

NATIONAL QUALITY FORUM

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MAP HOSPITAL WORKGROUP

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WEDNESDAY

DECEMBER 4, 2019

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The Workgroup met at the National Quality Forum, 5th Floor Conference Room, 1099 14th Street, N.W., Washington, D.C., at 9:00 a.m., R. Sean Morrison and Cristie Upshaw Travis, Co-Chairs, presiding.

PRESENT:

R. SEAN MORRISON, National Coalition for Hospice and Palliative Care, Co-Chair

CRISTIE UPSHAW TRAVIS, Memphis Business Group on Health, Co-Chair

ANDREEA BALAN-COHEN, IMPAQ Health, Subject Matter Expert

AMY CHIN, Greater New York Hospital\*

PAUL CONWAY, American Association of Kidney Patients

AKIN DEMEHIN, American Hospital Association

ANNA LEGREID DOPP, Pharmacy Quality Alliance

FRANK GHINASSI, National Association for Behavioral Healthcare

KELLY GIBSON, Society for Maternal-Fetal Medicine\*

MARYELLEN GUINAN, America's Essential Hospitals

MARTIN HATLIE, Project Patient Care

AMY HELWIG, UPMC Health Plan

JACK JORDAN, Henry Ford Health Systems

NIKOLAS MATTHES, Press Ganey

LISA MCGIFFERT, Mothers Against Medical Error

DENISE MORSE, City of Hope

SARAH NOLAN, Service Employees International  
Union  
AISHA PITTMAN, Premier Healthcare Alliance  
PHOEBE RAMSEY, Association of American Medical  
Colleges  
KAREN SHEHADE, Medtronic-Minimally Invasive  
Therapies Group  
STANLEY STEAD, American Society of  
Anesthesiologists\*  
LINDA VAN ALLEN, American Case Management  
Association  
DEBORAH WHEELER, Molina Healthcare\*  
JACKSON WILLIAMS, Dialysis Patient Citizens  
LINDSEY WISHAM, Telligen, Subject Matter Expert  
MICHAEL WOODRUFF, Intermountain Healthcare

FEDERAL LIAISONS:

MIA DeSOTO, AHRQ  
REENA DUSEJA, CMS  
RONIQUE EVANS, CMS  
DAN POLLOCK, CDC  
MICHELLE SCHREIBER, CMS

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and CEO  
TAROON AMIN, Consultant  
JORDAN HIRSCH, Project Analyst  
MADISON JUNG, Project Manager\*  
ELISA MUNTHALI, Senior Vice President, Quality  
Measurement  
JANAKI PANCHAL, Project Manager  
SAM STOLPE, Senior Director

ALSO PRESENT:

ANNESE ABDULLAH-McLAUGHLIN, CMS  
BO FENG, IMPAQ International  
JOEL MESSINA, KECC\*  
VINITHA MEYYUR, CMS  
JESSE ROACH, CMS  
DEBORAH ROSENSTEIN, Mathematica\*  
BROCK SLABACH, National Rural Health Association

\* present via. teleconference

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

2 9:02 a.m.

3 MR. STOLPE: All right, everyone.

4 Let's go ahead and get started.

5 Hello and welcome on behalf of the NQF  
6 leadership and staff. We're delighted to be  
7 hosting you here at our new headquarters for  
8 this, the 2019-2020 MAP Hospital Workgroup in-  
9 person meeting.

10 I'm Sam Stolpe. I'll be conducting on  
11 behalf of the NQF staff for the duration of the  
12 day. And we are joined by our two fantastic co-  
13 chairs, Sean Morrison and Cristie Upshaw Travis,  
14 whom I'll hand over to opening remarks in just  
15 one moment after I get through just a couple of  
16 housekeeping items.

17 So first as I mentioned, Poll  
18 Everywhere is going to be the platform that we'll  
19 be using for voting today. If at any point you  
20 have any trouble with it, simply raise your tent  
21 card, or if you're on the web platform raise your  
22 hand and a staff member will assist you.

1                   We have meeting materials for this  
2 meeting available online. Simply go to  
3 [public.qualityforum.org](http://public.qualityforum.org) and search for "hospital"  
4 and it will pull up our workgroup materials if  
5 you do not have them already. They're also  
6 attached to the calendar invite that you had for  
7 this meeting.

8                   Related to the tent cards, we're all  
9 very familiar at this point I think with our  
10 traditional approach to drawing attention to  
11 ourselves when we wanted to make a comment. It's  
12 just simply to tip your tent card up like so, and  
13 the co-chairs will acknowledge you once we get  
14 the cue from whoever is in front of you. Those  
15 on the web platform, you can simply raise your  
16 hand and we'll be able to identify you that way.

17                  A couple of last items. We do have  
18 restrooms here. They're just inside the foyer  
19 near the elevator, so if you walk past the  
20 reception desk and through the glass doors,  
21 you'll see them on the left. And lastly, just a  
22 note to please mute your cell phones while you're

1 here at the meeting. If you need to step out to  
2 take a call, we understand. And for our audience  
3 members, we do have microphones throughout the  
4 room, so if you -- that will actually pick you  
5 up. So if you're going to have a conversation,  
6 please step out and conduct that in the hall.

7 So with that, I'll hand it over to our  
8 co-chairs to offer some welcoming remarks.

9 MS. JUNG: So we're going to do a few  
10 muting of the beeping in and out real quick, so  
11 if you don't mind just pausing for a second so we  
12 don't hear -- and interrupting your opening  
13 remarks.

14 MR. STOLPE: Very good. Thank you.  
15 And while we're waiting --

16 (Telephonic interference.)

17 MR. STOLPE: While we're waiting,  
18 would folks please just rotate their tent cards  
19 so the Chairs can see them? With some of the  
20 glare, it's a little challenging to see names.  
21 Thank you very much.

22 CO-CHAIR UPSHAW TRAVIS: Thank you for

1       that.

2                   MR. STOLPE:   Thank you.

3                   CO-CHAIR UPSHAW TRAVIS:   That is so  
4       much easier.   So thank you all.   Well I'm Cristie  
5       Upshaw Travis, and I'm the CEO of the Memphis  
6       Business Group on Health.   And I serve on the NQF  
7       Board of Directors as well, and I've been co-  
8       chair of this Committee for a while.   But I want  
9       to welcome everybody.   I want to thank those who  
10      are returning.   It's always good to see old faces  
11      --- not old-old, but --

12                               (Laughter.)

13                   CO-CHAIR UPSHAW TRAVIS:   -- faces that  
14      have been on the Committee for some time, and I  
15      also want to welcome those who are joining us for  
16      the first time.   This is a wonderful opportunity  
17      for us to actually as a group think about the  
18      measures that are going into the CMS programs and  
19      to make our recommendations.

20                               So thank you all, especially the lead  
21      discussants for the additional work that you did  
22      in order to prepare for today, and I look forward

1 to working with you all today. And I'll turn it  
2 over to our new co-chair, Sean.

3 CO-CHAIR MORRISON: Hi, Sean Morrison.  
4 I am the chair of Geriatrics and Palliative  
5 Medicine for the Mt. Sinai Health System in New  
6 York and I have been chair now for I think about  
7 five minutes.

8 (Laughter.)

9 CO-CHAIR MORRISON: I just wanted to  
10 echo everything that Cristie said and to welcome  
11 all of you. This is a very important meeting.  
12 The advice that you give CMS is critical in terms  
13 of improving quality for our patients and our  
14 families.

15 I wanted to actually make one further  
16 comment and note, which is because some people  
17 leave early, and particularly some in the back  
18 may leave, this is Cristie's last meeting as co-  
19 chair, and I just -- I will -- we will say more  
20 formal thank yous towards the end, but I did want  
21 to publicly thank Cristie for all of her  
22 incredible work. I'm actually terrified because

1 if they keep me, I will be the first person in  
2 how many years who doesn't have her sort of  
3 guiding the meeting through.

4 But I really wanted to thank Cristie  
5 for the incredible work that she has done. For  
6 those of you who have been on this committee know  
7 just words are not enough to describe leadership  
8 and what she has done for this group. So I  
9 wanted to thank her before we started.

10 (Applause.)

11 CO-CHAIR UPSHAW TRAVIS: Well, thank  
12 you. And I'll tell you, Sean, just remember,  
13 there is hope that you get to retire as co-chair.

14 (Laughter.)

15 CO-CHAIR UPSHAW TRAVIS: Thank you,  
16 Sean.

17 MR. STOLPE: Well thanks very much to  
18 the both of you. At this point we'll move to our  
19 disclosure of interest portion of the agenda, and  
20 I'll hand it over to our Senior Vice President of  
21 Quality Measurement, Elisa Munthali.

22 MS. MUNTHALI: So, thank you,

1 everyone. Thank you, Cristie. Thank you, Sean.  
2 And thank you all for being here and serving on  
3 this workgroup. My name is Elisa Munthali. I'm  
4 the Senior Vice President of Quality Measurement  
5 at the National Quality Forum.

6 And today what we're going to do is  
7 combine our introductions with disclosures.  
8 We're going to do it in two parts because there  
9 are two types of workgroup members that serve on  
10 the workgroup. There are organizational  
11 representatives and there are subject matter  
12 experts.

13 The majority of you -- which is good,  
14 it will be less complicated -- are organizational  
15 representatives, and we'll start with you, first  
16 with the org reps in the room and then remote.  
17 We asked you a few questions as organizational  
18 representatives -- not as many as we did for  
19 subject matter experts. We expect you to come to  
20 the table and bring your stakeholder perspectives  
21 to the discussion today.

22 So what we're going to do is start to

1 my left, and I think we'll start with Frank. And  
2 Frank, if you could tell us your name, who you're  
3 with and if you have any conflicts. And then  
4 we'll go to the phone; just go around the room.

5 MEMBER GHINASSI: Sure. Frank  
6 Ghinassi, President and CEO of Rutgers University  
7 Behavioral Health. I'm representing the National  
8 Association for Behavioral Health, and I have no  
9 conflicts.

10 MS. MUNTHALI: Okay. Thank you.

11 MEMBER JORDAN: I'm Jack Jordan. I  
12 have no conflicts. I represent Henry Ford Health  
13 Systems.

14 MEMBER WILLIAMS: Jackson Williams,  
15 Dialysis Patient Citizens. I have no conflicts  
16 to disclose.

17 MEMBER WOODRUFF: Mike Woodruff with  
18 Intermountain Healthcare, and I have no  
19 conflicts.

20 MR. SLABACH: I'm Brock Slabach with  
21 the National Rural Health Association in the role  
22 of liaison to this coordinating committee, to

1 this workgroup, and I'm non-voting and I have  
2 nothing to disclose.

3 MEMBER HELWIG: Amy Helwig with the  
4 UPMC Health Plan, and I have nothing to disclose.

5 MEMBER MORSE: Denise Morse with City  
6 of Hope Cancer Center. I have nothing to  
7 disclose.

8 MEMBER VAN ALLEN: Linda Van Allen  
9 representing the American Case Management  
10 Association and I work for Tenet Healthcare,  
11 which is a company that owns several hospitals  
12 across the country, which is my disclosure.

13 MEMBER SHEHADE: And I'm Karen Shehade  
14 and I work with Medtronic-Minimally Invasive  
15 Therapies Group, and I hold stock in the company,  
16 so disclosed.

17 MEMBER GUINAN: Good morning.  
18 Maryellen Guinan representing America's Essential  
19 Hospitals. No disclosure.

20 MR. POLLOCK: Dan Pollock, federal  
21 liaison representative from the Centers for  
22 Disease Control and Prevention. Not voting. No

1 conflicts.

2 MEMBER NOLAN: Sarah Nolan, Service  
3 Employees International Union. No conflicts.

4 MEMBER HATLIE: Marty Hatlie, Project  
5 Patient Care. We're an improvement coalition in  
6 Chicago. I have no conflicts.

7 MEMBER RAMSEY: Phoebe Ramsey,  
8 Association of American Medical Colleges. No  
9 conflict.

10 MEMBER DEMEHIN: Good morning. Akin  
11 Demehin with the American Hospital Association.  
12 No conflicts.

13 MEMBER DOPP: Good morning. Anna  
14 Legreid Dopp. I'm representing the Pharmacy  
15 Quality Alliance today, and I work for the  
16 American Society of Health System Pharmacists. I  
17 have nothing to disclose.

18 MEMBER MCGIFFERT: Lisa McGiffert.  
19 I'm representing Mothers Against Medical Errors,  
20 and they are a member of a relatively new  
21 coalition, Patient Safety Action Network, and I  
22 have nothing to disclose.

1                   MEMBER MATTHES:  Nikolas Matthes with  
2                   Press Ganey Associates.  Patient experience,  
3                   clinical quality, engagement safety.  I hold  
4                   stock in the company.

5                   MS. MUNTHALI:  Thank you.  So on the  
6                   phone do we have Stanley?

7                   MEMBER STEAD:  Hello.

8                   MS. MUNTHALI:  Hi, Stanley.  We can  
9                   hear you.

10                  MEMBER STEAD:  Great.  I'm Stan Stead.  
11                  I am representing the American Society of  
12                  Anesthesiologists, and I have no conflicts to  
13                  disclose.

14                  MS. MUNTHALI:  Thanks, Stan.  Amy  
15                  Chin?

16                  MEMBER CHIN:  Hi.  Can you hear me?

17                  MS. MUNTHALI:  We can.

18                  MEMBER CHIN:  Okay.  Amy Chin with the  
19                  Greater New York Hospital Association, and I have  
20                  no conflicts to disclose.

21                  MS. MUNTHALI:  Thank you.  Deborah  
22                  Wheeler?

1                   MEMBER WHEELER: Yes, it's Debbie  
2 Wheeler. I'm representing Molina Healthcare, and  
3 I no conflicts.

4                   MS. MUNTHALI: Thanks, Debbie. And  
5 Kelly Gibson?

6                   MEMBER GIBSON: Yes, Kelly Gibson.  
7 I'm representing the Society for Maternal-Fetal  
8 Medicine. I have no conflicts.

9                   MS. MUNTHALI: Great. Thank you very  
10 much.

11                   So we have four subject matter  
12 experts, that includes your co-chairs as well,  
13 and they received a conflict of interest form  
14 that was a lot lengthier. We asked them about a  
15 number of activities as they're related to the  
16 hospital workgroup.

17                   And we had a couple of reminders for  
18 you because you did disclose quite a bit of  
19 information. You do not represent anyone who may  
20 have nominated you on the committee or your  
21 employer. We are interested in activities that  
22 are both paid and unpaid. And perhaps the most

1 important reminder is: just because you disclose  
2 does not mean you have a conflict of interest.  
3 We go through this process in the interest of  
4 openness and transparency. And so we'll start  
5 with Sean.

6 CO-CHAIR MORRISON: Nothing to  
7 disclose.

8 MS. MUNTHALI: Okay. Cristie?

9 CO-CHAIR UPSHAW TRAVIS: I will just  
10 disclose that I am on the board of directors of  
11 The Leapfrog Group, and that's all I have to  
12 disclose.

13 MS. MUNTHALI: Thank you very much.  
14 Lindsey?

15 MEMBER WISHAM: Yes. Good morning.  
16 Lindsey Wisham. I am a subject matter expert for  
17 health informatics, and I would like to disclose  
18 that my employer, Telligen, does have CMS  
19 contracts.

20 MS. MUNTHALI: Thank you. And  
21 Andreea?

22 MEMBER BALAN-COHEN: Andreea Balan-

1 Cohen. Good morning. I would like to disclose  
2 that I work for IMPAQ International. My employer  
3 also has CMS contracts, and I will recuse myself  
4 from the discussion on the various related  
5 measures.

6 MS. MUNTHALI: Thank you.

7 And before I turn the meeting over to  
8 my colleagues, we did want to let you know we  
9 have federal liaisons on the workgroup, and  
10 they're not voting members. We also have CMS  
11 representatives here. And so we're going to ask  
12 our federal partners to introduce themselves, and  
13 we'll start with Ronique.

14 MS. EVANS: Good morning, everyone.  
15 My name is Ronique Evans, and I work at CMS on  
16 the PCHQR Cancer Hospital Program, and I also  
17 assist with various other programs such as the  
18 Home Health Program under Post-Acute Care.

19 MEMBER DUSEJA: Good morning. My name  
20 is Reena Duseja. I'm the Chief Medical Officer  
21 of the Quality Measurement and Value-Based  
22 Incentives Group.

1                   MEMBER SCHREIBER: Thank you and good  
2 morning. I'm Michelle Schreiber. I'm the  
3 Director of the Quality Measurement and Value-  
4 Based Incentives Group at CMS, and I have nothing  
5 to disclose.

6                   MS. MUNTHALI: Dan?

7                   PARTICIPANT: I think he went already.

8                   (Simultaneous speaking.)

9                   (Laughter.)

10                  MS. MUNTHALI: Dan's representing the  
11 CDC. And then we have Mia, I'm not sure, from  
12 AHRQ.

13                  MEMBER DeSOTO: Hi. Yes, hi.

14                  MS. MUNTHALI: Oh. Oh.

15                  MEMBER DeSOTO: Hi. I'm Mia DeSoto.  
16 I am from the Agency for Healthcare Research and  
17 Quality. I am lead of the Quality in Behaviors  
18 Program at the Agency, and I have nothing to  
19 disclose.

20                  MS. MUNTHALI: Thank you very much.  
21 So if at any time you remember that you have a  
22 conflict, we want you to speak up. You can do so

1 in real time or you can approach any one of us  
2 here in the front, your co-chairs or anyone on  
3 the NQF staff. And likewise, if you believe that  
4 one of your colleagues is acting in a biased  
5 manner, we want you to speak up. So thank you  
6 very much.

7 CO-CHAIR MORRISON: Very good. Thank  
8 you, Elisa. At this point we'll also introduce  
9 the NQF staff. I've already introduced myself,  
10 but let's go ahead and start with Taroon and  
11 introduce the rest of the staff.

12 MR. AMIN: Good morning, everyone.  
13 Taroon Amin. I'm a consultant with NQF. It's  
14 good to see everyone again, and I'm helping to  
15 support the MAP Coordinating Committee.

16 MR. AGRAWAL: Shantanu Agrawal, CEO.

17 MS. JUNG: Hi, I'm Madison Jung,  
18 Project Manager. I've been with the MAP Hospital  
19 Workgroup these past few years, so glad to see  
20 the familiar faces around the table.

21 MR. HIRSCH: Hi, everyone. My name is  
22 Jordan Hirsch. I got to meet many of you

1 bringing you upstairs today --

2 (Laughter.)

3 MR. HIRSCH: -- and I am the Project  
4 analyst. This is my first season on MAP. I  
5 worked on PAC LTC, Hospital and Clinician. It's  
6 wonderful to meet you all.

7 MR. STOLPE: All right. Thank you.  
8 Well with that we can move forward into our  
9 agenda in earnest, so I'll hand it over to our  
10 co-chairs to walk us through the agenda, our  
11 objectives, and take us through the rest of the  
12 meeting. Cristie and Sean?

13 CO-CHAIR UPSHAW TRAVIS: Sure. So you  
14 all see the meeting objectives that we have for  
15 today. Obviously our major objective is to  
16 review and provide the input on the measures  
17 under consideration that we lovingly call MUC  
18 that are applicable to the hospital quality  
19 programs.

20 In addition one of our objectives has  
21 already been addressed in detail, but if there  
22 are gaps, we do need to think about where some of

1       those gaps may be in these programs in order to  
2       give that type of input to CMS. We had a call  
3       about that earlier in the fall, as you all will  
4       recall, but if you think of anything else today,  
5       please feel free to identify the gaps as well.  
6       And I feel like I'm reading off of a  
7       teleprompter.

8                       (Laughter.)

9                       CO-CHAIR UPSHAW TRAVIS: So if  
10       somebody will change the slide, that would be  
11       helpful to me.

12                      (Laughter.)

13                      CO-CHAIR UPSHAW TRAVIS: Okay. Those  
14       are our meeting objectives. Before I turn it  
15       over to CMS for their opening remarks, you'll see  
16       that our agenda is quite full today. We have  
17       measures that we're going to be reviewing -- and  
18       thank you all for doing your preparation for that  
19       -- but we also are going to hear from CMS this  
20       morning about the Meaningful Measures Program  
21       Initiative and Updates. And the way that we  
22       would like to do that is to make this highly

1 interactive.

2 Dr. Schreiber has said that what she's  
3 very much interested in learning is what our  
4 input is --- our reaction, but also our input.  
5 So this is important because it does help drive  
6 kind of the role that we play here at the  
7 Hospital MAP Workgroup. So we will just move  
8 straight on to that right now. Michelle, if  
9 you'd like to give us your update?

10 MS. SCHREIBER: Thank you very much.  
11 And first of all, Cristie, I don't know what  
12 these meetings are going to be like without you.  
13 Thank you for --

14 (Laughter.)

15 CO-CHAIR UPSHAW TRAVIS: Well thank  
16 you.

17 MS. SCHREIBER: And thank you to NQF.  
18 Welcome to your new space. It's really very  
19 nice. And in particular thank you to everybody  
20 here for your participation. We very much  
21 appreciate the input. I am now one year and a  
22 couple of weeks into this job. Last year when

1       you met me I was a couple of weeks into the job.

2                       (Laughter.)

3                       MS. SCHREIBER: And so it's been a  
4       pleasure to work with some of you actually in  
5       this past year.

6                       I want to assure you that really your  
7       input into these meetings does make a difference.  
8       Some people say we come to these, we give input.  
9       Whatever happens? And I will say that we took  
10      off some measures last year that we had thought  
11      we would put into programs based on feedback from  
12      these committees. We have changed some of the  
13      measures based on feedback from these committees.  
14      And so it really does make a tremendous impact,  
15      and we look forward to hearing about it.

16                      That being said, I just want to make  
17      sure that we all recall that although we truly  
18      take your advice seriously, decisions here aren't  
19      binding to CMS, and CMS does make the final  
20      determinations on these programs and what goes  
21      into them.

22                      But our collaboration and our

1 partnership is really more important than ever.  
2 It is part of our business strategy, even it is  
3 written into CMS' plans about outreach and  
4 partnerships with associations, with specialty  
5 societies, and with patients to try and bring  
6 consensus, alignment, patient empowerment,  
7 reduced burden, and most of all value and the  
8 highest quality care to our beneficiaries. And I  
9 actually hope that over the past year some of you  
10 have sensed that even more. And so we take it  
11 very seriously.

12           The other thing is transparency.  
13 We're trying very hard to be transparent and to  
14 make all of these measures, and even our  
15 conversations and what we're doing transparent so  
16 that people have plenty of opportunity to comment  
17 on them.

18           I just want to sort of preemptively  
19 answer a few questions that I am getting  
20 frequently because some of you may have been  
21 involved in these things. Number one, many of  
22 you have provided input to the hospital stars.

1 We're continuing to look at what that program  
2 will look like. It goes into formal rule  
3 writing. NQF and some of you in this room  
4 participated in the NQF stars collaboration on  
5 that. And once the final proposal is out, we  
6 would be happy to entertain thoughts of bringing  
7 that group back together for further comment, but  
8 we have to do it obviously within the confines of  
9 rule writing.

10 The HHS Deputy Secretary Quality  
11 Summit that is underway is also something that  
12 some of you have been participating in. We don't  
13 know the final recommendations, but we certainly  
14 look forward to them. A report is supposedly due  
15 out this month, and it may have implications for  
16 what we will term the quality measurement  
17 enterprise.

18 Today we have somewhat fewer measures  
19 than what we've had the past. Actually this week  
20 is the whole MAP week. So yesterday was supposed  
21 to do care, today is hospital, tomorrow is  
22 clinicians. And if you look back a couple of

1 years, we had close to 100 measures that came  
2 through. And last year there were about 40-some  
3 measures that came through. And this year quite  
4 honestly there are less than 20, and part of that  
5 really shows that CMS is supporting and creating  
6 fewer measures, quite honestly, in development  
7 and few are going into programs in an effort to  
8 reduce burden. And many of the measures that we  
9 create and bring forward actually will eventually  
10 be replacing measures that perhaps aren't as  
11 robust or maybe they're not electronic, or maybe  
12 there's another reason for having them.

13 And so there's been a constant and  
14 iterative change to programs and the measures  
15 that we have. And Reena's going to go over that  
16 a little bit, but we've had substantive changes  
17 on the hospital side. I think it's like 40, 60  
18 percent?

19 MEMBER DUSEJA: 40 percent for  
20 hospital --

21 (Simultaneous speaking.)

22 MS. SCHREIBER: We've had a 40 percent

1 reduction in the measures used in the programs.  
2 So we are really making an effort to streamline  
3 as much as possible, and again this is in an  
4 iterative way over time.

5 This gives us at least a little  
6 opportunity today to have more of a conversation  
7 on the directions of measurement and programs,  
8 and that's what we wanted to bring to you. Many  
9 of you are familiar with the Meaningful Measures  
10 Initiative that kicked off a couple of years ago.  
11 We are now starting what we'll term Meaningful  
12 Measures 2.0.

13 And so what might that look like? And  
14 I'm going to share with you where our priorities  
15 really are, but very much want to hear back what  
16 do you think? Are we on the right track? Are we  
17 not? Are there gaps? Are there things that  
18 we're missing, or is this making sense so that as  
19 we develop Meaningful Measures 2.0, you've had an  
20 opportunity to really provide some input into  
21 them and to help set our direction that is  
22 meaningful to all of you.

1                   So if we can go to the first slide  
2           please? I'm going to try and run through these  
3           relatively quickly so that we do have an  
4           opportunity for conversation. Our primary goal  
5           of course is to ensure the highest quality,  
6           safety and value for our patients -- and by our  
7           patients, CMS has such a broad reach that  
8           although we traditionally think of the Medicare  
9           beneficiary, we're really talking about all  
10          patients in America because this impacts  
11          everybody.

12                   There has been a significant  
13          commitment, as I said before, to patients over  
14          paperwork, really demonstrating our commitment to  
15          improving clinicians' and organizations'  
16          interaction with some of the measures in the  
17          programs so that they are less burdensome, but at  
18          the same time -- and most importantly --  
19          providing information that is meaningful and  
20          useable to patients.

21                   Next slide, please? This is actually  
22          the overall strategic priority of CMS with

1 patients right at the center. And you can see  
2 the big themes are empowering patients, focusing  
3 on results and unleashing innovation. And if you  
4 count them up, there are actually 16 different  
5 boxes within them, but they include things like  
6 inoperability, and they include things like  
7 innovation so that you can see what the key  
8 priorities for CMS are as a whole.

9 Next slide, please? Again many of you  
10 have heard of the Meaningful Measures Initiative.  
11 We launched it in 2017 to improve outcomes for  
12 patients, reduce the data burden, and focus this  
13 quality measurement around what we thought was  
14 most important so that we can align with what's  
15 most meaningful to patients.

16 Next slide? Sorry, I don't have  
17 control of the slides. There are several  
18 crosscutting themes, and even as we think of  
19 Meaningful Measures 2.0, I would ask you to think  
20 of these crosscutting themes and are there  
21 opportunities to put other things into this? So  
22 addressing high-impact measures that safeguard

1 public health, that are patient-centered and  
2 meaningful and understandable by patients in  
3 particular, but also clinicians and providers,  
4 are outcome-based as much as possible. So you've  
5 seen over time there's been a transition to more  
6 outcome-based, but I have to go on record by  
7 saying there are good process measures also that  
8 actually change behavior, and we shouldn't just  
9 kick them all to the side.

10 We obviously have to fulfill the  
11 requirements that are in statute, minimize the  
12 burden for providers, identify significant  
13 opportunities for improvement. So you've seen we  
14 retire measures that get to a topped-out status  
15 because they're topped out and there isn't a  
16 significant opportunity for improvement. That  
17 doesn't mean that organizations shouldn't still  
18 track them. What it means is that they're not  
19 going to be in our programs because there's not  
20 an opportunity for improvement.

21 Addressing measures that are more  
22 population-based because underlying this whole

1 theme is this drive to value which includes  
2 value-based payment and driving into value-based  
3 payment models. And then aligning across  
4 programs, and I just want to make a comment about  
5 alignment because we've been doing a tremendous  
6 amount of work trying to align measures across  
7 many different continuums, certainly across the  
8 federal government. And we've worked with the VA  
9 and the DoD in particular to try and align  
10 measures there and we've worked with an NQF  
11 initiative with AHIP -- America's Hospital  
12 Insurance Plans -- to determine core sets of  
13 quality measures that we can align across all  
14 payers.

15 So again, the nirvana dream is that we  
16 have a set of measures that are aligned across  
17 the entire continuum of healthcare no matter what  
18 the payer is because we know that some of the  
19 burden is not just the burden of what's the check  
20 box in the EHR, but it's the burden of the 10  
21 different iterations on trying to measure the  
22 same thing.

1                   Next slide please? This is the  
2                   meaningful measures framework. Some of you may  
3                   have this card. And what we have done is  
4                   identified the top six domains. And under those  
5                   there are 19 specific areas that we have really  
6                   focused on. So the domains are: effective  
7                   communication and coordination of care, effective  
8                   prevention and treatment of chronic disease.  
9                   Next one is really wellness. It's working with  
10                  communities for best practices of healthy living,  
11                  but this is about wellness. Affordability.  
12                  Safety --- making care safer by reducing harm  
13                  because we recognize that that remains a major  
14                  problem. And of course last but definitely not  
15                  least, is strengthening the person and family  
16                  engagement to make sure that patients are central  
17                  and partners to their care. And you can see that  
18                  there are 19 within them. I'm not going to go  
19                  over them because many of you have seen this  
20                  before.

21                         But as we go into Meaningful Measures  
22                         2.0, what are we missing? Are there places that

1 we should be focusing on more or focusing on  
2 less?

3 Next slide please? Reena, do you want  
4 to pick up and talk a little about what's  
5 happened with transformation over time?

6 MEMBER DUSEJA: Yes, I'm happy to.  
7 And I'm going to make my comments brief because I  
8 think Michelle and I agreed prior that we really  
9 want to have discussion and hear from you during  
10 the time that we have today, but I wanted to just  
11 provide some framing comments about how we  
12 implemented the meaningful measure framework in  
13 2017 and the impact it had on rulemaking.

14 Michelle mentioned how it's affected  
15 the measure under consideration list over the  
16 last few years, and to the point of having less  
17 than 20 measures this year across our program  
18 shows how we really are taking a hard look at  
19 these measures as we think about putting them  
20 into our program.

21 For the hospital inpatient programs,  
22 if you look at what's being implemented, we've

1 had a 40 percent reduction of measures. So for  
2 example, in IQR currently -- we started like in  
3 2017 with 42 measures and then we're down to 23  
4 measures in that program. And similarly, if you  
5 look at -- across the programs, including IPF,  
6 we've had a couple of measures removed from  
7 there, ESRD. Also in the outpatient setting. So  
8 for ambulatory care we've seen three measures  
9 removed; 10 to 7. And a significant number of  
10 measures in outpatient quality reporting  
11 programs, we've gone from 21 measures to 13  
12 measures.

13 Now a lot of that effort had to do  
14 with looking at, as Michelle mentioned, the --  
15 looking at topped-out status, looking at low-bar  
16 measures, process measures. If we do have  
17 process measures, are they really linked to  
18 outcomes as the evidence shows? A great example  
19 would be sepsis. I know it's a controversial  
20 measure, but it is a measure we know from our  
21 data that has decreased mortality for our  
22 patients as we've implemented within the program.

1                   And I think also just to give you some  
2                   context -- I know this is the Hospital Workgroup.  
3                   We also have the Clinician Workgroup meeting  
4                   tomorrow and then yesterday the Post-Acute Care  
5                   Workgroup met, and we've seen reduction across  
6                   all our programs. So for example, in MIPS we've  
7                   had a 20 percent reduction of measures and we  
8                   just finalized the -- what we called MBPs, which  
9                   is a framework for the MIPS value pathways. And  
10                  so I think that's an additional opportunity for  
11                  alignment across those categories, but also to  
12                  have a more concise set of measures that are  
13                  really trying to drive toward value.

14                 And I'll just add just one framing  
15                 thought as Michelle talks about kind of future  
16                 directions, the LAN met, the Learning Action  
17                 Network met in October of this year and some --  
18                 I'm seeing shaking heads here, nodding heads --  
19                 there was some very aspirational goals that were  
20                 set out, and our secretary also spoke at that  
21                 meeting. And one of the goals was for us to move  
22                 from fee-for-service to alternative payment

1 models by 2025. And we're making progress, but  
2 we have a lot more to do.

3 But this really behooves us to think  
4 about: how are we driving toward value? And part  
5 of that is really thinking about beyond the  
6 quality measures about: how do we align that with  
7 cost? And so there's been a lot of thinking  
8 through that, especially through the MIPS program  
9 because we've developed some cost-based measures.  
10 But we want to do that across the continuum.

11 And then there's also really thinking  
12 about: how do we align our measures at the  
13 clinician level, at the facility level, as in for  
14 these programs as well as we think about it from  
15 the entity level?

16 And then last I will say I think  
17 critical is really thinking about: how do we  
18 actually measure in a way that's least burdensome  
19 patient-reported outcomes? And we've spoken  
20 about this in the Committee before, but there's a  
21 continued interest within our agency to partner  
22 with others to continue to move that effort. And

1 I will turn it back to Michelle.

2 MS. SCHREIBER: Thanks.

3 MS. DUSEJA: Yes.

4 MS. SCHREIBER: If we can have the  
5 next slide please? So we wanted to take just a  
6 moment to talk about what our development  
7 priorities are, and get your feedback on if these  
8 seem reasonable or not, and then to open up the  
9 discussion around Meaningful Measures 2.0, what  
10 you would like to see, comment on our priorities.  
11 And you can -- and comment on the program or  
12 others as well.

13 So as Reena pointed out, patient-  
14 reported outcomes is something that is very  
15 important to us. I know there is work that has  
16 been done here around that, so this is an ongoing  
17 pursuit to try and find not only operationally  
18 how we can best make patient-reported outcomes  
19 kind of work and fit within people's workflow,  
20 because it's clunky right now, but how can we  
21 really unleash comments from and feedback from  
22 patients? We need to understand what's important

1 to them, but we believe that by unleashing  
2 patient comments it will actually transform  
3 measurement and reporting as we start seeing more  
4 and more of those and they become commonplace.

5 A comment about electronic measures.

6 And I'll broaden this a bit to not just  
7 electronic clinical quality measures that we  
8 traditionally associate with getting data  
9 directly out of the electronic medical record,  
10 but how do we base all of our measures on  
11 electronic data systems, because they could be  
12 data systems beyond the electronic medical record  
13 as well, although that's fundamental.

14 I'm going a bit out on a limb here,  
15 but we are hoping at some point in time that we  
16 can commit to at some year -- which I will not  
17 begin to predict what year that would be -- we  
18 will have all measures based in electronic  
19 clinical data systems. And we're doing a lot to  
20 drive that, including converting a number of our  
21 measures actually into fire-based standards,  
22 using APIs for exchanging information, working on

1       standardized data elements. And sometimes this  
2       isn't the thrilling stuff, but it's the nitty-  
3       gritty work that has to be done in order to make  
4       these work.

5               And so we are obviously promoting and  
6       supporting interoperability, ensuring that  
7       there's not data blocking, making sure that we at  
8       least are supporting the fire-based standards and  
9       see this as the future direction for how we  
10      interchange clinical information. So there's a  
11      tremendous amount of work going on in driving  
12      measurement towards not only supporting  
13      interoperability, but making sure that they're  
14      electronic because of the belief that this is the  
15      only way to capture data relatively with less  
16      burden once those systems are built.

17             I recognize the burden of building  
18      them, but once those systems are built there's  
19      less burden in capturing them. You can have much  
20      more timely feedback rather than the two to  
21      three-year wait sometimes in seeing data. We can  
22      have feedback that's relatively quick. And of

1 course we can leverage then artificial  
2 intelligence, big data analytics, whatever you  
3 want to call it, in order to really do much more  
4 prediction and outlier identification, and just a  
5 better understanding analytically of what it is  
6 that we have. So a lot of work there.

7 The appropriate use of opioids  
8 obviously is something that remains a key  
9 principle in lot of work going on here. I would  
10 expand that that it's not just opioids; it's pain  
11 management, and I think mental health has to kind  
12 of go along with that. So although it says the  
13 appropriate use of opioids, I think it has to  
14 encompass a somewhat broader range.

15 Nursing home infections is something  
16 that has caught the attention of CMS because of  
17 some nursing home harm issues quite honestly, and  
18 so there's more and more work coming around  
19 nursing homes in particular. Some of that is on  
20 the conditions of participation and the  
21 accreditation side, but some of that will also be  
22 around the measurement side.

1                   Safety measures should actually be  
2                   called out as a separate bullet point. So  
3                   patient safety as something that we are working  
4                   on. And you will be hearing today one of the  
5                   electronic measures for patient safety with the  
6                   hope that as we have more electronic patient  
7                   safety measures that we will then ultimately  
8                   develop a composite measure of the electronic  
9                   patient safety measures; and I don't know that  
10                  I'm really going to announce this in public, but  
11                  I will, with the hope that eventually it replaces  
12                  PSI 90, which I know everybody loves so much.

13                               (Laughter.)

14                  CO-CHAIR MORRISON: So that's just  
15                  kind of future things to come. Maternal mortality  
16                  -- and I know we have something that's coming  
17                  here today that may be a bit controversial, but I  
18                  will share with you that one of the reasons that  
19                  that is here is because the fact that America has  
20                  the highest maternal mortality rates in any  
21                  country is something that cannot be tolerated,  
22                  and there's a lot of effort at CMS to be thinking

1 through what is it we can do to, number one, send  
2 a signal that working on this is important.

3 We will over time -- and it's not  
4 ready this year, but hopefully next year perhaps  
5 at this time or the year after --- we are working  
6 on an electronic measure of maternal morbidity.  
7 Not mortality because frankly the numbers are so  
8 small for that it's hard, but a composite  
9 maternal morbidity. And we're working on that  
10 actually in combination with the Joint  
11 Commission, so we hope to be bringing that  
12 forward to you.

13 But the reason for the measure that  
14 you see today -- I recognize it's a structural  
15 measure. It is not quite this kind of quality  
16 measure we've thought of before, but it was meant  
17 as really just a signal and an indication to ask  
18 organizations if they're participating in quality  
19 improvement that is meaningful to reduce maternal  
20 mortality.

21 And finally, sepsis. You heard Reena  
22 talking about that before. We're looking to do a

1 more outcomes-based and again electronic measure  
2 around sepsis that over time then would probably  
3 replace the hand abstract strep and sepsis  
4 measure.

5 What I don't have up here is cost. We  
6 have lost of cost measures that are on the table.  
7 Most of those are on the clinical side as opposed  
8 to the hospital side, but there's a lot of focus  
9 on cost. And so this is where CMS is setting its  
10 development priorities, and we actually look  
11 forward to your comments on that.

12 I think we have one more slide that  
13 I've covered really pretty much already. It's my  
14 soapbox plea for electronic measures of the  
15 future. So developing more APIs, using the  
16 prototype of fire, interoperable electronic  
17 exchanges, harmonizing across registries and the  
18 idea of timely and actionable feedback and the  
19 use ultimately of artificial intelligence, or big  
20 data as you might call it.

21 So I would like to turn the rest of  
22 the time actually back to our co-chairs and

1 really have a discussion of: are we on the right  
2 strategy? Do you agree, do you not agree? What  
3 changes would you like to see? And help us craft  
4 Meaningful Measures 2.0. So thank you.

5 CO-CHAIR MORRISON: Thank you,  
6 Michelle. Thank you, Reena. So the floor is now  
7 open.

8 And Michelle, just to highlight again,  
9 you guys are really interested in really three  
10 areas: one, general reactions; two, future  
11 directions in terms of what you -- strong support  
12 for or perhaps against. And any gaps that --

13 MS. SCHREIBER: Yes.

14 CO-CHAIR MORRISON: -- people have  
15 that might be identified.

16 MS. SCHREIBER: Thank you.

17 CO-CHAIR MORRISON: Is that it?

18 MS. SCHREIBER: Yes. Perfect.

19 CO-CHAIR MORRISON: Okay. The floor  
20 is open to tent cards.

21 MS. SCHREIBER: And by the way, if you  
22 don't talk, I'll assume that we're all right,

1       so --

2                       (Laughter.)

3                       CO-CHAIR MORRISON:  Martin, you get to  
4       start us off.

5                       MEMBER HATLIE:  I have two comments.  
6       First of all, I like structural measures a lot.  
7       I think that they get to culture, and I think as  
8       we look back now especially 20 years after the  
9       IOM Report on Safety, where we're all looking  
10      back at looking at the progress we've made and  
11      the progress we haven't made that the impediment  
12      is often culture.  It's fear of litigation.  It's  
13      fear of embarrassment.  It's fear that our  
14      patients won't understand what we're giving them  
15      in terms of information.  And I think structural  
16      measures play a real part there.

17                      I'm looking at Jack Jordan across the  
18      table because we were involved in the network of  
19      the partnership of patients with the development  
20      of structural measures there that really brought  
21      the patient and family not just in at the point  
22      of care, but into improvement work and into

1 governance. And those were structural measures  
2 that are beginning to now generate data about  
3 making a difference. So I will just encourage  
4 you to keep going at that for culture change  
5 reasons because culture eats strategy for  
6 breakfast.

7 The second thing I wanted to say is I  
8 really hope that in the meaningful measure  
9 development priorities list you will call out  
10 patient safety the way you did verbally here as a  
11 bullet. This new data last year globally shows  
12 that more people now die from poor quality and  
13 unsafe care than from lack of access to care in  
14 137 countries.

15 The World Health Organization  
16 published a brand new resolution in May calling  
17 upon this as a reminder that this is a huge  
18 priority for the world, for every country,  
19 probably because we're not really tracking well  
20 the amount of harm from preventable process  
21 failure or system failure. So I think that  
22 really does deserve to be called out as an

1 explicit priority. And I worry that it gets  
2 subsumed under safety in a way that loses  
3 urgency. It certainly belongs there, but there's  
4 something urgent about really calling out patient  
5 safety as an ethical imperative for us as well as  
6 quality imperative.

7 So those are my comments. Thank you,  
8 Sean, for the floor, and great work.

9 CO-CHAIR MORRISON: Jackson? I've  
10 Jackson, Akin and then Jack.

11 MEMBER WILLIAMS: Dr. Schreiber, as  
12 you noted, the meaningful measures card contains  
13 16 boxes and 19 priority areas, and I think most  
14 of us at this table in our professional lives  
15 work in organizations or units that have about  
16 three priorities at any given time. So to me  
17 saying we have 19 areas is almost like saying  
18 there are none. And I realize I've worked at  
19 CMS, and I know there are stakeholders who want  
20 to get their area in there --

21 MS. SCHREIBER: You think?

22 MEMBER WILLIAMS: -- so that's why

1       it's there. But I think it would be helpful to  
2       this group if you could tell us I guess what your  
3       view of the real top three are.

4               MS. SCHREIBER: I mean I could give  
5       you my view, but frankly I'd rather hear your  
6       view. Yesterday at the PAC meeting they actually  
7       prioritized for us. And so we'd be happy to hear  
8       what you all think, if you had to vote your top  
9       one might be -- because everybody will have a  
10      different -- maybe we'll get to three.

11             MEMBER WILLIAMS: Okay.

12             (Laughter.)

13             MS. SCHREIBER: Don't want to go  
14      first?

15             CO-CHAIR MORRISON: Akin and then --

16             MEMBER DEMEHIN: So first of all,  
17      thank you for the overview of the Meaningful  
18      Measures Initiative. I would say that we were  
19      and continue to be very strong proponents of this  
20      approach. I think there's a real discipline to  
21      outlining the list of areas that will shape CMS'  
22      measurement programs.

1                   Just a couple of thoughts: if I were  
2                   picking a priority area writ large to focus a lot  
3                   of energy and attention on, frankly it would be  
4                   patient safety. It is really good to hear that  
5                   you are looking at ways of transitioning away  
6                   from old claims-based measures like PSI 90, of  
7                   which we have many opinions and have stated them  
8                   many times. I think that is a good way to really  
9                   use an EHR to its greatest effect to drive safety  
10                  forward.

11                  The other thing that comes to mind as  
12                  we -- as I kind of look this list, I do think  
13                  that the notion of trying to align across payers  
14                  is an incredibly important one. A lot of the  
15                  measurement burden that we hear about from our  
16                  members comes from having to report different  
17                  versions of -- like is effectively the same  
18                  measure. I do think eQMs are one way of getting  
19                  there because the data are agnostic to the payer,  
20                  but really emphasizing the need to create that  
21                  cohesion and coordination across payers in terms  
22                  of measurement would go a very, very long way.

1                   And the last thing I guess is more of  
2                   a question for all of you. So this meaningful  
3                   measures framework was developed two years ago.  
4                   As I look at the list of priorities, it still  
5                   looks like a good list and a fairly current list.  
6                   Could you comment a little bit on how you see CMS  
7                   maintaining, altering, expanding, contracting the  
8                   list of 19 priority areas in this framework over  
9                   time?

10                   MS. SCHREIBER: I think that to  
11                   address both points, one is to narrow it down  
12                   even further so that we can be focusing on very  
13                   key or strategic areas.

14                   Now that being said, we think of 19 as  
15                   too much. We are covering the country here in  
16                   the entire continuum healthcare. But I think to  
17                   focus it even more would -- is one of the things  
18                   that we're looking to do.

19                   I think the second focus quite  
20                   honestly is the shift to the electronic world and  
21                   how we capture that, because it's really not  
22                   quite captured in meaningful measures as it

1 currently stands. So there are a couple of  
2 underlying themes.

3 And then the other thing that frankly  
4 we haven't talked about -- we had a huge debate  
5 yesterday -- is: where does disparities fit into  
6 this framework example? Is it its own domain?  
7 Is it crosscutting? Is it sort of where does it  
8 fit in? And that's another conversation that  
9 will go into this, but it's so complicated that I  
10 don't know that any of us have an answer right  
11 now.

12 MEMBER DUSEJA: Can I just -- can I  
13 add?

14 MS. SCHREIBER: Yes, please.

15 MEMBER DUSEJA: The other area I think  
16 that's sort of driving toward value is really  
17 thinking about resource utilization and the  
18 demand that we have around making care  
19 affordable. So I think there's a lot of work.  
20 At least I know this from the clinician  
21 standpoint that we're also thinking about it  
22 across other spaces and we're partnering with

1 specialty societies to really get better  
2 measurement in that area.

3 CO-CHAIR MORRISON: Jack?

4 MEMBER JORDAN: All right. So a  
5 couple things: one, it didn't seem like your key  
6 priority areas included specialty and sub-  
7 specialty care at all, which seems like a big  
8 gap. And then I wanted to comment on your  
9 statement you made about sepsis mortality getting  
10 better. There's an interesting report that the  
11 HIMSS had from their evaluation. If you look at  
12 it in a population base, it's flat. We haven't  
13 made any dent at all in the population. But it's  
14 just taking us more tries in the hospital to kill  
15 you, but we eventually do from sepsis.

16 (Laughter.)

17 MEMBER JORDAN: So looking at it at  
18 the hospital base gives you a really different  
19 answer than population, so I would ask you to  
20 maybe think about that.

21 When you're going down the road for  
22 cost, I think thinking about making sure you're

1 including the cost of avoiding a procedure  
2 altogether. You know, you get your cheapest  
3 procedures are on the lowest need kind of  
4 patients. And that's -- I think that's trickier  
5 to do, but I think it's important to think about.

6 And the other thing to think about on  
7 your patient-reported outcomes is we tend to  
8 always frame them as episode-based, and maybe if  
9 you think about them as time-based, that every  
10 year when you sign up for your insurance you take  
11 a PROMISE12 and that sets kind of the HCC  
12 scoring, and now we've got wonderful data for the  
13 whole country on where the population is at.

14 And I know a lot of the specialties  
15 are going to balk at that because they want to  
16 have the really specific question for their  
17 patient-reported outcome, but I think going  
18 global like that is something to consider that's  
19 a little bit different than how people are  
20 thinking about it.

21 And then my last one is the soapbox  
22 on: when you do go to eQMs, make the turnarounds

1 quick. Share them with your contractors the next  
2 day, not three months later after they've been  
3 cleaned. And I think that's the real advantage  
4 to eCQMs, if you have government contractors, to  
5 seek the data the next minute to help people out.

6 CO-CHAIR MORRISON: Great. Lindsey.  
7 Then I've got Nikolas and Lisa.

8 MEMBER WISHAM: Yes, I just wanted to  
9 provide a comment that I appreciate and support  
10 the desire to move to 100 percent electronic data  
11 capture. I think that's truly been untapped. As  
12 someone that's been a part of eCQM since their  
13 inception, we've seen some iterative changes, but  
14 we've also seen big leaps in some of the  
15 standards that have been used. And I think it's  
16 just a constant reminder that you will continue  
17 to see evolvement. They will not stand still.  
18 The standards won't. And that shouldn't deter us  
19 from embracing them and utilizing them in  
20 measurement programs. I think we just have to go  
21 in with -- knowing and embracing that the  
22 standards will continue to evolve as measurement

1 needs change and evolve as well. So thank you.

2 CO-CHAIR MORRISON: Nikolas?

3 MEMBER MATTHES: Yes, I just wanted to  
4 say I'm really in support of the meaningful  
5 measures framework and -- so one perhaps area to  
6 think about as well, and I was just curious  
7 whether you had or what your thoughts are  
8 currently is sort of to think about the  
9 organizations' commitment to provide engagement.  
10 So like as we think about the clinical and  
11 professional work environment, the impact it has  
12 on employee satisfaction and on actually better  
13 caregiver outcomes and patient outcomes, that  
14 that may be an area for consideration as well.

15 CO-CHAIR MORRISON: Lisa? And then  
16 just so you're prepared, I've got -- Amy, you're  
17 next.

18 MEMBER MCGIFFERT: Okay. Let's see.  
19 I definitely think we need to focus more on  
20 hearing from patients, especially in the arena of  
21 patient safety because I think these events  
22 overall are kind of under the radar with regard

1 to the public and people who have oversight of  
2 the system. And that means directly asking them  
3 if they've been harmed. What happened to them?

4 And I really like the idea that Jack  
5 said about doing some kind of annual feedback  
6 from people rather than just after they left the  
7 hospital. And I think we don't have any  
8 questions to patients that say did you get an  
9 infection? Did you have a complication that was  
10 preventable? Or describe some of the things that  
11 happened.

12 With regard to infections; and most of  
13 my comments are on patient safety, I would like  
14 to see us move towards a composite of all the  
15 infections that happen in a facility. And we are  
16 nowhere near doing that right now. The public --  
17 people want to know how likely am I going to get  
18 an infection at that facility? They don't want  
19 to know how likely am I going to get a CLABSI or  
20 a CAUTI or a -- they want to know am I going to  
21 get -- how does it rate? So I think we really  
22 need to think about that. The current measures

1 are really I think more useful for providers, and  
2 they were designed to be that way. And I  
3 understand that, but it's now time to think about  
4 the public a little bit more.

5 With regard to disparities in the area  
6 again of patient harm, I think we just need to  
7 tread very carefully so we don't continue to  
8 support poorer care for certain populations  
9 through risk adjustment. And I think that that's  
10 very dangerous when it comes to anything relating  
11 to patient safety. And I know when these  
12 conversations first started many years ago and a  
13 few of us were going, wait, whoa, what, we were  
14 told these would never be applied to patient  
15 safety measures or about patient safety. And I'm  
16 seeing it creep in and I just want to say that  
17 from my perspective it's not an appropriate thing  
18 to happen. Thanks.

19 CO-CHAIR MORRISON: Amy?

20 MEMBER HELWIG: I just had a couple of  
21 comments on priorities. I would encourage more  
22 prioritization of functional outcome measures,

1 especially change in functional status and  
2 whenever that's possible and as it relates to  
3 different treatments. The benefit is that it  
4 hits patient-reported outcomes. It hits  
5 appropriate care. It hits cost of care.

6 I think of some specific examples  
7 within the Joint Replacement Program where we  
8 currently look at the functional status. It's  
9 required both before and after surgery, six and  
10 nine months and a year after surgery. But now  
11 moving to that new phase of actually to see, all  
12 right, not only was an assessment done, but did  
13 it make a difference? And what was -- what's the  
14 minimum difference that you need to see so that  
15 we can better determine what's appropriate care  
16 and how to best use resources? So any other  
17 areas where we can continue to incorporate those  
18 changes in functional statuses I think would be  
19 very beneficial.

20 CO-CHAIR MORRISON: And, Michael?

21 MEMBER WOODRUFF: So first of all,  
22 thank you. And the direction is perfect and I

1 love the frame, the lens of measures that are  
2 meaningful to patients. That's going to be  
3 really helpful. The challenge I think will be in  
4 making that operationalized in the creation of  
5 the individual measures, and I think we'll see  
6 some of that in the discussion today.

7 I would echo the focus on safety. And  
8 in particular what I didn't see is a focus on  
9 measures that improve transition, the safety of  
10 transitional care, which is a big area in our  
11 need in our whole system.

12 I also wanted to pick up on Nikolas'  
13 comment about provider engagement as that's sort  
14 of fundamental to everything we're trying to  
15 achieve for patients, and in particular your  
16 focus on trying to improve or increase time for  
17 clinicians and patients together. So I wanted to  
18 ask if there had been thought in the eCQM work  
19 about measures that actually improve the  
20 useability of EHRs and safety of EHRs.

21 MS. SCHREIBER: So I just want to  
22 thank you for that comment. In the promoting

1 interoperability piece of the IPPS rule that went  
2 out this past year, we actually had very specific  
3 RFI around that that was put in there for a very  
4 specific reason, exactly what you're talking  
5 about. And I was surprised we got very little  
6 comment back, because I think that that's  
7 important.

8           So I would just encourage people to  
9 comment to us on that, because even -- we even  
10 asked a question of should people be reviewing  
11 the safer guidelines that are out there, things  
12 like that, because as we use more and more EHRs  
13 we have to make sure that we're safely using EHRs  
14 and that we're promoting usability of the EHRs.

15           So thank you for the comment. We  
16 actually did ask it specifically in an RFI, so we  
17 will be continuing that train of thought.

18           CO-CHAIR MORRISON: Linda?

19           MS. SCHREIBER: I say that because I  
20 wrote that part.

21           MEMBER VAN ALLEN: Yes, thanks. I  
22 actually want to build on something that Lisa

1       said around patients don't understand the  
2       language we use, and that is that these measures  
3       need to be more transparent and available to the  
4       patients because -- for example, in case  
5       management many times we're sharing metrics and  
6       information when patients are trying to make a  
7       post-acute provider choice, but we're having to  
8       do a lot of education on that. They're not so --  
9       they don't really understand what the measures  
10      mean, et cetera.

11               And so I'm sure for hospitals, when  
12      they're looking at hospitals, they have no idea  
13      what's going on with these measures. They --  
14      it's a rare patient that will go, frankly, to the  
15      compare sites. I think it's the hospitals are --  
16      the providers are going to the compare sites to  
17      see how they stack up, but patients -- I don't  
18      know, maybe you have data that says differently,  
19      but our experience is that patients are unaware.

20               So is there a way to push the data and  
21      make it more public to the patient and the user  
22      and to frame it in a way that makes sense to a

1 patient versus the way it makes sense to us?

2 CO-CHAIR MORRISON: Akin, is that your  
3 card?

4 MEMBER DEMEHIN: Sorry.

5 CO-CHAIR MORRISON: It is? Okay. Go  
6 ahead.

7 MEMBER DEMEHIN: On a kind of slightly  
8 different track just looking back again at the  
9 list of priority areas, we certainly agree with  
10 the notion of having better measures around the  
11 appropriate use of opioids. One of the points  
12 that you made earlier I think is a really  
13 important one, and that is understandably the  
14 opioid crisis is consuming a lot of attention  
15 just given the gravity of the crisis. There is a  
16 much broader need for good measures of behavioral  
17 healthcare writ large that go well beyond just  
18 opioid use. So as you continue to explore  
19 measures in that area, I would strongly encourage  
20 you to broaden your lens just a little bit on  
21 that.

22 And to the point that Linda just made,

1       it is certainly a challenge to figure out exactly  
2       how to make the data that are transparent  
3       understandable and accessible to patients.  
4       That's part of the crux of the ongoing  
5       conversations I know we've had around hospital  
6       star ratings, but that sort of translation and  
7       making sure that patients are engaged and  
8       involved and how we make that translation, I  
9       think that's part of the value of the group that  
10      the NQF convened to give input on that is to  
11      really make sure that everybody around the table  
12      has an opportunity to help shape how that  
13      information gets displayed.

14                   CO-CHAIR MORRISON: I've got Brock,  
15      Andreea and then I'm going to give Cristie a  
16      word.

17                   MEMBER SLABACH: Thank you, Sean.

18                   And thank, Michelle. I always get a  
19      little nervous when my head shakes in agreement  
20      with CMS --

21                   (Laughter.)

22                   MEMBER SLABACH: I -- really I was

1     able to hear the -- some of this presentation  
2     yesterday and now today. It's been really good  
3     to get an update on some of your priorities, so  
4     thank you.

5             From our perspective, having worked on  
6     the Rural Measures Application Partnership  
7     Project since 2015, one of the key areas of our  
8     concern that hasn't been expressed in the  
9     materials yet is access to care, and how we  
10    develop measures and put them into use that  
11    measure how distance to care and transportation  
12    needs are critical to be able to secure  
13    healthcare in a timely and effective fashion.

14            I will refer to you in 2018, December,  
15    a year ago, our workgroup here at NQF published a  
16    very nice composite summary of the access to care  
17    issues. So I would refer that to you. I think  
18    it would be very helpful background on the topic  
19    without me talking all day about it. But I think  
20    that's an important area as we have hospitals  
21    closing and -- 119 so far since 2010.

22            And then talking about maternal

1 morbidity and mortality, we've had over 200  
2 maternal delivery sites close in rural  
3 communities all over the United States since the  
4 year 2000. So these are really important issues  
5 that I think have to be addressed and needs to be  
6 incorporated somehow into our measurement  
7 systems.

8 CO-CHAIR MORRISON: Andreea?

9 MEMBER BALAN-COHEN: First of all  
10 thank you for the comments and for sharing the  
11 views. I just wanted to make a couple of  
12 comments. First of all, the priority areas.  
13 Like I wanted to echo the sentiments around like  
14 patient safety and its importance.

15 In addition to that, I also wanted to  
16 bring to your attention like in terms of maternal  
17 mortality and morbidity, I do think that that's  
18 really important and it's really something that  
19 it's like striking in a global context like  
20 across like the U.S. It's something that we  
21 really should be doing more towards. So I really  
22 wanted to put that like high on your list like in

1 terms of like priorities.

2 In terms of gaps I wanted to build a  
3 little bit on what Jack mentioned earlier and  
4 maybe give a little bit more thought around like  
5 low-value care, like more generally. We do have  
6 now a lot of evidence in terms of like certain  
7 procedures and other things that are lower-value  
8 care and like building towards and developing  
9 some measures and really capturing that. I think  
10 that would really help like both in terms of  
11 focusing a little bit outcomes and potentially on  
12 the cost side as well since I know that that's  
13 one of your areas as well.

14 I also wanted to echo like the  
15 sentiment around like moving more towards like  
16 eCQMs, and certainly like building up on what  
17 Lindsey said earlier, the standards will change,  
18 especially as we focus more towards electronic  
19 data systems, but along with that I think that  
20 there is some work that needs to be done and  
21 maybe even started thinking -- and that's maybe  
22 also for NQF as well, right? I mean the way we

1 test eQMs and the we're going to do that in our  
2 electronic data system, especially if we start  
3 talking about developing measures and focusing on  
4 AI and other advanced analytic methods, are going  
5 to be different. So just beginning to do some of  
6 -- laying some of the groundwork for that to get  
7 there when we get there I think would be  
8 important as well.

9 CO-CHAIR MORRISON: Cristie?

10 CO-CHAIR UPSHAW TRAVIS: You can tell  
11 I've been on the committee too long.

12 Well, just a couple of comments. One,  
13 I think care -- where care is being delivered is  
14 changing and there's a significant movement out  
15 of the hospital into the ambulatory setting. I  
16 will use surgical procedures as kind of the  
17 obvious movement that is happening. So as much  
18 as I think it's important that we think about a  
19 parsimonious measure set, I think it's also  
20 important to think about where are the trends  
21 taking healthcare and where it's being delivered.  
22 And we may need -- in fact, I would suggest we do

1 need to be measuring how that change is  
2 happening. and so just thinking about ambulatory  
3 surgical centers especially and hospital  
4 outpatient surgical.

5 And those are somewhat complicated to  
6 measure, but at the same time if care is moving  
7 that direction, we need I think to be prepared  
8 ahead of time to be able to say is it being  
9 appropriately moved and are we getting better  
10 outcomes, not just less expensive. And I'm  
11 always looking at cost, but we want to be sure  
12 that we've got the cost and the quality measures.

13 The other -- another piece that's kind  
14 of hit me ask we've talked is really looking at  
15 system change versus individual measures, and  
16 I've kind of used the safety -- the patient  
17 safety composite as an example. And really at  
18 NQF we've been talking about measure sets and  
19 measure systems.

20 I think the reason we have 19  
21 priorities; and within those 19 priorities  
22 there's lots of measures, is because we're

1 attacking pieces of the system versus thinking  
2 about the system as a whole. And I believe that  
3 we will never get to that latter part by only  
4 addressing top three individual measures. And so  
5 obviously the payment system is one big payment  
6 -- big system change and then a measurement  
7 system that goes along with a payment system that  
8 would probably I would suggest be more like the  
9 measure set or the measure system level.

10 And certainly from the private  
11 purchasers' standpoint they have a lot of the  
12 same interests that patients have, which is to  
13 get an overall view, not necessarily down at an  
14 individual measure view, because that's how  
15 they're making decisions on what health plans to  
16 offer is, and they don't know exactly what their  
17 employees and their families are going to be  
18 going and accessing the system for. So you  
19 really want to look at the system view in order  
20 to understand where you want to go.

21 And the only other question, the only  
22 other thought I have, and it may be because I'm

1 not as engaged in this, but what we hear and from  
2 -- in the private purchaser standpoint is that  
3 moving toward electronic is obviously something  
4 we support, but that there seem to be barriers in  
5 the marketplace for that. And nobody's mentioned  
6 it, so I don't know whether I'm just not  
7 understanding the situation, but there's  
8 difficulty with the different vendors.

9 And I don't know if we're  
10 appropriately or adequately engaging the vendors.  
11 Maybe we're trying to go through the hospitals to  
12 put pressure on their vendors, but sometimes  
13 that's a chicken or the egg. So that would just  
14 be the other piece that I would add there.

15 And then my final piece is to echo  
16 what's been said about mental health and actually  
17 behavioral health for both mental health and  
18 substance use disorder. The system is broken. I  
19 can't imagine that it's not broken for the CMS  
20 beneficiaries as much as it's broken for  
21 everybody else in this country.

22 And really taking a hard look at where

1 the system is broken and what we can do to try to  
2 have a short-term strategy as well as a long-term  
3 strategy, measurement-based care does not exist  
4 in behavioral health. And I think that this is  
5 something that I know we're focusing on with the  
6 business coalitions across the country right now,  
7 thinking about how we can address these problems  
8 in our regional markets.

9 And so I'll be glad to share with you  
10 all some of the information that we've pulled  
11 together because we've actually measured through  
12 the National Alliance of Healthcare Purchaser  
13 Coalitions -- we've actually gone out and  
14 measured health plan performance around some of  
15 this and it highlights where the issues are.

16 And so I really think we have to do  
17 that. And opioids is a component of that, but  
18 it's broader as everybody else is concerned.

19 CO-CHAIR MORRISON: So I've got five  
20 more minutes devoted to this session, guys. And  
21 as typically happens all the cards go up at that  
22 time.

1 (Laughter.)

2 CO-CHAIR MORRISON: So I'm going to  
3 try and take the cards on the table that are up  
4 now because I was told my number one job is to  
5 get people out on time.

6 (Laughter.)

7 CO-CHAIR MORRISON: So I would ask  
8 people to be succinct, and if it's already been  
9 said, it doesn't need to be said again.

10 That being said, we're starting with  
11 Sarah.

12 MEMBER NOLAN: Well, I'll be very  
13 succinct and echo what I think some people have  
14 expressed, which is a concern for large -- for  
15 sort of systemic questions. And the one thing  
16 that I don't think has been said is one part of  
17 the system that I think needs paying attention to  
18 is the workforce. That's particularly true in  
19 the case of nursing homes, but not only, where it  
20 seems to be impossible to address safety without  
21 considering the low wages nursing home workers --  
22 and frankly, a workforce shortage due to those

1 low wages, lack of access to training, lack of  
2 certain -- a possibility for developing that  
3 workforce, lack of staff, staffing standards.  
4 And I would just note that some other NQF  
5 workgroups; the one a couple years ago on long-  
6 term care, did include in developing measures,  
7 workforce-related measures.

8 CO-CHAIR MORRISON: Lisa?

9 MEMBER MCGIFFERT: I just wanted to  
10 address the issue that was brought up about how  
11 to get to the public better, and I think with the  
12 hospital compare; I think someone talked about  
13 people don't use it, I think that it's too big  
14 and people want to hear about their local  
15 situation. So if there was some way that CMS  
16 could break it down even by state, I think that  
17 would be something. Or be sure that state media  
18 gets a hold of when they'll update it so they can  
19 talk about the local issues. And in large cities  
20 like New York and San Francisco that is so  
21 important. They don't -- they just have to sift  
22 through so much to see how they compare to

1 others.

2 CO-CHAIR MORRISON: Dan?

3 MEMBER POLLOCK: Very quickly,  
4 patient-generated health data. Be it functional  
5 outcomes, be it ASCs, ambulatory surgery centers,  
6 in the patient's home who've got complications,  
7 be it hospitals where post-surgical care is  
8 frequently on the outpatient side more so than  
9 ever, we have devices that patients are using  
10 every day to communicate with practitioners where  
11 they're reporting changes in functional status or  
12 complications.

13 But unfortunately much of that data is  
14 getting sequestered on smart phones and tablets.  
15 It's not making its way into a shared record  
16 keeping space. I think we need more coherent and  
17 consequential policy incentives to bring the data  
18 from the smart phone and the tablet into the  
19 mainstream electronic health record resource so  
20 that it's available for quality measurement.

21 CO-CHAIR MORRISON: Anna?

22 MEMBER DOPP: Thank you. I always

1 appreciate the update that you provide. And I  
2 have been reflecting back two years ago when we  
3 heard about the meaningful measure framework and  
4 wondering at the time how you were going to get  
5 all the measures to start the margin line with  
6 those, and it's nice to see how they're there and  
7 starting to line up. And also thinking about  
8 the shift now from Triple Aim to the Quadruple  
9 Aim mentioned this on the workforce side.

10 I'm hesitant to throw in one more  
11 priority because it's been expressed that  
12 priorities should be singular and not plural, but  
13 thinking about provider burnout and well-being  
14 resilience, and especially now that the National  
15 Academy of Medicine released their consensus  
16 study, and there's also a newly formed working  
17 group that's looking at organizational best  
18 practices and measurement, I'll tell you that  
19 within that working group the very first thing  
20 we're thinking about are what are the unintended  
21 consequences of measurement within well-being  
22 resilience, but just to encourage CMS to keep

1       that dialog and listening ear to that work as it  
2       progresses and seeing how it might fit into this  
3       as well.

4                   CO-CHAIR MORRISON:   Frank?

5                   MEMBER GHINASSI:   Thank you very much.

6                   Thanks for the update on the  
7       priorities.   I really appreciate it.

8                   Just two quick points:   One, I want to  
9       reinforce the importance of innovation.   I think  
10      that's really critical for creating a safer and  
11      more effective environment.

12                   I think I also want to point out that  
13      anything CMS can do to help in reducing the  
14      barriers to innovation -- two things that jump  
15      out are, number one -- three actually -- number  
16      one, licensure itself; I realize it's a state-  
17      related issue, limits the ability to do  
18      innovative care.   An example:   We talked about  
19      mental health needs and you talk about managing  
20      chronic care.

21                   It's very, very clear that integrating  
22      behavioral health into physical healthcare,

1 primary and pediatric and all other areas, would  
2 help enormously in that area, and yet there are  
3 payment and licensure barriers that make that  
4 almost impossible to do without grants. And  
5 that's got to change, number one.

6 Number two, we should be thinking  
7 about expanding payment structures to allow for  
8 coordination of care efforts that meet patients  
9 where they want to be met, which includes smart  
10 phones, FaceTime, all the things that they do.  
11 And there needs to be ways for that to be  
12 reimbursable activity which right now it's not.

13 And then the second one is a related  
14 issue. Cristie mentioned system coordination  
15 before and I really laud the focus on 30-day  
16 readmissions. I realize that people coming back  
17 into the hospital is not what we want to see. I  
18 also laud 7 and 30-day follow ups. But we are  
19 focusing on one part of a complex inter-digitated  
20 system where senders have to have receivers.

21 And when you look at metropolitan  
22 areas or you look at frontier areas or rural

1 areas, a lot of work can be done to connect  
2 people to care, but if that care is simply not  
3 available, locking systems into a measurement  
4 system that says 7 and 30 is the target when the  
5 reality of a community, city, region might be 30  
6 days is the reality.

7 So I think if we're going to be  
8 measuring the sender, can we coordinate  
9 measurement and expectations on the receivers as  
10 well? Just a thought.

11 CO-CHAIR MORRISON: Marty?

12 MEMBER HATLIE: I don't think I've  
13 heard this mentioned, but a continuing challenge  
14 and gap is measuring the cost of poor-quality  
15 born by families, and in the behavioral health  
16 area it was Cristie's comments that really  
17 triggered it for me. It's just financially  
18 devastating to have a family member that you're  
19 taking care of because the systems just don't  
20 exist. So as we think about value, we've got to  
21 be thinking about all those costs that don't get  
22 built into our formulations about value. And

1       it's not just families. It's the social  
2       networks, it's the schools, it's the law  
3       enforcement mechanisms that really absorb a lot  
4       of the costs of us not having a system in place  
5       there. So please pay attention to the costs of  
6       patients and families, too.

7                   CO-CHAIR MORRISON: Anybody have a  
8       last dying point they have to get in?

9                   (Laughter.)

10                   (Simultaneous speaking.)

11                   MEMBER MCGIFFERT: I have one. I'm  
12       just going to say one thing. Medical implants.  
13       We need something, some kind of measures on that.  
14       That's all I'm going to say.

15                   (Laughter.)

16                   (Simultaneous speaking.)

17                   MEMBER MCGIFFERT: There's nothing  
18       going on with that.

19                   CO-CHAIR MORRISON: Michelle, Reena,  
20       you opened this up.

21                   (Laughter.)

22                   CO-CHAIR MORRISON: I hope you got

1        what you needed from the group. I just -- I want  
2        to take chair's prerogative, take my hat off and  
3        just one quick comment, if I could. And I'm not  
4        sure what the gap is, but there's a gap, which is  
5        we've been working really hard for over a decade  
6        on value-based care and I think that we've made a  
7        tremendous amount of strides on the numerator in  
8        terms of quality. And I think that should be  
9        stated, I mean that there really has been  
10       improvement. And we're kind of working on the  
11       cost a little bit, I get that.

12                    But every year Dan's group puts out  
13       the life expectancy numbers, and despite all of  
14       that our life expectancy is going down. So  
15       somewhere there is a big gap. And I can't  
16       believe that after 10 years of really working on  
17       this we haven't made improvements. So somewhere  
18       there's a gap in terms of our nation's health.  
19       And I think we need to step back from a very big  
20       picture and think about what is it that we're not  
21       addressing, because the big numbers are going in  
22       the wrong direction.

1                   And I don't -- that's not your job.  
2           As I put my academic research hat on, that's my  
3           job, but I think we really need to begin to shine  
4           a light on that because we are missing something,  
5           and it's a big gap.

6                   MS. SCHREIBER:   Sure.   I agree.   So I  
7           may take a moment to first of all express thanks  
8           on the part of CMS and us in particular  
9           personally.   These conversations are really  
10          important and they will help us shape as we move  
11          forward what Meaningful Measures 2.0 looks like.  
12          So thank you and thank you for the opportunity to  
13          do this today.

14                   CO-CHAIR MORRISON:   Thank you, guys.  
15                   All right.   Sam, I think the ball is  
16          in your court now, is that right?

17                   MR. STOLPE:   Very good.   Thank you.

18                   This next portion of our agenda will  
19          be reviewing our processes and procedures before  
20          we move into discussions of each of the  
21          individual measures.

22                   Just to make sure that we have a

1 general overview of how we're going to be  
2 proceeding, undoubtedly there will be some  
3 questions about this process which staff are  
4 making themselves available during this time for  
5 you to ask and gain some clarity.

6 Just as a general overview of the  
7 approach, we conduct our MAP voting sessions  
8 through a three-step process. First, we provide  
9 an overview of the programming question that  
10 gives a general outline of the structure and of  
11 incentives of the quality measures, et cetera,  
12 for the program itself.

13 And next we jump into those quality  
14 measures just briefly so that you can understand  
15 the context of the measures that we are going to  
16 be considering. For each measure we want to  
17 evaluate, which is this last step, the extent to  
18 which the measures under consideration fit in and  
19 are appropriate for the program under  
20 consideration. So this is the application  
21 portion of the Measure Applications Partnership.

22 Let's go to the next slide, please.

1       So the evaluation of the measures under  
2       consideration will be asking each measure to  
3       receive a formal recommendation from the  
4       workgroup. We have standardized decision  
5       categories, which I will be reviewing with you  
6       briefly in a moment, and each decision will be  
7       accompanied by a statement, which we'll craft,  
8       that outlines the rationale for why we have  
9       arrived at the decision that we did.

10               We'll also capture the event that we  
11       have strong dissenting opinions, those opinions  
12       as well. Those will go into our final report as  
13       well as a structured field of rationale for each  
14       of the measures, which we will pass on for our  
15       colleagues at CMS, as well as to the MAP  
16       Coordinating Committee, which they will consider  
17       at their in-person meeting in the middle of  
18       January.

19               We do want to note that we have heard  
20       your feedback from last year about that  
21       dissenting opinion and we'll make sure that that  
22       is highlighted and if in the event that we have

1       -- well, we're getting pretty close to the votes.

2               Related to the preliminary analyses,  
3       you'll note inside of your meeting materials that  
4       staff has conducted a preliminary analysis for  
5       each measure under consideration. Now we've  
6       developed -- as the Measure Applications  
7       Partnership we've developed together the criteria  
8       and algorithm under which these preliminary  
9       analyses are conducted. This is called our  
10      measure selection criteria. The analysis is  
11      meant to offer you simply a starting point for  
12      the discussion. It's a succinct profile of the  
13      measures and is not in any way intended to  
14      override the committee's discussion. In fact  
15      it's just the very starting point for you make  
16      your considerations and share your insights.

17              Next slide. So let's go ahead and jump  
18      into the action analysis algorithm itself. So  
19      there are seven total steps inside of the  
20      preliminary analysis. The first is assessing  
21      whether the measure addresses a critical quality  
22      objective not adequately addressed by the

1 measures in the program set. If the answer to  
2 that question is yes, the review continues. If  
3 no, then the measure will receive a do not  
4 support.

5 The same holds true for the second  
6 criteria. The measure is evidence-based. It is  
7 either strongly links to outcomes or an outcomes  
8 measure. What we're looking for here is for  
9 process and structural measures, that there's  
10 adequate evidence to suggest that a desirable  
11 outcome is connected directly through empirical  
12 evidence to the structure or process under  
13 consideration.

14 For outcome measures we have a little  
15 bit of a different consideration; namely, we  
16 assume that the outcome itself is desirable and  
17 that there is some evidence base for a process,  
18 structure, intervention or service that a  
19 provider could implement to address that outcome.  
20 Obviously we would not be interested in measures  
21 around outcomes that are not actionable on the  
22 side of the provider who's being held accountable

1 to the measure.

2           Next up our third criteria. The  
3 measure addresses a quality challenge. And what  
4 we mean by that is that the measure specifically  
5 addresses a topic with a performance gap or  
6 addresses a serious reportable event such as a  
7 safety event that should never happen or that the  
8 measure addresses unwanted or significant  
9 variation in care that is evidence of a quality  
10 challenge. And as with the other two, in the  
11 event -- the criteria before this the event --  
12 the answer to this is yes, that the measure does  
13 address the quality challenge, the measure  
14 continues. If not, the measure receives a do not  
15 support designation.

16           So our fourth assessment criteria is  
17 that the measure contributes to efficient use of  
18 measurement resources and/or supports alignment  
19 of measurement across programs. I feel like this  
20 is pretty self-explanatory for what we mean by  
21 that, that what we're looking at is that measures  
22 are not duplicative and they capture a broad

1 population and they contribute to this alignment  
2 across programs and that there's demonstrated  
3 value to both patients and consumers that  
4 outweighs any burden associated with  
5 implementation.

6 If we say yes to this, then the review  
7 continues. If no, the highest rating for this  
8 measure is a do not support with potential for  
9 mitigation, the assumption being that a  
10 suggestion would come from that in that instance  
11 and how the measure developer could actually  
12 improve the measure for a future support  
13 categorization.

14 Next up our fifth criteria. The  
15 measure can be feasibly reported. This is just  
16 simply what it says, that a measure can be  
17 operationalized. If so, review continues. If  
18 not, again potential for mitigation with an  
19 explanation from the MAP on what could possibly  
20 be done to make it feasibly reportable.

21 Our sixth assessment criteria is that  
22 the measure be applicable and appropriately

1 specified for the program's intended care  
2 settings, level of analysis, population. This is  
3 often reflected through the NQF endorsement  
4 process. We really kick the tires on measures  
5 when they come to our consensus standards  
6 committees -- or excuse me, or consensus  
7 development process committees, the standing  
8 committees that we have to evaluate the -- for  
9 endorsement of each of the measures. They'll  
10 look very carefully at the scientific  
11 acceptability, feasibility, evidence base, et  
12 cetera, of the measure.

13 And measures that do not have this,  
14 the highest rating can be a conditional support.  
15 And then the MAP rationale would essentially  
16 explain that categorization that should go for  
17 NQF endorsement.

18 Lastly, if the measure is in current  
19 use and there's been no unreasonable  
20 implementation issues or significant negative  
21 consequences that outweigh the benefits of  
22 implementing the measure and that constitutes our

1       final -- our priority to consider and our  
2       preliminary MAP analysis.

3               Okay. Now I'll pause there just  
4       briefly to see if there's any questions about the  
5       preliminary analyses or the algorithms.

6               (No audible response.)

7               MR. STOLPE: All right. Very good.  
8       Well, let's move forward to our decision  
9       categories, and I mentioned some of these in my  
10      previous discourse, but I wanted to outline the  
11      categories themselves in some detail.

12              Our first category is support for  
13      rulemaking, and it's fairly straightforward here.  
14      It's just simply the MAP supports the  
15      implementation of the measure as it stands and  
16      that we've reviewed the preliminary analysis  
17      algorithm for categories 1 through 6, that it's  
18      met with criteria. And if it is in current use,  
19      that it meets Criteria 7 as well.

20              The conditional support for rulemaking  
21      and the do not support for rulemaking with  
22      potential for mitigation are similar, but have

1 some distinctions that are important to clarify.

2 Conditional support for rulemaking  
3 implies that the first three assessments, we  
4 checked those boxes and that it's looking good in  
5 that respect. Where a measure can potentially  
6 need some refinement but receives the support of  
7 our workgroup to move forward pending the  
8 adjustments that the -- will be contained in the  
9 rationale for this decision category, then the  
10 distinction is that the CMS may address the MAP-  
11 specified conditions without needing it to come  
12 back for evaluation by this workgroup or MAP in  
13 general.

14 With do not support for rulemaking  
15 with potential for mitigation, this generally  
16 occurs when there's actually a structural element  
17 of the measure that needs to be addressed  
18 adequately before having the full endorsement of  
19 this workgroup to move forward for implementation  
20 in the federal program under discussion. So this  
21 is typically when a measure fails to meet one of  
22 the first three criteria. And the expectation

1 would be that the decision category assumes that  
2 the other four criteria we're okay with and that  
3 should this measure be appropriate, it would be  
4 because of substantial change in how the measure  
5 itself is formulated.

6 The last decision category is fairly  
7 straightforward and it is simply that the  
8 workgroup does not support the measure for  
9 rulemaking. And again, this would typically  
10 occur because a measure substantially does not  
11 adequately address the first three evaluation  
12 criteria.

13 Next slide.

14 CO-CHAIR UPSHAW TRAVIS: Can I just  
15 make a comment on that?

16 MR. STOLPE: Please do.

17 CO-CHAIR UPSHAW TRAVIS: To me the  
18 rewording of this was very important because it  
19 clearly distinguishes between the two supports  
20 and the two do not supports. And not to rehash  
21 what we've done in the past, it was a little  
22 confusing in those two middle.

1                   So from my perspective I find this a  
2                   lot easier for me; I hope we'll see when we go  
3                   through the process, to actually distinguish  
4                   between conditional support and then do not  
5                   support for -- with potential for mitigation.  
6                   It's just a cleaner line. And I think that's  
7                   where we've had some confusion or some angst in  
8                   the past. So that's kind of how I'm going to be  
9                   focusing on it and just thought I'd share that  
10                  with you.

11                 MR. STOLPE: All right. Let's move  
12                 forward into our key voting principles. I just  
13                 want to clarify that we are at quorum, so we're  
14                 sitting in a good spot here. A quorum is defined  
15                 as having at least 66 percent of the voting  
16                 members of the committee present in person or by  
17                 phone, which we have.

18                 We also want to clarify the 66 versus  
19                 60 members. It's easy to conflate these two. So  
20                 MAP has established for our consensus threshold  
21                 greater than or equal to 60 percent. We actually  
22                 had a brush with 60 percent yesterday and had to

1 reassess whether or not that was passing, but it  
2 was -- it is indeed. So if we actually do hit 60  
3 percent, measure passes.

4 Now one of the things that makes MAP  
5 distinct from our CDP process is that every  
6 measure under consideration will receive a  
7 decision. We have sort of gray area categories  
8 inside of our CDP process. That's not true for  
9 MAP.

10 Okay. Just next slide here. We're  
11 looking at some more process-oriented elements.  
12 So staff will be providing an overview of this  
13 process at the start of each in-person meeting.  
14 Once we give an introductory presentation that  
15 gives the context of the program itself, we'll  
16 begin going through this discussion and then  
17 we'll have voting conducted.

18 So the discussion guide is organized  
19 into distinct categories based on programs for  
20 hospital and each measure under consideration  
21 will be subject to this preliminary staff  
22 analysis based on the decision algorithm that has

1       been approved by the MAP Coordinating Committee.  
2       So please know that inside of the preliminary  
3       analyses is offered the staff's recommendation  
4       based on the analysis conducted using the  
5       algorithm that was approved by the committee.

6               So for the voting procedure the first  
7       step is that the staff will walk through the  
8       preliminary analysis for each measure under  
9       consideration. Following that we'll move to the  
10      lead discussants who will review and present  
11      their findings. We have Brock here representing  
12      the Rural Workgroup who will provide a brief  
13      overview of the work -- Rural Health Workgroup's  
14      review of each of the measures. So this is a new  
15      step for this year. We did this in clinician  
16      last year, but this is the first time that  
17      hospital will have the benefit of Rural's  
18      perspective.

19              So, Brock, thank you once again for  
20      joining us.

21              Next step, the second step. The co-  
22      chairs will be asking for clarifying questions.

1 Now we're not going to answer these questions  
2 right away. We're going to compile them first.  
3 Once we have them all compiled, measure  
4 developers will respond to questions that clarify  
5 the measure itself. NQF staff are happy to  
6 clarify any questions on the workgroup decision  
7 and to talk through any parts of the PA or other  
8 questions you might have. And lead discussants  
9 will of course respond to questions related to  
10 their analyses.

11 Our third step is voting on acceptance  
12 of the preliminary analysis decision. So we  
13 don't actually vote on categories. Our first  
14 step is to vote whether or not to accept the  
15 preliminary analysis as it is written by staff.  
16 So this is simply framed as a yes/no vote. If we  
17 hit 60 percent or greater, then we keep the  
18 preliminary analysis assessment. If less than 60  
19 percent of the workgroup votes to accept the  
20 preliminary analysis, then we open for discussion  
21 on the measure further.

22 So discussion and voting as step four

1 may or may not occur, but if it does, we do not  
2 accept the preliminary analysis, then the  
3 workgroup members should participate in the  
4 discussion to make your opinions known for why  
5 you dissented with the preliminary analysis.

6 Now, after this discussion the co-  
7 chair will open up the measure under  
8 consideration for a vote. Staff will summarize  
9 the major themes from that discussion. Co-chairs  
10 will determine what decision category to put  
11 first towards a vote based on where they think  
12 we're landing as a group.

13 If the co-chairs do not feel there's  
14 a consensus position to use as the initial spot  
15 for voting, we will go first with conditional --  
16 or sorry, with support, then conditional support,  
17 then do not support with potential for  
18 mitigation, and then do not support.

19 Now, if a decision category put  
20 forward by the co-chairs receives greater than or  
21 equal to 60 percent of the vote, the motion will  
22 pass and the measure will receive that

1 designation.

2 Now, if no decision category achieves  
3 greater than 60 percent to overturn the  
4 preliminary analysis, the preliminary analysis  
5 will stand. This will be marked by staff and  
6 noted for the Coordinating Committee's  
7 consideration. Okay. So that's our voting  
8 instructions in a nutshell.

9 I want to pause here also to make sure  
10 we've answered any questions about voting  
11 procedure.

12 MR. AMIN: Sam, I might just emphasize  
13 to the group that the rationale that currently  
14 stands as a preliminary analysis, sort of  
15 qualitative feedback, all of the discussion from  
16 the group, the MAP rationale will be expanded,  
17 and that's what will go to the Coordinating  
18 Committee, and ultimately the summary of that  
19 qualitative input is what will be given to CMS,  
20 which is equally as important as voting.

21 MR. STOLPE: All right. Very good.

22 Well, if there are no further

1 questions about our process, we can go ahead and  
2 pause here.

3 Are we going straight for the break,  
4 or do we have Rural?

5 CO-CHAIR MORRISON: I think the  
6 Rural --

7 MR. STOLPE: Okay. Well, let's  
8 briefly review this. Since this is a new part of  
9 our process then for a hospital, we'd like just  
10 to remind everyone and update those of you may  
11 not be aware of our -- the existence of our MAP  
12 Rural Health Workgroup, of which we actually have  
13 more than one person in the room who's been  
14 around the table for those discussions. So  
15 thanks for everybody who's been able to join, and  
16 Brock specifically here to represent that  
17 perspective.

18 The charge of the MAP Rural Health  
19 Workgroup is to provide input on the measurements  
20 from the perspective of rural communities, both  
21 on the provider side and on the patient side, and  
22 to lend those perspectives to the discussion that

1 we have here on the other setting-specific MAP  
2 workgroups. This is specifically to help address  
3 priority rural health issues including challenges  
4 associated with low-case volume.

5 So each of the measures under  
6 consideration was reviewed by the Rural Health  
7 Workgroup. The relative priority is assigned.  
8 They do that through both qualitative and  
9 quantitative methodologies. So they vote on the  
10 prioritization of the measure itself. And the  
11 qualitative portion of that vote is captured and  
12 then an average presented as well as the actual  
13 tally for each of those.

14 You can go to the next slide. The  
15 other thing that's captured inside of this, and  
16 you'll see this inside of the PAs as well, is a  
17 succinct summary of the qualitative discussion  
18 that was held by the Rural Workgroup when they  
19 convened last week.

20 Okay. With that being said, let's go  
21 ahead and transition to a 15-minute break, and  
22 then we can reconvene in just a few moments to

1 begin our discussion around the PPS-exempt cancer  
2 hospital quality reporting measures.

3 Thanks very much.

4 (Whereupon, the above-entitled matter  
5 went off the record at 10:39 a.m. and resumed at  
6 10:57 a.m.)

7 CO-CHAIR UPSHAW TRAVIS: Okay, I think  
8 we're going to get started. Okay, so let's all kind  
9 of focus. We're going to come back now. We're going  
10 to actually start our measure review. So, the fun  
11 part of the meeting starts now. So the first program  
12 we're going to look at is the PPS-Exempt Cancer  
13 Hospital Quality Reporting Program measures. And we  
14 have two measures that we're going to be looking at,  
15 and I'm going to turn it over to Madison, to give us  
16 an overview of the program itself.

17 MS. JUNG: Great. Before we get started,  
18 I think we have one more disclosure to do. Aisha, did  
19 you want to go ahead, at least, and do --

20 MEMBER PITTMAN: Hi. I'm Aisha Pittman.  
21 I'm the Vice President of Policy for the Premier  
22 Healthcare Alliance, and I have no disclosures.

1 MS. JUNG: Great. I think we're ready to  
2 get started then. So, for the work group members  
3 around the table, this should look familiar to you.  
4 This is some of the material we went over during or  
5 orientation and web meeting in the fall, but just as  
6 a refresher, before we dive in.

7 The program we're reviewing right now is  
8 the PPS-Exempt Cancer Hospital Quality Reporting  
9 Program. It's a quality reporting program, and it's  
10 a voluntary one for the 11 cancer hospitals that are  
11 exempt from the Inpatient Perspective Payment System  
12 and the Inpatient Quality Reporting Program.

13 Some of the goals are to encourage  
14 hospitals and clinicians to improve the quality of  
15 their care, share information and to learn from each  
16 other's experiences and best practices.

17 In the meeting materials, we have included  
18 the measure set for this program, as published in the  
19 most recent rule, and --

20 Next slide.

21 Different from what you saw during the web  
22 meeting is, we've included the updates that have

1 happened since you saw this program last year. So one  
2 measure was finalized versionable and one was adopted.

3 These were also the gaps that we noted  
4 during the web meeting as noted by CMS during, within  
5 the Needs and Priorities document. I won't review  
6 them in depth, but as a reminder, some of the gaps  
7 that we discussed during the orientation fall web  
8 meeting for this program were, work group members have  
9 suggested focusing on measures for patient-reported  
10 outcomes, specifically for functional status, patient  
11 quality of life, also measures related to access to  
12 care and survival. Survival meaning, one suggestion  
13 was, do you have a survivorship plan? So that was  
14 just some of, a refresher of what we did before,  
15 during the October web meeting.

16 CO-CHAIR UPSHAW TRAVIS: Okay, so now  
17 we're going to open it up for public comment on this  
18 program, for the measures under consideration. And  
19 I'll go first to the room, if there are any public  
20 comments in the room.

21 (No response.)

22 CO-CHAIR UPSHAW TRAVIS: Okay, I don't see

1 any. And I assume that the lines are open, if anybody  
2 has any public comments that are on the phone.

3 (No response.)

4 CO-CHAIR UPSHAW TRAVIS: Okay. I don't  
5 hear any. So we will continue then. We'll move on to  
6 our evaluation of this. What we're going to do first,  
7 kind of going back over our process that we learned  
8 about right before the break is that the staff is  
9 going to review the preliminary analysis, and then  
10 while that's happening, we discuss and skip many,  
11 because we're going to turn to you next.

12 So, staff want to review the preliminary  
13 analysis for the first measure, which is MUC2019-18,  
14 NHSN Catheter-Associated Urinary Tract Infection.

15 MS. JUNG: Okay. For this measure, MUC  
16 2019, the National Healthcare Safety Network Catheter-  
17 Associated Urinary Tract Infection Outcome Measure,  
18 this measure was recommended by the staff for support  
19 for rulemaking. This is a NQF-endorsed measure, and  
20 it's currently in the PCHQR program right now, as well  
21 as several other CMS programs.

22 But of note, this measure was just, went

1 through endorsement in this last cycle, the spring  
2 2019 CDP cycle, with the Patient Safety Committee.  
3 The developer noted that there was an inclusion of our  
4 updated risk adjustment model, but otherwise that  
5 measure is identical to the existing measure in PCHQR,  
6 as well as the other programs.

7 CO-CHAIR UPSHAW TRAVIS: Okay. So, just  
8 as a clarification and to be sure we're on the same  
9 page, the previous version of this measure is in this  
10 program already, and now we have an updated and  
11 revised submission specifications, that is, has been  
12 NQF endorsed.

13 Okay, so we'll go to our lead consultant  
14 -- our lead consultants. I'm sure you all feel like  
15 you're a consultant to this committee. Maybe that's  
16 why I said it that way. We'll go first to Akin, with  
17 the American Hospital Association.

18 Oh, and -- for the people in the room and  
19 on the phone, if you can tell us which organization  
20 you're with -- I just said who Akin's with, but  
21 that'll be helpful because they'll be able to  
22 understand the perspective that you're bringing to

1 your comments.

2 So, Akin.

3 MEMBER DEMEHIN: All right, thanks. So,  
4 I won't rehash too much of this, since the measure has  
5 been in the program for quite some time.

6 First of all, I do think that as a general  
7 principal, and measures that have been in programs for  
8 some time, and they undergo an update like this one,  
9 it is good practice for the MAP to have another crack  
10 at them, just to make sure that they're working as  
11 intended, and there haven't been any unintended  
12 consequences. So thank you to CMS for putting this  
13 back on the list for us to consider.

14 A couple of technical points about the  
15 measure, and then I'll outline where I think we stand  
16 on the preliminary recommendations. So, this is a  
17 measure that has been around for a while. It assesses  
18 facility-level performance on catheter-associated  
19 UTIs.

20 From what I can tell in reviewing the  
21 measure specifications, it is not hugely different  
22 than what currently exists in the program. It is

1 still a chart extracted measure. It still is effort  
2 for hospitals to collect and report the data, using  
3 the CDC's NHSN system.

4 In terms of the staff's recommendation,  
5 which is to support this rulemaking, I think that is  
6 the right recommendation for a number of reasons.  
7 CAUTIs remain the most common of healthcare-associated  
8 infections. Hospitals are certainly working hard to  
9 reduce the rate of catheter-associated UTIs, and have  
10 made significant performance gains, as the recent  
11 reports from the CDC have shown. There is no  
12 significant performance variation, and there is still  
13 a ways to go here.

14 A couple of considerations, as CMS  
15 implements this next version of the measure. One  
16 thing that was brought up during the endorsement  
17 review that I saw was how applicable this measure  
18 would be to spinal cord injury patients. If I'm  
19 reading the concern correctly, it was that for those  
20 particular patients, leaving an indwelling catheter in  
21 could have some quality of life benefits, just because  
22 their bladder function isn't going to be the same as

1 other patients, so.

2 And I know there was a healthy debate  
3 about whether there's any evidence to support  
4 excluding them from the measure or not. I guess I  
5 would say that continuing to monitor that issue and  
6 conducting further study would be a good idea, just to  
7 be sensitive to that issue.

8 The other issue is a little more specific  
9 to PPS-exempt cancer hospitals in applying this  
10 measure. Infection measures certainly are important  
11 for that kind of hospital. I guess the sensitivity  
12 here is how you compare the rates generated from PPS-  
13 exempt cancer hospitals to other kinds of facilities.

14 Patient population treated at these  
15 hospitals tends to be much more immunocompromised then  
16 at general acute care hospitals, so constructing the  
17 performance benchmarks and comparison groups with  
18 great care, I think, is a really important thing.

19 The last thing, and we don't necessarily  
20 have to discuss it in the context of this, but these  
21 are updated versions of the CAUTI and CLABSI measures,  
22 so I do wonder when we might talk about those in the

1 context of the IQR, whether there's a benefit to it.  
2 I mean, frankly, most of the comments I would have  
3 here would be equally applicable there, but maybe just  
4 kind of a process question on when we might talk about  
5 them, so.

6 CO-CHAIR UPSHAW TRAVIS: Great. Thank  
7 you.

8 Stan, from the American Society of  
9 Anesthesiologists, I think you're on the phone.

10 MEMBER STEAD: Yes. Thank you very much.

11 I do support moving forward with this  
12 measure. I think that the issues that were just  
13 mentioned about spinal cord injury are appropriate.  
14 I don't believe that they conclude that we should be  
15 adding exclusionary criteria.

16 I will point out that in a recent JAMA's  
17 article in July of this year pointed out that the  
18 difference in urinary tract infection rate between the  
19 cancer hospitals and those that are not was actually  
20 significant. And the rate in the PPS-exempt cancer  
21 hospitals was 6.4 percent versus 4.0 percent with an  
22 odd ratio of 1.58.

1                   So it seems to me that this is an  
2                   appropriate measure, the measure. And it is an area  
3                   that there is a significant gap in care. And I think  
4                   that it's reasonable for us to move forward on this,  
5                   is that sepsis still remains one of the most different  
6                   care between the PPS-exempt hospital and those that  
7                   are not.

8                   CO-CHAIR UPSHAW TRAVIS: Thank you, Stan.  
9                   Denise, for the City of Hope.

10                  MEMBER MORSE: Yes. Denise from the City  
11                  of Hope. We're a cancer center in Southern  
12                  California. We have a lot of the same comments as  
13                  we've previously heard. It is a longstanding measure.  
14                  It has been one of the first measures of the PCHQR  
15                  program. We continue to support it.

16                  It's a useful and feasible metric, high  
17                  resource-burning, but the benefits outweigh the cost.  
18                  And there was not a lot of substantive differences  
19                  between the previously endorsed measure and this one.

20                  As was mentioned, we do support  
21                  benchmarking to like centers, the other PPS-exempt  
22                  cancer centers, and we've also discussed if there

1 would be benefit in adding additional comments  
2 regarding a standardized utilization ratio measure as  
3 well, to look at differences between the hospitals and  
4 the utilization of catheters.

5 CO-CHAIR UPSHAW TRAVIS: Thank you. And  
6 then our last lead discussant is Aisha.

7 MEMBER PITTMAN: Hey. I have the benefit  
8 of going last because I can pretty much confirm  
9 everything that we've done. In our cumulative, the  
10 focus was monitoring over time for spinal cord injury,  
11 and then ensuring that different types of hospitals  
12 are benchmarked against like hospitals.

13 CO-CHAIR UPSHAW TRAVIS: Okay. Wonderful.  
14 Well it does seem that our lead discussants anyway are  
15 in support of the preliminary analysis for this  
16 measure. But we'd like to hear from you for input  
17 from the Rural Work Group.

18 MR. SLABACH: Well thank you, Cristie.

19 This is going to be brief on this measure,  
20 since the 11 cancer hospitals are located in urban  
21 areas. This is not a large concern to our rural  
22 providers. However, obviously a lot of our patients

1 in rural communities go to urban centers for cancer  
2 care, and these are big and important safety measures.

3 I think the Rural MAP was in consensus  
4 that this was important and would be good to consider  
5 for approval.

6 CO-CHAIR UPSHAW TRAVIS: Okay, wonderful.  
7 Well thank you. Thank you for that.

8 We're going to move into our time right  
9 now for clarifying questions. I'm -- and I'll kind of  
10 emphasize clarifying questions. And we will -- after  
11 we get the clarifying questions, we will go to those  
12 who are most appropriate to answer those questions.  
13 And then we will have time for discussion prior to our  
14 first vote.

15 So does anybody have any clarifying  
16 questions either for the measure developers, for the  
17 lead discussants, for NQF staff or others? And I'll  
18 start with Jack.

19 MEMBER JORDAN: Is there actually an  
20 existing SIR model for cancer hospitals that they  
21 would be using?

22 MEMBER POLLOCK: Yes. So, thank you,

1 Jack. There is -- I'm Dan Pollock. I was sitting  
2 over there before. I've moved over here to --

3 (Laughter.)

4 MEMBER POLLOCK: So, I lead the unit  
5 that's responsible for this, a healthcare safety  
6 network at CDC. We have a model, a predictive model  
7 for hospital CAUTIs that was developed in 2016 using  
8 2015 incidence data. We've been collecting data from  
9 cancer hospitals and cancer patient care locations for  
10 years.

11 Our strategy has been to try to use the  
12 full component of the data that we have, and take a  
13 cancer hospital's status and cancer patient location  
14 into account in the predictive model, which we do.

15 And so, it's a single model that we can  
16 use, both for cancer hospitals and for non-cancer  
17 acute care hospitals. And so that's what we have.  
18 And what is described as an update to the measure is  
19 really a use of a model, a predictive model that we've  
20 had in use since 2016, extending it to the cancer,  
21 PPS-exempt cancer hospitals.

22 In lieu of reporting rates, now we will

1 report a ratio of the observed to predicted number of  
2 infections in those hospitals, CAUTIs as well as  
3 CLABSIs.

4 CO-CHAIR UPSHAW TRAVIS: Okay. Wait.  
5 That was somebody else. That was yours?

6 MEMBER STEAD: I asked a --

7 CO-CHAIR UPSHAW TRAVIS: Yes. And please  
8 state your name and organization for the people in the  
9 room.

10 MEMBER STEAD: Thank you. My name is Stan  
11 Stead. I'm with the American Society of  
12 Anesthesiologists.

13 In the new way of reporting this, are you  
14 going to report the PPS-exempt cancer centers with  
15 other NPI-designated cancer centers in addition, so  
16 that we'll actually have that second data point? Or  
17 are these simply going to be a ratio of the PPS-exempt  
18 cancer centers against all other hospitals that  
19 provide cancer care?

20 MEMBER POLLOCK: So, I think the short  
21 answer to your question is, our coverage, and what we  
22 report on half of hospitals to CMS includes both PPS-

1 exempt cancer hospitals as well as non-PPS-exempt  
2 cancer hospitals. So we provide facility-level data  
3 to CMS for various quality measure and reporting  
4 programs on the CMS side, facility by facility, at the  
5 CMS certification number, CCN level.

6 CO-CHAIR UPSHAW TRAVIS: So as a --  
7 obviously we're not following the format, but I'll ask  
8 a follow-up question to that, actually.

9 So, in terms of how CMS is thinking about  
10 reporting this, is there any -- and we've all thought  
11 through how you will be reporting this information.  
12 Will it be compared only with other PPS-exempt, or  
13 will it be compared with all hospitals?

14 MS. EVANS: Well if I could take one, this  
15 is Ronique Evans again. So yeah, it'll be our compare  
16 to other PPS-exempt cancer hospitals, but of course,  
17 CMS is always open to a discussion about how we can  
18 improve reporting mechanisms, going forward, so -- but  
19 as of now, yes. It's --

20 CO-CHAIR UPSHAW TRAVIS: Just to the other  
21 PPS-exempt --

22 PARTICIPANT: Explicit to this program,

1 and it will be compared within this program.

2 CO-CHAIR UPSHAW TRAVIS: Okay, good.

3 Okay.

4 Any other questions? Any other final  
5 comments from the developer or anybody? CDC? Okay.

6 All right, so I think that we can move on  
7 to our first vote, which is relative to whether or not  
8 we accept the preliminary analysis, which was support  
9 for rulemaking. And this will also be our way to test  
10 the voting system, to be sure that we all know how to  
11 vote correctly. And so I'm going to turn it over to  
12 staff to kind of walk us through what we're supposed  
13 to do.

14 MR. HIRSCH: All right. Voting for MUC  
15 2019-18, the National Healthcare Safety Network  
16 Catheter-Associated Urinary Tract Infection Outcome  
17 Measure. Do you vote to support the preliminary  
18 analysis as the more correct nation, which is support  
19 for rulemaking? It's now open for voting.

20 PARTICIPANT: Oh, I see. I was looking  
21 over there.

22 (Laughter.)

1 MS. JUNG: I think we're looking for two  
2 more votes, so if everyone could just double check.  
3 Our colleagues on the phone, please let us know if  
4 you're having any issues with the platform. And if  
5 you are, please feel free to chat your vote to us via  
6 email or the web platform.

7 CO-CHAIR UPSHAW TRAVIS: And just to be  
8 sure, all we have to do is click.

9 MS. JUNG: Yes. That is correct. Yes.

10 CO-CHAIR UPSHAW TRAVIS: There's no Submit  
11 button?

12 MS. JUNG: Correct.

13 CO-CHAIR UPSHAW TRAVIS: Okay.

14 MR. HIRSCH: Anna?

15 MEMBER DOPP: Mine is spinning at the  
16 moment, so I'm good.

17 MR. HIRSCH: Ah.

18 MEMBER DOPP: I'm the one you're looking  
19 for. I was logged in, but it's --

20 MR. STOLPE: Do you wish to give your vote  
21 verbally? You may if you wish. Or you can chat your  
22 vote.

1 CO-CHAIR UPSHAW TRAVIS: Or you can  
2 whisper it to --

3 MR. STOLPE: Or you can whisper your vote.

4 (Laughter.)

5 MEMBER DOPP: If it's --

6 (Simultaneous speaking.)

7 (Laughter.)

8 MR. HIRSCH: Voting confirmed, MUC2019-18,  
9 the National Healthcare Safety Network Catheter-  
10 Associated Urinary Tract Infection Outcome Measure is  
11 now closed. The workgroup has voted 24 to yes, one  
12 no, in supporting, support for rulemaking based on the  
13 preliminary analysis. Our recommendation.

14 MR. STOLPE: Thank you.

15 CO-CHAIR UPSHAW TRAVIS: Okay. Thank you,  
16 for that.

17 So we will move on now to MUC2019-19,  
18 which is the National Healthcare Safety Network  
19 Central Line-Associated Bloodstream Infection Outcome  
20 Measure. And you will note that there are some  
21 similarities, although obviously a different measure,  
22 some similarities to the one that we just voted on.

1           So I will turn it over to Madison, to go  
2 over the preliminary analysis.

3           MS. JUNG: Thank you.

4           So this measure, similar to the previous  
5 measure, just recently went through NQF endorsement in  
6 the past spring 2019 cycle. It was recommended for  
7 endorsement by the Patient Safety Standing Committee.  
8 And again, similar to the previous measure, it is  
9 otherwise identical to the existing measure, but with  
10 the inclusion of an updated risk adjustment model.

11           The NQF Staff preliminary recommendation  
12 for this is support for rulemaking.

13           CO-CHAIR UPSHAW TRAVIS: Okay. So I will  
14 come back to Brock, for any comments related to this  
15 particular measure from the Rural Work Group.

16           MR. SLABACH: At the risk of being  
17 repetitive I'll just say ditto on the last --

18           (Laughter.)

19           MR. SLABACH: This is the same issue, but  
20 it, we would favor this adoption.

21           CO-CHAIR UPSHAW TRAVIS: Okay. Thank you,  
22 Brock.

1 MR. SLABACH: You're welcome.

2 CO-CHAIR UPSHAW TRAVIS: All right. We'll  
3 move to our lead discussants, and we have a different  
4 set of lead discussants this time, so we'll start with  
5 Maryellen from America's Essential Hospitals.

6 MEMBER GUINAN: I will keep this brief,  
7 mainly because I don't want to start coughing. And  
8 I'm pretty sure that's why Dan moved, or --

9 (Laughter.)

10 MEMBER GUINAN: But, so at the outset, I  
11 want to say this is the, as we said before, with  
12 CAUTI, CLABSI is a process measure in multiple  
13 programs, IQR, VBP, HAC. Definitely support its use  
14 for both the fact that CLABSI has significant risk of  
15 morbidity and mortality as well as just increased  
16 cost. So we would support the preliminary result from  
17 NQF in terms of support for rulemaking.

18 Another thing that I just wanted to, for  
19 my own edification but clarity of, kind of, from the  
20 developer side, I know we've seen -- as it was  
21 reported, there was a 10 percent decrease that was  
22 reported from 2015-16, and it looks like now we're

1 kind of going down in terms of our -- a 9 percent  
2 decrease.

3 So I don't know if that's indicative of,  
4 this is kind of becoming more of a gap area, or what  
5 the trending going down in terms of our success with  
6 this measure would be a result of, but something  
7 definitely to monitor.

8 And then my other kind of comment,  
9 question is, in terms of CDC exploring different ways  
10 to incorporate other factor into the measure itself,  
11 I know it was noted that the time that a line is  
12 actually in has a significant impact in terms of  
13 infections, and whether that will be included, kind of  
14 in future measure calculations, is something that I  
15 think was of interest to us.

16 So with that, I will turn it over to my  
17 other lead discussants.

18 CO-CHAIR UPSHAW TRAVIS: Well thank you  
19 very much, and we'll come back and get some answers to  
20 some of those questions in a moment.

21 Jack, from the Henry Ford Health System.

22 MEMBER JORDAN: Yes. The group of us kind

1 of huddled, and none of us had any really serious  
2 concerns. I do think, though, in the future, to  
3 really look at this to say, are there differences in  
4 the patients other than the type of flora would be a  
5 good thing for moving forward.

6 I don't think that should hold it back and  
7 wait here, but I do think for the CDC to start to look  
8 at, are there different types of cancers or types of  
9 treatments that give you wildly different expected  
10 rates is something that should be kind of considered  
11 to look at in the future. But I don't think it's a  
12 reason to not go forward now. I think we should start  
13 with this, but then think about that as a possible  
14 enhancement in the future for more understanding.

15 CO-CHAIR UPSHAW TRAVIS: Thank you, Jack.

16 Karen, with Medtronic.

17 MEMBER SHEHADE: Karen Shehade with  
18 Medtronic, and again, we all are in agreement with  
19 this measure and appreciate the overview, the measure  
20 itself. I will just call out that it definitely  
21 aligns with patient safety. And it does look at the  
22 observed versus predicted, so it's not looking to get

1 to exact from zero but, you know, is somewhat, you  
2 know, focused on trying to move the needle.

3 As a longstanding PA, I will say that this  
4 is something that you can actually take action on, so  
5 it is something that has real steps that you can work  
6 towards as a clinician to see improvements, and was  
7 actually called out in here by the AHRQ Toolkit so,  
8 you know, in response to anyone who might think that  
9 there's not anything you can do to move the needle,  
10 there are, you know, very real things that we can do,  
11 real steps. So I think that's what makes it very  
12 valuable.

13 CO-CHAIR UPSHAW TRAVIS: Thank you.

14 So, now we will -- oh, I'm sorry, Andrea.  
15 That's why you have a co-chair.

16 (Laughter.)

17 CO-CHAIR UPSHAW TRAVIS: Andrea, thank  
18 you.

19 MEMBER BALAN-COHEN: So as a subject  
20 matter expert, so I just wanted to say, again like we  
21 discussed, it's like preliminarily, definitely like no  
22 because there is an accepted way, like more like from

1 a technical standpoint. But I did appreciate, like  
2 the move to the center using like the centralizing  
3 conduction ratio, like moving further away, and  
4 looking like the predicted one, as well as the  
5 updating of the model, like using the latest possible  
6 data.

7 2015 is still like 2015, so to the extent  
8 like possible, like continue to move forward within  
9 the direction of getting even more recent data, like  
10 more up-to-date, like update to be valuable.

11 I also wanted to highlight, I also really  
12 appreciate the use of the ARM, so the adjusted ranking  
13 metric. In this particular case, like exposure really  
14 matters. So this is essentially a way to adjust for  
15 reliability, like due to exposure. So the use of this  
16 like for this particular metric was, works very good.

17 And other than that, like definitely in  
18 favor of support for the measure.

19 CO-CHAIR UPSHAW TRAVIS: Okay now -- thank  
20 you, Andrea.

21 Now we will get any input from Brock. Or  
22 did we already do that?

1 MR. SLABACH: We already did that.

2 CO-CHAIR UPSHAW TRAVIS: I knew that.

3 (Laughter.)

4 CO-CHAIR UPSHAW TRAVIS: Not really,  
5 because I was supposed to wait until after that.

6 MR. SLABACH: That's okay.

7 CO-CHAIR UPSHAW TRAVIS: Okay. So do we  
8 have any clarifying questions? I know that we had one  
9 that we'll get to in a moment, relative to the  
10 decreases kind of slowing down, that we've seen in  
11 this measure. Are there any other clarifying  
12 questions, or any issues you'd like to have covered by  
13 the developer, or the lead discussants or NQF?

14 (No response.)

15 CO-CHAIR UPSHAW TRAVIS: Okay. I didn't  
16 know if anybody wanted to comment on that.

17 MEMBER POLLOCK: Sure, sure. So, we are  
18 making progress with CLABSIs, but there's still  
19 thousands and thousands of CLABSIs every year in  
20 American hospitals. And so we have to continue our  
21 efforts, and we think that a measurement of CLABSIs is  
22 a very important impetus for prevention. So we want

1 to double down, and certainly extending the use of the  
2 observed to predicted ratio, replacing rates in the  
3 cancer program, I think is a step forward.

4 The opportunities to prevent, as they're  
5 used, will decrease the frequency of CLABSI events,  
6 and we are exploring now the use of another metric,  
7 the time between events metric. So much as you might  
8 see at an industrial site, the time since the last  
9 accident, that type of strategy and quantitative  
10 approach is one that we think has the potential value  
11 as CLABSIs continue to decrease.

12 We also are proponents of taking the  
13 volume of exposure into account, through a metric  
14 called the adjusted ranking metric. We think that  
15 volume of exposure should be taken into account when  
16 facilities are ranked. And it's part of our NQF  
17 measure that was re-endorsed this year.

18 In terms of capturing patient-level data  
19 for risk adjustment purposes, we would love to. We  
20 would love to be able to gather additional data for  
21 risk adjustment purposes, for purposes of having a  
22 more complete understanding of the events themselves.

1 There's always a tradeoff, but risk adjustment data  
2 that are captured, the risk factors data, are captured  
3 for the entirety of the denominator.

4 And so, in the programs that are using,  
5 the CMS programs that are using this measure, it's the  
6 intensive care units and medical and surgical wards.  
7 It's a lot of patients that are exposed, potentially,  
8 to having central lines. So when we talk about  
9 capturing risk factor data, such as comorbidities in  
10 those patients, we have to look at what the burden is,  
11 and what the availability is, electronically, of these  
12 types of data.

13 We would love to be able to have those  
14 data collected and submitted to us, but we also  
15 recognize that in the present state of electronic  
16 healthcare record-keeping, it would be a major, major  
17 challenge to people.

18 CO-CHAIR UPSHAW TRAVIS: Okay, thank you.  
19 Thank you, Dan.

20 Lisa?

21 MEMBER MCGIFFERT: I just want to go back  
22 to your first, your first response, and make clear,

1       you don't think you've reached a plateau in the  
2       decrease? There's still so many --

3               MEMBER POLLOCK: Oh, right.

4               MEMBER McGIFFERT: -- happening that this  
5       is kind of a blip that it, the decrease went down.

6               MEMBER POLLOCK: Yes.

7               MEMBER McGIFFERT: Right, so there's --

8               MEMBER POLLOCK: It was -- well there's  
9       about 25,000 CLABSIs a year.

10              MEMBER McGIFFERT: Yes. Well that would  
11       be more than thousands and thousands, I think. Yes.

12              MEMBER POLLOCK: Well, however you want to  
13       separate it.

14              MEMBER McGIFFERT: Yes, that's --

15              MEMBER POLLOCK: Tens of thousands, you  
16       could say.

17              MEMBER McGIFFERT: Well, you probably  
18       couldn't say that, technically.

19              And then the other thing was, this has  
20       always been a problem with how an agency like CDC,  
21       that focuses on infection -- I think somebody brought  
22       in the integration. CMS might have that information

1 on claims forms about comorbidities and all that  
2 stuff. And is anyone looking at trying to merge  
3 those?

4 And I guess the electronic medical record  
5 is hoping to get there. I thought I'd see it in my  
6 lifetime, 30 years ago, but I don't think it's going  
7 to happen. And so it just seems like, we are  
8 collecting this data. We're collecting it over here,  
9 and over here, and how do we get them together, so we  
10 can have more analysis of who's affected, and what  
11 kind of people are affected, and how do spinal cord  
12 injury patients, or how are they affected, and all of  
13 that. It just seems like we should be there by now.

14 MS. EVANS: I just want to point out, CMS  
15 and CDC work together. Yes, very closely, on a lot of  
16 other initiatives and measures. So I think that's  
17 something that we can definitely continue to explore  
18 and discuss, and try to figure out whether or not  
19 there is some identical and logistical mechanisms that  
20 we could bring all the information.

21 MEMBER MCGIFFERT: It seems like it would  
22 be really a great study to have a hospital to offer

1       their data integrated with the infection data, just to  
2       see if there's any possibility to look at the data as  
3       measured to which are -- so that we can have better  
4       information.

5               MEMBER POLLOCK:   So yes, those studies are  
6       done and reported.   And we have also looked at the  
7       case mix index that CMS provides, which is DRG-based.  
8       And without, you know, getting into an extensive  
9       methodologic conversation regarding some variations in  
10      coding practices that might be influencing all of  
11      that, it is a concern.   I will just say the bottom  
12      line, it is a concern.

13              Our preference would be to get to the  
14      actual clinical record of care, and to interrogate the  
15      clinical record of care, perhaps using the finer  
16      standard as a resource to enable the acquisition of  
17      those types of data.

18              But, you know, like you, Lisa, I'm  
19      surprised we're not there.   And again, without getting  
20      into an extensive philosophical policy conversation  
21      regarding where our \$35 billion investment in  
22      electronic health record systems got us, I thought, as

1 did many, that the promise that was held out, for  
2 patient safety and quality measurement would have been  
3 realized, to a much greater extent than it has.

4 I think a fundamental there -- I'll just  
5 editorialize for one second, we lost sight of  
6 meaningful usability, meaningful usability for the  
7 front line practitioners. And now we're playing  
8 catchup with that. And we have opportunities to  
9 accelerate that catchup. And we want to have quality  
10 measurement, patient safety and public health at the  
11 table, as we're playing catchup. But it is a matter  
12 of catchup, and I don't think we're going to have 35  
13 billion to spend again on that anytime soon.

14 I also am very concerned, as was expressed  
15 this morning, about the proprietary nature of  
16 electronic health record systems, and the extent to  
17 which information is blocked, and gets in the way of  
18 interoperability, notwithstanding the goals that we  
19 have. I think there's a lot of work to be done.

20 MEMBER MCGIFFERT: Thank you, Dan.

21 MEMBER POLLOCK: Okay.

22 MEMBER DUSEJA: I just want to add that

1 CMS also is, you know, through our interoperability  
2 polls this year, are trying to get at some of these  
3 issues, including intra-email, that information  
4 blocking, so whatever levers we have, we are trying to  
5 push that as well.

6 CO-CHAIR UPSHAW TRAVIS: Thank you both.  
7 Akin.

8 MEMBER DEMEHIN: I guess this is more of  
9 a clarifying question for Dan.

10 In terms of public reporting, can you  
11 remind me of the way in which the ARM figures in to  
12 the SIR or does not figure into the SIR? I conflate  
13 the two easily.

14 MEMBER POLLOCK: Sure. So, the SIR is our  
15 abbreviation for the standardized infection ratio.  
16 It's a subway measure that we use when we report  
17 facilities-level data to CMS. And so it's a ratio.  
18 It is a ratio of the number of observed infections to  
19 the number of predicted infections.

20 As was said earlier, it is not a ratio  
21 that takes differences in volume of exposure into  
22 account. So a hospital that has use of central lines

1 at a fraction of another hospital's use of central  
2 lines, and yet has the same ratio of observed to  
3 predicted infections is essentially identical with  
4 respect to the summary measure.

5 For a variety of reasons, not the least of  
6 which is equity, we think that the volume of exposure,  
7 the risk that a facility is taking on should be taken  
8 into account. And the ARM is a reliability-adjusted  
9 version of the SII, okay. We at one point called it  
10 that. And it was a little bit unwieldy, and we found  
11 some people were confused by it.

12 The SIR still has value in tracking  
13 institutional progress. But the ARM is preferred.  
14 It's an approach that has gained a great deal of  
15 traction in quality measurement circles, applying our  
16 old Bayesian methods to the prediction of the number  
17 of infections, that's an approach that we are  
18 encouraging use of. And our intent is to build the  
19 arm into the NHSN application, so that managers and  
20 users will have the opportunity to look at their  
21 adjusted ranking metric summary statistic as well as  
22 their SIR.

1 MEMBER DEMEHIN: That's helpful. Thank  
2 you.

3 MEMBER POLLOCK: Okay.

4 CO-CHAIR UPSHAW TRAVIS: Thank you.

5 I thought I saw another card, but it must  
6 have gone down. Any other questions before we move on  
7 to voting?

8 Yes, Maryellen.

9 MEMBER GUINAN: Can I ask the, any  
10 discussant, where we are on the testing stage of any  
11 electronic recording for decrease of burden?

12 MEMBER POLLOCK: Yes.

13 MEMBER GUINAN: It's pretty significant  
14 right now.

15 MEMBER POLLOCK: Right. So CLABSI, just  
16 about CLABSI, we have a very active help line, help  
17 email exchanges. And I would say over 50 percent of  
18 the user requests and questions we get relate to  
19 CLABSI, because CLABSI is essentially a rule-out.  
20 You've got a bloodstream infection, is it coming from  
21 a pneumonia, the urinary tract, the GI tract, some  
22 other localized source?

1                   And you have to rule those out. And what  
2                   you're left with, if there's no other source,  
3                   secondary source, is a central line. And so we have  
4                   to have definitions for each of those infections. And  
5                   those definitions have to be applied consistently.  
6                   And again it goes back to my earlier comment about the  
7                   status of where we are with electronic healthcare  
8                   record-keeping, and what's available, in a way that  
9                   would allow the electronic capture of information  
10                  about these other types of infections.

11                 We're not there. What we are exploring,  
12                 and moving toward, is hospital-onset bacteremia that  
13                 would lend itself to electronic capture, because it  
14                 would be using the results of our blood culture  
15                 testing, and would not need to take into account the  
16                 clinical definitions that we make available for these  
17                 other sources of infection.

18                 It raises other issues. It's a broader  
19                 scope than CLABSI. But it raises issues of  
20                 preventability. And we are doing studies right now,  
21                 looking at the preventability of hospital-onset  
22                 bacteremia. They're both -- again, if I could take

1 one more minute, go back to our conversations of this  
2 morning, the patients entering hospitals want to know,  
3 well what's my risk of X, Y or Z.

4 And CLABSI may not be in their mental  
5 horizon. Bloodstream infection may be an easier  
6 grasp. And so, patients rightly expect, if I go to  
7 the hospital, I'm not going to get a bloodstream  
8 infection as a result of that hospital care. So that  
9 we think there's merit, from a patient perspective, in  
10 moving towards hospital-onset bacteremia, but there  
11 are a number of challenges associated with it.  
12 Electronic healthcare data are not a panacea, but they  
13 can be helpful.

14 MEMBER GUINAN: Thank you.

15 CO-CHAIR UPSHAW TRAVIS: I think we know  
16 where you stand.

17 MEMBER POLLOCK: Okay, then.

18 CO-CHAIR UPSHAW TRAVIS: On, which is  
19 good.

20 Okay. It looks like we're ready to move  
21 to the vote. And the first vote that we're going to  
22 take on this is whether or not you agree with the

1 preliminary analysis, which was to support for  
2 rulemaking.

3 PARITICIPANT: Do we need to refresh, or

4 --

5 (Off microphone discussion.)

6 MR. HIRSCH: For MUC2019-19, National  
7 Healthcare Safety Network Central Line-Associated  
8 Bloodstream Infection Outcome Measure, do you vote to  
9 support the preliminary analysis as work group  
10 recommendation? Again, the PA analysis was support  
11 for rulemaking. Voting is now open.

12 Okay. That's the last few. Voting is now  
13 closed for MUC2019-19, National Healthcare Safety  
14 Network Central Line-Associated Bloodstream Infection  
15 Outcome Measure. The work group is recommending  
16 support for rulemaking, with 25 votes for yes, 0 votes  
17 for no.

18 CO-CHAIR UPSHAW TRAVIS: The one last item  
19 that we have under this particular program is if there  
20 are any gaps that anyone would like to suggest. Am I  
21 doing this right? Okay.

22 PARTICIPANT: You're good.

1 CO-CHAIR UPSHAW TRAVIS: Everybody was  
2 talking. We need to be sure.

3 So does anybody have any suggestions  
4 regarding gaps? And I assume this is for the entire  
5 program, right, Madison?

6 MS. JUNG: Yes. This is building off of  
7 the --

8 CO-CHAIR UPSHAW TRAVIS: Discussion.

9 MS. JUNG: -- that we had in the web  
10 group.

11 CO-CHAIR UPSHAW TRAVIS: Right. Okay. Do  
12 you have something?

13 MEMBER NOLAN: Sarah. Do you mean gaps,  
14 or --

15 CO-CHAIR UPSHAW TRAVIS: Proposals to fill  
16 those gaps. Well it would be gaps, and if you have a  
17 proposal to fill it, that would be even better. So do  
18 you have something you'd like to add?

19 MEMBER NOLAN: I don't have a proposal,  
20 but I would say as more speaking from a personal than  
21 the FEIU perspective, I would say that the handoff to  
22 hospice is a huge gap. I don't know how to fill that

1 gap, but it's presumably a process measure.

2 CO-CHAIR UPSHAW TRAVIS: Thank you, Sarah.

3 Lisa?

4 MEMBER MCGIFFERT: Yes, I would say  
5 handoffs, across the board, is an issue. A lot of the  
6 issues I had in my gap notes were covered in our prior  
7 conversation with CMS, certainly maternal care, most  
8 common reason people go into the hospital. We have  
9 nothing.

10 We really don't have much on medical  
11 errors. And we need more surgical infection  
12 information.

13 CO-CHAIR UPSHAW TRAVIS: We are  
14 concentrating on the cancer hospital --

15 MEMBER MCGIFFERT: Oh, I'm sorry. Cancer  
16 hospital.

17 CO-CHAIR UPSHAW TRAVIS: -- program right  
18 now. Sorry.

19 MEMBER MCGIFFERT: Okay. Sorry.

20 CO-CHAIR UPSHAW TRAVIS: Just related to  
21 this cancer hospital program.

22 Yes, Denise.

1                   MEMBER MORSE: Yes, hi. So somebody had  
2 mentioned earlier about the survival of patient-  
3 reported outcomes function status. When you -- when  
4 -- some sort of measurement regarding standardization  
5 versus personalized medicine, with some of the new  
6 therapies that have come out, as well as appropriate  
7 genetic testing.

8                   CO-CHAIR UPSHAW TRAVIS: Thank you.

9                   Jack.

10                  MEMBER JORDAN: There are about 300 cancer  
11 measures out there. I remember from having a to-do  
12 list, but I ran out those. And, you know, a lot of  
13 them get captured in, you know, kind of the tumor  
14 registries, so that they go off. Maybe the most  
15 efficient way with the least burden would really be to  
16 have CMS link to kind of the standard registries that  
17 are out there in the cancer world to, you know, let  
18 patients give to, versus building something separate,  
19 you know, here, as kind of a -- I think there are lots  
20 of gaps, but they're actually filled by existing  
21 things. And maybe partnering with them versus  
22 creating something separate from CMS might be a

1 strategy to pick from.

2 CO-CHAIR UPSHAW TRAVIS: Thank you, Jack.

3 Other thoughts? Okay.

4 Madison, do I have anything else I'm  
5 supposed to do in this section?

6 MR. STOLPE: No, you don't. There is one  
7 point of clarification from the staff that because --  
8 this is not to draw too much attention to the  
9 representative from the Pharmacy Quality Alliance, but  
10 we misinterpreted your vote. It was actually supposed  
11 to be yes. So, as a matter of public record, that was  
12 a clean sweep of 25 and 0.

13 CO-CHAIR UPSHAW TRAVIS: Well, thank you.  
14 Thank you for that.

15 (Off microphone discussion.)

16 CO-CHAIR UPSHAW TRAVIS: Okay. What are  
17 we doing about --

18 MS. JUNG: I think we're going to go  
19 through, do one more.

20 CO-CHAIR UPSHAW TRAVIS: Okay. That  
21 sounds good.

22 CO-CHAIR MORRISON: So, Cristie's

1 experience has got us 30 minutes ahead of schedule,  
2 which is why she can't leave. So, unless there is  
3 strong dissent, I think we can probably get through  
4 the next program before pausing for lunch, before  
5 going, yes? I'm seeing nods. Okay.

6 So, we are going to move the Inpatient  
7 Psychiatric Facility Quality Reporting Program  
8 Measure. CMS needs somebody who can create acronyms  
9 better than this.

10 (Laughter.)

11 CO-CHAIR MORRISON: And I think, Sam,  
12 you're providing the overview, correct?

13 MR. STOLPE: Yes. Thanks very much. For  
14 this program, this is a pay for reporting and public  
15 recording program type. The incentive structure is  
16 such that inpatient psychiatric facilities that do not  
17 submit data are penalized, with a 2 percent reduction  
18 in their annual payment update.

19 The program goals, as they're stated is to  
20 provide consumers with a quality of care information  
21 to make more informed decisions about healthcare  
22 options, and also to encourage hospitals and

1 clinicians to improve the quality of inpatient  
2 psychiatric care, by ensuring the providers are aware  
3 of and reporting on best practices.

4 Our next slide shows a list of the program  
5 measures, which are there for your reference.

6 Go ahead and move forward, please. And we  
7 can go and -- the next slide as well.

8 I wanted to -- this will bring us to our  
9 high-priority meaningful measurement areas for IPFQR,  
10 the first being to strengthen person and family  
11 engagement, as partners in their care, and the second  
12 being to make care safer by reducing harm caused in  
13 the delivery of care.

14 Now, during our orientation call, we  
15 discussed this measure set, and identified some  
16 measure gaps, which I'll just highlight for you  
17 briefly here, as soon as I can pull up my notes. My  
18 apologies. Yes.

19 So then the work group suggested that CMS  
20 identify the patient populations within units for  
21 inpatient psychiatric facilities, especially as to  
22 whether units are geriatric units, or general

1 population. And we'll continue that discussion on  
2 measure gaps once we get through the next measure.

3 Let's go ahead and move forward.

4 CO-CHAIR MORRISON: Okay, so public  
5 comments, from the back of the room? From the phones?

6 (No response.)

7 CO-CHAIR MORRISON: Hearing none, we'll  
8 move forward to the MUC, which is MUC2019-22, Follow-  
9 Up After Psychiatric Hospitalization. We're good.

10 MR. STOLPE: All right. So, just a couple  
11 of highlights from this measure. This is a process  
12 measure that assesses the percentage of inpatient  
13 discharges with principal diagnoses of select mental  
14 illness or substance use disorders, for which the  
15 patient received a follow-up visit for treatment of  
16 mental illness or SUD.

17 This does align with meaningful  
18 measurement area of prevention treatment and  
19 management of mental health as well as the promoting  
20 effective communication and care coordination.

21 We wanted to note that this measure has  
22 been reviewed by NQF under a different -- under the

1 measure 0576, and it is in, it is currently in IPF --  
2 excuse me, IPFQR. But it's undergone some substantial  
3 changes.

4 When it was last reviewed by NQF's  
5 Standing Committee, they noted that substance use  
6 disorder is a very important follow-up condition to be  
7 included as well. That was included. And the  
8 conditional support for rulemaking is based on an  
9 evaluation of that measure with the expanded  
10 conditions by the appropriate NQF committee. That's  
11 the staff analysis.

12 CO-CHAIR MORRISON: So let's take our  
13 discussants. I've got Linda first, from American  
14 Case Management Association.

15 MEMBER VAN ALLEN: Yes. We were looking  
16 at several of the recommendations. The American Case  
17 Management Association is absolutely in support of the  
18 need for follow-up care for the expanded population,  
19 not only the inpatient psychiatric discharges, but  
20 including these SUD patients.

21 There are some concerns, however, on  
22 behalf of the Association. And it really has to do

1 with the process measure itself, not the inclusion of  
2 the SUD. It's, the concern is more about measuring  
3 the patient actually, the numerator being the patient  
4 actually participating in follow-up care, and getting  
5 a follow-up visit versus a follow-up visit being  
6 arranged.

7 And that's the main concern that the  
8 Association has. And related to that are two other  
9 concerns that somewhat relate to that. One is, is  
10 still a challenge related to even arranging an  
11 appointment, and that is access to follow-up care.  
12 And that has to do both with timeliness, so within  
13 those 7 and 30-day time frames as well as the actual  
14 provider access and the availability of the provider.

15 And the second concern is risk, potential  
16 for risk for hospital providers, and specifically case  
17 managers in their profession to potentially incur some  
18 violation of referral source arrangements, that are  
19 prohibited under Stark Laws, with regard to addressing  
20 -- trying to do the right thing and address some of  
21 the barriers to these follow-up appointments, which is  
22 maybe transportation or some kind of incentive for the

1 patient to actually complete their follow-up care.

2 And that has to do, you know, with the  
3 challenges, frankly, of the patient population. So  
4 those are the concerns that the American Case  
5 Management Association would bring forward, and for  
6 that reason, at this time not endorse the measure.

7 CO-CHAIR MORRISON: Frank, National  
8 Association of Behavioral Healthcare.

9 MEMBER GHINASSI: Thank you very much.

10 I agree with my colleague. I just want to  
11 add a few things to that. The Slide 48 indicates that  
12 the program goal on this, these measures are to  
13 provide consumers with quality of care information to  
14 make more informed decisions about healthcare options,  
15 and to encourage hospitals to improve quality. The  
16 dilemma with this measure is, and I completely agree  
17 with the intent of the measure, the dilemma is the  
18 specificity of what's being judged and measured.

19 So it appears that it's attempting to  
20 measure the quality of care in a hospital. I would  
21 submit for the group's consideration that it's  
22 actually better measuring a variety of variables that

1 are contaminating this, which includes regional access  
2 realities.

3 It includes a myriad of social  
4 determinants that impact patients, including unstable  
5 housing, transportation issues, which is already  
6 raised, childcare issues, and the unfortunate  
7 realities of what can be a chaotic lifestyle.

8 For many people in this room, an  
9 appointment at 2 p.m. next Thursday is a very easy  
10 thing to do. For many of the people that we work  
11 with, that's an impossible thing to do. They have no  
12 idea where they're going to be or what's going to be  
13 happening at 2 p.m. next Thursday.

14 I would also submit that the measure and  
15 processes aggressively fail to measure if a hospital's  
16 actually doing the behaviors, with the best position  
17 the person to do it, since it's solely focused on the  
18 outcome, not what actually happened in order to affect  
19 the outcome.

20 And if you're really looking at quality,  
21 I think this measure could only then look at what were  
22 the actual steps taken by a hospital, because what

1 could happen is, you could do every single right step  
2 and fail the measure.

3 And then the third thing I just want to  
4 focus on is, there is an unintended consequence of  
5 this, and I see this happening in communities. I've  
6 worked in three states over the last 35 years. When  
7 you throw a rule out like this to say, 7 or 30 days,  
8 organizations should want to please CMS, even in the  
9 ambulatory world. They will focus enormously on the  
10 7 and 30-day, but the second appointment or the third  
11 can be weeks and weeks later.

12 And so what you do is you create a 7-day  
13 appointment, but then the follow-up from the 7-day  
14 might be a month and a half away. And so I found the  
15 measure well-intended, but flawed, and I can't  
16 recommend moving forward, not if it's going to be put  
17 forward as a measure of quality of the hospital  
18 entity. Thank you.

19 CO-CHAIR MORRISON: Thanks, Frank.

20 Nikolas, Press Ganey.

21 MEMBER MATTHES: I just had sort of a  
22 high-level comment, because I can't comment to the

1       measure, you know, specific measure, details and  
2       communication challenges, which I suppose would have  
3       been partially discussed as part of the process  
4       already.

5               And I reviewed, you know, those issues  
6       when the measure was endorsed in 2017, and looked at  
7       those.

8               (Simultaneous speaking.)

9               MR. STOLPE: Just a point of clarification  
10       on that.

11              MEMBER MATTHES: Yes.

12              MR. STOLPE: And forgive me for  
13       interrupting you. So the measure is not endorsed.  
14       It's based on a measure --

15              (Simultaneous speaking.)

16              MEMBER MATTHES: No, not yet. It was the  
17       17, the old 2017 measure.

18              MR. STOLPE: Correct. Okay. So --

19              MEMBER MATTHES: Yes. That's what I  
20       referring to.

21              MR. STOLPE: Right.

22              MEMBER MATTHES: So --

1 MR. STOLPE: I do want to make sure that  
2 this is clarified, if I did misarticulate it. The  
3 measure, as it's being discussed, has not been  
4 endorsed, but is based on an endorsed measure.

5 MEMBER MATTHES: That's right. So I  
6 wasn't going to that measure from 2017, that probably  
7 at best some of the issues that were just brought up  
8 in the discussion. So I don't want to talk, don't  
9 want to comment on that.

10 I just think that what was put forward in  
11 terms of expanding on an existing measure, in terms of  
12 the criteria outlaid and how they were discussed in  
13 terms of, you know, critical objective, how do we want  
14 addressed, you know, the meaningful outcomes, the  
15 addressing quality challenges, you know, measurement,  
16 effort. It's a pains based measure. And whether it's  
17 feasible, and whether it's over specified, I agree  
18 with those evaluations that have been put forward, if  
19 only narrowly, all those questions.

20 One general question I have is, is an  
21 expansion from mental into something in this order?  
22 And so you're expanding it with one measure. And if

1       you think about publicly quartering, I would be  
2       interested from the measure developers whether there  
3       had been, like a decision point, whether it could have  
4       been two measures, that look at the separately  
5       substance disorder versus, you know, mental illnesses  
6       and what the rationale was of combining to make it  
7       one.

8                   MR. STOLPE: I'm going to hold that,  
9       Nikolas --

10                  CO-CHAIR MORRISON: Yes.

11                  MR. STOLPE: -- that question period. And  
12       then, who do I have last, sorry? Sarah, so Service  
13       Employees International Union.

14                  MEMBER NOLAN: So I -- we support the --  
15       so I believe the proposal in here is conditional.

16                  MR. STOLPE: It is.

17                  MEMBER NOLAN: Good, good, yes. So, I  
18       support conditional endorsement. I recognize some of  
19       the issues that have been raised, it being of very,  
20       having by prove the Health Services Advisory Group got  
21       methodologies imported from this measure. There's a  
22       clear blank to the admissions. There's variation

1 among facilities, which speaks to need, to the need  
2 for a measure.

3 And I think, to echo something Mia, you  
4 brought up in our earlier discussion, this is a  
5 measure that seems to me to reflect a potential cost  
6 to families and social networks of the measure not  
7 existing.

8 I would echo what Linda said about some of  
9 the concerns, particularly the actual follow-up, not  
10 just arrangements for follow-up.

11 I would say, in terms of the issue of  
12 failure, that CMS was very clear that they did not  
13 expect this to approach a hundred percent, and that  
14 the -- I won't quote from the report, the studies  
15 indicate that IPF can influence rates of follow-up  
16 care for patients hospitalized for mental illness or  
17 SUD.

18 I agree, it's a particularly challenging  
19 demographic. It happens to be, maybe say for the  
20 mental illness, a demographic, low-income,  
21 particularly that we organize all the time and we find  
22 people, and track them down. So I would suggest that

1       that is part of the job of facilities to do.

2                   And I would say, frankly, that in a  
3       industry that is dominated or at least half for-profit  
4       facilities, including one for-profit health system  
5       that has had lots of problems, that these measures are  
6       particularly important to ensure quality of care.

7                   CO-CHAIR MORRISON:   So we are now going to  
8       Brock.

9                   MR. SLABACH:   Well thank you.   I'll start  
10      with just a higher-level discussion, and have a couple  
11      of questions that the group were inquiring about in  
12      this measure.

13                   The first is, obviously, it's an important  
14      area for rural patients and providers being, giving  
15      referrals into psych hospitals.   The first question  
16      would be, does this apply to only psych hospitals or  
17      all psych beds?   In other words, is it just for  
18      inpatient psychiatric facilities, or would it apply to  
19      psychiatric beds and SUD beds outside of that?

20                   MEMBER MATTHES:   Just facilities.

21                   MR. SLABACH:   Just the facilities.   Okay.  
22      So, I thought so, but I just wanted to clarify because

1 that was an important point that was made. Given  
2 that, they thought that it would be appropriate that  
3 there was more enthusiasm for this measure than what  
4 the spread of the votes in the analysis shows.

5 There was distribution among all of the  
6 numbers of a hospital between one to five, and so it  
7 was difficult to discern a direct correlation here to  
8 the enthusiasm, but it was, because the, holding  
9 accountable, the providers of these services, for  
10 aftercare is, seemed to be of high value.

11 The unintended consequence that I think  
12 would really possibly come from this is, would there  
13 be selection, or adverse selection of patients from  
14 rural areas to be admitted to these programs if  
15 they're going to have exceedingly high problems of  
16 getting them referred for aftercare once they are  
17 returned back to the community.

18 And that goes to the fact that there's a  
19 tremendous loss, or low numbers of professionals,  
20 mental health workers and behavioral health workers in  
21 rural areas. So, we would hate to see an adverse  
22 selection from rural communities because of their not

1 being able to get the after care that this measure  
2 would require.

3 The other question would be, is if  
4 telehealth follow-up would be counted as a yes for  
5 meeting this measure. I think it would be more  
6 acceptance to it if telehealth services were being  
7 able to be counted as part of the follow-up care  
8 provided in this context. So is that -- does anybody  
9 know?

10 CO-CHAIR MORRISON: Brock, hang on, and  
11 I'll put that in when --

12 MR. SLABACH: Okay. I'll try -- I'm  
13 sorry.

14 CO-CHAIR MORRISON: -- for the -- no, no,  
15 just because there's discussion there, so I think the  
16 answer is, we will find out.

17 MR. SLABACH: Okay, thank you. Well, I  
18 just didn't want to move on -- I mean, I'm really  
19 about finished, but I think that given the advantages  
20 of this, and recognizing some of the unintended  
21 consequences that could perhaps happen with adverse  
22 selection, there was enthusiasm for this, because

1 after care is important. And it is necessary as part  
2 of the treatment of this problem.

3 CO-CHAIR MORRISON: So we're going to open  
4 up for clarifying questions before discussion now. So  
5 this is clarifying questions. And I've got Brock's  
6 question about whether telehealth is included for  
7 follow-up care, and I've got Nikolas' question about,  
8 the rationale behind including substance use disorder  
9 within behavioral health rather than splitting it.

10 I've got those two. You guys want to  
11 tackle those first up, and then I'll get to you,  
12 Marty?

13 (Simultaneous speaking.)

14 MEMBER DUSEJA: I just want a little bit  
15 of clarification, Brock, because we went back and  
16 looked at your question with regard to -- there are  
17 standing facilities within the program, but they're  
18 also within IPPS hospitals, the units itself, that are  
19 also, it's applicable to.

20 MR. SLABACH: So that --

21 (Simultaneous speaking.)

22 MEMBER DUSEJA: Yes, it is.

1                   MEMBER MATTHES: Even for the future  
2 hospitals?

3                   MEMBER DUSEJA: That's right. Yes. So I  
4 apologize for that.

5                   CO-CHAIR MORRISON: And the follow-up  
6 question? Is telehealth included in after care?

7                   MEMBER DUSEJA: It's not, but it's a very  
8 good question, and I think, you know, if we can expand  
9 that, I think that's a direction that I think would be  
10 good.

11                  MR. SLABACH: It would change the game.

12                  MEMBER DUSEJA: Yes.

13                  CO-CHAIR MORRISON: And the question  
14 around the decision-making behind just putting opioid  
15 use disorder, substance use disorder into this measure  
16 rather than separating it out? Is there anything --

17                  MEMBER DUSEJA: Do you want to speak to  
18 that? The decision from the top decision plan?

19                  MS. MEYYUR: So, basically we did not  
20 consider reporting it separately but, I mean, we could  
21 -- so there, the intent of the measure was the earlier  
22 measure, just have the mental health diagnoses in the

1 cohort, and we wanted to expand that to include the  
2 substance use disorder.

3 So, we are looking at it as one population  
4 as of now. And so the group had combined both,  
5 because a lot of it is coexisting as well, in the  
6 setting. And so the, we have not actually made a  
7 decision to report it separately.

8 Well we could, but we would have to do  
9 some additional testing to see if it could actually  
10 hold good to record separately, in terms of sample  
11 size and reporting the measure itself, and if it would  
12 be reliable, if it's reported separately, so.

13 CO-CHAIR MORRISON: Amy, then Marty.

14 MEMBER HELWIG: I just had a telehealth.  
15 From the health clinic perspective, this is a hospital  
16 measure, but we do have a hospitalization measure as  
17 well as after full release, or dependence, that would  
18 lay it out at NQMPs.

19 And there's a trend. There has been a  
20 significant expansion in the code sets, that for  
21 virtual, televisits, et cetera, and the adoption is  
22 extraordinarily critical for states like Pennsylvania,

1       which is very rural, and we have lots of access  
2       problems with mental health, especially follow-up, we  
3       know it's going to be important.

4               So if that is not in this measure, the  
5       acceptance of those code sets, I think that's a  
6       significant error for when you look at the rapid  
7       adoption of what we're doing in virtual health.

8               CO-CHAIR MORRISON:  Amy, is there a  
9       question in there?

10              MEMBER HELWIG:  No, it's just a --

11              CO-CHAIR MORRISON:  Okay.  So this is  
12       questions only, folks.

13              (Laughter.)

14              CO-CHAIR MORRISON:  I just want to -- I  
15       know, I just want to really highlight that, okay?  I  
16       just wanted to make sure I hadn't missed it.

17              Marty?

18              MEMBER HATLIE:  Sean, it's hard for us to  
19       hear, down at this end of the room, some of the  
20       comments, so this is purely a clarifying question.

21              I don't even know what the condition is  
22       that's being recommended here.  So is it just that it

1 go through the endorsement process of NQF? Okay.

2 CO-CHAIR MORRISON: Yes. The condition is  
3 through the endorsement process with NQF with the  
4 addition of the new substance use disorder.

5 MEMBER HATLIE: Okay. Addition. And I do  
6 have a question. How long, estimate, does that  
7 process take? Because there seems to be a high-risk  
8 population here that's --

9 MR. STOLPE: It's entirely dependent upon  
10 the preparation of the measure developer. Once they  
11 have their measure submission completed, it takes  
12 about six months to go through the full process.

13 MEMBER HATLIE: Okay. Okay. Those are my  
14 questions.

15 CO-CHAIR MORRISON: Akin.

16 MEMBER SCHREIBER: Can I clarify one --

17 CO-CHAIR MORRISON: Yes, you may. I'm  
18 sorry. Go ahead, Michelle.

19 MEMBER SCHREIBER: Even while a measure  
20 may be conditionally approved, waiting until NQF  
21 endorsement, that does not generally stop CMS from  
22 using it in a program. Okay. Because we recognize

1       that there's a time gap before it gets NQF  
2       endorsement. And so if there is support from the  
3       Committee, and based on CMS's thoughts about where  
4       this lies, we will use a measure pending NQF  
5       endorsement.

6               CO-CHAIR MORRISON: Thank you.

7               MEMBER SCHREIBER: We'll propose it for  
8       rulemaking, and that'll be fine.

9               MEMBER DEMEHIN: Sean, are we still on  
10      clarifying questions, or are we on --

11              CO-CHAIR MORRISON: We are on clarifying  
12      questions.

13              MEMBER DEMEHIN: Okay. I'll hold my --

14              CO-CHAIR MORRISON: Okay. Do you have  
15      some clarifying questions?

16              MR. SLABACH: Yes. How many facilities  
17      are being judged?

18              MEMBER DUSEJA: How many facilities? It's  
19      a hundred per scan that --

20              MS. MEYYUR: It's total of 1,600, and  
21      about 1,400 is in the kid care at the hospital, so  
22      behavioral health units and about 400 freestanding.

1 CO-CHAIR MORRISON: State your name.

2 MS. MEYYUR: Oh, my name?

3 MEMBER DUSEJA: Yes.

4 MS. MEYYUR: Oh, it's Vinitha Meyyur, from  
5 CMS.

6 MEMBER DUSEJA: This is a very simple  
7 question. Could people speak up, because we're right  
8 under a blower.

9 CO-CHAIR MORRISON: So, a very simple  
10 answer is yes.

11 (Off microphone discussion.)

12 CO-CHAIR MORRISON: So, any last  
13 questions? So now we're going to turn it over to --

14 MEMBER WHEELER: It's Debbie --

15 CO-CHAIR MORRISON: I'm sorry.

16 MEMBER WHEELER: It's Debbie Wheeler from  
17 Molina. Can you hear me on the phone?

18 CO-CHAIR MORRISON: Yes. Go ahead,  
19 Debbie.

20 MEMBER WHEELER: Great. I'm going to ask  
21 a clarifying question that you can't, or the  
22 Pennsylvania Health didn't ask, is, did the measure

1 developer look at all of the other similar measures,  
2 including those being reported by health plans?  
3 Because there's a lot of work in this area.

4 And if so, is it consistent then, with the  
5 measure specifications of those other programs, to  
6 make sure CMS has a consistent approach?

7 MS. MEYYUR: What I can say is yes, we  
8 have tried to harmonize the measure with the NCQA,  
9 that version of the measure. And the NCQA is of the  
10 -- that we have added the SUD to the cohort. And we  
11 will be submitting documentation in that regard when  
12 we submit the measure to NQF in January for review.  
13 Yes. So we have harmonized with NCQA.

14 MEMBER WHEELER: Well, and can I add one  
15 last comment on that? The telehealth issue, though,  
16 has not been harmonized, it doesn't look like. So,  
17 if you can look at that again, or somewhere in this  
18 process, I think that's a bigger issue for us, to make  
19 sure everything looks the same as possible.

20 MS. MEYYUR: Sure, thanks.

21 CO-CHAIR MORRISON: Okay. We are now  
22 going to move into the discussion point, which I know

1 everybody is anxious about. So just, before we do  
2 that, let me just summarize what I've heard, and I'd  
3 ask people if they have new comments, to bring them  
4 up, but otherwise I think staff and CMS have been very  
5 carefully paying attention.

6 So what I've heard is concerns about the  
7 numerator and the population. And I think this comes  
8 down to many debates that have been heard in this  
9 room, which is, how much do you hold facilities  
10 responsible for social determinants of health and  
11 basic population. I think I would just summarize that  
12 as a big issue, and I think we have heard that before.

13 The second is the potential risk for  
14 hospital providers, particularly around Stark  
15 regulations and self-referral. I've heard questions  
16 of particular concern around focusing on the first  
17 appointment, rather than the subsequent follow-up, and  
18 real efforts to meet that particular requirement at  
19 the expense of subsequent follow-ups.

20 I've heard from Brock around simply the  
21 fact that resources just may not be there,  
22 particularly since telehealth is not included in this.

1 And I have heard that, just a reminder that  
2 performance on this is not expected to be a hundred  
3 percent at the moment.

4 Did I miss anything from the discussants  
5 that are key?

6 (No response.)

7 CO-CHAIR MORRISON: Okay. American  
8 Hospital Association, Akin, you've been waiting very  
9 patiently.

10 MEMBER DEMEHIN: So, I would associate  
11 myself with the comments that both, or that Frank made  
12 around their concerns around this measure. I think no  
13 one would dispute the importance of getting follow-up  
14 care after psychiatric hospitalization. I think the  
15 real question here is whether measuring the IPF is the  
16 best way to accomplish that.

17 I also have sort of a more specific  
18 technical problem with the measure. As we looked at  
19 the evidence that was used to support the expanded  
20 patient population, there was really a mismatch. So  
21 for expanding the patient population, included here,  
22 that's included, drug and alcohol disorders and

1 dementia, the evidence that's actually cited in the  
2 TEP report is really more based on schizophrenia, and  
3 not really those specific patient populations.

4 And there really wasn't much of a  
5 resultant drop in readmission. So if we're hinging a  
6 decision to expand the patient population on that  
7 evidence, I just don't think the evidence backs it up.

8 I would also strongly underscore some of  
9 the challenges around the Stark Law. I mean, it is --  
10 in an ideal world, what a hospital could do is, at the  
11 end of a stay, make an appointment for a patient just  
12 about anywhere. But the law requires that we provide  
13 a full slate of choices to patients. We cannot steer  
14 patients to a particular facility.

15 And so, a measure like this does have the  
16 potential to put a lot of pressure, and it does  
17 potentially put providers at risk of violating those  
18 laws and those regulations.

19 The other point that was made that I think  
20 is a really important one, is that this particular  
21 measure's not the only game in town to get that sort  
22 of desired outcome, of getting patients who are

1 leaving an inpatient psychiatric stay to follow-up  
2 care. I would be very worried about the mismatch  
3 between this and any measures used at the health plan  
4 level.

5 And frankly, this measure was originally  
6 designed as a health plan measure, and I think with  
7 good reason. It is, to me, a little hard to create  
8 the mental model of the IPF being able to assure that  
9 follow-up care and to assure the network of access  
10 that you need to get that follow-up appointment.

11 It's a bit easier, although I'm sure very  
12 challenging on the health plan side. So if I'm  
13 looking at sort of the panoply of meaningful measure  
14 areas, I think the topic here is meaningful. I think  
15 who gets measured on this probably shouldn't be the  
16 IPF. So we would not support the inclusion of this  
17 measure in a program.

18 CO-CHAIR MORRISON: Jackson?

19 MEMBER WILLIAMS: Yes. So forgive me for  
20 asking a rookie question. This is my first meeting.  
21 But the complaints about sociodemographic issues, or  
22 regional issues, I think are relative to almost any

1 quality measure. And I'm just curious what the policy  
2 is here on -- I mean, theoretically, almost any of  
3 these things can be adjusted out, or they can be peer-  
4 grouped, so that facilities that serve a lot of rural  
5 patients are judged against peers rather than, you  
6 know, the suburbs of Connecticut or what have you.  
7 And I'm just curious, what is the procedure?

8 CO-CHAIR MORRISON: Well, that's a follow-  
9 up --

10 MEMBER MATTHES: Let's get the follow-ups.  
11 So I do work in this community as well. So I'm  
12 curious, since this measure rolled out, with NQF  
13 endorsement as one of these issues are general  
14 revision issues that will be addressed for those  
15 because it's provisional, I suppose on the NQF  
16 endorsement.

17 And what are we narrowly focusing on, on  
18 here? It seems to me, at least that I understand the  
19 endorsement process that there is some from life, some  
20 machine, some mixing of questions, that we should be  
21 looking at and addressing, and working as part of the  
22 endorsement process.

1 CO-CHAIR MORRISON: Jack, is that a  
2 follow-up or do you want me to try and clarify?

3 MEMBER JORDAN: Go ahead and clarify.

4 CO-CHAIR MORRISON: All right. So, I'm  
5 going to try and clarify as best I can. There really  
6 is no policy. Okay. It really depends on whether you  
7 believe, as some in this room have, that facilities  
8 and/or those who are being measured are accountable  
9 for the people who are living in their community, and  
10 that includes social determinants of health.

11 There are those who believe that that's  
12 not a fair practice. We have had debates back and  
13 forth, very healthy. I think that's the right word.  
14 Some of it depends on who you represent, and I will  
15 say that it has not come to the point where there is  
16 consensus. And this is one of those where you vote  
17 your conscience, or you vote your organization. Okay.  
18 Because I don't think anybody has actually come to a  
19 strong agreement on that. Okay.

20 Jack?

21 MEMBER DUSEJA: Can I just add to that?

22 CO-CHAIR MORRISON: Yes.

1                   MEMBER DUSEJA: So, the endorsement  
2 process will address the measure, you know, scientific  
3 properties, right. So the questions that are being  
4 brought up about intended consequences, looking at the  
5 reliability, validity will be addressed in that  
6 process.

7                   What we're looking for in the MAP process  
8 is really for your input on whether it's an applicable  
9 measure within the program. Is there shared  
10 accountability among facilities who are trying to  
11 arrange care coordination.

12                  CO-CHAIR MORRISON: And that, we don't  
13 have an answer for yet.

14                  Jack.

15                  MEMBER JORDAN: Yes. I just, I wanted to  
16 comment, kind of, to the group as you're thinking  
17 about this, that because a measure is hard, and  
18 because a measure is going to look bad, doesn't have  
19 anything to do with if it's the right thing to do or  
20 not.

21                  You know, so I hear some kind of comments  
22 in this that are kind of going down, oh, we're going

1 to look abysmal at this, or -- but it's, it is a real  
2 problem. And sometimes just drawing attention to  
3 having it, how bad it is, does help with a lot of  
4 things.

5 So, if you're thinking about this in some  
6 sense to say, oh wow, we're going to -- this is really  
7 terrible, that's not a reason to vote against it. It  
8 may actually be a reason to draw attention to, oh my  
9 God, only 20 percent of the people are getting follow-  
10 up, we need to get this to 50 or whatever. So just my  
11 comment on that.

12 CO-CHAIR MORRISON: Any last thoughts,  
13 comments before we go to a vote?

14 MEMBER DESOTO: Yes. Hi. I'm Mia DeSoto  
15 from AHRQ. I just had one last comment, just to throw  
16 into the mix to what Jack was saying that, you know,  
17 we also need to be mindful that as smaller practices  
18 are being bought up by bigger health systems, access  
19 is really becoming an issue.

20 So, it's not about whether it's going to  
21 make us look bad, but is it somewhere we start, and  
22 should we start at this point? So, that's all. Thank

1       you.

2                   CO-CHAIR MORRISON:   So, any last -- thank  
3       you. Any last thoughts, comments?

4                   Sarah.

5                   MEMBER NOLAN:   So I agree that we have had  
6       robust discussions about who's responsible for social  
7       determinants of health. I disagree that I always come  
8       down on the same side about who's responsible. I  
9       think there are cases where the facility is less  
10      responsible.

11                  I think in a case like this, where some of  
12      the issues and challenges to doing follow-up with  
13      these patients that have been identified are  
14      specifically aspects of their mental illness. And it  
15      seems to me it is the job of these facilities to be  
16      treating mental illness.

17                  CO-CHAIR MORRISON:   I didn't mean to point  
18      a finger at anybody; we are not schizophrenic on the  
19      same thing at the same thing or the same time. So --

20                  MEMBER NOLAN:   Sorry to -- in this case --

21                  CO-CHAIR MORRISON:   It is -- yes. And no.

22                  MEMBER NOLAN:   I think there is a reason

1 to tilt towards holding the facility --

2 CO-CHAIR MORRISON: Yes.

3 MEMBER NOLAN: -- more responsible rather  
4 than less.

5 CO-CHAIR MORRISON: Yes. No. I was going  
6 to say, it's, it really depends. It really depends.  
7 Akin, I don't know well. If Nancy was here, I'd pick  
8 on the American Hospital Association.

9 MEMBER DEMEHIN: That's fine. You can  
10 pick on me. That's all right.

11 CO-CHAIR MORRISON: So, shall we go for a  
12 vote, guys? So the initial staff recommendation was  
13 support with condition? Support, conditional support.  
14 So if you agree with the staff's recommendation,  
15 support with conditions, you vote yes. If you do not  
16 agree, you vote no. And depending on what that shows,  
17 we will move forward.

18 MS. JUNG: Do you want to kind of maybe  
19 reiterate what the staff condition was?

20 CO-CHAIR MORRISON: Oh, I'm sorry. The  
21 staff condition -- thank you, Madison. Thank you.  
22 The staff condition was to send it back for

1 endorsement, to NQF endorsement around the addition of  
2 the substance use disorder parameter. That was the  
3 condition. That was the condition.

4 MEMBER JORDAN: Clarifying question?

5 CO-CHAIR MORRISON: Yes.

6 MEMBER JORDAN: So if we wanted to add the  
7 other condition of allowing for e-visits or whatever,  
8 then we would vote no and come --

9 CO-CHAIR MORRISON: That is correct.

10 MEMBER SCHREIBER: Allowing for what? Can  
11 you repeat that, Jack?

12 MEMBER JORDAN: Telehealth, telehealth.  
13 E-visits, yes.

14 MEMBER SCHREIBER: Oh, e-visits.

15 MEMBER JORDAN: Yes.

16 MEMBER SCHREIBER: Thank you. Can I --  
17 can we add a comment on that? It was looked at,  
18 because this is a claims measure, and it's not always  
19 so easy to capture that, that's why it wasn't there.

20 CO-CHAIR MORRISON: Did you guys at the  
21 end of the room hear Michelle?

22 PARTICIPANT: Yes.

1 CO-CHAIR MORRISON: Okay.

2 CO-CHAIR UPSHAW TRAVIS: May I have -- can

3 I ask a --

4 CO-CHAIR MORRISON: Of course.

5 CO-CHAIR UPSHAW TRAVIS: -- clarifying

6 question?

7 PARTICIPANT: The answer was no. Some

8 people didn't hear Michelle.

9 CO-CHAIR MORRISON: The answer was no?

10 MEMBER SCHREIBER: So, because it's a  
11 claims-based measure and it's not always easy to  
12 capture telehealth in a claims-based measure, so  
13 telehealth is provided, and charged for. I mean, to  
14 say that's even covered, telehealth, for behavioral  
15 health, sometimes.

16 (Laughter.)

17 CO-CHAIR UPSHAW TRAVIS: So I guess what  
18 I was trying to -- my clarifying question was, if a  
19 claim was filed for telehealth, it would be in the  
20 claim. I'm going to ask if it is included in the  
21 specifications that you would capture it.

22 MS. MEYYUR: Yes. If it was. And then it

1       also depends on the diagnosis, right, so whatever is  
2       captured. Not everything, all diagnoses in the  
3       telehealth may end up in the claim. So it's still not  
4       completely synched at that level.

5               MEMBER DUSEJA: So I think there's some  
6       mapping that needs to be done to see if we're  
7       capturing it in a reliable way. And for what I'm  
8       hearing, it really does depend on if the claim comes  
9       through. But it has been the thought at our Technical  
10      Expert Panel, and there was a decision made not to  
11      include it in this particular measure.

12             CO-CHAIR UPSHAW TRAVIS: It was there and  
13      you don't know you're counting it.

14             MEMBER DUSEJA: Yeah.

15             CO-CHAIR UPSHAW TRAVIS: I mean, you might  
16      be counting some, is what I'm hearing, but maybe not  
17      all of them, so the issue still stands, apparently.

18             CO-CHAIR MORRISON: Okay.

19             MEMBER GHINASSI: Clarification question.  
20      So, the recommendation is to approve with --

21             CO-CHAIR MORRISON: Pending NQF  
22      endorsement.

1                   MEMBER GHINASSI: Yes. And the idea was  
2 to include substance abuse in there. But if we  
3 believe that also addressing the idea of electronic  
4 connections with people, telehealth, whether it's  
5 provided by the hospital entity who could bill for it,  
6 or a community entity who could bill for it, if we  
7 believe that should be in the mix here, and it's not,  
8 we should vote no?

9                   CO-CHAIR MORRISON: Correct.

10                  MR. STOLPE: So, that would fall under the  
11 do not support with potential for mitigation, with the  
12 mitigating factor being you adjust the specifications  
13 to include telehealth.

14                  MEMBER GHINASSI: All right, thank you.

15                  MEMBER SCHREIBER: Thank you. Good  
16 question.

17                  CO-CHAIR MORRISON: Thank you. Are we  
18 ready, guys? Okay.

19                  MR. HIRSCH: Voting for MUC 2019-22,  
20 Follow-Up After Psychiatric Hospitalization, do you  
21 vote to support the preliminary analysis as the work  
22 group recommendation, and again, conditional support

1 for rulemaking is now open. Your options are yes or  
2 no.

3 CO-CHAIR MORRISON: Twenty-four? That's  
4 -- is that it? Okay. So we have our first no -- we  
5 have our first no of the day. So now, Sam --

6 MR. STOLPE: Now you can open it to  
7 discussion.

8 CO-CHAIR MORRISON: Now I can open for  
9 discussion. I will entertain a proposal as to where  
10 we should land on this, in terms of the next vote.  
11 Just to summarize from the discussants who had the  
12 pleasure of reviewing this in great detail, two voted  
13 do not endorse.

14 Nikolas, I didn't actually know where you  
15 landed.

16 MEMBER MATTHES: Sorry. I did  
17 conditionally support it.

18 CO-CHAIR MORRISON: I had a conditionally  
19 support, and I had a fully support. So the  
20 conditionally support and the fully support are now  
21 off the table. So we are now at support -- do not  
22 support with modifications, or do not support at all?

1 MS. JUNG: Don't we have to move through  
2 the other two to --

3 CO-CHAIR MORRISON: Do we have to move  
4 through the other?

5 MR. STOLPE: At the co-chairs' discretion,  
6 if the co-chairs feel like we are aggregating in  
7 general around a given category, we can move directly  
8 to that category, if you wish to vote on that. If  
9 it's not clear, then we go in sequence, starting with  
10 support for rulemaking.

11 CO-CHAIR MORRISON: So I'm going to  
12 suggest we start with do not support with mitigation.  
13 If we can get sort of a mitigation on the table that  
14 seems reasonable, we can go to a vote. And if we  
15 can't get that, then we are down to do not support,  
16 period. Does that work for people?

17 MEMBER GHINASSI: Can I just ask a  
18 question?

19 CO-CHAIR MORRISON: Of course.

20 MEMBER GHINASSI: When you say, a  
21 mitigation, does that mean ideas that people want to  
22 put on a list, from this room?

1 MR. STOLPE: Yes.

2 CO-CHAIR MORRISON: Yes.

3 MR. STOLPE: Yes. We would capture that  
4 in the rationale. And the material changes and  
5 specifications that the work group has identified  
6 would be communicated to --

7 MEMBER GHINASSI: Do you want those ideas  
8 from this group?

9 MR. STOLPE: Yes.

10 CO-CHAIR MORRISON: Yes, yes.

11 MEMBER GHINASSI: That's what I'm asking.

12 CO-CHAIR MORRISON: Yes. So if you have  
13 mitigation ideas, now is the time to speak. Oh,  
14 Frank. Frank is --

15 MEMBER GHINASSI: I have a couple. So one  
16 would be that we broaden the category of what  
17 constitutes a successful follow-up visit to include  
18 electronic contact, and that that's as broad as  
19 possible.

20 Number two, that it would be a paid  
21 service, and number three, that those kinds of follow-  
22 up care management services could equally be billed by

1 receiving entities who are trying to case manage as a  
2 receiver in the ambulatory world.

3 I would also submit that the mitigation  
4 include that the hospital, who is currently only able  
5 to bill for what happens within their walls, are also  
6 able to bill against those same ambulatory codes, and  
7 to continue to provide active case management,  
8 carrying that person to the next level of care in a  
9 way for which they can be reimbursed. Those would be  
10 my --

11 CO-CHAIR UPSHAW TRAVIS: Well, I just have  
12 a kind of an overarching question for that, because  
13 Frank, that included payment policy, not just, you  
14 know, what we are looking at, which is measurement.  
15 So I guess what I'm -- I guess the question I'm having  
16 is, in my own mind, if this is a payment policy or a  
17 coverage issue, that's a whole other process to go  
18 through.

19 So I'm trying to evaluate your comments in  
20 to how important all that component of it was, to  
21 which you saw as the potential medication --

22 MR. STOLPE: Mitigation, or medication,

1       yes.

2                   CO-CHAIR UPSHAW TRAVIS: Mitigation. I  
3       need medication.

4                   (Laughter.)

5                   CO-CHAIR UPSHAW TRAVIS: I won't even try  
6       to say it right.

7                   MEMBER GHINASSI: Mitigation.

8                   CO-CHAIR UPSHAW TRAVIS: Mitigation, thank  
9       you. So I guess that just concerned me a little bit  
10      when we were putting payment policy on --

11                  MEMBER GHINASSI: Well, I think I  
12      submitted those for the consideration of the group,  
13      because I think it better reflects the realities of  
14      this situation. I think that the barriers here are  
15      that the current structure is that the IPF is being  
16      held accountable for something that occurs after their  
17      direct influence is possible.

18                  And all the procedures that happen that  
19      make it possible happen up into the moment that the  
20      person leaves the facility. Many of the factors that  
21      then affect whether that person successfully gets  
22      their's happen in a space they're not operating in.

1 I would submit that they be allowed to operate in that  
2 space as well, and be reimbursed for it.

3 And that's -- and I'm bringing it up. I  
4 realize it makes it complex, but my feeling is, it is  
5 complex.

6 MR. STOLPE: So the suggestion from the  
7 staff on this point, Frank, would be that you do not  
8 support the measure.

9 MEMBER GHINASSI: I do not --

10 MR. STOLPE: As we -- we would say that  
11 that's outside of the realm of the measure developer,  
12 to make it significant adjustments, that we would  
13 consider mitigatable factors. So if it's a payment  
14 policy or related issue where the structure of our  
15 current system does not allow for a good  
16 implementation of the measure, from your perspective,  
17 then we would suggest --

18 MEMBER GHINASSI: So I wouldn't be able to  
19 vote for mitigation then.

20 MR. STOLPE: That's correct.

21 MEMBER GHINASSI: Okay.

22 MR. STOLPE: Yes. You would not support.

1 CO-CHAIR MORRISON: Amy.

2 MEMBER HELWIG: I just had heard --

3 (Simultaneous speaking.)

4 MEMBER HELWIG: -- said that --

5 (Simultaneous speaking.)

6 CO-CHAIR MORRISON: And I'm sorry, I need  
7 to keep the conversation down.

8 CO-CHAIR UPSHAW TRAVIS: We're having a  
9 hard time hearing Amy.

10 MEMBER HELWIG: I was going to say, just  
11 really quick -- with what NCQA has recently published,  
12 with especially as it goes to vertical health.

13 CO-CHAIR MORRISON: In effect, even for  
14 mitigating circumstances?

15 MEMBER DEMEHIN: I will be fully  
16 transparent and say I'm not sure how mitigatable this  
17 measure really is. But if I am thinking about  
18 strategies for potentially making it better, we're  
19 still really bothered by this mismatch between the  
20 expanded population and the evidence base for that  
21 expanded population. So some further examination of  
22 that, I think would be very important.

1 I do think that delving into -- and I know  
2 that this is always controversial, but delving to the  
3 issues of SES, and how to account for it in this  
4 measure would be incredibly helpful, if we're going to  
5 move forward with it.

6 And to Amy's point, alignment with health  
7 plan measures, I think, and partnerization, at a  
8 minimum, would be an important mitigating factor.  
9 Frankly, I still have a broader conceptual challenge.  
10 I'm just not sure I can get my head around here. But  
11 if you are looking at strategies for potentially  
12 improving this, those would be a couple.

13 CO-CHAIR MORRISON: You will get your  
14 chance in a moment to decide. The developer has asked  
15 for a moment, so I'm going to pause here before I go  
16 to next cards. Jack, keep it up, but just -- we have  
17 the developer on the phone?

18 (Simultaneous speaking.)

19 CO-CHAIR MORRISON: Mathematica, you're on  
20 the phone.

21 MS. ROSENSTEIN: Mathematica is on the  
22 phone.

1 CO-CHAIR MORRISON: And you had a comment?

2 MS. ROSENSTEIN: Oh, I did want to go back  
3 to the point about telehealth. Telehealth is accepted  
4 if it's billed with a modifier of GT. So I think that  
5 goes back to somebody mentioned earlier about how it  
6 can be covered by -- you know, it covered only that  
7 specific -- it adds that modifier. So I did want to  
8 mention that.

9 CO-CHAIR MORRISON: Thanks. Thank you.

10 Aisha, you have up -- are you down, or are  
11 you up?

12 MEMBER PITTMAN: I was up, because of that  
13 plan.

14 CO-CHAIR MORRISON: Okay.

15 MEMBER PITTMAN: We just recently expanded  
16 it, so -- and if the measure at all pulling in the  
17 codes associated with health in -- it was either this  
18 year or last year, for expanded telehealth for some  
19 substance use treatment.

20 MEMBER DUSEJA: So, do Mathematica's claim  
21 agency bill this as well?

22 MS. ROSENSTEIN: It is, if it is actually

1 coded by the GT modifier, for the current measure that  
2 you guys are evaluating.

3 CO-CHAIR MORRISON: Anna, I think you got  
4 the last --

5 MEMBER DOPP: I'm in the last --

6 CO-CHAIR MORRISON: -- the last word, as  
7 it were.

8 MEMBER DOPP: Yes. I signed the back. I  
9 don't know it's, that this is compared to the  
10 medication continuation, NQF 3205 measure. And it had  
11 said that there were weak correlations with the  
12 medication continuation measure for the seven days,  
13 but moderately positive correlations at 30 days.

14 I just wonder if there's some less  
15 ancillary between the two, understanding that the  
16 important access, so kind of alluding to medications  
17 and kind of alluding to follow-up care, although, and  
18 they're both claims-based measures, but they're  
19 different in the pharmacy realm, too. But just  
20 because that was part of the background, I thought  
21 that that was interesting, to kind of overlay the two,  
22 as you think about it.

1 CO-CHAIR MORRISON: Okay. I am going to  
2 throw just a small monkey wrench in here, because the  
3 first vote we had was based upon the fact that there  
4 was uncertainty around telehealth. And I guess my  
5 question is sort of a straw poll. Should we read this  
6 as the first vote, because would that have changed  
7 people's perceptions about how they would vote and now  
8 that we know that telehealth is included with the GT  
9 code --

10 MEMBER SCHREIBER: The specific elemental  
11 code.

12 CO-CHAIR MORRISON: -- with the specific  
13 telehealth modifier. It's easy to do. And then if we  
14 -- then we can move on.

15 MR. STOLPE: I agree to revote. Yes.

16 CO-CHAIR MORRISON: Revote, okay. All  
17 right, so first we're going to go back to staff  
18 recommendation, which was, conditional support with  
19 the condition being including substance use disorder.

20 MEMBER SCHREIBER: And NQF codes.

21 CO-CHAIR MORRISON: And NQF endorsement.

22 MEMBER GHINASSI: Clarification. That GT

1 code that approves a telehealth visit, is that a code  
2 that is usable both by the IPF and an ambulatory site,  
3 or is it only an ambulatory site can use that?

4 CO-CHAIR MORRISON: Frank, I love the fact  
5 you're looking at me and -- like I know the answer to  
6 this question.

7 (Laughter.)

8 CO-CHAIR MORRISON: That is --

9 (Simultaneous speaking.)

10 MEMBER GHINASSI: Because the reason I'm  
11 asking is because if the intent here is to judge the  
12 quality of the hospital, and the hospital has an  
13 ability to use a tool to help make this happen, as in,  
14 you know, telehealth, then I think it changes the  
15 stakes. If the answer to that is not really, then I  
16 don't see how that impacts the entity that's being  
17 judged in this measure. That's my question, and  
18 statement.

19 MEMBER SCHREIBER: It's a payment policy,  
20 and I don't know that we can answer it. We can try to  
21 find out. My best guess is, though, when a claim is  
22 submitted, it's submitted by whoever is rendering that

1 service. And so, for the most part, I would think  
2 that that service is who's providing the telehealth  
3 service.

4 MEMBER GHINASSI: The receiving entity?

5 MEMBER SCHREIBER: Probably the --

6 (Simultaneous speaking.)

7 CO-CHAIR MORRISON: The receiving end.

8 The receiving end, the receiving end who's providing  
9 the service.

10 MEMBER GHINASSI: The telehealth addition  
11 here does nothing to further empower the IPF.

12 CO-CHAIR MORRISON: That is my -- that is  
13 what I'm hearing.

14 CO-CHAIR UPSHAW TRAVIS: But --

15 CO-CHAIR MORRISON: That is the basis --

16 CO-CHAIR UPSHAW TRAVIS: It's a payment  
17 policy.

18 CO-CHAIR MORRISON: But it's a payment  
19 policy which we have to check.

20 CO-CHAIR UPSHAW TRAVIS: Well, the one  
21 comment I'll make on that is it does expand the access  
22 to a broader array. In other words, it doesn't limit

1 access only to an in-person visit.

2 MEMBER GHINASSI: But it is broadening it  
3 for entities --

4 CO-CHAIR UPSHAW TRAVIS: That's correct.

5 MEMBER GHINASSI: -- who are not being  
6 measured by this measure.

7 CO-CHAIR UPSHAW TRAVIS: And I agree with  
8 you. Yes. That is -- so it does, but there were lots  
9 of concerns around access, and it does broaden access  
10 for that follow-up.

11 CO-CHAIR MORRISON: Phoebe.

12 MEMBER RAMSEY: I would just mention that,  
13 in terms of a payment policy, it's also kind of  
14 beneficiary-dependent, whether or not telehealth would  
15 be paid for, for that beneficiary, based on that  
16 beneficiary's locality, and that in general it's going  
17 to not pay for telehealth for the beneficiary from  
18 their place of service at their home. They have to be  
19 in a facility or at a doctor's office.

20 MEMBER SCHREIBER: And if you remember,  
21 that's why the question went to whether telehealth  
22 units are those, sometimes.

1 (Simultaneous speaking.)

2 CO-CHAIR MORRISON: Okay. So we are going  
3 to go back to vote. So, let's do it.

4 MR. HIRSCH: Voting for MUC 2019-22,  
5 Follow-Up After Psychiatric Hospitalization, do you  
6 vote to support the preliminary analysis as the work  
7 group recommendation, conditional support for  
8 rulemaking, is now open for voting. Your options are  
9 yes or no.

10 MS. JUNG: So we do not have consensus.

11 CO-CHAIR MORRISON: So we don't have  
12 consensus. So now we are going to move to do not  
13 support with potential for mitigation. And we have  
14 heard the mitigating circumstances.

15 So, yes, Cristie?

16 CO-CHAIR UPSHAW TRAVIS: I just would like  
17 Sam to repeat, if you can, that if it's a payment  
18 policy issue, where should we be voting?

19 MR. STOLPE: Yes. If your concern is that  
20 the current environment does not allow for the  
21 implementation of this measure, that there's not a  
22 mitigatable circumstance by the measure developer to

1       adjust the measure in a way that would be satisfactory  
2       for inclusion inside of this measure set, then you  
3       should vote do not support.

4               MR. AMIN:  So if we're looking at the  
5       question, the next vote, which is do not support with  
6       potential for mitigation, the mitigating elements that  
7       we've heard, that seemed to jibe with the group --  
8       well first we already have the expansion of the  
9       population, further considerations about how  
10      telehealth could be introduced into the specifications  
11      could also be an element for the measure developer to  
12      consider.  It seems like that is challenging.  That is  
13      all I -- that's all I got.  Because everything else is  
14      payment.  Right.  And if that's not satisfying, then  
15      --

16             MR. STOLPE:  There was the mention of the  
17      expansion of the evidence base, which I will  
18      acknowledge.  And that would mainly come under  
19      consideration when the measure goes in for NQF,  
20      evaluation for endorsement.  There's a thorough look  
21      at the evidence base, and if the expectation that  
22      there's a direct connection between the conditions of

1 interest and evidence that supports it.

2 CO-CHAIR MORRISON: Are we good to vote  
3 then?

4 MEMBER MATTHES: Just to repeat that  
5 piece, if the payment issue was the actual problem,  
6 it's a no on the next one?

7 CO-CHAIR MORRISON: That is correct.

8 MEMBER MATTHES: If I go to the payment  
9 issue --

10 CO-CHAIR MORRISON: If it is a payment  
11 issue, you should vote no because the measure  
12 developer can't mitigate a payment issue. Yes.

13 MR. HIRSCH: Prior to moving on, just for  
14 the official record, the vote was 11 yes and 13 no for  
15 do you support the work group recommendation for  
16 Follow-Up After Psychiatric Hospitalization measure.

17 CO-CHAIR MORRISON: Okay. So, vote your  
18 conscience, folks, or your organization, depending on  
19 where you're coming from.

20 MR. HIRSCH: For MUC 2019-22, Follow-Up  
21 After Psychiatric Hospitalization, do you vote, do not  
22 support with potential for mitigation? Your options

1 are yes and no.

2 CO-CHAIR MORRISON: Well, we're missing  
3 two. Missing two votes.

4 (Off microphone discussion.)

5 MR. STOLPE: Did we lose one? We lost  
6 one.

7 MS. JUNG: We're still at 24, so did  
8 everyone on the phone as well, and in the room, just  
9 make sure you selected your option. We're only seeing  
10 23 on the screen right now. Oh, okay. We got a  
11 message that one of them is still working.

12 (Off microphone discussion.)

13 CO-CHAIR MORRISON: So we still don't have  
14 consensus. So the final vote was 12 to 12, 50. So  
15 now we'll move to the last question, and this -- you  
16 guys are going to love this. You're going to love --  
17 so do we --

18 MEMBER SCHREIBER: We had 25 voting  
19 members. Did we lose somebody?

20 CO-CHAIR MORRISON: We lost one.

21 MEMBER SCHREIBER: Okay.

22 CO-CHAIR MORRISON: Yes. So now the

1 question is, do you not support the measure? Okay.

2 So, if you vote yes, and 60 percent vote yes, so the  
3 measure is not supported. However, if 60 percent vote  
4 no, then the staff's recommendation is, moves forward.  
5 So just be -- I know, I know. I knew you were going  
6 to love this.

7 So a vote not to endorse means the measure  
8 is not endorsed. If that does not carry, the staff's  
9 recommendation carries forward. So just be careful  
10 how you're voting.

11 MEMBER GHINASSI: So a yes means no.

12 CO-CHAIR MORRISON: A yes means no.

13 (Laughter.)

14 CO-CHAIR MORRISON: A yes means no. Yes.  
15 Your vote -- a yes means you are not endorsing. It's  
16 a double negative. I told you this was going to be  
17 fun.

18 MEMBER SCHREIBER: Do not support.

19 CO-CHAIR MORRISON: Do not support.

20 MEMBER GHINASSI: Yes means do not  
21 support.

22 CO-CHAIR MORRISON: Yes means do not

1 support.

2 Akin, you are looking --

3 MEMBER DEMEHIN: I think we should vote,  
4 but if we end up voting no, I would be curious to hear  
5 more about the rationale for why the staff  
6 recommendation would carry forward, when it's clear  
7 that there doesn't -- it would be clear that there  
8 really wasn't consensus. But let's vote first.

9 CO-CHAIR MORRISON: Let's jump off that  
10 bridge if we come to it, please.

11 (Laughter.)

12 MR. HIRSCH: All right. Voting for MUC  
13 2019-22, Follow-Up After Psychiatric Hospitalization,  
14 do you vote, do not support, is now open. Your  
15 options are yes or no.

16 MS. JUNG: We have one online vote, that  
17 is in addition for the yes vote. So we have reached  
18 consensus.

19 CO-CHAIR MORRISON: We have reached  
20 consensus. See Akin, no worries.

21 (Laughter.)

22 MS. JUNG: For everyone in the room, to

1 restate the final vote for MUC 2019-22, Follow-Up  
2 After Psychiatric Hospitalization for do not support  
3 is a yes, with 15 votes, and a no with 9 votes.

4 MR. AMIN: So before I move on, can I just  
5 take two seconds? So there was a lot of conversation  
6 on this measure. I just want to capture some of the  
7 key issues. Evidence, there's issues around  
8 attribution, there's issues around the Stark self-  
9 referral question. There's obviously an issue related  
10 to the telehealth component and receiving -- basically  
11 what role inpatient psychiatric facilities have in  
12 terms of being able to provide telehealth for being  
13 judged on this measure.

14 Anything else that's key conceptual issues  
15 of not being able to move forward on this?

16 CO-CHAIR UPSHAW TRAVIS: I would just  
17 clarify a little bit on the telehealth. I mean, it  
18 seems to me that it's sometimes covered and sometimes  
19 not. So it wasn't just a matter of the inpatient  
20 facility being able to provide this telehealth  
21 service, it was also that it's not always a covered  
22 service.

1                   MR. AMIN: Okay. That's good. And then  
2 I would like to provide a quick clarification on the  
3 voting process and how we end up back with that. We  
4 can provide feedback about this, but the rationale of  
5 how we got to this point, is at the Coordinating  
6 Committee discussion, we did want to make sure -- the  
7 Coordinating Committee sort of discussion on voting  
8 was that there should be a decision on every measure.  
9 And the decision should be derived by the decision  
10 categories and the algorithm that was determined by  
11 the Coordinating Committee and the input from the MAP.

12                   So, in the event that there isn't  
13 consensus, obviously all the rich conversation will be  
14 carried forward to the Coordinating Committee. But at  
15 the very least, the objective criteria that was used  
16 should land us in a place as a starting point for  
17 discussion.

18                   MR. STOLPE: So what that means is that  
19 the conversation would move forward, that the  
20 Coordinating Committee would pick up where we left  
21 off, and incorporate your comments, your discussion  
22 into how they consider the staff recommendation, and

1 make a decision based on that.

2 CO-CHAIR UPSHAW TRAVIS: So it goes  
3 forward just to the Coordinating Committee?

4 MR. STOLPE: Correct.

5 CO-CHAIR UPSHAW TRAVIS: But we wouldn't  
6 know what --

7 MR. STOLPE: Right. I just wanted to  
8 clarify.

9 MEMBER HATLIE: Just a comment to  
10 underscore, because there was a lot of discussion here  
11 about the importance of this issue for this high-risk  
12 population, and so I hope that will be carried forward  
13 with some -- there was consensus about that.

14 MR. AMIN: Yes. Agreed.

15 CO-CHAIR MORRISON: So just, in  
16 communication training we call this a closed-ended  
17 question, were there any gaps that people identified  
18 that were not previously identified on our call  
19 before? And we can put those back up. But this is  
20 the opportunity to put in gaps that you believe were  
21 not previously identified.

22 Jack.

1                   MEMBER JORDAN: I think just the general  
2 capacity of psychiatric care in the country is a  
3 gigantic issue. Now how you get that with measuring,  
4 you know, that you're measuring kind of the capacity,  
5 but there's nothing more disturbing than to be at a  
6 hospital quality huddle, and say, we have a patient in  
7 the ED 150 hours, there's no place we can place them  
8 for psych care.

9                   You know, and we can fix any of the other  
10 measures we have, but if there isn't a safe place to  
11 put them, it's kind of a moot point.

12                  MR. STOLPE: Absolutely.

13                  CO-CHAIR MORRISON: All right, guys, I  
14 have successfully lost us all the time that Cristie  
15 has gained.

16                  (Laughter.)

17                  CO-CHAIR MORRISON: Why don't we take --  
18 why don't we reconvene at 1:30 for the afternoon, and  
19 lunch is right out here. I apologize. You can come  
20 this way through the door.

21                  (Whereupon, the above-entitled matter went  
22 off the record at 12:45 p.m. and resumed at 1:30 p.m.)

1 CO-CHAIR UPSHAW TRAVIS: Okay, I think  
2 we're going to get started. Okay. Well thank you all  
3 for coming back after lunch. I hope you enjoyed the  
4 time.

5 So the next program we're going to be  
6 looking at is End Stage Renal Disease Quality  
7 Incentive Program measures. And I'm going to turn it  
8 over to Madison, who's going to give us a review of  
9 the program.

10 MS. JUNG: Thank you.

11 So again, this is information we saw  
12 during the web meeting in the fall, but this is the  
13 ESRD QIP program. It is a pay for performance and  
14 public reporting program. The intent to structure is  
15 that as of 2012, payments to dialysis facilities are  
16 reduced to facilities who do not meet or exceed the  
17 required total performance score.

18 Payment reductions will be on a sliding  
19 scale, which could come out to as much as 2 percent  
20 per year. The goal for this program being improve the  
21 quality of dialysis care and produce better outcomes  
22 for beneficiaries.

1                   Again, in the reference materials, there  
2                   are the program set as of the most recent rule. And  
3                   according to the most recent rule, these are the  
4                   updates contained. About four measures were moved for  
5                   payment year 2021, two were added for payment year  
6                   2022, and then one measure not finalized for payment  
7                   year 2022.

8                   The priorities identified for this program  
9                   by CMS in the Needs and Priorities document are care  
10                  coordination, safety, patient- and caregiver-centered  
11                  care. And the work group identified a few gap areas  
12                  to note during our discussion. So there's -- and this  
13                  is on ESRD patient experience measures, specifically  
14                  ones that were not part of the process, so ones that  
15                  could be broken out and reported separately.

16                  An example given was, suggested was that  
17                  in-center hemodialysis caps questions could be broken  
18                  out. The work group also emphasized that where  
19                  possible, there should be alignment with other CMS  
20                  program sets.

21                  CO-CHAIR UPSHAW TRAVIS: Is that it?

22                  MS. JUNG: Yes.

1 CO-CHAIR UPSHAW TRAVIS: Okay. I'd like  
2 to open it up for public comment, for the ESRD  
3 measures. Any in the room?

4 (No response.)

5 CO-CHAIR UPSHAW TRAVIS: Okay. I don't  
6 see any. How about on the line?

7 (No response.)

8 CO-CHAIR UPSHAW TRAVIS: Okay. No public  
9 comment. So we will move first to the staff review of  
10 the preliminary analysis.

11 MS. JUNG: So, this measure currently  
12 exists in the ESRD QIP. It is an NQF-endorsed  
13 measure, Measure Number 2979, but it is actually  
14 undergoing review right now in the upcoming fall 2019  
15 cycle, with the Renal Standing Committee.

16 The measure was resubmitted to NQF for  
17 endorsement because it's had significant updates in  
18 the specifications. Specifically, we noted that there  
19 had been substantial updates related to the codes used  
20 in the transfusion definition and handling of Medicare  
21 Advantage.

22 The staff preliminary analysis conditional

1 support pending NQF review and endorsement. I should  
2 note that this has also been through the Scientific  
3 Methods Panel, and it did pass the Scientific Methods  
4 Panel last month for reliability validity.

5 CO-CHAIR UPSHAW TRAVIS: Thank you,  
6 Madison.

7 So we'll move to our lead discussants.  
8 Paul is not with us today; is that correct?

9 MS. JUNG: That's correct.

10 CO-CHAIR UPSHAW TRAVIS: Okay. So we'll  
11 go to Jackson Williams with the Dialysis Patient  
12 Citizens.

13 MEMBER WILLIAMS: Thanks. So this is a  
14 measure of a unit of management for dialysis patients.  
15 Previously there was a quantitative measure of  
16 hemoglobin. In 2010 or 2011, a researcher identified  
17 cardiac events resulting from overuse of EPOGEN. So  
18 the quantitative measure was abandoned.

19 Also at that time, EPOGEN seems to be  
20 reimbursed on a fee for service basis. It was, the  
21 entire dialysis payment was moved to a bundle payment,  
22 or a prospective payment system.

1           This is an outcome measure now, that is  
2           very important not only because of the fatigue but  
3           also because too many transfusions can interfere with  
4           the ability to receive a transplant.

5           This is a measure to guard stinting in the  
6           bundled environment. So patients are worried that, if  
7           their clinic doesn't have enough money to pay for EPO  
8           this month, that they may not get their full dose. To  
9           my knowledge, this is really the only check on the  
10          possibility of stinting in the bundle.

11          We did comment to CMS this year that it  
12          would be nice if they could somehow audit the use of  
13          medications or do something, you know, survey-wise.  
14          They said they can't. So this is the only game in  
15          town.

16          And anyways, because of the change to ICD-  
17          10, CMS changed this to a reporting measure, which is  
18          the participation trophy option in the ESRD QIP. I'm  
19          not sure whether reporting measure is a term of art  
20          that's only used in the QIP, as opposed to being used  
21          across measure sets. And that will be one of the  
22          clarifying questions I would ask when I get that up to

1       you. And I support the recommendation.

2                   CO-CHAIR UPSHAW TRAVIS: Okay. That's  
3       what I was going to ask. Thank you so much, Jackson.

4                   Debbie Wheeler, with Molina Healthcare.

5                   MEMBER WHEELER: Yes, I'm here. So I  
6       think I also support this measure, so I won't go into  
7       much detail since we just talked about it. But my one  
8       question that seemed to come up during the discussion,  
9       the discussion about the measure was whether this is  
10      an outcome measure or not.

11                   Eventually, it was decided to be one, but  
12      I'm wondering, is this really an outcome measure or is  
13      it more a process measure to, you know, look at those  
14      transfusion ratios? Because to me, I think it's more  
15      of a process or not even intermediate outcome but some  
16      sort of process measure to manage the anemia, but not  
17      an outcome measure. That's my only comment.

18                   CO-CHAIR UPSHAW TRAVIS: Okay, thank you.

19                   And Amy, with UPMC Health Plan.

20                   MEMBER HELWIG: Just a couple of comments  
21      to add to the discussion. I do support it as  
22      conditional. A couple of things to add. One is, it's

1 entirely claims-based, which is what is reflects  
2 safety, in terms of exposure to transfusions. It also  
3 reflects appropriate care. And because it is  
4 underlying, reflects, I think, management of anemia,  
5 in that regard, almost an indirect measure of quality  
6 of life, just in terms of fatigue.

7 Just in terms of look at market trends,  
8 one thing that I don't think that's been mentioned  
9 here, they mentioned issues with Medicare Advantage  
10 and the data with Medicare Advantage, so just -- and  
11 other trends, in 2021, Medicare Advantage plans will  
12 start covering dialysis.

13 So as Medicare Advantage plans, now once  
14 patients initiate on dialysis, they're actually going  
15 to move for fee for service, so we don't bear that  
16 long-term cost. But that changes in 2021, so that  
17 members can elect to -- receiving dialysis can elect  
18 to stay in our plan, or they can come on to the plan.

19 So they, the health plan, it changes the  
20 things for us because suddenly we're going to be  
21 looking at trying to really heavily incentivize, and  
22 look at our products to do more home-based dialysis

1 when that's what the patients want, and the incentives  
2 change.

3 And with that in mind, just, I think it's  
4 going to be a recorded, not a score or performance  
5 measure, as it's adopted. I think I would just point  
6 out that that is a good decision, since we don't know  
7 how we even nominate, or how the populations are going  
8 to shift, because starting in 2021, they may have a  
9 very significant shift in terms of who actually stays  
10 in facilities getting dialysis versus who moves to the  
11 home environment, and also who moves to transplant,  
12 because the whole incentives change, in terms of how  
13 we're looking at this population.

14 CO-CHAIR UPSHAW TRAVIS: Thank you for  
15 that. Any feedback, Brock from the rural?

16 MR. SLABACH: Thanks, Cristie.

17 Yes, I think that obviously this is a  
18 priority condition for rural patients that are  
19 experiencing the need for dialysis. And so there was  
20 a general consensus in the support category, we could  
21 see from distribution of the votes taken.

22 And then we don't see any unintended

1 consequences, necessarily, except that there's some  
2 distances that are really problematic for many rural  
3 residents to have to take to get these services. And  
4 other than that, there was no -- there was general  
5 consensus.

6 CO-CHAIR UPSHAW TRAVIS: Okay, thank you.

7 All right. Are there some clarifying  
8 questions that people have? And let's try to stick to  
9 just questions at this point.

10 Phoebe.

11 MEMBER RAMSEY: I have one question that  
12 came from our review of the measure was whether  
13 mechanical assist patients, so LVADs or RVADs, if  
14 they're excluded only if they have an immediate  
15 diagnosis.

16 CO-CHAIR UPSHAW TRAVIS: Okay. Let's make  
17 a list, and then we'll come back and ask the  
18 developers to respond.

19 Lisa.

20 MEMBER MCGIFFERT: I would kind of -- my  
21 understanding of the description is that there was,  
22 there have been changes in the codes, and some changes

1 in the transfusion definition, to go along with  
2 Medicare Advantage, and I'm curious on how that works  
3 with claims. And I don't understand completely the  
4 whole issue of -- it sounds like the issue of changing  
5 to ICD-10 itself made the results change, but I can't  
6 really tell.

7 CO-CHAIR UPSHAW TRAVIS: All right, thank  
8 you.

9 Jackson.

10 MEMBER WILLIAMS: And yes, I did wonder at  
11 the CMS folks, if you will -- whether you will  
12 determine the way the measure versus reporting measure  
13 is used in other programs. And I thought it was  
14 unusual in this case because the facility does not  
15 report this. This is based on hospital claims. So in  
16 the past, reporting measures have actually rewarded  
17 facilities who are reporting value on something that  
18 happened in their facility.

19 CO-CHAIR UPSHAW TRAVIS: Great, thank you.

20 Okay. Well, I think we do have some  
21 questions for the measure developers related to this.  
22 Do you need me to repeat them or --

1 MR. ROACH: No.

2 MEMBER DUSEJA: Jesse, can you just  
3 introduce yourself?

4 MR. ROACH: Oh, hi. I'm Jesse Roach. I'm  
5 a nephrologist. I'm the ESRD measure lead at CMS for  
6 equipment for dialysis.

7 I'm going to skip the first question and  
8 leave that for the, our measure developers. It's very  
9 specific about the LVAD, so I don't want to say  
10 something wrong. So, they're on the line, so when I'm  
11 done answering the second question, we can get to  
12 that.

13 In terms of the -- I'll just give a brief  
14 explanation. So, this measure was previously in the  
15 QIP. It -- where there was a non-endorsed measure  
16 that involved using value codes to determine  
17 transfusions. It was found that using those value  
18 codes introduced potential bias into the situation and  
19 was -- into the measure, and wasn't reflecting the  
20 true nature and had some geographic bias towards it.

21 So, then we came up with the current  
22 measure, which took those value codes out, and just

1       used the ICD-9 codes, because those were being used  
2       more reliably.

3               With the switch to ICD-10, we found that  
4       people were, began coding differently, and using the  
5       value codes more, and using the ICD-10 codes less,  
6       which then made this measure less reliable. At that  
7       point, that's when they made it -- when we realized  
8       that, that's when we made it the reporting measure,  
9       which I do realize is not typical because the  
10      facilities aren't actually reporting it.

11              But we have a statutory requirement to  
12      leave it, to have it in the program, and we think it's  
13      important to report this, but we didn't want to hold  
14      facilities accountable while we were figuring out what  
15      was going on.

16              This new measure basically goes back to  
17      the old measure, with a couple of changes, one of  
18      which is moving the Medicare Advantage patients  
19      because we found it wasn't reliable, the data, the  
20      measure wasn't reliable when those were included. But  
21      it basically goes back to using those value codes.

22              We've been able to demonstrate now that

1 the codes are, don't introduce geographic bias  
2 anymore, and do a much better job of capturing the  
3 actual transfusions now. So that's why we want to go  
4 back to something that's similar to that old measure,  
5 now that we've demonstrated that there's no bias  
6 involved with it.

7 So, that's the basic gist. I hope that  
8 answered your question.

9 CO-CHAIR UPSHAW TRAVIS: So the plan is to  
10 go back to using ICD-10?

11 MR. ROACH: No. Well it's to include --  
12 it's to use ICD-10 and the value codes. We found  
13 those weren't biased, so we can use both. We can use  
14 both of them.

15 CO-CHAIR UPSHAW TRAVIS: Okay. Can you  
16 explain what a value code is?

17 (Laughter.)

18 CO-CHAIR UPSHAW TRAVIS: Sorry.

19 MR. ROACH: No.

20 CO-CHAIR UPSHAW TRAVIS: It isn't that  
21 complicated a question, but --

22 MR. ROACH: So, it's -- so you can use --

1 no.

2 CO-CHAIR UPSHAW TRAVIS: No?

3 (Laughter.)

4 CO-CHAIR UPSHAW TRAVIS: I'll accept that  
5 it's better with it in there.

6 (Laughter.)

7 MEMBER McGIFFERT: I thought the value  
8 codes were ways that you could add more information  
9 than the ICD-10.

10 MR. ROACH: Yes. You have your claims,  
11 and your diagnoses, and then the value codes are ways  
12 to add different things on to it. So I want to add a  
13 transfusion. You can also code for it in the ICD-10  
14 codes, but you can also add value codes, and you can  
15 do it from either way. So there's ways to add value  
16 to your claim, basically, to add different things to  
17 your claim, so.

18 CO-CHAIR UPSHAW TRAVIS: Okay. And so now  
19 you're using -- in this measure, looking at it, ICD-10  
20 plus value codes?

21 MR. ROACH: Correct.

22 CO-CHAIR UPSHAW TRAVIS: Okay. And does

1 the measure specify which value codes have to be  
2 included?

3 MR. ROACH: That -- it should. I just  
4 want to make sure, I just want to make sure, or  
5 is KECC on the line?

6 MR. MESSINA: Yes, Jesse, this is Joel  
7 Messina.

8 MR. ROACH: So what was your question  
9 again?

10 MEMBER McGIFFERT: Does the measure  
11 include which value codes must be included?  
12 Because my understanding is there's a lot of  
13 them, and hospitals and facilities are using them  
14 sort of ad hoc.

15 MR. MESSINA: So one thing I will add  
16 is, in addition to value codes, which there's one  
17 specific value code that we're using to identify  
18 one or more transfusions in some of the passwords  
19 that we've done, where we've believed that value  
20 codes are reliable indicators that blood was  
21 transfused, but whether or not they were accurate  
22 in terms of the number of units, so we took the

1 conservative approach.

2           So the value code says two units of  
3 blood. That meant one transfusion of that. The  
4 other piece that's important, for those of you  
5 who are familiar with inpatient billing, are  
6 revenue center codes. So the revenue centers of  
7 38 and 39, those two families of revenue centers  
8 describe information about inpatient and out-  
9 patient costs associated with administration, or  
10 either administration of blood, storage and  
11 administration of blood, or purchase, storage,  
12 and administration of blood, depending upon  
13 whether the source for the blood was a for-profit  
14 blood bank or a donated blood bank.

15           And so the original STrR measure  
16 utilized the presence of a revenue center code  
17 with or without an ICD procedure code as evidence  
18 of a transfusion event. That was changed when we  
19 went back in 2016 to NQF because of the regional  
20 variation concerns Jesse described, and we went  
21 to requiring an ICD-9 procedure code at that  
22 time.

1                   This current measure goes back to the  
2                   original approach, which allows a revenue center  
3                   code and/or a procedure code, and/or a value code  
4                   for a blood transfusion as evidence of a  
5                   transfusion event, and everything else Jesse said  
6                   about the reliability and the reduced regional  
7                   variation is correct.

8                   MEMBER RAMSEY:   And what about LVAD?

9                   MR. ROACH:   So can I get a little bit  
10                  of a clarification?   So, wait, who asked that?  
11                  I'm sorry.   So --

12                  CO-CHAIR UPSHAW TRAVIS:   Phoebe.

13                  MEMBER RAMSEY:   So essentially, when  
14                  our clinicians who gave us feedback were  
15                  reviewing the measure, they were concerned that  
16                  there was the exclusion for anemia, but not  
17                  specifically for medical assist devices, and that  
18                  a patient with an LVAD or an RVAD or other one,  
19                  that those patients, then they will not do PSAs.  
20                  They'll do a transfusion because of the concern  
21                  for pump thrombosis.   Again, I'm an attorney, so  
22                  --

1 (Laughter.)

2 MEMBER RAMSEY: -- simply reading the  
3 clinician notes, and they wanted to know whether  
4 an LVAD or RVAD will only be excluded in the  
5 event of an anemia diagnosis being documented.

6 MR. ROACH: Okay. So I wanted --  
7 okay. So you want to know if simply having an  
8 LVAD without --

9 MEMBER RAMSEY: No. Without anemia.

10 (Simultaneous speaking.)

11 MR. ROACH: An LVAD, for those who  
12 don't know, left ventricular assist device.

13 MEMBER RAMSEY: Thank you.

14 MR. ROACH: So if you have that  
15 without a diagnosis of anemia listed, is that  
16 still excluded from this measure? And I do not  
17 have that specific case. Do you guys know at  
18 KECC?

19 MR. MESSINA: I do not believe that  
20 the presence of an LVAD excludes you from a  
21 measure. It was not raised as one of the  
22 critical conditions in the clinical technical

1 expert panel that was used to originally develop  
2 the measure.

3 And I suspect that, although it's a  
4 growing, a number of patients, the, I would still  
5 suspect that the number of individual out-  
6 patients who are on chronic dialysis with a  
7 ventricular assist device is potentially small,  
8 and it wouldn't affect the level of metric, but  
9 we don't have specific information or analyses to  
10 support that. That's just based on my clinical  
11 experience.

12 MEMBER RAMSEY: Yes, I think their  
13 concern was that the anemia diagnosis might not  
14 always be captured, but the device will certainly  
15 be captured.

16 CO-CHAIR UPSHAW TRAVIS: All right.  
17 Thank you. I think that covers the questions  
18 that we had. Any other questions from anyone?

19 I might ask one, and it may be that  
20 I'm a little confused, so I apologize, but with  
21 the change in the Medicare Advantage being able  
22 actually to provide this service at some point in

1 Medicare Advantage, do you all -- does the  
2 methodology, will it kind of compensate perhaps  
3 for patients that move out of this program and  
4 into the Medicare Advantage? Or I'm trying to  
5 figure out, you know, how that might impact this  
6 measure.

7 MR. ROACH: So you're saying, you're  
8 saying it's more -- how are we accounting for the  
9 fact that more patients will move into Medicare  
10 Advantage, and will that affect the reliability  
11 of the measure?

12 CO-CHAIR UPSHAW TRAVIS: Right.

13 MR. ROACH: I -- the answer is I don't  
14 know, and it's something we'll have to monitor as  
15 things go along. I think, just like we found  
16 this issue with the -- when we monitored with the  
17 switch to ICD-10, I think that we'll have to do  
18 the same thing as we go forward to see exactly  
19 how many patients switch over, and what it does  
20 to the measure as we monitor it, and we'll be on  
21 it pretty closely.

22 CO-CHAIR UPSHAW TRAVIS: That's fair.

1                   MEMBER SCHREIBER: And furthermore,  
2 this really becomes something very common in MA  
3 plans, whether or not this is a measure that  
4 needs to go into --

5                   MR. ROACH: Right.

6                   MEMBER SCHREIBER: -- MA plan  
7 evaluations.

8                   CO-CHAIR UPSHAW TRAVIS: And just one  
9 other followup question on that, this is just in-  
10 facility transfusions versus --

11                  MR. ROACH: No. These are all  
12 transfusions. So --

13                  CO-CHAIR UPSHAW TRAVIS: Oh, okay.

14                  MR. ROACH: -- in out-patient or in  
15 the hospitals. Most --

16                  CO-CHAIR UPSHAW TRAVIS: Or at home.

17                  MR. ROACH: -- or --

18                  CO-CHAIR UPSHAW TRAVIS: I mean, can  
19 it be home transfusions?

20                  MR. ROACH: It could be if it was  
21 coded for, but most transfusions, the large --  
22 almost no transfusions are done in the --

1 CO-CHAIR UPSHAW TRAVIS: Okay.

2 MR. ROACH: -- dialysis facility.

3 CO-CHAIR UPSHAW TRAVIS: Okay.

4 MR. ROACH: So it's other facilities,  
5 as long as it shows up in the coding, it gets  
6 counted.

7 CO-CHAIR UPSHAW TRAVIS: Any other  
8 questions? Yes.

9 MEMBER BALAN-COHEN: I would, yes, it  
10 was actually a really good question, whether  
11 there are like any plans to move some more into  
12 methodology, given the new treatment payment  
13 models, and given that, you know, for instance,  
14 there are incentivized transfusions, like at-home  
15 transfusions that might not be like a typical,  
16 you know, like at this point, but if it's  
17 something that may come out further down the  
18 road.

19 MR. ROACH: So it would be something  
20 that we looked at, and we are working with the  
21 CMMI, who are developing the models with their  
22 quality measures. So we're going to be

1 monitoring that as we go forward.

2 CO-CHAIR UPSHAW TRAVIS: Great. I  
3 don't see other cards up. Is there any  
4 additional discussion that anybody wants to have  
5 before we move into voting?

6 MR. AMIN: Can I just ask a clarifying  
7 question, Cristie?

8 CO-CHAIR UPSHAW TRAVIS: Yes.

9 MR. AMIN: I'm still perplexed by this  
10 question about whether this is an outcome  
11 measure.

12 CO-CHAIR UPSHAW TRAVIS: Oh, I'm  
13 sorry. We kind of missed that.

14 MR. AMIN: Can I get some feedback on  
15 that so we can just make sure to either update  
16 the PA as we go to the coordinating committee? Or  
17 just -- because it is a discussion criteria.

18 MEMBER WILLIAMS: Yes, Jackson  
19 Williams. I'd consider it an outcome measure.  
20 This is the, this is the -- what you're trying to  
21 avoid.

22 MR. AMIN: Okay.

1 CO-CHAIR UPSHAW TRAVIS: Is a  
2 transfusion.

3 MR. AMIN: Yes, okay. That's fine.  
4 Okay.

5 MR. ROACH: And I think that the  
6 process would be ESA administration, avoidance of  
7 anemia, steps to avoid anemia, and the outcome is  
8 prevention of transfusions.

9 MR. AMIN: Okay. Thank you.

10 CO-CHAIR UPSHAW TRAVIS: Okay. So the  
11 recommendation on the preliminary analysis is  
12 conditional support based on NQF endorsement, so  
13 we'll start with a vote relative to that.

14 MR. HIRSCH: From MUC2019-64,  
15 standardized transfusion and transfusion ratio  
16 for dialysis, do you vote to support the  
17 preliminary analysis as the work group  
18 recommendation? Conditional support for  
19 rulemaking is the preliminary analysis option.  
20 Your voting options are yes or no. We are  
21 waiting on two more votes.

22 MS. JUNG: We've got one coming in via

1 the chat, and we are at -- so that means we're at  
2 24. We're looking for one more vote. Is anyone  
3 having any technical difficulties? If everyone  
4 could just click again and reconfirm.

5 We have 24. So are we comfortable  
6 closing the vote with 24? I can't tell, we can't  
7 tell who's missing.

8 CO-CHAIR UPSHAW TRAVIS: Who hasn't,  
9 okay.

10 MS. JUNG: Yes, we have quorum.

11 CO-CHAIR UPSHAW TRAVIS: Well, we, and  
12 we know the --

13 MS. JUNG: Yes.

14 CO-CHAIR UPSHAW TRAVIS: -- answer is  
15 yes.

16 MS. JUNG: Yes.

17 CO-CHAIR UPSHAW TRAVIS: Is that --  
18 I'm going to look to NQF staff though. Okay. So  
19 yes, we can go on and close.

20 MR. HIRSCH: MUC2019-64 standardized  
21 transfusion ratio for dialysis, voting is now  
22 closed. The work group has elected to accept the

1 preliminary analysis of conditional support for  
2 rulemaking with 24 votes yes, 0 votes no.

3 CO-CHAIR UPSHAW TRAVIS: Thank you.

4 Your turn.

5 (Simultaneous speaking.)

6 CO-CHAIR UPSHAW TRAVIS: No, it's  
7 mine. It's still --

8 CO-CHAIR MORRISON: No, no, it's, no,  
9 it's mine. It's mine.

10 CO-CHAIR UPSHAW TRAVIS: No, no, it's  
11 still mine, because I have to do gaps.

12 CO-CHAIR MORRISON: Oh, you have to do  
13 gaps.

14 CO-CHAIR UPSHAW TRAVIS: Yes.

15 MEMBER WILLIAMS: Right. Right,  
16 right, right.

17 CO-CHAIR UPSHAW TRAVIS: Yes, I can  
18 tell that Sean's getting the difficult ones this  
19 time around. And Jackson, some gaps you'd like  
20 to mention?

21 MEMBER WILLIAMS: Yes, I circulated  
22 results of our members' survey of about 600

1 dialysis patients, and I had to confess that the  
2 items that I put on here were somewhat arbitrary,  
3 but six of the top seven dimensions of care that  
4 patients think are important are patient  
5 experience issues that are on the CAHPS survey,  
6 but only three of these are reported separately.  
7 So we have urged CMS to report them separately.  
8 I don't know if that requires bringing them  
9 forward as measures, official measures here or  
10 not. But I think it's information that patients  
11 would like.

12           And the number eight item, which is  
13 this number two clinical item is patient safety,  
14 and I would just reiterate what Ms. McGiffert  
15 said this morning -- that it would be great if  
16 patients did have an opportunity to report safety  
17 events. Right now the CAHPS survey asks them: in  
18 the last three months, did any problems occur  
19 during your dialysis? And I consider that a  
20 patient safety question, but it's so vague and  
21 amorphous that it would really be nice to have  
22 that retooled along the lines that we discussed

1       this morning.

2                   And of course, there was a tap on  
3       measures, and the patients overwhelmingly chose  
4       patient safety as an area they wanted to report  
5       on, so I hope CMS will follow up on that. And  
6       finally, I would reiterate it's absolutely  
7       critical to get measures in Medicare Advantage.

8                   CO-CHAIR UPSHAW TRAVIS: Great. Thank  
9       you, Jackson. Amy?

10                  MEMBER HELWIG: Just a couple of  
11       comments on some gaps. I think safety will --  
12       it's currently looked at, but I think it also, we  
13       need to keep our eye on that as well, especially  
14       again as the payment models change, and suddenly,  
15       we might have a large shift of people who need to  
16       do home dialysis.

17                  I'm just wondering if there will be  
18       unintended consequences? I think it's great, but  
19       I think we just have to keep our eye out for any  
20       unintended consequences of maybe shifting too  
21       many people who maybe will not be ready for that.

22                  And the other is on functional status

1 and quality of life. And again, as we look at  
2 the new payment models coming, I think what  
3 someone's functional status and quality of life  
4 measures will be critical in determining really  
5 where are they best served, whether it be in the  
6 facility dialysis, in home dialysis, or again,  
7 moving more rapidly to transplant. So I think  
8 that's something that should definitely be kept  
9 on the horizon.

10 CO-CHAIR UPSHAW TRAVIS: Can I ask a  
11 clarifying question? Maybe Jackson can chime in  
12 here too. Are there particular safety concerns  
13 that would be in a dialysis facility? Maybe one  
14 or two examples. We don't need to go into  
15 everything, but I didn't know if there were  
16 particular safety issues that you --

17 MEMBER WILLIAMS: I'm a lawyer too, so  
18 I don't know the answer to that.

19 CO-CHAIR UPSHAW TRAVIS: Well you  
20 should know that for sure if you're a lawyer.  
21 Yes.

22 MR. ROACH: So I -- can I answer?

1 CO-CHAIR UPSHAW TRAVIS: Yes, please.

2 MR. ROACH: So in our, obviously with  
3 patients, one of the big ones is infection, and  
4 vascular -- and their vascular access. So those  
5 are two of the big safety issues that patients  
6 are repeatedly concerned about, and as it turns  
7 out, those are also -- those are some of the  
8 things that kill the patients the most. So --

9 CO-CHAIR UPSHAW TRAVIS: Right.

10 MR. ROACH: -- they are in tune with  
11 what's going on inside.

12 CO-CHAIR UPSHAW TRAVIS: All right.

13 Thank you.

14 MEMBER NOLAN: Sorry. We couldn't  
15 hear the first thing you said --

16 MR. ROACH: Oh, sorry. Infections are  
17 one of the things that they're the most concerned  
18 about because it's very common, and then their  
19 vascular access.

20 CO-CHAIR UPSHAW TRAVIS: Marty?

21 MEMBER HATLIE: I just want to  
22 underscore, because I haven't said this yet, so

1 I'm another lawyer jumping in here with Jackson  
2 in this case. But we --- it's a vast  
3 underutilized resource to not have a vehicle for  
4 patients to report this sort of thing --  
5 especially patients with chronic conditions or  
6 their family members, they develop an expertise,  
7 and we just don't learn about it because we don't  
8 have a vehicle for it.

9 CMS is trying to do it. There was  
10 some great design work done a few years ago at  
11 AHRQ about developing a system for patients to  
12 actually report things, because we see them using  
13 the open narrative of their patient satisfaction  
14 surveys as a proxy for that. You can look at  
15 those comments and see the events reported there  
16 that we're not getting through any other source.  
17 So we really should be thinking about this as a  
18 priority as we move forward.

19 And certainly patients have been  
20 calling about it for years -- calling for it for  
21 years, and you know, we've got some of the tools  
22 developed. They just haven't been implemented.

1 So I wanted to jump in with the other lawyers,  
2 and just stress this point.

3 CO-CHAIR UPSHAW TRAVIS: Jack?

4 MEMBER JORDAN: Yes. At the urging of  
5 a former boss, I was just sent to pick on our  
6 dialysis people once, and one of the crazy  
7 measures that we talked about, you know, dialysis  
8 rules peoples' lives. So what percent of your  
9 people can hold down a job?

10 CO-CHAIR UPSHAW TRAVIS: Right.

11 MEMBER JORDAN: You know, I think just  
12 some level of functional status for the patients  
13 of what they can do in their life. I mean,  
14 holding down a job might be pretty extreme, with  
15 the every other day thing, but still I think  
16 that's a gap that we're really missing is, how  
17 can we make dialysis something that is less  
18 intrusive in someone's ability to function in  
19 life, is, I think, a gap area. You know, that  
20 would be really helpful.

21 CO-CHAIR UPSHAW TRAVIS: Thanks. Yes,  
22 Frank?

1                   MEMBER GHINASSI: To that same point,  
2 I'm very surprised that they took screening for  
3 depression off of this. That seems like a  
4 natural that you would want to screen for,  
5 behavioral disorders, and/or, you know, histories  
6 of trauma.

7                   I mean, there are things you'd want to  
8 know about these folks. It just seems odd that  
9 they, this is not endorsed. I'm -- did we remove  
10 that from the, I don't, I don't think we did  
11 remove the, I thought it, I thought it said got  
12 not endorsed. Did I read that wrong?

13                  MR. ROACH: Well, it might not be  
14 endorsed, but we have a depression screening  
15 measure in the clip.

16                  MEMBER GHINASSI: It said not  
17 endorsed, based on NQF --

18                  CO-CHAIR UPSHAW TRAVIS: Yes.

19                  MEMBER GHINASSI: I don't know what  
20 that means.

21                  (Simultaneous speaking.)

22                  PARTICIPANT: -- didn't endorse it, or

1 does it mean it just never was --

2 MEMBER GHINASSI: Maybe I don't know  
3 what that means.

4 MR. ROACH: It means it's in the  
5 program; however, it does not have NQF  
6 endorsement status.

7 (Simultaneous speaking.)

8 PARTICIPANT: But it would be helpful  
9 to know --

10 MR. ROACH: So it's in the seven.

11 CO-CHAIR UPSHAW TRAVIS: Okay.

12 MR. ROACH: Okay.

13 PARTICIPANT: Oh, if it was reviewed  
14 and not endorsed, but we don't know that, right?

15 CO-CHAIR UPSHAW TRAVIS: It says based  
16 on NQF number 0418, but it says not endorsed.

17 MR. ROACH: Yes.

18 MEMBER GHINASSI: That would just  
19 surprise me that it -- that it wouldn't be a  
20 natural.

21 MS. JUNG: So it would -- we would  
22 designate if it failed endorsement.

1 CO-CHAIR UPSHAW TRAVIS: Okay.

2 MS. JUNG: So, yes.

3 PARTICIPANT: Yes, failed endorsement.

4 CO-CHAIR UPSHAW TRAVIS: So it just  
5 hasn't gone through it then --

6 MR. ROACH: Correct.

7 CO-CHAIR UPSHAW TRAVIS: -- I guess?

8 MS. JUNG: Yes.

9 CO-CHAIR UPSHAW TRAVIS: Okay.

10 MS. JUNG: That would be the  
11 implication then.

12 PARTICIPANT: Oh, okay.

13 MR. ROACH: So just to be clear, for  
14 this, so this particular measure is based on a  
15 measure that has NQF endorsement, but this  
16 measure itself has not been reviewed by an NQF  
17 standing committee.

18 CO-CHAIR UPSHAW TRAVIS: Okay. Okay.  
19 So it's in there. It's in the program. Thank  
20 you. Other comments on gaps? Now --

21 CO-CHAIR MORRISON: She still did  
22 well. Even, all right. So we're going to go

1        onto inpatient quality, inpatient quality  
2        reporting program. We've got two measures under  
3        consideration here, and I will turn to Sam for an  
4        IQR overview.

5                    MR. STOLPE: Thanks, and I have the  
6        unfortunate task of reading the most lengthy name  
7        of any program under the sun. It's the Hospital  
8        Inpatient Quality Reporting Program, IQR, and  
9        Medicare and Medicaid Promoting Interoperability  
10       Program for Eligible Hospitals and Critical  
11       Access Hospitals. That is the actual name of the  
12       program.

13                   Now, this is a paper reporting and  
14       public reporting measure, and the incentive  
15       structure is such that hospitals that do not  
16       participate, or participate but fail to meet  
17       program requirements, receive a 140 reduction,  
18       the applicable percentage increase in their  
19       annual payment update.

20                   The program goals, as they've been  
21       already stated, are progress towards paying  
22       providers based on the quality, rather than the

1 quality of care. They get patients  
2 interoperability between EHRs and CMS data  
3 collection, and to provide consumers information  
4 about hospital quality so they can make informed  
5 choices about their care.

6 So this is the list of the measures  
7 inside of IQR currently. They're there for your  
8 reference. Next slide. And these -- well let's  
9 go back to that one. These are the proposed  
10 updates for you to consider as well. So we're  
11 not just thinking about measures as they are  
12 currently included, but what is slated for  
13 inclusion in the future. Okay. Let's go to the  
14 next slide.

15 These are the high priority meaningful  
16 measurement areas for a hospital IQR, namely  
17 strengthening person and family engagement, the  
18 promotion of effective communication and care  
19 coordination, the promotion of effective  
20 prevention and treatment of chronic disease, and  
21 to make care safer specifically by reducing harm  
22 caused in the delivery of care.

1                   We've now arrived at what I'll call  
2                   the Friday afternoon of our time together. We've  
3                   got two measures to go, and our co-chairs and  
4                   yourselves have done a remarkable job of keeping  
5                   us on time, such that we will have to come to a  
6                   decision of whether or not we want to take our  
7                   break or plow on after we finish this first  
8                   measure. And that first measure is going to be a  
9                   discussion around what we, as staff, have flagged  
10                  as one of the most potentially controversial  
11                  measures, and that'll be maternal morbidity.

12                  But before that, I'll hand it back  
13                  over to our co-chairs to put out for public  
14                  comment.

15                  CO-CHAIR MORRISON: Public comments in  
16                  the room? Public comment on the phone? Okay.  
17                  Who has the joy of describing this measure from  
18                  staff?

19                  MR. STOLPE: That would be me.

20                  CO-CHAIR MORRISON: That would be you.

21                  MR. STOLPE: And a pleasure it is. So  
22                  this is a very interesting measure. The first

1       that we're going to approach is NQF2019-114,  
2       maternal morbidity. This is perhaps the -- one  
3       of these kids that is doing his own thing of the  
4       measures that we're considering today, and it's  
5       the only measure that is a structural measure,  
6       and it's the only measure that doesn't have some  
7       NQF-endorsed either basis for the measure itself,  
8       or it's the measure actually being fully reviewed  
9       and endorsed.

10               So this measure is a simple one-  
11       question attestation, which I'm going to read the  
12       question in its entirety for the group. And  
13       it's: does your hospital or health system  
14       participate in a QI collaborative program, i.e.  
15       state perinatal collaborative, federal  
16       collaborative, registry, or purchaser  
17       collaborative aimed at improving maternal  
18       outcomes during inpatient labor, excuse me,  
19       labor, delivery, and postpartum care, such as  
20       hemorrhage, sepsis, thrombosis, severe  
21       hypertension, preeclampsia, eclampsia, or death?

22               And the options are: yes, no, or not

1 applicable for hospitals that do not provide  
2 inpatient labor and delivery care. So we're  
3 simply stating: do you participate in a QI  
4 program?

5 The staff's preliminary analysis of  
6 this measure landed at do not support. Now the  
7 rationale behind that is that the evidence based,  
8 as we saw in the submission, was not adequate to  
9 say empirically that not only participation, but  
10 attestation to participation is directly  
11 connected to the sorts of outcomes that we would  
12 want to see.

13 Now, and not to put too fine a point  
14 on it, but there is a distinction between  
15 attesting to participation, the degree to which  
16 that occurs, and what that actually means to  
17 consumers who would be looking at IQR, presumably  
18 in determining which hospital they would want to  
19 go to, and hospital compare, and using this  
20 measure as a potential way of discriminating  
21 between two different hospitals. So that's a  
22 fairly quick synopsis of the -- of the PA for

1 this particular measure.

2 CO-CHAIR MORRISON: Thank, Sam. Lisa,  
3 and Mothers Against Medical Error, I have you as  
4 the first discussant.

5 (Simultaneous speaking.)

6 CO-CHAIR MORRISON: Oh, I'm sorry,  
7 clarifying, no, no. We --

8 PARTICIPANT: We had some just --

9 CO-CHAIR MORRISON: Okay.

10 PARTICIPANT: -- clarifying  
11 statements.

12 CO-CHAIR MORRISON: Oh.

13 MS. ABDULLAH-McLAUGHLIN: Yes. So I'm  
14 Annese Abdullah-McLaughlin, and I work for CMS,  
15 and I work on this measure. And we actually  
16 refined the question --

17 CO-CHAIR MORRISON: Okay.

18 MS. ABDULLAH-McLAUGHLIN: -- because  
19 when we first put the question on the MUC list,  
20 it was very early development. And I did send  
21 this over about a couple weeks ago to the MAP  
22 that stated our new question.

1                   So it's still a one question, but it  
2       reads: does your hospital or health system  
3       participate in a statewide and/or national  
4       perinatal quality improvement collaborative  
5       program aimed at improving maternal outcomes  
6       during inpatient labor, delivery, and postpartum  
7       care, which includes implementation of patient  
8       safety practices or bundles to address  
9       complications including but not limited to  
10      hemorrhage, severe hypertension/preeclampsia, or  
11      sepsis, and the answers are the same. It will be  
12      yes, no, or not applicable if your hospital does  
13      not provide inpatient labor and delivery care.

14                  So I just wanted to mention that  
15      before we got beyond that.

16                  MR. STOLPE: Thank you for that.

17                  MEMBER SCHREIBER: Can I just ask a  
18      question? Because this is very different, and it  
19      really isn't sort of the traditional measure that  
20      you think about, I'm going to ask the co-chairs:  
21      would it be helpful for us, as CMS, to frame this  
22      to begin with, or do you want to hear everybody's

1 conversation and then have us respond?

2 CO-CHAIR MORRISON: Go ahead and  
3 frame, Michelle.

4 MEMBER SCHREIBER: You know, this is  
5 obviously what I want to do. You know, this is  
6 not your standard measure per measure. This is  
7 really an attestation signal that hospitals who  
8 do deliveries are participating in some sort of  
9 -- we say national or state, but you know, we're  
10 willing to be pretty flexible about this, but  
11 you're participating actively in a program, such  
12 as the California Collaborative, or AIM, or a  
13 statewide initiative like used to exist in  
14 Michigan, to decrease maternal complications.

15 And all it is, is stating: I'm in it,  
16 or I'm not. This is a signal from CMS that  
17 maternal mortality is such an important issue  
18 that we want to make sure organizations are at  
19 least participating now in QI.

20 To say that there is no evidence that  
21 QI actually improves outcomes I think flies  
22 against the grain of everything that we've

1 learned about QI, because that's why we do it, to  
2 improve outcomes.

3 Whether or not an attestation measure  
4 improves it, I don't know that I can say that,  
5 but it's certainly a signal that shows that CMS  
6 feels that organizations should be participating  
7 in this, and that it may appear on Hospital  
8 Compare.

9 In the long run, I shared earlier this  
10 morning, that we are working on an electronic  
11 maternal morbidity measure with the Joint  
12 Commission, but as all of you know, that's a ways  
13 going in getting it, you know, onto some kind of  
14 a reporting structure. It's probably at least  
15 two years out.

16 And so we really wanted to ensure that  
17 organizations are aware that CMS thinks this is  
18 an important issue, and really give organizations  
19 a little prodding to be participating in these  
20 very important collaboratives.

21 CO-CHAIR MORRISON: Thank you.

22 MR. STOLPE: One other thing that was

1 included in the PA that I think is worth noting  
2 is that CMS stated in their submission that this  
3 will likely eventually be replaced with what we  
4 would all consider the obvious outcome measure  
5 associated with this.

6 So one other thing to consider here  
7 that this may be this, part of a crawl-walk-run  
8 approach with the signal, as Michelle stated,  
9 being this measure, but eventually moving towards  
10 an outcome measure.

11 CO-CHAIR MORRISON: Lisa.

12 MEMBER MCGIFFERT: Okay. Well I'm an  
13 outcome measure proponent. I have problems with  
14 the attestation, because I'm not sure how  
15 meaningful it will be. I think that everybody's  
16 going to say: yeah, we're doing that.

17 I mean, that's what's kind of happened  
18 with antibiotic resistance programs, antibiotic  
19 stewardship, and we really don't know. What are  
20 they doing?

21 So my biggest concern about this is  
22 that we have a really big problem, and I don't

1       need to go on. Everybody read how many people  
2       are affected by this, and that there are  
3       organizations that have been working for 10 years  
4       to try to come up with a protocol to recommend  
5       for hospitals, and throughout the documents, I  
6       see no evidence, no evidence, no evidence, but  
7       maybe it was no evidence for attestation.

8               But there is evidence that certain  
9       protocols help. So why don't we put those out  
10      there and say: you need to participate in this  
11      protocol that has shown to work? And --

12               (Simultaneous speaking.)

13              MEMBER MCGIFFERT:  -- yes.

14              MEMBER SCHREIBER:  That usually is the  
15      gist of this. You know, participate in something  
16      like --

17              MEMBER MCGIFFERT:  That's what you  
18      were going for.

19              MEMBER SCHREIBER:  -- the California  
20      Collaborative that has --

21              MEMBER MCGIFFERT:  Exactly. That's  
22      the one that I --

1 (Simultaneous speaking.)

2 MEMBER SCHREIBER: -- shown

3 improvement.

4 MEMBER MCGIFFERT: -- looked at. And

5 so I guess I have, I have a problem with like

6 going off on this, and maybe people will be

7 believing that we're doing something, when we're

8 really not doing something.

9 And I have a -- I'd like to know how

10 many, how many organizations or facilities you

11 think are already doing this, and that are going

12 to say yes. And if they all say yes, we're doing

13 something, then, you know, we're back where we

14 started from.

15 I just don't think from the public's

16 perspective that that's going to -- I think the

17 public's going to see that as an assurance that

18 they're -- the hospital is doing something, and

19 I'm not sure that that's a true assurance to the

20 public.

21 And so those are my, you know, main

22 concerns, that we're not pushing forward with

1 some outcome measures, and it looks like you're  
2 working on that, for morbidity. I think you said  
3 mortality, right?

4 MEMBER SCHREIBER: Yes, morbidity.

5 MEMBER MCGIFFERT: Morbidity, okay.

6 So --

7 MEMBER SCHREIBER: Mortality is too  
8 small numbers to measure.

9 MEMBER MCGIFFERT: Yes. Yes. And I  
10 would just like to see some reporting that's real  
11 information about harm to women, so many women --  
12 women of color especially -- and to document that  
13 so that the public can see it.

14 And I don't see that in the future,  
15 really. I see, they're going to go to a  
16 protocol. They're going to, you know, apply a  
17 protocol, and I understand that's all great, but  
18 from the public's perspective, we're not the  
19 experts. We don't care what you do. Just bring  
20 the numbers down and keep women safe, and that's  
21 the ultimate measure that we need to get for this  
22 population as well as others. So I would support

1 the recommendation that was made.

2 CO-CHAIR MORRISON: Thanks, Lisa. Who  
3 do I got? I got I think Marty. Yes, Marty.  
4 Project patient care?

5 MEMBER HATLIE: Yes. So I don't  
6 support the recommendation that was made. After  
7 the preliminary analysis, I think we should  
8 support this for rulemaking. This is an area  
9 where we're going backward, from the data that I  
10 read. I mean, I love the fact that CMS is  
11 sending this signal that this needs to be a  
12 prioritized area for every hospital to be working  
13 on. This is how we make change in this country;  
14 we do it collaboratively. This is our change  
15 engine for achieve large scale change is to get  
16 someone involved in a collaborative, or to get  
17 everyone involved in a collaborative. And we do  
18 have a lot of evidence of success.

19 I mean the one that's sort of obvious  
20 is the early elective delivery success that we  
21 achieved in this country. I mean that was  
22 something that everybody knew there were tools to

1 do, but until we really encouraged people to be  
2 involved in a collaborative where they shared  
3 lessons and shared data, and used that data to  
4 compare themselves to one another, we didn't see  
5 the change that we knew was possible until that  
6 kind of change actually got into place.

7 I know it's not an outcome measure.  
8 Lisa and I chatted about this at lunch. And  
9 there's comments that I looked at from various  
10 organizations about burden, and about lack of  
11 specificity, about whether it's connected to  
12 other initiatives like this in the same area, but  
13 that's the beauty of a collaborative -- that you  
14 can actually have multiple things going on, and  
15 the collaborative sets goals, and it gets  
16 everybody aligned to achieving those goals.

17 So I think it's actually a relatively  
18 low burden, and every hospital should be working  
19 on this. And so I do see it as sort of a nice  
20 big impact next step on the way to achieving  
21 change here.

22 I also just want to, I mean we've been

1        talking about this for 20 years, maybe 25, but  
2        when the airline industry really identified a  
3        safety issue like this, they didn't really wait.  
4        They went into action, trying to create these  
5        all-teach, all-learn environments, where we can,  
6        you know, problem solve together, and that's what  
7        a collaborative does.

8                    We've got two organizations here.  
9        AHA. Akin, I haven't really met you yet, but  
10       it's nice to meet you, and Premier, who have been  
11       very involved in the handiwork, and achieving the  
12       kinds of results that I think are possible here.

13                   So that's why I think we should all  
14       just get behind this and support this as an  
15       important signal and an important rule.

16                   CO-CHAIR MORRISON: Thanks, Marty.  
17       Kelly, are you still with us on the phone?

18                   MEMBER GIBSON: Yes, I am. Can you  
19       all hear me?

20                   CO-CHAIR MORRISON: Yes. Go ahead.

21                   MEMBER GIBSON: Okay, thanks. So I  
22       would actually agree with the recommendation. I

1 think it is so important that we have a measure  
2 to look at maternal morbidity. It is an  
3 incredibly important issue in this country that I  
4 don't think has gotten the attention that it  
5 really needs. But I do worry that just by having  
6 someone check a box and say they've participated  
7 in some kind of a quality project about something  
8 related to maternal outcomes is really not  
9 sufficient for saying if they're participating in  
10 a quality collaborative that's actually  
11 associated with improved outcomes.

12 There's a lot of work being done,  
13 maternal, or Society for Maternal Medicine just  
14 published a map that can show you, you know,  
15 which states have maternal or perinatal quality  
16 collaboratives. Most maternity hospitals  
17 participate in their state quality  
18 collaboratives, but it doesn't really tell you  
19 about what they're implementing on the ground.

20 So I think a better measure would be  
21 to say: are you implementing specific bundles  
22 that have been associated with improved outcomes?

1 The Joint Commission just brought out two new  
2 measures that are going to be looked at next year  
3 specifically relating to hypertension and to  
4 hemorrhage, two of the largest preventable causes  
5 of maternal morbidity and mortality, and I think  
6 maybe having something that's a little more  
7 specific about what a hospital is doing, rather  
8 than just saying, are you participating in some  
9 kind of a quality program, might actually give  
10 you a more meaningful assessment of what's being  
11 done, especially if this is something we're  
12 trying to then show to consumers, or present as  
13 representative of what kind of quality care a  
14 hospital is providing to women.

15 CO-CHAIR MORRISON: Thank you, Kelly.  
16 Brock, from the rural folks?

17 MR. SLABACH: Yes, thank you. There  
18 wasn't a strong notion one way or the other in  
19 the rural work MAP on the maternal measure. I  
20 think the first big question, and one that would  
21 need to be answered, is, and I think it's  
22 obvious, but the question was, what would, what

1 would the definition of -- it would be obviously  
2 for only hospitals with planned deliveries, so  
3 hospitals that don't do deliveries in a planned  
4 basis would not participate, and what would be  
5 the definition of the volume required in order to  
6 be considered a planned delivery site?

7 For rural facilities that have low  
8 volumes, that's, you know, could be, could be one  
9 issue. The -- I think that my personal  
10 experience as a hospital administrator  
11 historically, I participated in a number of  
12 collaboratives around specific issues, and they  
13 are very robust in terms of the making change to  
14 improve patient care.

15 So I don't think that, in general, we  
16 or the group had any aversion to this. I think  
17 that when I look at the workgroups that I've  
18 participated in on this topic, for example, at  
19 the AAMP, we had a inter-association  
20 collaborative to talk about this. We came up  
21 with working recommendations, and a collaborative  
22 like this was not one of them, but that doesn't

1 mean that it can't be useful.

2 And I know that CMS in June of this  
3 year had a full day on this topic here in  
4 Washington, and I know that there was a need to  
5 do something, and maybe this is a great start.

6 The other thing I will point out is  
7 that for critical access hospitals, they  
8 technically do not report in the IQR, so I am  
9 assuming that they would not be needing to attest  
10 in this particular program, so they would be  
11 excluded from this measure, which can be an  
12 issue, I think, in terms of those that are doing  
13 deliveries.

14 And then last but not least, and I  
15 think that this is probably the most important  
16 question is, this is making the assumption that  
17 there are collaboratives available for all  
18 hospitals in the United States to participate in.  
19 And I can tell you they've got a nice  
20 collaborative in Alaska, for example, that was  
21 reviewed on the call, but there may be, in many  
22 states, nothing organized yet. And I can tell

1       you that collaboratives I've participated in,  
2       it's taken really federal resources to create the  
3       collaborative environment, usually through the  
4       Flex program, which is the Medicare Flexibility  
5       Program that HRSA operates to be able to organize  
6       care around the collaboratives, around some of  
7       those kinds of resources.

8               So we would need a discussion as to  
9       how hospitals that didn't have access to a  
10      collaborative, how we can create that, because I  
11      think that's going to be a very important feature  
12      to this work.   So --

13              CO-CHAIR MORRISON:   Okay.   Clarifying  
14      questions?   Marty?

15              MEMBER HATLIE:   I have one more thing  
16      I want to say on the attestation issue.   One of  
17      the things that's happening simultaneously in our  
18      environment is that hospital boards of directors  
19      are being encouraged to pay attention to safety  
20      and quality much more.

21              So if you're signed up to a  
22      collaborative like this, it's likely to be on the

1 hospital board of directors, your report card.  
2 And I think that's another reason to think that  
3 there's some hope beyond the sort of check the  
4 box problem that's been already addressed.  
5 Thanks.

6 CO-CHAIR MORRISON: Okay. Clarifying  
7 questions? Lisa.

8 MEMBER MCGIFFERT: So in the IQR  
9 program, there would be a specific penalty if  
10 they did not say yes?

11 MEMBER SCHREIBER: No. No.

12 MEMBER MCGIFFERT: No?

13 MEMBER SCHREIBER: It's just --

14 MEMBER MCGIFFERT: No penalty. No  
15 penalties involved. And the other thing that  
16 someone made the comment to me, and I corrected  
17 them, but I may not have been right.

18 Would this apply, would the measure be  
19 -- well I guess it's a facility measure, so it  
20 would apply for Medicare and Medicaid patients,  
21 right? I mean, it's a facility, whether the --

22 (Simultaneous speaking.)

1                   MEMBER MCGIFFERT:  -- facility is  
2 participating, and that's been kind of a fear  
3 that everything going through CMS, and it's going  
4 to be Medicare, but we need these measures for --

5                   MEMBER SCHREIBER:  No.

6                   MEMBER MCGIFFERT:  -- Medicaid.

7                   MEMBER SCHREIBER:  This is a facility  
8 measure, which is --

9                   MEMBER MCGIFFERT:  Yes.

10                  MEMBER SCHREIBER:  -- an important  
11 distinction, because Medicaid pays for 43 percent  
12 of all deliveries --

13                  MEMBER MCGIFFERT:  Right.  Right.

14                  MEMBER SCHREIBER:  -- in the United  
15 States.  And obviously we couldn't have a  
16 Medicare measure in practice.

17                               (Simultaneous speaking.)

18                  MEMBER MCGIFFERT:  Yes.  And then in  
19 my state I think it's even higher than that.  
20 Yes.

21                  CO-CHAIR MORRISON:  Lindsey, question?

22                  MEMBER WISHAM:  Kind of a, yes,

1 clarifying item, which is, and I think we all  
2 know that eCQM being adopted into the IQR program  
3 has been an evolution. I do think that an  
4 introduction of a measure like this does prepare  
5 facilities to better be able to report and feel  
6 comfortable with their results being reported  
7 eventually with a longer term eCQM.

8 I would like to find out though: is  
9 there any idea of an auditable aspect to this,  
10 right? Can you find out, has it been considered,  
11 as far as the IQR program, to give it a little  
12 more teeth?

13 Is that, I'm not just attesting yes or  
14 no, but I'm actually having to declare which  
15 collaborative I'm being a part of. That may be  
16 something that may alleviate some of the value  
17 that may be lost with just a yes or no.

18 CO-CHAIR MORRISON: Yeah, please.

19 MEMBER SCHREIBER: So the IQR program  
20 is an auditable program. There is a certain  
21 sample size every year that does get audited, and  
22 this would be added to that.

1 I'm not going to tell you that the  
2 sample size is huge, quite honestly, but I think  
3 in the future, the other thing to think through  
4 is as there is this electronic composite maternal  
5 morbidity measure, that if somebody is doing  
6 particularly poorly, but they're attesting that  
7 they're participating in all of this, that would  
8 probably be a flag for looking at it.

9 MEMBER WISHAM: Okay.

10 CO-CHAIR MORRISON: And Michael.

11 MEMBER WOODRUFF: So it feels a little  
12 bit like a lost opportunity, as you hinted. If  
13 it's a single question: is there a mechanism  
14 through this type of measure to gain information  
15 and understanding from the participants on what  
16 the barriers are, or what they're facing, so we  
17 can be in more of a learning mode during this?

18 MEMBER SCHREIBER: So thank you for  
19 that question, because in all honesty, we had a  
20 big debate about this, and should we be requiring  
21 more information, for example, to get to the  
22 point of the person from MFM on the phone, there

1 was some discussion about: should we be listing  
2 out specific initiatives and making people attest  
3 to them?

4 Then it started getting into this  
5 question of burden, and how much are people  
6 really having to report? And that's why it  
7 landed back to really this kind of single simple  
8 question, recognizing full well that it's the  
9 beginning until we have more measures. But  
10 that's the rationale behind it. We could have,  
11 and it was thought about, but we landed on this  
12 language to be least burdensome.

13 CO-CHAIR MORRISON: And I've got Akin  
14 and Andreea, questions?

15 MEMBER DEMEHIN: So sort of along the  
16 lines of the question that I heard last, have you  
17 given any thought to in some ways tailoring the  
18 -- I don't know if tailoring the attestation is  
19 exactly the right terminology here, but to the  
20 point that Brock raised earlier, not every  
21 hospital does planned deliveries or has labor and  
22 delivery service.

1                   So have you thought about, within the  
2                   measure, laying out the kinds of things that the  
3                   hospitals would have to participate in that would  
4                   align with the kind of services that they  
5                   deliver?

6                   As it's framed right now, it sounds  
7                   pretty wide open without a lot of definition  
8                   around how and what. And I certainly get the  
9                   concerns about the burden, identifying a specific  
10                  initiative, or for the potential for it to be a  
11                  little arbitrary for CMS to identify those  
12                  measures, but could you talk a little bit about  
13                  whether you've thought through those pieces.

14                 MEMBER SCHREIBER: Thanks, Akin, for  
15                 the question, and you're right. I mean, there's  
16                 obviously big referral centers who take care of  
17                 high-risk pregnancies, and you know, their not  
18                 only resources but their participation is  
19                 probably going to be somewhat different than what  
20                 a community hospital might be.

21                 The problem for us is figuring out all  
22                 of that, because as you know, when we do these

1 reports, we don't actually always know that, so  
2 that would mean that either we get information  
3 from AHA, or the hospitals are going to have to  
4 fill out this long form, you know, this is how  
5 many deliveries that we have done. This is the  
6 services that we have, because we just don't know  
7 that. And so I understand where you're coming  
8 from with it, it's just that that's very hard for  
9 us to know.

10 MEMBER DUSEJA: Akin, I was just  
11 asking the second part, you know, with all of the  
12 measures we have, you know, these guidelines and  
13 specification manuals, so the hospitals sort of  
14 interpret the question, and what they should be  
15 attesting to would be provided there as well.

16 CO-CHAIR MORRISON: Maryellen?

17 MEMBER GUINAN: I think, Michelle, you  
18 said in the beginning of the day that this  
19 measure was probably more of a signal that you  
20 were sending out, versus an actual quality  
21 measure at this stage.

22 And so I guess am I correct to assume

1       that then the legwork has been done kind of CMS's  
2       side, in terms of looking at all of the  
3       collaboratives that are out there, looking at  
4       their membership lists, which are public, in  
5       terms of how many hospitals, and they're by name,  
6       and then realizing there is a gap right now, and  
7       wanting to truly send out a signal to say, you  
8       know, folks are not participating in these  
9       collaboratives, that you have kind of statistics  
10      already on who is participating?

11               MEMBER SCHREIBER:  So, I don't know  
12      that we have looked at every collaborative,  
13      because I suspect there are many out there that  
14      we are not aware of, but we certainly have been  
15      in conversations with the big collaboratives.  
16      And there is definitely opportunity for  
17      organizations to be participating.

18               MS. ABDULLAH-McLAUGHLIN:  All right.  
19      And so I wanted to just add to that.  We did do  
20      an environmental scan and a literature review, so  
21      we do know what states are participating in  
22      quality improvement collaboratives, and I also

1 did my own research, as far as AIM goals, and  
2 there are 28 states that are currently  
3 participating in the AIM program.

4 And I also wanted to address the other  
5 gentleman's question about states being able to  
6 participate in an actual state perinatal  
7 collaborative.

8 And even if a state does not have one,  
9 the AIM program is national, and so they would be  
10 able to participate in that. It is free, and you  
11 can get everything offline, and it gives you also  
12 some access to data resources as well. So we do  
13 have that data.

14 CO-CHAIR MORRISON: Andrew?

15 MEMBER GUINAN: Can I just, sorry.  
16 Just a followup.

17 CO-CHAIR MORRISON: I'm sorry.

18 MEMBER GUINAN: I think it would merit  
19 though, because I think there's a big distinction  
20 between wanting to know who is actually involved  
21 in the states specific, because then you can  
22 delve into how that collaborative is actually

1 working, versus if they're in a national like  
2 AIM, and that's not going to be captured in a  
3 strict attestation measure. And that was not a  
4 clarifying question.

5 MEMBER BALAN-COHEN: And mine was  
6 actually, I think, related to some of the earlier  
7 points. Again, I'm appreciating the burden of  
8 not having this as a yes/no question, but I  
9 wonder if there's at least like the possibility  
10 of having the hospitals report which  
11 collaborative.

12 Like, just the name. I mean, like  
13 they're almost doing the step there, because I  
14 think that can inform, can lay like the  
15 groundwork a little bit for better understanding,  
16 you know, what's really working, right?

17 So later on, when you get to the point  
18 where you have like the outcome measure being  
19 developed, then you can already like, some  
20 analysis can be done on whether, you know, like  
21 what kind of methods are working and where.

22 CO-CHAIR MORRISON: And Cristie, I

1 know you had several questions.

2 CO-CHAIR UPSHAW TRAVIS: Maybe just  
3 one.

4 CO-CHAIR MORRISON: Oh.

5 CO-CHAIR UPSHAW TRAVIS: But maybe  
6 not. I was wondering, are there other mechanisms  
7 that CMS would have, other than IQR, to collect  
8 this information and send this signal?

9 MEMBER SCHREIBER: I mean, there are  
10 other mechanisms. Most of those would be frankly  
11 through conditions of participation, and  
12 mandating it, which takes years to get in, and I  
13 don't think anybody really wants.

14 This is, quite honestly, the simplest,  
15 fastest way to send a signal. I mean, we can do  
16 surveys. AHA, frankly, could do surveys, but  
17 it's not quite the same.

18 CO-CHAIR UPSHAW TRAVIS: Okay. I  
19 think that was mine --

20 CO-CHAIR MORRISON: That's it?  
21 Jackson?

22 CO-CHAIR UPSHAW TRAVIS: -- until we

1 get to discussion.

2 MEMBER WILLIAMS: Are private parties  
3 like US News and World Report, Leapfrog Group,  
4 Consumer Reports not doing anything on this  
5 issue?

6 MEMBER SCHREIBER: If, I can't answer  
7 for all of them. Leapfrog, I believe, has asked  
8 questions around this. I don't know it's, how  
9 it's scored in their patient safety score, but  
10 they have asked questions.

11 Do you remember on the Leapfrog  
12 survey? So they have. I don't think it shows on  
13 US News and World Report, and you guys can all  
14 correct me if I'm wrong. I don't know.

15 CO-CHAIR MORRISON: Okay. So let me  
16 just summarize what I've heard, and then we can  
17 move into discussion, if that works. And then I  
18 think, so I heard in terms of, it's a very  
19 important issue, and I've heard strong belief  
20 that collaboratives work, and that they should be  
21 supported.

22 I've heard concerns about whether the

1       attestation is meaningful. I've heard questions  
2       around the baseline, and using the, is it talked  
3       out, and I'm not sure that we've gotten  
4       information back about how many, how much, how  
5       many hospitals are participating, versus how many  
6       are not, at the present time.

7               I've heard concerns about, that the  
8       association may be about the quality of the  
9       collaborative, not just the collaborative itself,  
10      and that this doesn't actually get at that.

11              I've heard that there are concerns  
12      about what's being done is not being measured so  
13      that what people are actually doing from the  
14      collaborative, as a part of the collaborative, is  
15      not being measured.

16              And then I have conversely heard, we  
17      don't know a lot about the collaboratives  
18      volumes, and who's participating in the  
19      collaboratives per se, rather than from the  
20      hospital denominator.

21              And then, concerns about access.  
22      Those are what I've heard from the group. Did I

1 miss anything? Okay.

2 Let's open up for discussions for  
3 those things that haven't been raised, or  
4 concerns that haven't been addressed. Marty?

5 MEMBER HATLIE: I'm thinking about the  
6 exchange that Michelle and Cristie just had. I  
7 think there are other things that CMS can do, but  
8 this would reinforce the things that CMS is doing  
9 through its other vehicles.

10 And it feels like an opportunity for  
11 NQF to actually step into that role with this  
12 kind of measure, and play that reinforcing punch,  
13 and really sending that signal, strengthening the  
14 signal that this is an expectation that hospitals  
15 take this on.

16 I mean, I just don't know that we've  
17 had that opportunity before to consider a measure  
18 like this.

19 CO-CHAIR MORRISON: All right. Lisa?  
20 I'm sorry. Continue.

21 MEMBER MCGIFFERT: No, that's okay. I  
22 just, I assume this would be publicly reported,

1 and I didn't hear on your list that, how  
2 meaningful it is to the public.

3 CO-CHAIR MORRISON: Oh, I'm sorry. I  
4 missed that.

5 MEMBER MCGIFFERT: Yes.

6 CO-CHAIR MORRISON: I'm sorry.

7 MEMBER MCGIFFERT: And you know, to  
8 have this vague understanding that they're doing  
9 something. So --

10 (Simultaneous speaking)

11 CO-CHAIR MORRISON: I'm sorry. I had  
12 that written, and I just went right over it.

13 MEMBER MCGIFFERT: Yes. Thanks.

14 CO-CHAIR MORRISON: I've got Linda,  
15 then I've got Cristie.

16 MEMBER VAN ALLEN: Maybe I should've  
17 made a comment in the question section, because  
18 it's a comment, not a question, which is, I feel  
19 a little stupid, but my first meeting, so be  
20 patient.

21 It seems like we ought to be measuring  
22 morbidity and reporting it. Are we doing that

1 already and I just missed it? I mean, why  
2 wouldn't we just go for it?

3 CO-CHAIR MORRISON: I, I'll paraphrase  
4 Michelle, but the morbidity numbers are actually  
5 quite small.

6 (Simultaneous speaking)

7 CO-CHAIR MORRISON: Yes, the morbidity  
8 numbers are high, the mortality numbers are  
9 small. Was that the question?

10 MEMBER VAN ALLEN: No.

11 MEMBER SCHREIBER: And actually, even  
12 the individual morbidity numbers are relatively  
13 small, which is why the goal of the measure  
14 that's under development, it's a composite  
15 morbidity measure, so that we will have more  
16 robust data.

17 And it is in development, but it's not  
18 in any way, shape, or form, ready for  
19 implementation.

20 MR. STOLPE: Yes, but was the question  
21 not, why do we not proceed directly to the  
22 outcome?

1                   MEMBER SCHREIBER: Because we don't  
2 have it.

3                   MR. STOLPE: That's what, that's what  
4 you mean by just going for it, correct?

5                   MEMBER VAN ALLEN: Yes, just, right.

6                   MR. STOLPE: Yes, so --

7                   MEMBER SCHREIBER: Thank you. We  
8 don't have data on morbidity. We don't have it  
9 right now.

10                  MEMBER McGIFFERT: We don't have any  
11 data on morbidity, like coding, or, I mean, you  
12 know, the thing is I've worked for almost 20  
13 years now on developing the infection reporting,  
14 and it took a really long time, but I can assure  
15 you that even though everyone knew there was a  
16 big problem with infections, no one was going to  
17 do anything about it until they were mandated to  
18 report what was happening.

19                  And that kickstarted the movement to  
20 get into protocols, and collaboratives, and all  
21 that stuff, and did CMS, and gave money to help  
22 that happen.

1                   But that's the, that's the model we  
2                   have, and it's a long-term model, but it's, I  
3                   don't know that it's longer than the model that  
4                   you're envisioning.

5                   MEMBER SCHREIBER: Yes, we don't know  
6                   that we have it as --

7                   CO-CHAIR MORRISON: Okay. I've got  
8                   Cristie to start.

9                   CO-CHAIR UPSHAW TRAVIS: Okay. Well,  
10                  just a, just a couple of things. I'm actually a  
11                  little concerned about the unintended  
12                  consequences of publicly reporting, and I think  
13                  this probably goes along with Lisa, where, you  
14                  know, if I was looking at two hospitals, and  
15                  one's in a, in a collaborative, and one is not,  
16                  and you know, if I'm thinking about making a  
17                  choice based on that answer, I'm not really sure  
18                  that I could interpret that the quality of care  
19                  I'm going to get that is better at one than the  
20                  other.

21                  So I do think it's, there's a strong  
22                  communication issue that's relative to something

1       such as this. The other thing, quite honestly,  
2       and this is just from my experience in a  
3       marketplace, with particular hospitals and  
4       providers, it's all about execution.

5               It is not just about knowing what you  
6       should do. It's about knowing whether you're  
7       actually doing what you should do. And what  
8       worries me, although I see collaboratives as a  
9       good way to help you get there, you know, if,  
10      indeed, we have a lot of hospitals already in,  
11      doing collaboratives, something's missing.

12             And the other thing is, on the early  
13      elective deliveries, there were collaboratives,  
14      but it was public reporting that drove a lot of  
15      it, and I know in my particular market, it made a  
16      huge difference.

17             And I don't think we would've seen the  
18      acceleration of, you know, the, of the change and  
19      the improvement, with, had there not been also  
20      kind of public reporting and accountability.

21             MEMBER SCHREIBER: And we're not  
22      disagreeing with that.

1 CO-CHAIR UPSHAW TRAVIS: No, I know  
2 you're not. But I guess my concern is that  
3 there's this unintended consequence that, if I  
4 look on IQR, this is why I asked if there were  
5 other ways this could be done, versus being in  
6 IQR, where it's publicly reported, because we  
7 could be getting false positives for people if  
8 they saw this as, you know, a way to make a  
9 decision between hospitals, because execution  
10 makes the difference, not just participating in  
11 the collaborative.

12 CO-CHAIR MORRISON: Okay.

13 MEMBER DEMEHIN: I echo some of  
14 Cristie's concerns around, you know, that was  
15 part of the reason why I asked the question I  
16 asked earlier about sort of tailoring  
17 participating into the particular needs of a  
18 hospital.

19 You know, if they don't do planned  
20 deliveries, that they can choose not to say that  
21 they're participating in the collaborative, what  
22 does that say about them?

1 I will say it's a general principle.  
2 Marty said this earlier. We are fond of  
3 collaboratives. They do a lot of good. I don't  
4 think we would dispute the notion that in quality  
5 improvement processes and collaboratives can lead  
6 to better care. Absolutely.

7 There's a part of me that feels like,  
8 for something like this, maybe if you're thinking  
9 about a structural measure to get people started  
10 and to send a signal, it's less about the  
11 collaborative participation, and maybe it's more  
12 about a specific practice that you want to see.

13 And somebody raised the notion of the  
14 Joint Commission standards that were recently  
15 approved that outline some steps that hospitals  
16 will take, I think largely focused on perinatal  
17 hemorrhage, and the kinds of training that staff  
18 have to have.

19 There's a part of me that thinks that  
20 if that attestation were a little more specific  
21 to some specific set of practices, they might  
22 have a little more bite, and little more meaning

1       than just participating in a collaborative.

2               It may be that hospitals will find it  
3       the most helpful to bring those practices online  
4       to participate in a collaborative that gives that  
5       to them, that helps sort of walk them through  
6       that process.

7               Otherwise, it feels a bit disconnected  
8       from sort of the kinds of, the sort of behavior  
9       changes that you want to see in the field, and  
10      the kinds of practices that you want to see  
11      implemented.

12              It feels like we're talking more about  
13      the collaborative than we are about the care, if  
14      that makes sense.

15              CO-CHAIR MORRISON:   So I've got Brock.  
16      I've got Kelly on the phone.   I've got Marty, and  
17      then if there's not anything that people feel  
18      that burning desire they need to say, I think  
19      we'll close.   So Brock. And I've got you, Anna,  
20      too.   Sorry, I've got you, I've got you.

21              MR. SLABACH:   Yes, just real quick, I  
22      will comment that the recent legislation has

1 funded and stood up maternal mortality review  
2 committees in each state.

3 So that, many states have had that  
4 already, and they're starting the work that does  
5 a little bit about what Lisa's talking about,  
6 collecting the data, doing interventions, in  
7 terms of ways to improve those situations.

8 I just looked up, ACOG just published  
9 in September of this year that 45, there are 45  
10 statewide perinatal quality collaboratives in the  
11 United States.

12 So I did not realize that until just  
13 now, so I'm assuming that at least all the five  
14 states apparently have some kind of collaborative  
15 going on in this space, which is good to know. I  
16 don't know.

17 Going to the point made earlier, if  
18 it, if it applies to every one of the providers  
19 within that space, in terms of the content of  
20 their service, and then 26 are currently AIM  
21 states. So yes, that's good news to me, at least  
22 in terms of the presence of that. So thank you.

1 CO-CHAIR MORRISON: So I've got Anna,  
2 Kelly, and we'll give Marty the last word.

3 MEMBER DOPP: I'm going to go out on a  
4 limb just to try to reinforce what Marty shared,  
5 and your very thoughtful initial comments, and as  
6 a pharmacist, I'm going to shamelessly try to  
7 draw parallels to medication-related measures as  
8 much as possible today, apparently.

9 But if we look at the MedRec measures  
10 in their, in their early stages, and say what you  
11 will about the merit of MedRec measures, they  
12 started out a lot like this, and they led to  
13 systems being put in place.

14 And granted, those systems are not  
15 always evenly applied across practice settings,  
16 and, but they did start the wheels turning to  
17 make medication reconciliation more of a standard  
18 expectation with providers and with patients, and  
19 then, and then we've seen more refinement of the  
20 measures since then.

21 So like the medication reconciliation  
22 measure within ESRD is way more robust than the

1 early just yes, no, with some criteria to meet  
2 the measure.

3 So I, just to reinforce your point,  
4 there's precedence for taking these smaller steps  
5 to build systems first, and then come back and  
6 refining them.

7 CO-CHAIR MORRISON: Kelly?

8 MEMBER GIBSON: Just two things. So  
9 my first question was whether this would be tied  
10 to anything to do with the maternal levels of  
11 care, just in terms of kind of stratifying from  
12 smaller hospitals to larger hospitals.

13 The second point I just wanted to echo  
14 what some of the others have said, is that maybe  
15 this is a focus too much on being in a  
16 collaborative, rather than on the care we're  
17 giving to women.

18 You know, we're participating at my  
19 hospital. We're part of the State Quality  
20 Collaborative, but that doesn't mean that we have  
21 implemented some of the bundles specific to some  
22 of the causes that are really most associated

1 with maternal mortality, and so just  
2 participation in a quality collaborative, I just  
3 don't think that's the marker for what we're  
4 really trying to ask.

5 CO-CHAIR MORRISON: So at the risk of  
6 giving a lawyer the last word --

7 MEMBER HATLIE: I was just going to  
8 say, because the Joint Commission has come up  
9 several times through this discussion, they filed  
10 a comment strongly supporting this measure.

11 So I wanted to make sure we were all  
12 aware of that. They see it as a strengthening of  
13 the signal that they're trying to accomplish  
14 through their different entities.

15 CO-CHAIR MORRISON: So just a quick  
16 check of the room. Does anybody have a burning  
17 issue, particularly those who haven't spoken,  
18 they'd like to get on the table before we go to a  
19 vote? Once? Twice?

20 MEMBER DeSOTO: Just one last thing.  
21 I just wanted to say that, you know, somebody had  
22 mentioned access to collaboratives and learning

1 programs.

2 AHRQ had, in 2018, done safety program  
3 for perinatal care, which is available, and it  
4 actually allows hospitals to create their own QI  
5 kind of a program to address severe maternal  
6 morbidity. So there is, there is stuff out  
7 there, and I think it's a, it's a good idea to  
8 start here.

9 CO-CHAIR MORRISON: All right. Should  
10 we go to the vote? Let's do it.

11 MS. JUNG: So our number for this is  
12 24. I realize that Aisha Pittman didn't come  
13 back, so --

14 CO-CHAIR MORRISON: Okay.

15 MS. JUNG: -- we're at 24 right now.

16 CO-CHAIR MORRISON: We're at 24.

17 Okay. So --

18 CO-CHAIR UPSHAW TRAVIS: So this is  
19 one of those double negative things?

20 CO-CHAIR MORRISON: Yes. So what  
21 you're doing is you --

22 (Simultaneous speaking)

1 CO-CHAIR MORRISON: Yes, yes, yes,  
2 yes. So do you support the preliminary  
3 recommendation of staff and the preliminary  
4 recommendation of staff was, do not support? So  
5 if you agree with staff, vote yes.

6 MR. HIRSCH: For MUC2019-114, maternal  
7 morbidity, do you vote to support the preliminary  
8 analysis as the workgroup recommendation is now  
9 open for voting. Your options are yes or no.

10 MEMBER JORDAN: Yes means you do not  
11 want to have this --

12 MR. HIRSCH: That's correct.

13 MEMBER JORDAN: -- since hospitals  
14 know we --

15 CO-CHAIR MORRISON: That is correct.

16 (Simultaneous speaking)

17 CO-CHAIR UPSHAW TRAVIS: Or some other  
18 permutation.

19 CO-CHAIR MORRISON: Permutation or  
20 comment. Yes, which we will get to if we need  
21 to.

22 MS. JUNG: Okay. So we have a total

1 of 14 votes for yes, for this measure, and then a  
2 total of 10 votes for no for this measure, so  
3 this means the workgroup does not accept the  
4 staff's preliminary recommendations, and co-  
5 chairs, we should motion on what category we'd  
6 like to open up for.

7 CO-CHAIR MORRISON: What, no, no, no,  
8 no. No, no. Wait.

9 CO-CHAIR UPSHAW TRAVIS: What is the  
10 answer?

11 CO-CHAIR MORRISON: What is the  
12 answer?

13 MS. JUNG: So you --

14 CO-CHAIR MORRISON: Oh, it's 60  
15 percent.

16 MS. JUNG: It's 60 percent. We needed  
17 a count of 15 --

18 CO-CHAIR MORRISON: Right.

19 MS. JUNG: -- and there was 14 in  
20 total --

21 CO-CHAIR MORRISON: Okay.

22 MS. JUNG: -- counting the one that

1 came in through the chat box.

2 CO-CHAIR MORRISON: Okay.

3 MS. JUNG: So the work group does not  
4 accept the staff's preliminary analysis. Co-  
5 chairs, similar to last time, I put it towards  
6 you to make a motion on what category, or ask the  
7 workgroup what category we'd like to start the  
8 discussion with.

9 CO-CHAIR MORRISON: We've got to start  
10 from the top.

11 (Simultaneous speaking)

12 CO-CHAIR MORRISON: We've got to start  
13 from the top. So we're going to start from, do  
14 you support the measure? The first is, do you  
15 support the measure? As it is --

16 MS. JUNG: Support for rule making.

17 CO-CHAIR MORRISON: Support for rule  
18 making, as it is written.

19 MR. HIRSCH: For MUC2019-114, maternal  
20 morbidity, do you support? You can vote for yes  
21 or no.

22 (Off microphone comments)

1 CO-CHAIR UPSHAW TRAVIS: No.

2 (Simultaneous speaking)

3 MR. HIRSCH: Support for rule making.

4 CO-CHAIR MORRISON: Support for rule  
5 making. Would you like to see this move forward  
6 for rule making?

7 MR. HIRSCH: For MUC2019-114, maternal  
8 morbidity, do you vote to support? The workgroup  
9 has voted 17 for no, and 7 for yes. The  
10 workgroup does not support recommendation for  
11 rule making.

12 CO-CHAIR MORRISON: Okay. So now we  
13 go to support with condition? Now we need to go  
14 to support with conditions, and I need to hear  
15 conditions nominated from the group as to what  
16 the conditions would be to put this into rule  
17 making.

18 (Off microphone comments)

19 CO-CHAIR MORRISON: Because we did  
20 not, we did not accept the committee's  
21 recommendation that it not be endorsed, staff  
22 recommendation, thank you. The committee voted

1       that it could not go through to rule making as it  
2       is currently written, so we are in no person's  
3       land at the moment.

4               So the next stage is, we vote on  
5       whether it should go through to rule making with  
6       conditions, and so all of those who voted no just  
7       a minute ago, I'm open to hearing conditions as  
8       to what would make it a yes.

9               CO-CHAIR UPSHAW TRAVIS: We still have  
10      another category.

11              CO-CHAIR MORRISON: We still have  
12      another category.

13              MEMBER MCGIFFERT: So one of the  
14      conditions could be that it goes through NQF.

15              CO-CHAIR UPSHAW TRAVIS: Yes.

16              CO-CHAIR MORRISON: Okay. So yes, one  
17      of the, one of the conditions could be NQF  
18      endorsement.

19              CO-CHAIR UPSHAW TRAVIS: That's right.

20              PARTICIPANT: That's typically what --

21              CO-CHAIR MORRISON: And that's often a  
22      condition. Thank you, Lisa. Anybody else? All

1 right.

2 So I have a proposed modification that  
3 is, the vote is, do you approve this for rule  
4 making if it goes through NQF endorsement first?

5 CO-CHAIR UPSHAW TRAVIS: If it's  
6 endorsed.

7 CO-CHAIR MORRISON: If it's endorsed,  
8 thank you. That is, that's all I've got as the  
9 only condition. So if you'd like to see that,  
10 vote yes.

11 MS. JUNG: We're --

12 CO-CHAIR MORRISON: We're not there  
13 yet.

14 MS. JUNG: Not ready yet.

15 CO-CHAIR MORRISON: Okay.

16 MR. HIRSCH: For MUC2019-114, maternal  
17 morbidity, do you vote conditional support upon  
18 NQF endorsement process?

19 MS. JUNG: We have 23 votes. Amy, if  
20 you could send it via the chat function.

21 MEMBER HELWIG: I think it's me.

22 MS. JUNG: Oh, it's you?

1 MEMBER HELWIG: My battery just died.

2 CO-CHAIR MORRISON: Oh, no.

3 MEMBER HELWIG: I wouldn't know.

4 CO-CHAIR MORRISON: Same deal. Okay.

5 MS. JUNG: So I'll read out the final

6 --

7 CO-CHAIR MORRISON: Yes.

8 MS. JUNG: -- number for the record.

9 CO-CHAIR MORRISON: Yes, I'm sorry.

10 MR. HIRSCH: Okay. The workgroup has  
11 voted 10 for yes, and 14 for no. The workgroup  
12 has not put forth maternal morbidity for a  
13 conditional support rule making.

14 CO-CHAIR MORRISON: Okay. So now we  
15 come to, do not support with, what --

16 MR. HIRSCH: Potential for mitigation.

17 CO-CHAIR MORRISON: -- do not support  
18 with potential for mitigation, and I think I need  
19 to hear what would be the mitigating  
20 circumstances.

21 MR. AMIN: I think the only thing I  
22 can offer on reflection, if the idea here is that

1       it's still basically a question, and an  
2       attestation would be closest to what I think Akin  
3       was suggesting, which is that the questions are,  
4       the question that's being asked is around the  
5       actual practices that we believe influence  
6       maternal morbidity.

7               I think that's, of the conversation,  
8       seems to be the closest thing we can offer for --

9               CO-CHAIR MORRISON: All right. Akin,  
10       sorry. Go ahead.

11               (Simultaneous speaking)

12               MEMBER DEMEHIN: -- then also, in  
13       addition to NQF endorsement, that --

14               (Simultaneous speaking)

15               CO-CHAIR MORRISON: Akin?

16               MR. AMIN: So I get what you're going  
17       through. I guess I would ask the question, I  
18       don't know if this is of staff or not, but I've  
19       asked the question whether that constitutes such  
20       a fundamentally different construct of this that  
21       it would still land here --

22               (Simultaneous speaking)

1 MR. AMIN: That's kind of where I'm  
2 stuck.

3 MS. MUNTHALI: So you're asking  
4 whether or not it's such a material change to  
5 what's in front of you, and you know, from the  
6 MAP perspective, it would be, but you are  
7 signaling to CMS that you'd like some additional  
8 review of the scientific properties of this  
9 measure.

10 So, and also, it is their discretion,  
11 as Michelle has mentioned, that, you know, this  
12 measure can go into program, but she is taking  
13 your recommendations and suggestions to heart as  
14 well.

15 CO-CHAIR MORRISON: Oh, I'm sorry,  
16 Kelly.

17 MEMBER GIBSON: Yes.

18 CO-CHAIR MORRISON: Did you have a  
19 comment, question, thought, life preserver?

20 (Simultaneous speaking)

21 MEMBER GIBSON: I was echoing, I was  
22 just echoing what was already said about really

1 making it more a question about what's been  
2 implemented, not just the participation in a  
3 quality collaborative, which may kind of change  
4 the focus, but if that's what we're really trying  
5 to ask when we title a measure maternal  
6 morbidity, not entitle it participation in a  
7 quality collaborative.

8 CO-CHAIR MORRISON: So what I'm  
9 hearing are two mitigating circumstances. One is  
10 NQF endorsement, and the second is a focus on  
11 what's actually being done rather than simply  
12 participation. Is that, are people okay with  
13 that to vote?

14 MEMBER MCGIFFERT: But when we vote,  
15 we'll be voting on those two mitigation factors -  
16 -

17 CO-CHAIR MORRISON: No, yes.

18 MEMBER MCGIFFERT: -- not another  
19 mitigation factor?

20 CO-CHAIR MORRISON: Not that, not that  
21 I've heard yet, Lisa.

22 MEMBER MCGIFFERT: Okay.

1                   MEMBER DEMEHIN: I mean, I guess I  
2 would ask the group, and I would ask CMS too, I  
3 mean, is the, is the spirit of the measure really  
4 to encourage participation in the collaborative?

5                   In which case, if we're making  
6 mitigating changes around the collaboratives,  
7 then I'd argue that the, refocusing the question  
8 on practices is actually something quite  
9 different than that.

10                  So I guess that's sort of more of a  
11 philosophical question to CMS. Like, where do  
12 you want to go? Is it really the collaborative,  
13 or is it really the uptake of the practices?

14                  MEMBER SCHREIBER: Actually, I think a  
15 good analogy was from Anna on medication  
16 reconciliation. Where we want to go is  
17 ultimately to make sure that all hospitals are  
18 implementing these practices, and that we see it  
19 in outcomes measures. Where we're starting is  
20 here, to encourage organizations to be in  
21 collaboratives.

22                  MEMBER GUINAN: I think we could go

1 from the philosophical to the practical. The,  
2 what would actually happen in terms of the  
3 mitigation process if that, if that were  
4 accepted?

5 It would go back to the developers,  
6 the developers would then come up with what  
7 specific practices hospitals would have to attest  
8 that they're doing --

9 MEMBER SCHREIBER: Yes.

10 MEMBER GUINAN: -- and I think that's  
11 a very different measure than just saying --

12 (Simultaneous speaking)

13 CO-CHAIR MORRISON: I don't think your  
14 proposal works.

15 MR. AMIN: I think it's then, with  
16 just NQF endorsement, it doesn't work either.

17 CO-CHAIR UPSHAW TRAVIS: Well, no,  
18 because --

19 CO-CHAIR MORRISON: We just voted  
20 against that.

21 CO-CHAIR UPSHAW TRAVIS: Yes, we voted  
22 against that. It's conditional --

1 (Simultaneous speaking)

2 MEMBER JORDAN: We're really to the  
3 next phase of kill or no kill. I mean, there  
4 isn't really a feasible modification coming up  
5 here.

6 CO-CHAIR MORRISON: We killed or no  
7 killed already. We let live. All right. I've  
8 got Lindsey and I've got Amy.

9 MEMBER WISHAM: To carry on the point,  
10 it's a good one though, but I do feel like I  
11 heard that that was going to be described in the  
12 specifications manual.

13 So whether or not they actually  
14 discreetly report on which of the practices  
15 they're, you know, being informed about through  
16 their collaborative, that's a different reporting  
17 aspect, but actually delineating which of the  
18 practices that they should be focusing on, I  
19 think that should be part of, that can be part of  
20 the specifications manual.

21 MEMBER SCHREIBER: And the answer  
22 could still be yes and no. Is that what you're

1 saying?

2 MEMBER WISHAM: Yes. Yes.

3 CO-CHAIR MORRISON: Amy, are you going  
4 to get us out of this box?

5 MEMBER HELWIG: I might.

6 CO-CHAIR MORRISON: Good.

7 MEMBER HELWIG: I do though think that  
8 it -- having the attestation leads to, at first  
9 you're arguing with 98 percent, 99 percent will  
10 say yes, because it's too broad, and I'm just  
11 wondering if CMS would consider putting it in  
12 conditions of participation as opposed to a  
13 quality measure?

14 MEMBER SCHREIBER: I won't say that it  
15 hasn't been discussed. I will say putting it in  
16 conditions of participation takes many years.

17 CO-CHAIR MORRISON: Cristie?

18 CO-CHAIR UPSHAW TRAVIS: Well, just  
19 one kind of comment, given that we're kind of in  
20 this conundrum. You know, I was thinking, just  
21 from a personal standpoint, that being more  
22 specific in the attestation would be more

1       accountable for actually implementing some of  
2       these practices. But it's still early.

3               I mean, you know, so it's not like we  
4       expect there to be outcomes from implementing the  
5       bundles, or whatever the best practices are.

6               And so to me, it still sends a strong  
7       signal that the signal isn't just participating,  
8       the signal is actually doing something.

9               And you could also think about framing  
10      it in such a way, we're going to have this  
11      outcome measure in a couple of years, and this is  
12      your, this is like the signal in your early  
13      warning that you need to go on and put these  
14      practices into place, and we need to know how  
15      many of them you've already put in, and you know,  
16      I would think there would be a frame it to where  
17      it shows action, not just, and I hate to say just  
18      participation, because that's an important piece,  
19      but it actually shows something is happening in  
20      the care that's being delivered.

21              And I love the idea that maybe it can  
22      still be a yes/no, if worded correctly. Might

1 have to think about how to do that, but that's  
2 why I was holding out for this particular one  
3 with mitigation, because I think you sold me on  
4 the fact that we need something early before the  
5 outcome, just wanted it to be a little bit more  
6 than just being in a collaborative.

7 CO-CHAIR MORRISON: So Cristie, can  
8 you put into a sentence the mitigation that you  
9 would make this work?

10 CO-CHAIR UPSHAW TRAVIS: Well, I was  
11 thinking that we kind of were at it earlier. It  
12 was kind of what Taroon said. Actually, I didn't  
13 understand why we would put NQF endorsement in  
14 there, because it would have to come back anyway.  
15 It would be a different measure.

16 But for, you know, the practices,  
17 implementing the practices, and that, I mean, I  
18 would have worded it like --

19 MR. AMIN: So let me try again, maybe.  
20 So the distinction that we made between last year  
21 and this year, between the conditional support  
22 and the do not support was potential for a

1 mitigation.

2 The fine, the distinct line there was  
3 that if we're going to make a change to the  
4 specification, that really puts us into the two  
5 do not support categories.

6 Interestingly, we find ourselves now  
7 trying to distinguish between the two do not  
8 support categories, and I don't think we would've  
9 found ourselves in this place. So this is an  
10 interesting measurement challenge.

11 But anyway, so Akin, I think you made  
12 the very important point, which is to say, at  
13 what, like, to, when, to what extent are you  
14 making specification changes that it's, you're  
15 basically just asking for a different measure?

16 I don't know that we have ever found  
17 the fine line on that. However, I think in the  
18 conversation here, there has been texture around  
19 what specifically we're looking at.

20 It's still essentially a structural  
21 measure that's looking for potentially starting  
22 with attestation, is still what I'm hearing. So

1       it's conceptually still, like, the same  
2       structure.

3                   The question is, what is the, like,  
4       what is the question? And it appears that the,  
5       where there's, appears to be some mitigation  
6       opportunity is around, the questions around, are  
7       more around the practices rather than  
8       participation in the collaborative.

9                   I don't want to put words in anyone's  
10      mouth, but I want to try to put words out there.  
11      So if we can, at least for the sake of this  
12      process, assume that for the do not support of  
13      the mitigation is support essentially for the  
14      concept of hospitals attesting to --

15                   (Simultaneous speaking)

16                   MR. AMIN: -- putting into practice  
17      these elements of the, you know, I don't want, I  
18      don't know the exact words, but we'll find them.

19                   But essentially, the practices that  
20      support improvement in maternal mortality. That  
21      would essentially be, I think, this category.

22                   Just to draw a distinction, do not

1 support would essentially be that really this  
2 needs a wholesale re-look. We don't, we don't  
3 like the idea of a structural measure for this  
4 area, and we really need to go back to the  
5 drawing board, recognizing that there's, the  
6 overarching feedback to the group has said that  
7 maternal mortality is an extremely important  
8 national imperative that needs attention.  
9 There's no question about that. I just want to  
10 be clear.

11 CO-CHAIR MORRISON: So let me try this  
12 then. The mitigating circumstances are, wait,  
13 first of all, it's a do not support. The  
14 mitigating circumstances are, we are comfortable  
15 with the, with a structural yes/no measure.

16 What we would like to see is a focus  
17 on both being part of a collaborative, and the  
18 implementation of collaborative processes within  
19 the institution.

20 Is that a reasonable summary of where  
21 you are? It's a, it's an and, not an or. I  
22 think it's the practices seem to be, well --

1                   MEMBER SCHREIBER: Not the  
2 collaborative, but practice.

3                   CO-CHAIR MORRISON: I think the  
4 practices seems to be the emphasis. Well, I  
5 guess the question, the question, the question is  
6 then you're at an individual level rather than  
7 where CMS started, which is the importance of  
8 being part of the collaborative, but it's the  
9 second, it's the second piece to that.

10                   Is it more than being part of the  
11 collaborative, are you integrating the  
12 collaborative's practices into your book of  
13 business?

14                   MEMBER MATTHES: Would it be possible,  
15 something like a, from this, you know, where  
16 their response is either a yes or no, versus a  
17 partially implemented, you know, mostly  
18 implemented, totally implemented, something like  
19 that.

20                   There has to be an option. So I'm  
21 kind of looking, well, I really like the idea,  
22 and I think it's a good thing to do, but I feel

1 constrained by the technical requirements of  
2 voting, of concerning certain technical  
3 requirements that kind of, I think what you  
4 outlined, I think specifications have to be  
5 changed.

6 So if the mitigation can be worded in  
7 a way that there is general support for the idea  
8 without being caught up on technical requirements  
9 that are made out here, that would be great. I  
10 don't know how to word it, but --

11 MS. ABDULLAH-McLAUGHLIN: So I just  
12 want to just reiterate the question. So the  
13 question that you're asking is, we are asking if  
14 the hospitals are participating in state or  
15 national collaboratives, but we also, the second  
16 piece of the question actually says, which  
17 includes implementation of patient safety  
18 practices or bundles.

19 So it does have that other piece.  
20 We're not just asking about participation. We're  
21 also saying that they are actually implementing  
22 the patient safety practices and bundles within

1 those collaboratives.

2 (Simultaneous speaking)

3 MS. ABDULLAH-McLAUGHLIN: -- related  
4 to hemorrhage, severe hypertension, preeclampsia,  
5 and sepsis. That is not what it limits to.

6 MEMBER McGIFFERT: Can you read the  
7 question one more time?

8 MS. ABDULLAH-McLAUGHLIN: Yes, let me  
9 read the question one more time. So this is the  
10 revised question that you all unfortunately  
11 didn't receive.

12 So it says, does your hospital or  
13 health system participate in a statewide and/or  
14 national perinatal quality improvement  
15 collaborative program aimed at improving maternal  
16 outcomes during inpatient labor, delivery, and  
17 postpartum care, which includes implementation of  
18 patient safety practices or bundles to address  
19 complications including but not limited to  
20 hemorrhage, severe hypertension/preeclampsia, or  
21 sepsis?

22 MEMBER McGIFFERT: Thank you for

1 reading that, because that is helpful. My  
2 understanding is the which includes is describing  
3 the collaborative, and, itself, and my  
4 understanding of the collaboratives, and I may be  
5 all wrong, is a hospital could go to meetings,  
6 send their people to trainings, as part of a  
7 collaborative, and not really actually implement  
8 anything, and I know the program, you've got the  
9 word implement, but that describes the  
10 collaborative is focused on implementing.

11 Do you see that as the hospital is  
12 actually implementing those things? Then it  
13 would maybe get to the practices. You see what  
14 I'm saying?

15 Because I think the collaboratives are  
16 pretty open-ended. I mean, we've got a lot of  
17 our people just get on the phone and complain,  
18 and, or just make some comments, and then they  
19 don't really participate fully.

20 MS. ABDULLAH-MCLAUGHLIN: So let me  
21 just try to answer that question. So when I read  
22 the question, and I actually am a registered

1 nurse still working at a hospital --

2 CO-CHAIR MORRISON: Okay. Let me, let  
3 me, because we're going to go back and forth on  
4 this.

5 MS. ABDULLAH-McLAUGHLIN: Okay.

6 MEMBER McGIFFERT: Okay.

7 (Simultaneous speaking)

8 CO-CHAIR MORRISON: I have, I have two  
9 proposals on the table. One is that there's  
10 enough, there's enough uncertainty on what the  
11 question is actually saying, that I'm not sure  
12 people now know what they're voting on.

13 My suggestion is one of twofold. A,  
14 we could just take a break and we can huddle and  
15 try and come up with something for you guys.

16 B, I would suggest that we could also  
17 say the mitigating circumstances are we need  
18 better clarity on what's actually being asked,  
19 because if these guys, if we can't figure out  
20 what's in the question and what's being asked, I  
21 think it's going to be hard for the public to  
22 understand that, and it's going to be hard for

1 hospitals to report on it.

2 So perhaps what you're hearing is a  
3 lot of confusion, and that the mitigating  
4 question is we'd like actually a better, a better  
5 question as to what you guys are actually asking  
6 and what you're hoping to accomplish, because I'm  
7 hearing that there's just a lot of confusion. So  
8 are you guys okay taking a vote with that, or a  
9 break?

10 CO-CHAIR UPSHAW TRAVIS: Let's take a  
11 break.

12 CO-CHAIR MORRISON: Break. All right.  
13 Fifteen minutes, and we will come back and try  
14 and resolve this.

15 (Whereupon, the above-entitled matter  
16 went off the record at 3:10 p.m. and resumed at  
17 3:28 p.m.)

18 CO-CHAIR MORRISON: Welcome back,  
19 everybody. I know how hard it is to break away  
20 from that and come back.

21 So we have two thoughts about moving  
22 forward. The first is that it's pretty clear

1 that we need to bring Scotch to this meeting for  
2 the afternoons.

3 (Laughter.)

4 CO-CHAIR MORRISON: I will do that  
5 next time.

6 The second is that, and more  
7 importantly here, is apparently some confusion  
8 over both the intent and the wording of the  
9 measure on the table, so I am going to ask CMS to  
10 give us the measure one more time, and the intent  
11 behind it. And then I, we're going to have a  
12 thought.

13 MR. STOLPE: Please know that it is  
14 projected first, some of you will have to turn  
15 around to see it.

16 MEMBER DUSEJA: Yes, I think it is  
17 helpful to put it up there. So maybe, I don't  
18 know if you can pull it up more, but --

19 MR. STOLPE: Yes.

20 MEMBER DUSEJA: So the question, as it  
21 reads, is does your hospital or health system  
22 participate in a statewide and/or national

1 perinatal quality improvement collaborative  
2 program aimed at improving maternal outcomes  
3 during inpatient labor, delivery, and postpartum  
4 care. And the word says which, but we actually,  
5 what our intent is, we want to say and, so  
6 there's like an additional step that the  
7 hospitals have to do, and includes the  
8 implementation of patient safety practices or  
9 bundles, and then we become, we get specific, to  
10 address complications including but not limited  
11 to hemorrhage, severe hypertension,  
12 preeclampsia, and sepsis.

13 MR. STOLPE: So Jordan, let's scroll  
14 down just a little bit so we can actually see  
15 that in action. So we've broken this out into  
16 two bulleted points.

17 The first preserves the language  
18 exactly as it stands for the first clause, and  
19 the second identifies what we just identified as  
20 potentially some area of confusion for the group,  
21 saying, and has implemented, rather than which  
22 includes implementation of. That's just a

1 clarification for what the expectation is for the  
2 measured entity.

3 MEMBER DUSEJA: So the expectation for  
4 the hospital would be, not only are they  
5 participating, but they're implementing in order  
6 for them to attest. Yes.

7 MEMBER NOLAN: So that means the  
8 hospital is implementing?

9 MEMBER DUSEJA: Yes.

10 MEMBER NOLAN: Yes. Correct.

11 CO-CHAIR MORRISON: So --

12 (Simultaneous speaking.)

13 CO-CHAIR MORRISON: Right. Before it  
14 was unclear as to who was doing the implementing.

15 MEMBER DUSEJA: It was clear  
16 grammatically. It was program.

17 CO-CHAIR MORRISON: Right. I am  
18 giving the benefit out to our colleagues at CMS.  
19 And --

20 MEMBER DUSEJA: Thank you.

21 CO-CHAIR MORRISON: You are welcome.

22 MEMBER DUSEJA: We appreciate that.

1 CO-CHAIR MORRISON: Remedial grammar  
2 may be in order.

3 So what I would propose to the group  
4 is that given the clarity now of the language,  
5 which appears to reflect what people were  
6 concerned about, which was are processes being  
7 implemented in the institution, that we go back  
8 up one voting step, where we will vote for  
9 conditional support on this measure, and the  
10 condition is NQF endorsement, okay?

11 So we go back to, we replace the and.  
12 It's clear that it is participating and  
13 implementation at the institutional level of  
14 processes, and the condition is NQF endorsement,  
15 and then we go back and re-vote at that level.

16 Do I hear major or even minor  
17 disagreement? And right now, I'm just looking  
18 for major. I will tell you, honestly.

19 CO-CHAIR UPSHAW TRAVIS: Akin is --

20 CO-CHAIR MORRISON: Akin?

21 MEMBER DEMEHIN: So I won't, I won't  
22 be, I won't make, belabor this point too much,

1 but I think that when the measure comes in front  
2 of the MAP, we're asked to evaluate what's in  
3 front of us, and it seems like we're kind of  
4 rewriting the measure on the fly, and being asked  
5 to conditionally support it.

6 To me, that feels like a step too far,  
7 and to me, if we are, if we're being asked to  
8 evaluate the measure as is, then that's what we  
9 ought to vote on. This sort of rewriting on the  
10 fly definitely makes me quite uncomfortable.

11 CO-CHAIR MORRISON: I guess my  
12 understanding, and I will turn to, is that we are  
13 not rewriting the measure. We are correcting the  
14 incorrect grammar, the way the measure was  
15 worded, because CMS is very clear that the  
16 language was supposed to mean you participate in  
17 the collaborative, and you, i.e. the institution,  
18 hospital in this regard, implement processes,  
19 blankety-blank, blankety-blank, not limited to,  
20 et cetera, et cetera.

21 If you feel very strongly that we are  
22 completely changing it, then it comes to, down to

1 I think where we are now, which is do not support  
2 with mitigation being, please go back and correct  
3 the grammar.

4 And I really, having discussed it with  
5 these guys, I really think it's grammar rather  
6 than rewriting the question. But I am, if people  
7 feel very strongly, you know, I would say don't  
8 vote for conditional support, and we will be back  
9 where we are.

10 MR. STOLPE: Yes, and typically, we  
11 consider serious modifications to specifications  
12 of the, of the measure as the condition for do  
13 not support with potential for mitigation.

14 From the staff standpoint, we see this  
15 as a very minor adjustment that reflects the  
16 intent, that would just be more of a conditional  
17 message, if you will.

18 MEMBER DEMEHIN: But my challenge with  
19 this is that this detail behind it, it's the  
20 first time we're seeing it, because we didn't see  
21 it when we got the list of measures.

22 So we're in the room, we're redoing

1 the measure on the fly. That's kind of what it  
2 feels like to me, so I would urge the group not  
3 to support the measure as is, but I won't belabor  
4 the point.

5 CO-CHAIR UPSHAW TRAVIS: I guess just,  
6 I'm sorry, I'm just thanking you, Akin, for your  
7 comment. If you could help me maybe understand  
8 what would be different, had it been clear to you  
9 that it was and at the beginning, would there be  
10 something different?

11 Is that what you're trying to say?  
12 Something you would've done differently to  
13 prepare for this meeting, or --

14 MEMBER DEMEHIN: I'm saying the detail  
15 behind which specific bundles, and which specific  
16 kinds of practices would be implemented --

17 CO-CHAIR UPSHAW TRAVIS: Those were in  
18 there. Those were in the language.

19 (Simultaneous speaking.)

20 MEMBER DEMEHIN: I did not see it.

21 MEMBER DUSEJA: So I think what the  
22 confusion perhaps was, we did submit changes two

1 weeks ago, but I'm, it appears that it didn't get  
2 to the, to the workgroup.

3 (Simultaneous speaking.)

4 MEMBER DEMEHIN: Correct, but  
5 reviewing that detail and having it read to us in  
6 the beginning of the meeting is a little  
7 different than getting it at the outset.

8 MEMBER DUSEJA: Okay.

9 MEMBER DEMEHIN: But I don't want to  
10 belabor the point.

11 CO-CHAIR MORRISON: Lisa?

12 MEMBER MCGIFFERT: Well, I'm going to  
13 help you. That's a surprise, because I feel, I,  
14 again, feel that if this comes to NQF, I mean, I  
15 don't want to predict what NQF is going to do,  
16 but it has to be backed by evidence, and it, you  
17 know, there's a lot of steps along that way, and  
18 that's a, that's a whole process that takes a lot  
19 of time.

20 And I just feel like an attestation is  
21 not something, I understand totally what you're  
22 trying to get at, but I wonder if it would be

1 just better to focus our attention on getting  
2 some outcome measures out as quickly as possible,  
3 and that's what my preference would be. So  
4 that's what I'll say.

5 CO-CHAIR MORRISON: So let me say this  
6 again. We advise CMS, we don't tell them what to  
7 do.

8 MEMBER MCGIFFERT: That's right.

9 CO-CHAIR MORRISON: Okay. We can be  
10 here until 9:00 tonight doing this. I would  
11 prefer not to be.

12 My suggestion is that we vote as  
13 conditional support. The condition that has, was  
14 raised was NQF endorsement, which is often, I  
15 would say universally the condition on endorsed  
16 measures that have come through this group within  
17 seven years.

18 Again, CMS can take that or not. If  
19 that does not pass, and we will come back to do  
20 not support with mitigation. What I'm hearing  
21 the mitigation from Akin is that we'd like better  
22 clarity on the language, and an opportunity to

1 review it again, at which case CMS can go back  
2 and rewrite it. I will provide grammar tutoring.

3 And we will see it again, I suspect.

4 And if it does not pass that, then it is not  
5 supported at all, because that was the initial  
6 vote, and I just, I'm not sure I see any way out  
7 of this conundrum except that, guys.

8 I know it's not satisfactory to  
9 anybody, particularly me, but I just don't see  
10 any way out of that conundrum. Should we vote?

11 (Off-microphone comments.)

12 CO-CHAIR MORRISON: Okay. Jordan, I  
13 need a vote.

14 (Off-microphone comments.)

15 CO-CHAIR MORRISON: Okay. So as  
16 Cristie points out to me, it's important to know  
17 what language we're voting on. We're voting on  
18 the substitution of and, rather than which.

19 So we are voting on, do you  
20 participate in a collaborative, and you have  
21 implemented process related to patient safety  
22 practices, bundles to address all kinds of bad

1 things.

2 MR. HIRSCH: On MUC2019-114, maternal  
3 morbidity, do you vote conditional support? Your  
4 options are yes or no.

5 MS. JUNG: I believe we are looking  
6 for 25 right now. We're not missing anyone.

7 CO-CHAIR MORRISON: Brock --

8 MS. JUNG: Oh.

9 CO-CHAIR MORRISON: -- yes, Brock  
10 left.

11 MS. JUNG: Yes.

12 (Off-microphone comments.)

13 CO-CHAIR MORRISON: Okay.

14 MS. JUNG: Let me check is there's one  
15 that we don't show.

16 (Off-microphone comments.)

17 MR. HIRSCH: On MUC2019-114, maternal  
18 morbidity, do you vote conditional support?  
19 There are 13 votes for yes, 12 votes for no. The  
20 workgroup does not vote for maternal morbidity  
21 with conditional support for rule making.

22 CO-CHAIR MORRISON: All right. So now

1 we are going to do not support with mitigating  
2 circumstances, and the only mitigating  
3 circumstances I have heard is clarity in  
4 rewriting the measure. So that's --

5 (Simultaneous speaking.)

6 CO-CHAIR MORRISON: I understand that,  
7 but --

8 MEMBER JORDAN: Maybe we should go to  
9 the, we've already voted this and moved back.  
10 Vote on the just kill it --

11 CO-CHAIR MORRISON: We can't do that.  
12 We've already -- Jack, we have already voted that  
13 way. We voted not to kill it. We voted not to  
14 kill it. We --

15 CO-CHAIR UPSHAW TRAVIS: The first  
16 vote.

17 CO-CHAIR MORRISON: -- the first vote.  
18 That's where we started the day. Sorry, my  
19 friend. So now, we're back to the last vote.

20 CO-CHAIR UPSHAW TRAVIS: We can end up  
21 there again.

22 MEMBER GUINAN: Wait, I'm sorry. When

1 we did the original, going through the four  
2 options, we did the do support or do not support?

3 CO-CHAIR MORRISON: We started with,  
4 we started with do you support the staff's  
5 recommendations. The staff recommendation was  
6 not to support the measure.

7 We said, staff, we disagree with you.  
8 We would like to vote on the other three options,  
9 and we are now on number three of those three  
10 options.

11 MR. AMIN: And if the --

12 CO-CHAIR MORRISON: I know it was a  
13 long time ago, but --

14 MR. AMIN: Yes. If the last do not  
15 support with mitigations doesn't pass, then it is  
16 the staff recommendation of do not support  
17 carries forward to the coordinating committee.  
18 Just to be clear. So we're almost out of this.

19 CO-CHAIR MORRISON: Yes.

20 MR. AMIN: Keep going.

21 CO-CHAIR MORRISON: Right. We're,  
22 yes, at the end, maybe, and say, so --

1 MR. AMIN: Do not support with  
2 potential for mitigation.

3 CO-CHAIR MORRISON: Thank you.

4 MR. AMIN: And I'll just emphasize  
5 that the mitigations, are, we, like balancing to  
6 make sure there's emphasis on the collaborative  
7 and the best, and the practices, making sure that  
8 practices are clear and specified, and obviously  
9 updating the question to reflect the balance of  
10 these two priorities that the committee  
11 discussed.

12 PARTICIPANT: And NQF.

13 MR. AMIN: And NQF endorsement. If we  
14 don't agree that collaboratives are the right  
15 approach at all, then just, you know, then you're  
16 not in support of this at all.

17 CO-CHAIR MORRISON: All right.

18 (Simultaneous speaking.)

19 CO-CHAIR MORRISON: We are ready to  
20 vote. Oh, I love it. Voting music.

21 (Simultaneous speaking.)

22 MR. HIRSCH: For MUC2019-114, maternal

1 morbidity, do you vote to, do you vote do not  
2 support with the potential for mitigation? Your  
3 options are yes or no.

4 MR. STOLPE: Unbelievable. You did  
5 it.

6 (Laughter.)

7 (Off-microphone comments.)

8 MR. STOLPE: That's a yes.

9 MR. HIRSCH: For MUC2019-114, maternal  
10 morbidity, do you vote not support with potential  
11 for mitigation, 15 votes for yes, 9 votes for no.  
12 The workgroup has moved, has recommended that  
13 MUC2019-114 maternal morbidity with do not  
14 support --

15 PARTICIPANT: Oh, wait a minute, that  
16 was a double negative, wasn't it?

17 MR. HIRSCH: -- with potential for  
18 mitigation.

19 CO-CHAIR MORRISON: Would anybody like  
20 to address gaps in this measure?

21 (Simultaneous speaking.)

22 CO-CHAIR MORRISON: Oh, we've got one

1 more measure. We've got one more measure. Okay.  
2 Hang on. Hang on. You're right. I was so far  
3 ahead of myself. We're going to the next  
4 measure.

5 MEMBER GUINAN: Can I just, on this  
6 measure, everyone lawyered up, so I'm going to  
7 have my lawyer moment as well. Can just staff  
8 reflect in the writeup for this measure review  
9 that the room was given a definition today, and  
10 that this vote reflects a vote on the definition  
11 that was provided today at the meeting? I think  
12 that's important.

13 MR. AMIN: Yes. I guess because the  
14 vote ended up with a do not support --

15 MEMBER GUINAN: This is a narrative  
16 for the --

17 MR. AMIN: Okay. Yes.

18 MEMBER GUINAN: -- context of the --

19 MR. AMIN: We will do that. We'll add  
20 it to it. Okay.

21 CO-CHAIR UPSHAW TRAVIS: I think  
22 that's fair.

1 CO-CHAIR MORRISON: Yes. All right.  
2 Hospital harm, severe hyperglycemia.

3 HOSPITAL HARM - SEVERE HYPERGLYCEMIA

4 MR. STOLPE: All right. Very good.  
5 Thank you. So moving onto our final measure.  
6 Last push, guys. Thank you very much for hanging  
7 with us through what is undoubtedly a challenging  
8 conversation for everybody.

9 So this Hospital Harm - Severe  
10 Hyperglycemia measure is a fully developed  
11 measure, which I'll read the measure description,  
12 which is fairly short.

13 This measure says that the portion of  
14 hospital days with a severe hyperglycemic event  
15 for hospitalized patients 18 or older who have a  
16 diagnosis of diabetes mellitus, that have  
17 received at least one administration of insulin,  
18 or an anti-diabetic medication during the  
19 hospital admission, or have had an elevated blood  
20 glucose level greater than or equal to 200  
21 milligrams per deciliter during their hospital  
22 admission.

1           So when staff's preliminary analysis  
2 of this measure, we rated it as a conditional  
3 support, pending NQF endorsement.

4           There is a measure comparable to this  
5 one that was endorsed at one time that is no  
6 longer endorsed, but the measure has been  
7 submitted for a review by NQF, as measure NQF  
8 3533.

9           The measure addresses a critical  
10 quality objective inside of the meaningful  
11 management area of preventable healthcare harm.  
12 It is an outcome measure.

13           The staff noted that the IQR currently  
14 does not include any measures assessing  
15 hyperglycemia events, and that this is a measure  
16 that could be easily reported, as it's easily  
17 extractable from the EHR. That's the review by  
18 the staff.

19           CO-CHAIR MORRISON: Thank you.

20           MS. JUNG: And --

21           CO-CHAIR MORRISON: I'm sorry.

22           MS. JUNG: And I'll just, I'll just

1 add some more to the previous measure that I  
2 reviewed.

3 This measure is in the NQF CDP process  
4 for fall 2019 being reviewed by the Patient  
5 Safety Standing Committee, and similar to the  
6 previous ESRD measure, this measure is reviewed  
7 by the S&P, and passed for reliability and  
8 validity this past month.

9 CO-CHAIR MORRISON: Thanks. Anna,  
10 you're the first discussant.

11 MEMBER DOPP: Sure.

12 CO-CHAIR MORRISON: Oh, I'm sorry.  
13 Public comment? No? Anna, you're up.

14 MEMBER DOPP: Okay. Well, the co-  
15 leads for this, co-lead discussants, we promise  
16 that this will be another robust and rich  
17 conversation, where we go back and forth between  
18 policy and practice.

19 On the, you provided a great overview  
20 of the measure, so I won't go into detail for  
21 that, but from the policy perspective, this  
22 represents an outcome measure that does target an

1 important area of preventable harm.

2 It's also one of the three pillars of  
3 the CDC national action plan for adverse drug  
4 event prevention.

5 From the practice level, there are  
6 some concerns that have been expressed from  
7 clinicians in terms of the clinical  
8 appropriateness of this, both in terms of  
9 potentially compromising patient safety to drive  
10 towards hypoglycemia.

11 And then also, maybe that is not as,  
12 the clinical concerns around hyperglycemia are  
13 not as strong as hypoglycemia.

14 But to remind everyone, last year, we  
15 had the MAP. We talked about the, we had the  
16 hypoglycemia measure, and we conditionally  
17 supported it at the time, and actually made  
18 comments that there should be a balancing measure  
19 to make sure that we don't reach the upper limit,  
20 and force towards hyperglycemia.

21 So this was nice to see a response  
22 come back from that comment, from this MAP group

1 last year. The hypoglycemia measure was not NQF  
2 endorsed last year at this time, but it was just  
3 recently endorsed in October of 2019.

4 So this hyperglycemia measure is  
5 following a similar path, it sounds like. Also,  
6 there is an existing, there was a measure that  
7 was NQF endorsed, had its endorsement removed in  
8 August of 2018, 2362-E, for glycemic control, for  
9 hyperglycemia, and NQF staff provided us with a  
10 detail that we didn't, we don't have, because  
11 it's not in the QPS quite yet.

12 And so our group was able to look at  
13 that and thought I would just call out some of  
14 the rationale for changes from that measure,  
15 where the endorsement was not maintained, to why  
16 a new measure was created.

17 One of them is a notable change in the  
18 higher threshold from 200 milligrams per  
19 deciliter to 300, trying to address concerns with  
20 clinicians to avoid unintended consequences of  
21 hypoglycemia.

22 Also, there is a difference that

1 metformin is not an exclusion, where it was in  
2 the earlier measure. However, they found that  
3 there was a negligible number of patients that  
4 had metformin in the denominator, so didn't feel  
5 that it needed to be excluded.

6 Another big change from the previous  
7 measure is how they define hospital days, and  
8 then also, the previous measure was risk  
9 adjusted.

10 The measure ahead of us today is not  
11 risk adjusted because of listening concerns  
12 about, in ICU patients, or other patients that  
13 might have a higher daily steroid use that were  
14 raised as concerns in the previous measure.

15 So I think that there's nice  
16 explanation as to why we're here with the  
17 existing measure versus the one that was  
18 previously endorsed.

19 I'll just add for other lead  
20 discussants get to, get to time in, and Brock  
21 asked if we would share the rural health aspect,  
22 because he had to leave.

1                   So the rural health MAP workgroup  
2                   shared that this is indeed an important patient  
3                   safety area in rural settings. They expressed  
4                   some concerns regarding laboratory data, and the  
5                   turnaround time for that, and incorporation of  
6                   it, of, into clinical data systems that might be  
7                   different at the rural health setting, but in  
8                   general, they ranked 3.9 out of 5 in terms of  
9                   suitability from the rural health perspective.

10                  CO-CHAIR MORRISON: Thank you, Anna.  
11                  So summary, you conditionally support, you're  
12                  supporting the staff?

13                  MEMBER DOPP: Well, I knew you were  
14                  going to ask that. That's where I am right now,  
15                  but I, but I could see the discussion changing  
16                  that.

17                  CO-CHAIR MORRISON: Okay. Okay.  
18                  Sorry. Karen, things to add?

19                  MEMBER CHIN: So Karen is actually out  
20                  sick.

21                  CO-CHAIR MORRISON: Oh, that's right.

22                  MEMBER CHIN: My name's Amy Chin and I

1 work with her, so I'm filling in. To, we are  
2 also supportive of the measure. I think it's  
3 great that we're moving towards eCQM  
4 stratifications, and you know, I think the  
5 measure is like, it's definitely feasible.

6 My only question, I guess, is a point  
7 of clarity, is, it seems like some of the  
8 response to issues around unintended issues is to  
9 pair it with the hypoglycemia measure, and I'm  
10 wondering if there's like any actual mechanism to  
11 like tether them together?

12 CO-CHAIR MORRISON: I will hold back  
13 for the clarifying question.

14 MEMBER SCHREIBER: Can I just answer -

15 -

16 CO-CHAIR MORRISON: You may just  
17 answer.

18 MEMBER SCHREIBER: -- since I have to  
19 step out in the few minutes?

20 CO-CHAIR MORRISON: Yes.

21 MEMBER SCHREIBER: The intent of this  
22 measure, and several others that you have seen,

1 is to ultimately create a composite measure that  
2 is an electronic composite measure of harm so  
3 that both hyper and hypoglycemia would be  
4 included together, along with other harms.

5 CO-CHAIR MORRISON: And Michael?

6 MEMBER WOODRUFF: Okay. I'm going to  
7 represent a somewhat different viewpoint that  
8 comes out of both discussions with my  
9 organization, as well as the public comments that  
10 are available here that bring up some really  
11 important issues.

12 While we clearly support the  
13 development of eCQMs that identify preventable  
14 harm, and help us prevent harm, I think there are  
15 some important issues here to identify.

16 The first one is the clinical  
17 reasoning that hyperglycemia isn't, an episode of  
18 hyperglycemia, the way it's defined in the  
19 measure, is actually a patient harm.

20 The only evidence we have for  
21 hyperglycemia being a patient harm would be in  
22 the ICU population, and would be in the surgical

1 population, and relates to outcomes of morbidity,  
2 infection, and so on.

3 So an isolated episode, which is the  
4 way this measure is written, it counts each day  
5 individually, really, they're very, it's a very  
6 different clinical process than hypoglycemia.

7 An episode of hypoglycemia is  
8 potentially fatal, and that can kill you. An  
9 episode of hyperglycemia, in the long-term, can  
10 impact outcomes.

11 And that gets to the second point,  
12 that this has been classified as an outcome  
13 measure, but it's really a process measure,  
14 because a single measurement of glucose is not an  
15 outcome.

16 The outcomes, and this has been  
17 established in the literature we have, is that it  
18 is mortality and infections in surgical patients.  
19 The other point that's been raised that's really  
20 important is that the scope of this, this applies  
21 to all admitted inpatients, right?

22 As I mentioned before, the evidence

1 base is, really comes in the ICU, critically ill  
2 patients, and surgical patients, and there's very  
3 little literature to support this being used  
4 broadly. And so a number of commenters brought  
5 up, rightly, that that's an issue.

6 I think I've hit all my points. I  
7 agree that the feasibility has been established,  
8 but I would support that we do not support this  
9 measure, but that it can be mitigated in a couple  
10 of different ways.

11 One would be by focusing down on the  
12 relevant population, where we know there's a  
13 strong evidence base.

14 CO-CHAIR MORRISON: Mike, can I ask  
15 you to --

16 MEMBER WOODRUFF: Yes.

17 CO-CHAIR MORRISON: -- hold those  
18 until --

19 MEMBER WOODRUFF: Absolutely.

20 CO-CHAIR MORRISON: -- yes. I'll come  
21 back to those. Don't worry. I've got you.

22 MEMBER WOODRUFF: Okay.

1 CO-CHAIR MORRISON: Lindsey.

2 MEMBER WISHAM: Yes. So obviously my  
3 other discussant is Anna, and we went through a  
4 couple of other tidbits to consider, but I think  
5 as we look towards potentially creating these  
6 eQMs that can be reported, and actually consumed  
7 by patients and consumers to inform their  
8 healthcare decisions, this topic is of  
9 importance, and can be reported as an eQM.

10 So just to keep that in the back of  
11 your mind. Also noted is that we did request  
12 initial information from NQF staff, is that they  
13 did provide us with the eQM.

14 It is currently being specified using  
15 QDM, an earlier version of QDM as a measure  
16 offering tool, so I would just like to recommend  
17 that those classifications be updated as soon as,  
18 to go ahead and include this in rule making.

19 And then, we did review the public  
20 comments, and there were some really great ones  
21 made, some great points, and we wanted to make  
22 sure we address those.

1                   One of those had to do with  
2                   feasibility. The feasibility testing has been  
3                   concluded by the measure developers. We wanted  
4                   to ensure that the rural health perspective was  
5                   also included in this, and as of note, there is  
6                   two of them, seven or eight hospitals that were  
7                   included in the testing were designated as rural,  
8                   and both of them did have success in identifying  
9                   that they could feasibly report these eight  
10                  elements in discrete fields. So that was, you  
11                  know, in a positive direction.

12                 The one limitation that was found in  
13                 the testing was that, not necessarily that the  
14                 lab results were there at the point of care, but  
15                 that the lab results were still codified in a  
16                 local code system, and had not been migrated over  
17                 fully, and that was found at one of the testing  
18                 sites.

19                 But that was the one rule limitation  
20                 in the reportability of this eCQM. So all in  
21                 all, my assessment is that it was a solid  
22                 specification, that, although the numerator is

1 fairly complex, it could be, it could be derived  
2 through a period out of an EHR.

3 CO-CHAIR MORRISON: Terrific. Open  
4 first to clarifying questions, either CMS or  
5 their measure developments?

6 All right. So open for discussion.  
7 Just let me sort of summarize what I'm hearing  
8 from the lead discussants.

9 (Off-microphone comments.)

10 CO-CHAIR MORRISON: I'm sorry. Yes.

11 MR. FENG: Can we make a, make a  
12 clarifying point. Based on the population, the  
13 initial population with denominator of this  
14 measure is definitely the people at risk of  
15 something as severe hyperglycemia, is definitely  
16 a population of relevance. I think that was one  
17 of the questions.

18 (Simultaneous speaking.)

19 CO-CHAIR MORRISON: I think that the,  
20 another question, the point was made that the  
21 evidence base for glycemic control and adverse  
22 outcomes was in ICU populations, and surgical

1 populations, not general medical or all, did I  
2 get that right, Michael?

3 MEMBER WOODRUFF: Yes.

4 CO-CHAIR MORRISON: Okay. So that was  
5 one of, what I heard was a question about, was  
6 it, questions about the clinical reasoning and  
7 the evidence behind the measure was the right  
8 populations being, right populations being  
9 targeted, was there evidence to support those  
10 populations?

11 I heard concerns that this really  
12 wasn't an outcome measure, it was a process  
13 measure, that hypoglycemia equals death,  
14 hyperglycemia, unless it's very hyper, it does  
15 not necessarily equal death, but equals a number  
16 of other bad things that happen after that.

17 I did hear support in terms of this  
18 being paired with the hypoglycemic measure that  
19 we reviewed last time, and I heard support in  
20 terms of it was both feasible to collect and  
21 feasible to report, and the burden would not be  
22 terribly high. I think that's what I heard. Did

1 I miss anything? Other thoughts, folks?

2 Discussion? Mike?

3 MEMBER WOODRUFF: I've just got one  
4 other point that the commenters made. If we, if  
5 we aggressively push on hyperglycemia, we will  
6 probably, by necessity, increase the incidence of  
7 hypoglycemia, which, as you very clearly stated,  
8 is dangerous. So there's a potential harm there.

9 CO-CHAIR MORRISON: Akin?

10 MEMBER DEMEHIN: We've heard some of  
11 the same concerns about that sort of balance  
12 between, obviously, when hyperglycemia happens,  
13 it's not a good thing, but the more dangerous  
14 condition really is hypoglycemia, which would  
15 certainly hurt folks more.

16 I guess I have one more clarifying  
17 question. So where, how many sites was this  
18 tested on, and how many different EHR systems was  
19 it tested on?

20 MR. FENG: So we've tested the measure  
21 across eight different sites with three different  
22 EHR systems.

1                   MEMBER DEMEHIN: Eight different  
2 sites, and three different EHRs?

3                   MR. FENG: That is correct.

4                   MEMBER DEMEHIN: Okay. Thank you.

5                   CO-CHAIR MORRISON: Other points of  
6 discussion? Okay. I think we're ready to vote,  
7 yes?

8                   So the, because it's been a very long  
9 time since we've done this. We start with  
10 whether you support NQF staff's recommendation  
11 or, it's not really a recommendation, is it?  
12 It's opinion. I it's a recommendation, which is  
13 conditional support, and the condition is NQF  
14 endorsement, okay?

15                   So if you, voting yes means that  
16 you're voting for conditional support with the  
17 condition being this needs to go through the NQF  
18 endorsement process.

19                   MR. HIRSCH: For MUC2019-26, hospital  
20 harms, severe hyperglycemia, do you vote to  
21 support the preliminary analysis as the workgroup  
22 recommendation? Again, the recommendation was

1 conditional support. Your options are yes or no.

2 MS. JUNG: I believe --

3 MEMBER GHINASSI: We lost two here.

4 MS. JUNG: -- we've lost two. Okay.

5 (Simultaneous speaking.)

6 CO-CHAIR MORRISON: Lisa, yes, we lost  
7 Lisa.

8 MEMBER GHINASSI: Two here, and then  
9 one down there. That's three, four.

10 MS. JUNG: Yes, so we've lost three  
11 voting members. Is that correct?

12 PARTICIPANT: Four.

13 MS. JUNG: Michelle --

14 (Simultaneous speaking.)

15 MS. JUNG: Lindsey, are you on the  
16 line yet? She mentioned she may be able to cast  
17 her vote that way. Okay. So, and then, Andreea  
18 has recused? That's correct? Okay.

19 So we have 21 votes that we're looking  
20 for. Is that correct? Oh, and then we've got  
21 one through the chat service. Okay.

22 (Simultaneous speaking)

1 MS. JUNG: So we are, we have all the  
2 votes in for analysis.

3 MR. HIRSCH: For MUC2019-26, hospital  
4 harm, severe hyperglycemia, do you vote to  
5 support the preliminary analysis as the workgroup  
6 recommendation? The workgroup put forth 17 votes  
7 for yes, 4 votes for no. The workgroup has  
8 recommended conditional support for MUC2019-26,  
9 hospital harm.

10 CO-CHAIR MORRISON: We are now open  
11 for a gap discussion on this program. I know  
12 people are tired, but we are in the home stretch,  
13 so this is the time, this is the time.

14 Maryellen, you, did you have, I shut  
15 you down before, right?

16 (Off-microphone comments.)

17 CO-CHAIR MORRISON: You've got, okay.  
18 Okay. Akin?

19 MEMBER DEMEHIN: We're on gaps, right?

20 CO-CHAIR MORRISON: We are on gaps.

21 MEMBER DEMEHIN: Okay. So I do think  
22 patient safety at large remains a gap here, even

1       within the hospital IQR program, and it is good  
2       that we had some conversation about limits,  
3       patient safety related here, notwithstanding the  
4       concerns that I articulated about it.

5               The other, I'm not quite sure what the  
6       best way of characterizing this is, but if one of  
7       the things that's always a challenge with this  
8       process is that we, sort of by necessity, talk  
9       about things on a program-by-program, and ergo, a  
10      silo-by-silo basis, having the opportunity to  
11      look across settings and across programs a little  
12      more strategically, I think would be helpful.

13             You know, if there is a gap area that  
14      we can identify in common across more than one  
15      setting, it would be really nice to try to  
16      reflect it here.

17             I think it may help us a little bit  
18      out in the talks that we were in when we reach  
19      back to the followup measure, where we were kind  
20      of grappling with it.

21             Is the IQF the right place to do it or  
22      not? So I don't know if it's a gap, but I do

1           perceive it as a challenge.

2                       CO-CHAIR MORRISON:   Lindsey?

3                       MEMBER WISHAM:   I couldn't agree with  
4           Akin more.   And you were actually talking about  
5           something earlier today, which is, you know, as  
6           much as this group is a wonderful group to work  
7           with, I think about not having a care setting  
8           specific workgroup, right, more of a  
9           longitudinal, from the true point of the patient,  
10          and that longitudinal care perspective.

11                      And with that, I'd like a seamless  
12          transfer of health information.   So I think that,  
13          with specific needs in the eye of the beholder.  
14          If you're putting the patient as the beholder,  
15          that is not happening, as to how their  
16          information, whether it's an IQR setting, to a,  
17          you know, a setting that they're being discharged  
18          to, whether it be home or not, is not happening.

19                      That would lend itself to a  
20          longitudinal measure, but would also lend itself  
21          to, you know, really assisting and bolstering IQR  
22          programs as well.

1 CO-CHAIR MORRISON: Marty?

2 MEMBER HATLIE: Again, I want to  
3 identify, is when we talk about person and family  
4 engagement, in most of the materials I've seen  
5 here, we kind of lean into the engaging patients  
6 and families as partners in care, or at the site  
7 of care, but in fact, by example, we're engaging  
8 them in a group of work in this committee.

9 It's come up a couple of times with  
10 reporting today, that the patients might give us  
11 input in reporting, and it's leading me back to  
12 the, why I like the proximal metrics.

13 There's a need, I think, for us to  
14 bring that voice to the patient and family up  
15 from the point of care into the organization in  
16 a, in a, in a bigger way.

17 So CMS, through their network, has  
18 been tracking how patients and families are  
19 engaged in the hospitals in improvement work,  
20 whether there's staff that really are there to  
21 support that engagement and improvement work, and  
22 also whether there are governors of hospitals.

1                   And after, it started in 2013. After  
2                   20, so 6 years of pushing, 50 percent of the  
3                   hospitals in the country still don't have  
4                   somebody who identifies as a patient or family on  
5                   their board of directors.

6                   I really think it's important that we  
7                   pay attention to the, I don't want to say  
8                   barriers, but just the challenges of getting that  
9                   kind of patient and family engagement into the  
10                  leadership of our systems.

11                  I'm on a hospital board since January  
12                  that made a decision in Chicago to actually bring  
13                  the patients and families on the board, and it is  
14                  amazing how the discussion changes when there's  
15                  actually users of care from a relatively poor  
16                  community that are, that are there, explaining  
17                  what it's like to be using that hospital.

18                  So I think it's an important thing for  
19                  us to keep track of this. There's also  
20                  literature on it, and frameworks about engaging  
21                  patients and families at multiple levels of the  
22                  process.

1 CO-CHAIR MORRISON: Thank you.

2 MEMBER HATLIE: You're welcome. Thank  
3 you.

4 CO-CHAIR MORRISON: No more cards, I  
5 now turn to the back for public comments. I turn  
6 to the phones for public comment.

7 MS. JUNG: Just to be clear, this is  
8 public comment, and not specific to any program.

9 CO-CHAIR MORRISON: This is public  
10 comment for anybody who wants to say anything.

11 (Laughter.)

12 CO-CHAIR UPSHAW TRAVIS: But you get  
13 two minutes or less.

14 CO-CHAIR MORRISON: But you get two  
15 minutes, so it's only two minutes. So --

16 MS. JUNG: Oh, I see one hand raised  
17 in the back.

18 CO-CHAIR MORRISON: Oh?

19 MS. JUNG: Cheryl Peterson?

20 CO-CHAIR MORRISON: Cheryl Peterson?

21 MS. JUNG: Yes.

22 CO-CHAIR MORRISON: You, go ahead.

1 Cheryl? Can we --

2 MS. PETERSON: Can you hear me?

3 CO-CHAIR MORRISON: We can hear you.

4 MS. PETERSON: Cheryl Peterson,  
5 American Nurses Association, and member of the  
6 MAP coordinating committee. I just wanted to  
7 say, I've listened to all of your dialogue today,  
8 and your comments, and I've taken copious notes,  
9 but really, thank you for your hard work.

10 It was, it was a, actually a pleasure  
11 to listen to you, and I was very glad I didn't  
12 have to be in the conversation.

13 CO-CHAIR MORRISON: Anybody else on  
14 the phone, Madison? So I'm going to shut up in a  
15 minute, but let me just take the minute to say  
16 thank you to Madison, to Jordan, to Sam, and  
17 Taroon, who, without this, could not have  
18 happened, and thank you for your very, very sage  
19 advice, particularly on some difficult issues  
20 today that we encountered.

21 To our colleagues at CMS, I know you  
22 take a lot of abuse from us, but thank you very

1 much. Thank all of you. I know it's been a very  
2 long day.

3 And most importantly, I want to thank  
4 Cristie. Cristie, as she reminded me, has been  
5 on this committee since its inception. I think I  
6 joined after the second meeting, when we were  
7 both out there.

8 You could always count on Cristie for,  
9 you know, sort of listening, hearing, and just  
10 hitting the exact right point in the right  
11 moment, and bringing the discussion back to where  
12 it needed to be focused. And I watched her do  
13 that over and over again.

14 I don't think there was a wasted, you  
15 know, word in anything that she said, and then,  
16 watching her facilitate for the past couple of  
17 years has just been a joy.

18 I don't think anybody could describe  
19 this type of meeting as a place they would  
20 really, really like to be, given other choices,  
21 and yet Cristie has made it fun.

22 She has kept us moving. Note, only

1 one of us kept us on time today, which she has  
2 done, and I think we are all going to miss her  
3 tremendously.

4 I really do wish she changes her mind  
5 and comes back, but it really has been a  
6 spectacular run, and thank you, Cristie, from all  
7 of us.

8 (Applause.)

9 CO-CHAIR UPSHAW TRAVIS: Well, thank  
10 you. I have to say, this is a trial by fire for  
11 Sean today. Notice, he got the difficult  
12 measures, and I want to thank the staff for  
13 giving me the easy ones.

14 I've had my share of difficult ones in  
15 prior years. I'm glad I got the easy ones today.  
16 But I want to add my thank yous to the staff, and  
17 to CMS.

18 Thank you all so much for, you know,  
19 really listening and hearing what our thoughts  
20 and concerns are. We really appreciate that, and  
21 to everybody here, thank you for everything you  
22 say, and to all of you, thank you.

1 CO-CHAIR MORRISON: And safe travels  
2 home, everybody.

3 PARTICIPANT: Next steps.

4 CO-CHAIR MORRISON: Yes, next steps.

5 PARTICIPANT: Jordan, I'll hand it  
6 over to you, and you can do the next steps.

7 MR. HIRSCH: All right. Thank you.  
8 Tomorrow, we have the MAP clinician in person  
9 meeting, which is basically right in the middle  
10 of December, the in-person workgroup meetings.  
11 So that'll be the last of the three.

12 (Off-microphone comments.)

13 MR. HIRSCH: In the end of December,  
14 into January, there will be public commenting  
15 period, and from January 24 to March 15, the pre-  
16 rule making deliverables will be released.

17 So public commenting period, as I  
18 mentioned, will be later this month. It will run  
19 from December 18th until January 8th. The  
20 coordinating committee will have their in person  
21 meeting to review all the measures that were put  
22 forth on January 15th, and final recommendations

1 are due to CMS on January 24th, and the hospital  
2 report will be presented on February 15th.

3 Finally, contact information, you can  
4 go to the public page on [qualityforum.org](http://qualityforum.org). As  
5 the workgroup, you are able to access the  
6 Sharepoint page at [share.qualityforum.org](http://share.qualityforum.org), and if  
7 you have any questions, please email us at  
8 [MAPhospital@qualityforum.org](mailto:MAPhospital@qualityforum.org), and I'd like to  
9 turn it back over to Sam and Taroon for final  
10 remarks.

11 MR. STOLPE: Thanks very much, Jordan.  
12 It just remains for us to thank you once again.  
13 It's really been a terrific opportunity for us to  
14 hear the insights from you all.

15 We have a fantastically quick  
16 turnaround that we require from each of you in  
17 order to participate in this discussion, and  
18 we're more appreciative of that than you probably  
19 realize.

20 OPERATOR: I'm sorry, there's been an  
21 internal error.

22 (Laughter.)

1 MR. STOLPE: Yes, that doesn't  
2 surprise me. That timing was impeccable. Yes.  
3 And last, we'd like to say a big thanks to our  
4 CMS colleagues for all the hard work that you do  
5 in bringing these things forward for us to  
6 consider.

7 It's a wonderful opportunity for us to  
8 engage with you, and it truly means a lot.  
9 Anything you'd like to add?

10 MEMBER DUSEJA: I'd just like to add,  
11 thank you so much for your participation. And  
12 this is my fourth hospital workgroup, actually,  
13 meeting, so I've been in other workgroups as  
14 well, and discussion at this one continues to  
15 like meet my expectations of the robust  
16 discussion around the group, and I, we really do  
17 truly appreciate it.

18 We take all of your comments to heart.  
19 I want to say thank you to the staff as well, and  
20 the co-chairs. And I also want to thank the CMS  
21 staff.

22 You know, to get us to this point

1           today takes a lot of work, and you have a lot of  
2           people behind the scenes, some of them you've had  
3           the pleasure of meeting today, but it really is  
4           an army of folks that have worked really hard in  
5           terms of improving the care for our  
6           beneficiaries. So I just want to extend my  
7           thanks to them as well.

8                         MR. STOLPE: All right. Well, thank  
9           you very much, everybody. Safe travels home. We  
10          are adjourned.

11                        (Whereupon, the above-entitled matter  
12          went off the record at 4:12 p.m.)  
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