, on the part of CMS to protect and share performance sensitive information to the EHR system.

Nancy Foster: You know, that's a – this is Nancy. That's a critically important point. Just to add to the discussion here, one of the challenges, I think, when the measures are coming from CMS and, I mean, no disrespect to CMS, they have incredible programs they run, but we do tend to get sort of elderly centric measures and I'm not sure that we have the right measures to be looking at for babies and for children and maybe we need to think about integrating that into this program as well.

And one of the things we talked about last year that goes along with some of the themes that I've heard folks mentioned on this call is we talked about the potential for an electronically captured measure that would be essentially an all-harm measure, which would be much more informative to the public, perhaps, and would certainly be more readily accessible to hospitals in improving care rather than waiting for somebody to come back a couple of years later and tell them that they've done, you know, claims data, they know that your performance wasn't up to snuff.

So, I think there are some real opportunities here. One tweak I would point out is that the information about the incentive here is not quite right. The IQR Program and the Meaningful Use Program essentially share the update, and if

you fail on the IQR Program, I think, in this year, it's a quarter of your annual update is in jeopardy. And if you fail on the meaningful use of three quarters of your annual update, it's a jeopardy plus some penalty.

So, meaningful use for reporting of the quality data, so I think, just a detail but want to bring that to your attention.

(Cindy Torres): Nancy, this is (Cindy Torres), and I noticed that as well. I'm going to send some edits over to NQF so we can get that updated on the slides.

Nancy Foster: Thank you, (Cindy).

Cristie Upshaw Travis: Thank you. Thank you for that.

Richard Bankowitz: It's Richard and I want to – so, I completely with Nancy on the need for a more global measure of harm.

And I think it takes us back to the goal of the IQR Program, which as stated is to provide consumer's information about hospital quality so they can make informed choices.

And I would just ask, if a program that has, you know, on the order of a hundred separate measures which exist in the context of a value-based purchasing program and in the context of a hospital-acquired conditional reduction program, and in the context of readmission reduction program, is it really helping, is it meeting that goal? I think that needs to be asked.

Helen Haskell: This is Helen Haskell.

When you talk about a global measure of harm, I'm not sure exactly what you mean, you know, hospitals have so many departments that can work very widely and so many different issues that can occur. So, I think you'd want to keep measuring specific procedures and departments as well as keeping infection rates, for example, separate from surgical mishaps. Maybe you could address that.

Cristie Upshaw Travis: Sure, you know, you're right, Helen, and that we want to be able to tease out various kinds of harm. But, at the end of the day, the question is not,

you know, did this patient leave us sicker than they came to us because we gave them an infection or because we did an incorrect surgery, the question is, did we harm them.

And so, getting at that and using – you know, the IHI has their trigger tool which has been around for a while that needs some refinement, but there are people working on that sort of thing and it's really about giving people the information in the moment so they can either minimize the harm to the patient or address it right then and there, so that they understand that something went on that was not intended. And that the patient was harmed.

So, it's – we think for public reporting, the global harm measure would make more sense, not to say that we couldn't then separate out some of the critical issues, but collecting it department by department is not as helpful as you might think. It just creates a lot more noise, or procedure by procedure is even more, it's just a lot of noise at that point.

Dolores Mitchell: I think – this is Dolores again, and I want to – I'll come back to something that Nancy said a few minutes ago.

Cristie Upshaw Travis: Are you there?

Male: She hearkened.

Cristie Upshaw Travis: Well, maybe – maybe when – Dolores, did you go on mute? Well, we may have lost her.

And so just – is somebody there?

Female: Cristie, we can hear you. I think Dolores might have dropped off.

Male: OK.

Dolores Mitchell: No, I did not.

Cristie Upshaw Travis: Well, good. We couldn't hear you, though.

Dolores Mitchell: Oh, all right, here I am. Can you hear me now?

Cristie Upshaw Travis: Yes.

Dolores Mitchell: All right, what I was going to say is that I thought Nancy brought up something that's really very important.

It's appropriate and necessary, I think, to look at these programs one by one. But I don't think we want to go so far as to be guilty ourselves at the same kind of silo thinking. That we say, pervades the industry at large, particularly true for Medicare because even though their obligation is to retirees who are in their system, given their privacy and their power in the whole field of medicine across the country, I think the implications of the things that they do and they support on all the rest of these are profound. And maybe that's a job for the Coordinating Committee to spend a little time thinking through what recommendations they want to make to CMS about cross-cutting (measures) within Medicare, but within the larger system as a whole.

And I can tell you, as a purchaser, a lot of what goes on in the Medicare world, we don't pay much attention to because except for, I don't know, 16 percent of us, like myself, a lot of us don't cover Medicare patients anymore.

So if you want to speak to the whole country about some of these issues, I think some attention needs to be paid to Medicare's larger responsibility, so thinking about these issues for all people, all Americans not just for retirees.

Cristie Upshaw Travis: Thank you, Dolores.

I think we have time for one last comment.

Wei Ying: And this is Wei Ying from Blue Cross Blue Shield of Mass.

The comment is really related to what Dolores just said earlier. The OB related measure set is really weak. Even though it may not be the CMS focus, but if you look at the younger population even within the Medicaid population per se, that's one of the dominant reason people – younger people goes to a hospital and get admitted. But, OB quality measure, it's just not there.

Cristie Upshaw Travis: Thank you so much for adding that.

So, Melissa, I think I'm going to turn it back over to you.

Melissa Mariñelarena: OK. Thank you.

(Off-mike)

Gregory Alexander: Hello, this is Greg Alexander. Could I make a quick comment?

Melissa Mariñelarena: Sure Greg, go ahead.

Gregory Alexander: Sorry about the background noise, I'll be quick.

I just wanted to sort of go back to the comment that the gentleman made about communication and connectivity, and as I look at this current program measure for effective communication, I'm – and I'm listening to others talk, I'm thinking that communication is such a huge part of all these different domains that we're talking about.

And I don't know that effective communication is really what is important. I think that it's the use of and the ability and capability of actually using information and how to use that as part of that effectiveness, I wonder if it's semantics, but I think that it's important because it's drilling down into what that means, and what those measures means could really stretch across all of these measures and I think it's important to think about.

Thank you.

Cristie Upshaw Travis: OK, Melissa.

Zehra Shahab: So Cristie, this is Zehra. I just wanted to jump in really quickly. Helen Haskell had sent us a few comments regarding the mental health measures but she was able to dial in. So I just wanted to read those too really quickly.

Helen said that, I agree that these measures are very petty when dealing with what is perhaps our greatest health crisis. I would add that there should be something addresses the dangers of polypharmacy not just multiple antipsychotics and psychiatric drug use.

Second, I think that the availability of inpatient beds for acute mental health crisis needs to be assessed.

Third, violence in psychiatric facilities, both against staff and patient is a huge issue.

And fourth, the lack of family involvement in psychiatric treatment, while admittedly complex, is a significant gap that often leads to avoidable crises.

Cristie Upshaw Travis: Thank you, Zehra.

Helen Haskell: And I'm dialed now, so I can make comments now. So thank you, Zehra.

Zehra Shahab: Great. Thank you, Helen.

Cristie Upshaw Travis: Thanks, Helen.

OK. Now, do you think we're ready for ESRD?

Male: I have one comment about the interoperability issue.

Does EHR executive program seem to be like a one-way street, I'd like to see some kind of gap about making it more a two-way street. The idea that Medicare has all this data on patients and it doesn't get shared with the EHRs at multiple different places and that's across, you know, all insurers.

You know, patients coming to an E.D. and they say, "I was in a different hospital two weeks ago" and they had this and we have still access to their type of information, which you call and get it faxed. That information needs to be more of a two-ways street. I don't know if it's something that it would be addressed in this.

But they've incentivized the hospitals to have the EHR, now, we just have to get some of the information that's out there that's not included in the EHR and just a comment about the interoperability. Because there was a ton of data out there on patients that would be nice to have if they just show up into an E.D. sometime, just a thought.

Cristie Upshaw Travis: Thank you very much.

OK. Melissa, are you up?

Melissa Mariñelarena: I'm up.

Cristie Upshaw Travis: OK.

Melissa Mariñelarena: OK. So the next program that we're gong to review is the ESRD Quality Incentive Program. And this program is also a pat for performance and pay for reporting program.

In 2012, CMS began reducing payments to dialysis centers if they did not meet or exceed the required total performance score for the selected measures. The payment reductions are on a sliding scale and they can amount to a maximum of 2 percent per year. The goal of this program is to improve the quality of dialysis care and produce better outcomes for beneficiaries.

To date, this program has 16 measures. The majority of the measures are related to effective communication and care coordination. Some of these measures include anemia management and vascular access. And some of these measures – this program does include some pediatric measures.

Mortality and blood stream infections are a couple of examples of patient safety related measures. And like many of the other programs, ESRD also have the patient survey with these caps.

So, the high-priority domain for future measure consideration that CMS has identified, under care coordination, they've identified medication reconciliation, preparing dialysis patient for kidney transplants, coordination of dialysis-related services among transient patients. Safety related measures include blood stream infections, vascular access-related infections, mortality, and measures that protects against over utilization of oral-only medications.

Patient and caregiver -centered experience of care includes quality of life including physical function, independence and cognition and life goals, and the patient-related outcome measures.

And now, I will turn it over to Ron. Oh, I'm sorry, yes, to Ron for the discussion.

Ronald Walters: So, feedback from the workgroup about suggestions for refinement or additions to the priority domains for future measurement.

Allen Nissenson: Yes. So this is Allen Nissenson. First, I appreciate being a part of this workgroup and look forward to meeting everyone in person in December.

I think the three domains that are outlined are much spot on in terms of what is currently needed and what the gaps are. The only one that's left out and it relates back to the categories or priority that in the National Quality Strategy around cardiovascular disease. And I know there are metrics that have recently been considered in that area related to fluid management. But I think fluid management infection vascular access issues and then patient-centered care are really the key areas that need to be focused on.

I would like to just point out that many of the concerns that I'm hearing in the other sites of care are very similar in the dialysis setting, particularly around the availability of data, and the ability to get data from other sites of care whether it's from physician practices related to medications or from hospitals, sniffs or other settings of care. So, I think this is a major issue for us and as more and more metrics are added where there needs to be information, particularly around care transitions, that that whole issue of making data available on a timely – in a timely way to the dialysis facilities and in the other direction having ways for us to provide the most up-to-date information when our patients go to other sites of care is going to continue to be very important.

Then the last comment I'll make is that, and it relates to something that was said earlier on in the call, is that we are moving into especially ACOs. CMMI, we've just began projects with CMMI called the ASCO's ESRD's Seamless Care Organizations which are basically ACOs where attribution is based on having end-stage renal disease.

And there, we have a whole different set of metrics that are much more focused on holistic care, managing comorbidities and so on.

And one of the challenges we have is that we are starting to experience some metric creep from the kind of care coordination into the fee-for-service dialysis facility metrics. And it's something which somehow we just need to watch and balance the ability and accountability of the facilities to actually deliver certain outcomes versus what's possible in an integrated care system.

So I'll stop there, thanks.

Ronald Walters: Thank you very much.

Nancy Foster: This is Nancy. Sorry, Ron, just to jump in. And I appreciate the fact that your expertise is going to be on the call and, you know, welcome to the group.

I would be, for one, very interested in seeing that ACO model list of measures and something that we might want to try to encourage coordination with or look to see if there are measures that ought to be code from that into this program.

And thank you for mentioning the measurement creep, that is, in fact, my chosen Halloween costume, so.

Ronald Walters: Any comments about ESRD? Anyone?

Shekhar Mehta: Yes, this is Shekhar representing the PQA. I just wanted to echo the comments on aligning some of the measures and also, I know Dolores had brought this up in terms of the clear definitions, I think, in the value-based purchasing discussion.

But, under the high-priority domains for this measure set, it's listed under care coordination as medication reconciliation. And I just wanted to kind of bring up a clear definition of what medication reconciliation would entail and whether it would be – and whether there would be any confusion with going a step further and introducing measures on medication therapy management, as

opposed or just reconciliation which is the documentation of the medication list.

Ronald Walters: Thank you. Ready to go to Zehra for HRRP?

(Crosstalk)

Ronald Walters: OK. Go ahead.

Zehra Shahab: So, good afternoon, everyone. This is Zehra. I'm just providing an overview of the Hospital Readmissions Reduction Program, which I will refer to as HRRP.

So, the program is both a pay for performance and public reporting program. And the measures are reported – are publicly reported annually on the Hospital Compare website.

So, HRRP provides an incentive for hospitals to reduce the number of excess readmissions that occur in their setting. And the incentive structure is based on the DRG payment rates which are reduced based on a hospital's ratio of predicted to expected readmissions. And the maximum payment reduction is 3 percent.

So, some of the program goals are to reduce readmissions in acute care hospitals that are paid under the Inpatient Perspective Payment System, and this includes more than three-fourths of all hospitals.

Additionally, the program – one of the program goals is also to provide consumers with the information they need to help them make informed decisions.

So, on this next slide, you will see that currently, HRRP includes these conditions, AMI, heart failure, pneumonia, COPD and elective total knee and total hip arthroplasty, and CABG will be included starting with the fiscal year 2017 payment determination.

So, also noted in the CMS needs and priorities document, the plan readmissions are excluded from the (accessory) readmission calculation for this program.

On the next slide, you will see that CMS has outlined the high-priority domains for this program, and this include measures that focus on the priority of communication and care coordination. And the care coordination measures that address high-impact conditions are identified by the MedPAC or AHRQ's HCUP reports.

And now, I will ask Cristie to conduct a workgroup discussion on suggestions for refinement to the – to domains or additions as well.

Cristie Upshaw Travis: OK. Thank you all for chiming in.

Any discussion?

Richard Bankowitz: Well, it's Richard. I would just say from an informational point of view, and I don't know how practical this is, but there is a gap in really understanding the nature of this readmissions.

And so, for in – it will be invaluable to understand how many of these are due to treatment failures as opposed to lack of coordination, as opposed to lack of access to care, as opposed to just inevitable progression of disease. I don't know how we do that, but that is a gap that if we could close it, would be very helpful.

Cristie Upshaw Travis: Thank you, Richard.

Nancy Foster: It's Nancy.

Female: I have a question.

Nancy Foster: Go ahead.

Female: Just a factual question. Do I assume that these conditions were chosen because they are the most common causes or diagnoses for people who are

readmitted, because I don't see anything in here about carcinoma and I can't believe that they don't have a lot of readmissions for people who have cancer?

Cristie Upshaw Travis: Any help from NQF staff on this?

Erin O'Rourke: Sure, I can attempt to answer this one. And Pierre, I might look to you to correct me if I misspeak.

These conditions were really written into the Affordable Care Act statute. And I believe they are derived from the MedPAC report on conditions that are really affecting – conditions where Medicare beneficiaries see a high number of readmissions.

Female: Although it is something that's not on that list. It is, in fact, it was not high on that list of known readmission causes.

Erin O'Rourke: I believe it would have – I (don't quite have) what the MedPAC report for you, but I think this came out of research sent by (DAP) and were then put into the Affordable Care Act to put into this program. So I …

(Crosstalk)

Pierre Yong: Erin, this is Pierre.

Erin O'Rourke: Pierre?

Pierre Yong: Correct.

Erin O'Rourke: Oh, Pierre.

Pierre Yong: Yes, I think you are correct on that.

(Mary Jo Condon): This is (Mary Jo). So building on that, our sister organization, Midwest Initiatives brings together hospitals and kind of hospital innovators come for every other month. And when we were recently reviewing these measures, one of the things that they wondered about is why there weren't more measures for patients with common chronic conditions, like those with the diagnosis of diabetes, and questioning whether or not that might also support a

focus on that care coordination aspect rather than just on events that might have occurred in the hospital.

Cristie Upshaw Travis: Thank you, (Mary Jo).

Other thoughts or comments?

Nancy Foster: This is Nancy …

Male: Yes, a …

Nancy Foster: … regard to that, I would say, it – we should think about other condition, perhaps, as being appropriate. But, I would caution us to remember that if we expect that patients during the – because of the course of their disease need to be readmitted, that probably makes that a very tough condition for which to get an appropriate measure of what are supposed to be preventable readmissions, right?

Female: Agreed. I think – so the point was that maybe we are – maybe we're too comfortable with patients needing to be readmitted for certain conditions when with better support inside and outside of the hospital, those additional admissions might not be necessary.

Nancy Foster: I don't think there's a hospital in the country that's (responsible) with this program, but OK.

Thomas Lutzow: Tom Lutzow again with iCare.

If I could just – from the dual's MAP perspective, you know, the concern here is flight of hospitals from the inner city, and are these measures or do we need to measure separately some kind of readmission for SCS-conditioned patients. Not that they have to be removed from the penalty, but would it be helpful to track them separately at least to begin developing knowledge about, you know, is – are hospitals that serve inner city folks at a disadvantage. And if they are, we will soon see them leave the inner city without some correction.

Helen Haskell: Yes. And this is Helen. I know that is a – something that's come up or what. I find it really sort of disturbing, the – I would frame it the other way that we

do not want to give people a pass for providing care to inner city people that might not be as good as what they would get at another hospital. I mean, I think the standards that everyone should be held to the same standard.

Female: Well, this certainly is …

Male: I don't know if this could take all day, but I do not disagree with that, although SCS is also correlated with other things like access to care. And if the only place you can go is to the emergency room under ERISA and you can't get into a provider, well, that is just a fact of your location as a hospital. So, I do not disagree with what was said but there are other factors involved.

Cristie Upshaw Travis: Well, just as a point of …

Female: Oh, sorry, Cristie, sorry to interrupt.

Cristie Upshaw Travis: Well, I was just going to point out that NQF is going to a trial period at this very moment. We're looking in detail at SCS and SDS factors. And there will be, you know, a lot more information, we will learn a lot about what the potential impact for looking at these SCS and SDS – SDS factors and characteristics are.

And in this trial period, the measure developers will be presenting information that also stratifies by different factors and characteristics so that we can begin to really learn more.

I think NQF has encouraged this type of stratification in the past, but it really – we have not focused on it but now it is being focused on. Now, that's all over under the consensus development process where measures go through NQF for endorsement. But I think we will be learning quite a bit during this trial period, so kind of more to come on some of those issues.

I think we have time for a few more comments.

Andrea Benin: Cristie, it's Andrea Benin. The only comment I'll just add apropos what Nancy was saying before around the challenges of some of the other types of diagnoses.

You know, I think we should just keep in mind that these metrics are based around billing codes and our – you know, our bills off of coding material. And so, to the previous conversation about some of the difficulties of using codes to bill these metrics, that can present one of the reasons why I think there's some caution about which diagnoses are appropriate for these types of metrics, and to make sure that you can identify things that are truly preventable from a billing code has a lot of challenges. And when the metrics are billed, they're billed – and, you know, validated in the charts but they are – you know, they take carefully to identify things that you can, you know, have a decent chance of identifying preventable readmissions using codes.

I don't know, and this may reflect my ignorance, but as we transition to ICD-10, the CMS have a, you know, is there a plan around that and presumably, there's been a lot of work around reevaluating these metrics. But I don't know the answer to that, I've not heard anything about that, I've just not been in that loop.

Pierre Yong: Sure, this is Pierre from CMS. And yes, we have been thinking about ICD-10 here for a long time that folks may know because of the log and claim between the time period in which the claims are filed and when they actually are used. In the quality reporting program, there is a gap of all of over two years for HRRP.

So, the ICD-10 codes are just being submitted now, won't actually be used in the quality reporting program for another couple of years.

So, as we are looking for to getting more claims data with ICD-10 codes so that we can do more sense of testing at that point.

Female: Thank you.

Cristie Upshaw Travis: Thank you, Pierre.

OK. I think we will move now to the Hospital Acquired Condition Reduction Program.

Zehra Shahab: Great. Thank you, Cristie.

So, I'm going to provide an overview of the HAC Reduction Program, and this provides an incentive for hospital to reduce the number of HACs.

So, as you can see, this is both a pay-for-performance and public reporting program. And the HAC scores have been reported on the Hospital Compare website since December of 2014.

So, the incentive structure for this program is that 25 percent of the hospitals with the highest rates of HAC will have their Medicare payments reduced by 1 percent.

The measures in this – in the program are classified according to two domains. Domain 1, which includes PSI-90, which is a composite. And then Domain 2, which includes infection measures that are developed by CDC's National Health Safety Network.

The HAC Reduction Program goals include an increase in awareness of HACs in order to eliminate the incidence of reasonably preventable HACs, improving patient cost and – improving patient outcomes and cost of care by reducing HACs. And also improving the care of Medicare beneficiaries, privately insured and Medicaid patients by improving the process within hospitals.

On the next slide, this is a table that shows the current measures in the HAC Reduction Program. And this is according to domain, as I mentioned earlier. Domain 1 includes the PSI-90. And in Domain 2, you can see CAUTI, CLABSI, surgical site infection, which begins in 2016, MRSA beginning in 2017, and also CDI clostridium difficile infection which begins in 2017 as well.

So, the high priorities that CMS has identified for this program are all topics under the NQF priority of Making Care Safer. And these include the adverse drug events, ventilator associated events, additional surgical site infection locations, and outcome risk-adjusted measures.

So now, I will ask Ron to conduct the workgroup discussion.

Ronald Walters: So, this is another one that probably could go on all day, but what discussion do people have about specifics regarding the high-priority domains and any gaps that exist on those.

Female: What measures do we have for adverse drug event, that seems like an enormous omission?

Ronald Walters: It was – it sounds like a rhetorical question. Do …

Female: No, just wondering …

(Crosstalk)

Ronald Walters: You're right. I mean, (gaps) due to such and such, I don't know exist. Harmful side effects, I don't know exist.

So, anybody else on the call, I mean, I guess …

Andrea Benin: Helen, there are some adverse – this is Andrea. There are some adverse drug events metrics that are used in kind of smaller circles, if you will. I don't know the extent to which if there are any that are NQF approved or not. But there are some that are being kind of used but they're all based on passive surveillance and reporting of different types of problem, you know, so they're imperfect and there's a lot of (vagaries) from site to site based on how the reporting is structured

That's been my experience. I don't know if there are other more nationally accepted metrics.

Ronald Walters: Yes.

You know, if your BUN and creatinine go up from various drugs, lot of EHRs are designed now to allergies of that, but I don't know of a measure around that certainly.

Any further – any discussion about this? I know it's a very complicated area in this, embedded in those four bullets are a lot of different ideas but …

Mitchell Levy: This is Mitchell Levy. I – in terms of the ventilator-associated events, we – so the definition was we worked about, I think, three or four years ago. And when it says CMS identifies these topics, are they going to bring data, are they looking for us to develop measures or the data from NHSN going to be presented to – with a suggested measure about ventilator-associated events?

(Crosstalk)

Male: ... here, I'll just jump in here. Certainly, these are areas we think are important for the program. Folks may know that the mock list is open. When we produce the mock list, it is open to suggestions from both internally within the federal government but also externally to external stakeholders.

So, folks do and we certainly do appreciate that they do suggest potential measures for the programs. We do have an internal reprocess that ultimately produces the mock list that we present to the MAP. So, hopefully, that helps us background.

Ronald Walters: OK.

Male: Regarding the adverse drug events, it seems like it's a big topic on each of the high-priority domains. What about measures that look at what hospitals are doing to provide safety that patients may understand better than an adverse drug event kind of a numerical score that patients may not understand, like just a – the simple use of having a pharmacist in the emergency department to help with, you know, rapid orders that come through and topics that, you know, that medications are getting more and more complicated like everything else.

Is there any measure out there that looks at that, like what hospitals are doing to prevent adverse drug events rather than, you know, a raw number of adverse drug events, which may be hard to identify if there's not a current measure out there, just a thought.

Nancy Foster: Ron, if I could – it's Nancy. If I could suggest two things that I don't see on the list not having to do with adverse drug events that this group has talked

about before, and that is an accurate measure of pressure ulcers. And a measure of falls with harm, which I know has been through NQF.

Ronald Walters: Absolutely.

Male: I would also add, and this came up earlier with – about rising BUN and creatinines, but acute renal failure require in the hospital is very common, it is not being studied well and that's a gap.

Helen Haskell: I have a couple of comments, this is Helen again. I mean, the surgical side infection locations, I've always been a little puzzled at why that should be procedure specific. I think we've only got with colon and abdominal hysterectomy right now.

I mean, there are many more available but I'm wondering why there's not a general SSI measure.

And then, my other thought is that when you're talking about an all-cause harm measure, I mean, that's the sort of – this would be a place that I would like to see that, I know (inaudible). But, it's something that people could understand and could – you know, could cut across a lot of different things, of the things that we've been talking about here.

(Mary Jo Condon): This is (Mary Jo). I just want to say I couldn't agree more with both of those comments.

Ronald Walters: Good. We have three more programs to get through. So, in the interest of time, I'm going to head and turn it back over to Zehra.

Zehra Shahab: Thanks, Ron.

So the third program I'm going to be reviewing today is PPS-Exempt Cancer Hospital Quality Reporting Program. This is a voluntary data reporting program. And the data is published on Hospital Compare.

So the goals of the program are to provide information about the quality of care that is provided in cancer hospitals, specifically there's 11 cancer hospitals that are exempt form IPPS and IQR Program.

Additionally, the program is used to encourage hospitals and clinicians to improve the quality of care, to share information and to learn from each other's best practices.

On the next slide, you will see a table with the measures currently in the program that are organized according to NQF priority. So, as you see, there's no measures in the health and well-being, and prevention and treatment of cardiovascular disease priorities.

Additionally, the affordable care and person- and family-centered care priorities only have one measure each. And affordable care and person- and family-centered care are CMS – are two of CMS's high-priority domains for this program.

So, here's another visual for this program. What you're looking at is a pie chart and this shows the proportion of measures addressing a given condition.

So there's an orange line in the middle of the pie chart to differentiate all of the cancer specific measures which are on the right and there the, you know, the heavier shades of green. And so that's about 57 percent of all the measures that are currently in the program.

And on the left, you can see that there's infectious disease which reflects about 31 percent. And there's patient survey and surgical site infection which are 6 percent each.

So, CMS has identified three NQF priorities for future measures in this program. And they include communication and care coordination, which is well represented in the diagram that we saw earlier, and making care affordable, which only has one measure and person-and family-centered – person and family engagement, which there's only one measure as well.

And now, I will ask Cristie to conduct the workgroup discussion on this program.

Cristie Upshaw Travis: Thank you. And due to our time beginning to run out, we'll have about five minutes or so to discuss this, but I will kick it off and see if any of you will have any comments or suggestions.

(Mary Jo Condon): Quick question, Cristie. This is (Mary Jo). Can you give any insight into why the proportion of the different measures focused on different types of cancer, kind of how that came about?

Cristie Upshaw Travis: I'll ask staff if they have any recollections regarding that or anyone else on the phone who may know.

Ronald Walters: So those were measures that were currently being collected through the American College of Surgeons' Commission on Cancer. And so processes are in place to reflect those. Basically, that's the story.

Cristie Upshaw Travis: Thank you, Ron.

(Mary Jo Condon): Thank you.

Cristie Upshaw Travis: I thought you'd know.

Any other comments or suggestions?

Nancy Foster: This is Nancy. I would just say this is probably one of those areas where I think they might help the rest of us by leading the way into a measure of quality of life for these patients going forward.

So – and I'm not sure exactly what group of cancer patients it would be best to start with, but we need to get there on all sorts of patients. So, I'd hope they could lead the way.

Cristie Upshaw Travis: Thank you, Nancy. I couldn't agree …

Ronald Walters: Challenge taken and there's five that we're waiting to see if they're going to be on the mock list or not.

We're all waiting for that just like you are.

Cristie Upshaw Travis: Other thoughts or comments?

OK. Well, hearing none and given our timeframe, I'm going to kick it back for – to Jean-Luc, I believe, for the Hospital Outpatient Quality Reporting Program.

Jean-Luc Tilly: Thanks, Cristie.

The Hospital Outpatient Quality Reporting Program which we'll call OQR. It's a pay-for-reporting program, it's about a 2.0 percent of penalty – payment reduction for non-participation.

The program goals are to establish a system for collecting and providing quality data to hospitals, providing outpatient services such as clinic visits, emergency department visits and critical care services. And of course, to provide consumers with quality of care information that will help them make informed decisions about their health care. The hospital's reform 9in quality measures is publicly reported on Hospital Compare.

So, you'll see this chart here shows relative our presentation of NQF priorities in OQR. So you'll see effective communication and care coordination is very well represented. Whereas health and well-being and person- and family-centered care are fewer measures.

You will see on our next slide, the latter two are two of the domains CMS has identified as high priority for new measures.

So, here are the four high-priority domain CMS has identified, Making Care Safer, best practices for healthy living, (prevention) screening, patient and family engagement and communication/care coordination enabling managing transition.

And I'll turn it over to Ron for the workgroup discussion.

Ronald Walters: You know, this is an interesting program as hospitals, so it's interesting that I noticed that health and well-being doesn't have any. And of course, it's mentioned in the high-priority domains and it overlaps as previously

mentioned an awful lot with other programs that exist within CMS and within the NQF.

So, there'll be some interesting discussion, I think, about what hospitals – what gaps hospitals noticed in the OQR area. Feel free. I know everybody's getting a little tired.

(Crosstalk)

Thomas Lutzow: This is Tom Lutzow again from iCare.

The, you know, patient engagement, I think there's a growing discussion of moving this concept of patient engagement closer to patient accountability.

And I think some – certainly the patient activation measure from the University of Oregon gets close to that concept. But, we – there's a tendency in our conversation and dialogue across this country about viewing the patient as victim and not colleague in the care delivery process and unless the patient is accountable, care will be futile, that's the result.

And somehow, we need to capture this concept that the patient is partner, not victim. And unless they assume responsibility for self-care in a meaningful way, we will fail in our care delivery.

Ronald Walters: Thank you.

Male: I think that address is one portion of the accountability. But I like the idea of more shared decision making metrics to come out, you know, where a dialogue actually happens and not one or the other is held accountable but a dialogue.

And it might have to be, you know, starts small and look bigger, but there's a lot to be said for the idea of a shared decision making model in this type of measure as well.

Martin Hatlie: This is Martin Hatlie. I just want to weigh in and say, that the shared decision making is important but there's an equal need for a sort of shared commitment

to supporting the patient after decisions are made and as they implement the decisions.

I think that's an area that we have a huge frontier work to be done. I mean, the activation measures are helpful, I think they're good but, you know, it's that support for the patient who's managing often without sufficient support from their various fractured providers that is part of the problem. So it's not just a patient accountability issue, it's a shared accountability issue for management.

Helen Haskell: This is Helen. And I have a question. I don't want to take up time, but when you talk about hospital outpatient, are you talking about health systems in general, so outpatient delivery that it's really not directly associated with the hospital environment, or is it just – is it something more closely linked?

Female: So this program really addresses hospital outpatient departments. Nancy, I'm sure you could elaborate better than I could.

Nancy Foster: Sure. And in fact, it's related to the comment I was just going to make, which is, I think part of the struggle here is there is not a monolithic set of hospital outpatient department.

Hospitals have a wide variety of things they do in the inventory arena from primary care clinic to specialty clinics, the ambulatory surgery, the – we'll have in radiology services, another imaging services that are not done for patients who are otherwise part of the hospital work, but they are done for private practice physician who's in their patient staff for a scan or something else that we might have a equipment for.

So, in approaching this, I'm wondering if we can get some data from CMS to look at sort of what are the most frequent outpatient services paid out under the OQR program or under the outpatient payment program, so that we could maybe target some measures that wouldn't be appropriate for all outpatient clinics, services, but may help to get at the quality in some very important types of clinic.

Does that make sense?

Ronald Walters: Yes, I agree. I – there – this has been a nebulous area from the get-go. And again, it's been mostly E.D. and procedures and, you know, endoscopies or things like that.

And we probably need some guidance of the type that Nancy said about exactly what are the high-focused areas here.

Pierre Yong: So this is Pierre from CMS. And we have to have a measure in both the (AFC) and NQF program, and I forgot the numbers, it's like a OQR25 or something like that. And I have to double check. But (Anita), are you on?

(Anita): Yes, I'm here.

Pierre Yong: Oh, do you know the volume measure?

(Anita): Yes.

Pierre Yong: Yes. Do you mind …

(Anita): It's …

Pierre Yong: … providing it to folks?

(Anita): OB26 …

Pierre Yong: Thank you.

(Anita): … seven.

Pierre Yong: And do you mind just telling folks what that measure is? And that measure is publicly – if that data is publicly available.

(Anita): Yes, it's a volume measure, it's kind of tracks the volume of surgery performed at the centers on yearly basis. So it's just – it's a – they are collected to the web portal of CMS and providers enter the volume for each of the areas like surgery on the CMS website and we have this data reported annually.

Nancy Foster: So that was – just for clarification, that would be volume of surgeries, volume of different radiology tests, different primary care visits, all of that would be widely available?

(Anita): It does not include primary care visits, but it's just the volume of surgery.

Nancy Foster: OK. I think we need a little bit more than that, Pierre, because there are pediatric clinics, there are ought about patient clinics that we run, OB, you know, and appropriately judge what are those high-volume frequently used services that we ought to be thinking about measures for, I think we kind of need to know the whole framework here and maybe Medicare doesn't have it.

Maybe it ought to come from some place else because you don't have the Blue Cross data or the other data. So we may be searching for a source here.

Ronald Walters: So I think – (I'm kind of soft) because we do have to get to the final program. Yes, we have high impact conditions that drove the inpatient readmission program. There ought to be a high impact list that drives the OQR program, too.

Jean-Luc, can you ought to do ASCs?

Zehra Shahab: So Ron, this is Zehra. I'm going to jump in. We're going to open for public comment for review of the last program. So, (Nan), can you please open the line for public comment?

Operator: At this time, if you'd like to make a comment, please press star one. We'll pause for just a moment.

And there are no public comments at this time.

Zehra Shahab: Thank you, (Nan).

Jean-Luc Tilly: OK, great.

Ronald Walters: Go ahead.

Jean-Luc Tilly: So, the Ambulatory Surgical; Center Quality Reporting Program and it's ASCQR requires ASCs to report performance information at CMS. This information is reported.

ASCs receive a 2.0 percentage point payment penalty to the annual payment update from that reporting.

The program goals are to promote higher quality, more efficient care for Medicare beneficiaries, and to establish a system for collecting and providing quality data to ASCs, and to provide consumers with quality of care information that will help them make informed decisions about their health care.

This table here lists the measures in the ASCQR based on latest proposed rule organize by NQF priority and by condition. You'll notice that there are no measures addressing a person- and family-centered care.

Now, this chart here shows health measures in the ASCQR and OQR program circle app. The January 15 – the January 2015, the previous cycle is MAP recommendations identified alignment between ASC and OQR as critical program objectives for both in order to facilitate comparisons across similar settings of care.

You'll see from the chart that about half, seven out of 14, of the ASCQR measures are aligned in about a quarter of the OQR measures, seven out of 29 are aligned.

And now, these are the high-priority domains that CMS has identified. It's actually included every NQF priority safe making care affordable.

Now, I'll turn it over to Cristie for the workgroup discussion.

Cristie Upshaw Travis: Thank you. I appreciate that, and as you all know, we're nearing the end of our time, but this is our last program so I hope you can stay on the line for just a few more minutes. I'd really appreciate that.

So, if there are any comments about Ambulatory Surgery Center Quality Program, we'll take them at this time.

Donna Slosburg: Hi, this is Donna Slosburg. And I do want to say that we do think that the patient and family engagement and complications of surgical site infections are critical measurement gaps.

We are actually working on measures as we speak. I think the bigger challenge for the ambulatory surgery industry is the behavioral health access and the multiple chronic conditions, since our time with the patients are limited.

And I do want to point out and I may be off by one digit and CMS can correct me, but I think just want to point out on the slide that had the – let me tell you the slide number, we were just there, slide 62. Of those OQR exclusives, I think 11 of those 22 are emergency department measures. I just want to clarify that when we're talking about alignment.

Thank you.

Cristie Upshaw Travis: Thank you. That is a question I had too, so thank you for that, Donna.

Any other comments or suggestions?

OK. Well, thank you all so much for hanging in with us as we went through these programs. I'm going to turn it back over to Zehra to talk a little bit about what the next steps are.

Zehra Shahab: Thanks, Cristie.

So I'll quickly review the next steps. This is the visual that Erin showed you earlier so I won't go over it again in detail. But, on the next slide, you can see two important dates.

First, is the November 13th All-MAP web meeting. And as Erin was mentioning earlier, this was going to include all the MAP workgroups and it'll be how – it'll show how we're going to be evaluating the measures, this process including voting and the changes specifically from last year.

So, we will also describe the preliminary analysis, which is how we're going to assess the measures. And there's going to be more detail to be provided on both the preliminary analysis both at this November meeting and also during the December in-person meeting, which is December 16th through 17.

So, you will receive a travel memo from the meetings department regarding how to book your travel and hotel for this in-person meeting approximately a month before, so in early November.

And I also wanted to point out that the last attachment, those provided in the e-mail and is also available on the link section is the MAP member guide book. So, I would encourage everyone to please review this in order to familiarize yourself because it will help you for both the November call and also the December in-person meeting and you can bring any questions you have from the guide book on to both the November call and the in-person meeting.

And lastly, I would like to thank Cristie and Ron for their leadership and also see if they would have any additional comments they would like to make before we end.

Cristie Upshaw Travis: This is Cristie. I'll just point out that in the member guide book, please pay special attention to the algorithm that's going to be used for the preliminary analysis and it's also going to form the basis for our review and recommendations and that's presented on page 32.

And then the voting procedures are also on page 34. And I say that because I think the staff and the MAP Coordinating Committee have done a really good job of trying to be sure that a class of workgroups, we are approaching our work and as consistent of fashion as possible certainly recognizing that there will be some differences because the work is different. But, I found both of these sections of the guide book to be very important and even though I've been on the MAP from the beginning for the Hospital Workgroup as many of you all have, these are new.

So, we will be talking about them in November on that web call, but it was extremely helpful for me to review this. So, I encourage you to do so.

Ron …

Male: Can you repeat those two sections those were, please?

Cristie Upshaw Travis: Yes, I just wrote down page 32 and page 34 were the ones – the page numbers for the sections I was talking about.

And Ron, any thoughts from you?

Ronald Walters: No, I'll be very brief. Thank you very much for your time and attention. Again, we really appreciate it. Have a good day.

Female: So …

Female: Thank you all.

Female: Thank you, everyone. We look forward to seeing you all in December.

Cristie Upshaw Travis: Same here. Thank you. Thanks to the staff. Bye.

Female: Thanks, everyone, bye-bye.

Operator: And this concludes our call. Thank you. And you may now disconnect.

END