NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
HOSPITAL WORKGROUP

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WEDNESDAY
DECEMBER 16, 2015

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Cristie Upshaw Travis and Ronald S. Walters, Co-Chairs, presiding.

PRESENT:

CRISTIE UPSHAW TRAVIS, MSHHA, Co-Chair
RONALD S. WALTERS, MD, MBA, MHA, MS, Co-Chair
ANDREA BENIN, MD, Children's Hospital Association
DAVID ENGLER, PhD, America's Essential Hospitals
NANCY FOSTER, American Hospital Association
SHELLEY FULD NASSO, National Coalition for Cancer Survivorship
MARTIN HATLIE, JD, Project Patient Care
JEFF JACOBS, MD, The Society of Thoracic Surgeons
HEATHER LEWIS, RN, Geisinger Health System
SHEKHAR MEHTA, PharmD, MS, Pharmacy Quality Alliance
ALLEN NISSENSON, MD, FACP, FASN, FNKF, Kidney Care Partners
KAREN ROTH, RN, MBA, CPA, St. Louis Area Business Health Coalition
LESLIE SCHULTZ, PhD, Premier, Inc.
BROCK SLABACH, MPH, FACHE, National Rural Health Association
DONNA SLOSBURG, BSN, LHRM, CASC, ASC Quality Collaboration

KELLY TRAUTNER, AFT Nurses and Health Professionals
WEI YING, MD, MS, MBA, Blue Cross Blue Shield of Massachusetts

INDIVIDUAL SUBJECT MATTER EXPERTS (Voting):
GREGORY ALEXANDER, PhD, RN, FAAN
ELIZABETH EVANS, DNP
JACK FOWLER, PhD
MITCHELL LEVY, MD, FCCM, FCCP
DOLORES MITCHELL
R. SEAN MORRISON, MD
MICHAEL P. PHELAN, MD, FACEP
ANN MARIE SULLIVAN, MD

FEDERAL GOVERNMENT LIAISONS (Non-voting):
PAMELA OWENS, PhD, Agency for Healthcare Research and Quality (AHRQ)*
DANIEL POLLOCK, MD, Centers for Disease Control and Prevention
PIERRE YOUNG, MD, MPH, Centers for Medicare and Medicaid Services (CMS)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON PRESENT:
THOMAS LUTZOW, PhD, MBA

NQF STAFF:
HELEN BURSTIN, MD, Chief Scientific Officer
ESLISA MUNTHALI, Vice President, Quality Measurement
TAROON AMIN, Staff Support
WUNMI ISIJOLA, Senior Project Manager
MELISSA MARINELARENA, Senior Director, Hospital Group
ERIN O'ROURKE, Senior Project Manager
ZEHRA SHAHAB, Project Manager
JEAN-LUC TILLY, Project Analyst
MARCIA WILSON, Senior Vice President, Quality Measurement

ALSO PRESENT:

HEIDI BOSSLEY, Federation of American Hospitals*

SUZANNAH BERNHEIM, MD, Centers for Medicare and Medicaid Services (CMS)*

AKIN DEMEHIN, American Hospital Association

MEGAN HAYDEN, Centers for Medicare and Medicaid Services (CMS)*

TARA LEMONS, Centers for Medicare and Medicaid Services (CMS)

KAREN SPALDING BUSH, Centers for Medicare and Medicaid Services (CMS)*

***participating by telephone**

C-O-N-T-E-N-T-S

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

9:03 a.m.

CO-CHAIR WALTERS: Welcome and thanks for coming to the meeting. Thanks for all your work prior to the meeting. That will pay off later on. Cristie and I are happy to be your chairs and try to put some order into this meeting, try to keep everybody pretty much on time and try to get everybody out sometime tomorrow.

(Laughter)

CO-CHAIR WALTERS: Those of you who are new shouldn't be scared by that last comment.

(Laughter)

CO-CHAIR WALTERS: You should just remember it.

(Laughter)

CO-CHAIR WALTERS: But welcome to those of you that are on the Committee for the first time, also.

So the thing we love is feedback, so please feel free to give feedback to staff or us,

or write it in Facebook or Twitter or whatever --

(Laughter)

CO-CHAIR TRAVIS: -- about any opportunities you see for improvement. We've made a lot of modifications over the years and we think this is now going to be the best version of this. So welcome again. Thanks for coming.

CO-CHAIR TRAVIS: Thank you, Ron. I'm pleased to be sitting next to Ron. He had this experience last year, so he's the one that I'm going to look to to be sure that we give everyone an opportunity, but that we do try to keep moving. And that will be our challenge today. But I just echo his thanks to everyone for all the work he's put in to date and over the next two days. Thank you.

CO-CHAIR WALTERS: Now, Ann, AKA Helen --

DR. BURSTIN: I am ready. Helen Burstin, Chief Scientific Officer here at NQF. I am actually Ann and Chris. So good morning, everybody. I'm serving -- and myself I guess

still. Pleasure to be back with MAP again this year. Some people refer to this as the holiday season. At NQF this is MAP season. But hopefully our efforts at continuous quality improvement, which have been pretty significant over the years, have both made it a better and more manageable experience for you as reviewers and members of the table, but also especially important to make it better that our staff do not work across the holidays as best we can.

So we look forward to a full and interesting discussion today. We recognize the importance of MAP. Hospital MAP in particular has always been on the cutting edge of discussing a lot of critical issues and we're looking forward to bringing up all those policy issues throughout the day.

So I'm also going to go through -- just to be efficient, we'll do introductions and disclosures at the same time, just so you guys can get to work since you have a lot on your plate for the next two days.

So most of you know you're divided into two different groups. There's the organizational members, as well as those who are individual subject matter experts and the federal liaisons. We'll do the disclosures differently across those different groups.

So organizational representatives, not surprisingly, we do expect that you would represent a particular viewpoint and usually represent the interests of those who have invited you to participate as their organizational representative. As part of your disclosure today we only ask that you disclose if you have an interest of $10,000 or more. In an entity that's related to any of the work before the Committee. Please tell us who you represent and if you have anything to disclose.

We'll do organizational members first. We'll see if there's anybody on the phone to do that. Then we'll come back and do the subject matter experts. We've seen your CVs since we got to pick you as part of our Committee process, so

if we went through your full CVs, you would never actually get to the IQR today.

(Laughter)

DR. BURSTIN: So short, brief introductions and any disclosures would be welcomed. So with that, I've got a lovely list here. We're going to begin with the Chairs, so we don't we begin with Cristie?

CO-CHAIR TRAVIS: Hi, Cristie Travis. I'm the CEO of the Memphis Business Group on Health and I have no disclosures to make, but I will also say that I'm very involved over on the consensus development process for the NQF, being a member of CSAC as well as the Admissions/Readmissions Standing Committee and some other committees that have been operating on that side. So I think I bring the CDP perspective to the MAP as well. So thank you.

CO-CHAIR WALTERS: Ron Walters. My day job is at MD Anderson Cancer Center in Houston, and I have nothing to disclose.

DR. BURSTIN: Thank you. I know that

Kelly Trautner will be joining us this afternoon from the AFT Nurses and Health Professionals.

I'm just going to run down this list just to make it simpler. So, Nancy Foster?

MEMBER FOSTER: Thank you, Helen. I'm Nancy Foster. I'm the Vice President for Quality and Patient Safety Policy at the American Hospital Association representing that organization today, and I have nothing to disclose.

DR. BURSTIN: David Engler?

MEMBER ENGLER: Good morning. I'm David Engler. I'm Senior Vice President of America's Essential Hospitals. It's my third year on MAP and I have nothing to disclose today. Thank you.

DR. BURSTIN: Welcome back to those who have returned to do this yet again.

Next Donna Slosburg, ASC Quality Collaboration.

MEMBER SLOSBURG: Can you hear me? Hi, I'm Donna Slosburg. I'm the Executive

Director of the Ambulatory Surgery Center Quality Collaboration. We develop quality measures for ambulatory surgery centers. And this is my third year as well, and the only thing I have to disclose is that I am a measure developer for ambulatory surgery center measures.

DR. BURSTIN: Thank you. Wei Ying from Blue Cross?

MEMBER YING: I'm Wei Ying. I'm Director of Performance Measurement and Population Health from Blue Cross/Blue Cross Mass. This is the third year I'm on MAPs, and nothing to disclose.

DR. BURSTIN: Andrea Benin?

MEMBER BENIN: Good morning. I'm Andrea Benin. I'm Senior Vice President for Quality and Patient Safety at Connecticut Children's Medical Center in Hartford. I'm a pediatric infectious disease doctor and I am representing the Children's Hospital Association, and I have nothing to disclose. Thank you.

DR. BURSTIN: Thanks, Andrea.

Heather Lewis?

MEMBER LEWIS: I'm Heather Lewis from Geisinger Health System. I am the Associate Vice President for Quality and Safety for the health system. I'm a nurse by training and I have nothing to disclose.

DR. BURSTIN: Thank you. Allen Nissenson?

MEMBER NISSENSON: I'm Allen Nissenson. I'm a nephrologist, Emeritus Professor of Medicine and former Associate Dean at UCLA Medical School, and currently Chief Medical Officer for DaVita Health Care Partners. And I'm representing Kidney Care Partners and also co-chair the Kidney Care Quality Alliance which is a measure development group for kidney care. And my disclosures, I am a full-time salaried employee at DaVita Health Care Partners.

DR. BURSTIN: Thank you, Allen. And our next organizational member is Mothers Against Medical Error. I know Helen Haskell is not here. Jennifer, are you on the phone?

MS. HUFF: I am.

DR. BURSTIN: Wonderful. Could you introduce yourself?

MS. HUFF: Jennifer Eames Huff. I am an independent consultant and a senior advisor to the Consumer Purchaser Alliance, and I am substituting for Helen for the morning half, and I have nothing to disclose.

DR. BURSTIN: Great. Thank you.

Shelley?

MEMBER FULD NASSO: Hi, I'm Shelley Fuld Nasso. I'm the CEO of the National Coalition for Cancer Survivorship, a patient advocacy group focused on quality of cancer care. This is my third year on the MAP and only my second in person because I did the first by phone, which I do not recommend.

(Laughter)

MEMBER FULD NASSO: So I'm glad to be here. And I'm also with Cristie and some others a member of the CSAC.

DR. BURSTIN: Thank you. Brock?

MEMBER SLABACH: Good morning. My name is Brock Slabach and I'm with the National Rural Health Association, former hospital administrator, and I have nothing to disclose.

DR. BURSTIN: Shek?

MEMBER MEHTA: Good morning. My name is Shek Mehta. I'm the Director of Clinical Guidelines and Quality Improvement at ASHB. I've been on the MAP -- this is going on my fourth year. I had represented ASHB in the past, but now I'm representing the Pharmacy Quality Alliance.

DR. BURSTIN: Martin Hatlie?

MEMBER HATLIE: Morning. I'm Marty Hatlie. I'm the CEO of Project Patient Care. We're a Chicago-based improvement coalition dedicated to bringing the voice of the patient and his co-partner in improvement and culture transformation work. And I'm a lawyer by training. I do not have anything to declare.

DR. BURSTIN: Excellent. Jeff, literally walked in just in time to -- and

introduce yourself and if you have any disclosures.

MEMBER JACOBS: My name is Jeff Jacobs. I'm a cardiac surgeon at Johns Hopkins All Childrens Heart Institute. I chair the Society of Thoracic Surgeons National Database Workforce. And other that, I really don't have anything else to disclose except I'm a little bit late.

(Laughter)

DR. BURSTIN: We saw. Leslie Schultz?

MEMBER SCHULTZ: Good morning. Leslie Schultz. I am with Premier and I am employed by Premier. I also have the privilege of sitting on the CPD for Patient Safety Measures, and nothing else to disclose.

DR. BURSTIN: Thanks, Leslie. Karen Roth?

MEMBER ROTH: Hi, I'm Karen Roth. I'm the Director of Research at the St. Louis Area Business Health Coalition. I represent purchasers and I have nothing to disclose.

DR. BURSTIN: Thank you. And Thomas Lutzow?

MEMBER LUTZOW: Yes, I'm Tom Lutzow. I'm President of iCare, an HMO in Milwaukee, and I'm a crossover representative from the MAP's Duals Group. Nothing to disclose.

DR. BURSTIN: Excellent. Thank you.

Next we're going to move on to the subject matter experts. These are a little different. You sit as individuals, and so we do ask you to give a bit more detail on your professional activities, particularly disclosures of any activities that are directly relevant to the work before the Committee today: grants, consulting, speaking arrangements, things of those kinds. But again, only if relevant to the Committee's work. We know your CVs.

Again, you sit as an individual. You do not represent the interests of a specific organization or anyone who may have nominated you. And we're just looking forward to hearing from you. And just because you disclose doesn't

mean you have a conflict. Obviously we just want to understand what people bring to the table.

So with that, let's go to the first person, Greg Alexander.

DR. ALEXANDER: Hi, I'm Greg Alexander. It's my first year on the MAP, first meeting here. I'm a registered nurse. I'm a professor at the University of Missouri. My background is I have research grants. I have several active ones right now, too. In particular, one through the Centers for Medicare and Medicaid Innovations Group and on hospital readmissions and long-term care trying to prevent avoidable hospitalizations.

And then I have another one through the Agency for Healthcare Research and Quality looking at quality measures related to IT adoption trends over several years. Thank you.

DR. BURSTIN: Thanks. Thanks, Greg. Jack Fowler?

DR. FOWLER: Hi, I'm Jack Fowler. I'm a part-time advisor these days on the research

agenda of the Informed Medical Decisions Foundation in Boston. And the foundation is now part of Healthwise, a non-profit organization that provides health information in a variety of forms to patients who are facing decisions and other medical issues.

DR. BURSTIN: Any disclosures? That's it?

DR. FOWLER: (No audible response)

DR. BURSTIN: Okay. So no other disclosures?

MEMBER FOWLER: Do you think --

DR. BURSTIN: I think we got it. Sorry.

DR. LEVY: Yes, I'm Mitchell Levy. I'm the Director of the Division of Pulmonary Critical Care Medicine at Brown University. I'm the subject matter expert for safety. I've been on the MAP for I think three or four years. My main work is in sepsis. I do a lot of work in quality improvement and performance improvement and knowledge translation. And I have no

financial conflicts of interest, although I've worked as one of the lead investigators of the Surviving Sepsis Campaign for about 12 years. And we developed the metrics that now have been taken up by CMS and are mandated nationally.

DR. BURSTIN: Thanks. Sean?

DR. MORRISON: Sean Morrison. I'm a professor of geriatrics and palliative medicine at the Icahn School of Medicine at Mount Sinai in New York. I direct the Palliative Care Institute there and the National Palliative Care Research Center. I receive funding from the NIH, from PCORI and private sector philantrophy, none of which is industry-related. And no disclosures.

DR. BURSTIN: Thank you. Dolores?

MS. MITCHELL: I'm Dolores Mitchell. I'm the executive director of the Group Insurance Commission of the Commonwealth of Massachusetts. And although I have informed this august organization three times that all of those initials after my name, which are totally incomprehensible to me; I don't even know what

they -- well, RN, I know what an RN is --

(Laughter)

MS. MITCHELL: -- and I'm not an RN, nor am I a CMM, nor am I an FACHE, nor am I an MSHA. So thank you for the honor, but I'm not entitled to any of them. I'm not sure who decided I was a subject matter expert. All I know about hospitals is what Nancy Foster and Rich Umbdenstock have tried to dis-inform me of my bad opinions.

(Laughter)

MS. MITCHELL: But I'm happy to be here. This is I think maybe my fourth year on this wonderful group. And I'm saying that without sarcasm, by the way. It's been a pleasure. And I think my only conflict could be construed as a non-financial one, namely that I sit on the board of the NCQA, which does develop measures. And I have nothing -- unfortunately I have nothing financial to disclose.

(Laughter)

DR. BURSTIN: Thank you, Dolores. It

was much cheaper than going to all those schools, wasn't it?

(Laughter)

DR. BURSTIN: We just pop it on a slide for you and you're good to go.

So, Mike, please?

DR. PHELAN: Can I have some of those initials, Dolores?

(Laughter)

DR. PHELAN: I am Mike Phelan. I'm an emergency medicine physician at the Cleveland Clinic. Also at that institution I'm on the quality side. And I work pretty extensively with the American College of Emergency Physicians, ACEP's Quality Patient Safety Committee. I have some small grants and other than that nothing really to disclose. Mostly related to research around quality and emergency medicine.

DR. BURSTIN: Thanks, Mike. Ann Marie?

DR. SULLIVAN: Hi, I'm Ann Sullivan. I'm the commissioner for the State of New York

Office of Mental Health and I'm also on the Medicaid MAP Workgroup. And nothing to disclose.

DR. BURSTIN: Thank you. And lastly, our federal representatives. Pierre, want to introduce yourself?

DR. YOUNG: Hi, I'm Pierre Young. I'm here representing CMS, and at CMS I work on the quality measures that we put into our program. So happy to be here.

DR. BURSTIN: Dan?

DR. POLLOCK: I am Dan Pollock. I'm representing Centers for Disease Control and Prevention. At CDC I lead the group that's responsible for the National Healthcare Safety Network, which is a surveillance system used, among other purposes, to measure healthcare-associated infections, antimicrobial use and resistance, and other adverse events and adherence to prevention practices. And a pleasure to be here.

DR. BURSTIN: And I know Pam Owens couldn't be here in person today. But Pam are

you on the phone?

DR. OWENS: I am. Thank you very much. And I am sorry that I'm not able to be there today. My name is Pam Owens. I'm the scientific lead on the AHRQ Quality Indicators and I'm an epidemiologist by training.

DR. BURSTIN: Great. Thanks, Pam.

So just my last word on this. Oh, I'm sorry. Go ahead.

MS. EVANS: Yes, I wasn't on that. I'm Beth Evans. I was also one of the expert --

DR. BURSTIN: Okay.

MS. EVANS: -- attendees. And I'm not on the list, but I'm here.

(Laughter)

MS. EVANS: My name is Beth Evans. I'm a nephrology nurse practitioner in Albuquerque, New Mexico. I'm representing American Nephrology Nursing Association and I'm also on the NQF Renal Standing Committee. Thank you.

DR. BURSTIN: Yes, you are. And

you're on my piece of paper, but you missed the slides. Our apologies. Thank you so much.

So lastly, the reason we do disclosures is just so everybody knows what everybody brings to the table as we have these discussions. Again, disclosures don't necessarily mean a conflict, but really importantly at any point during this meeting you have any concerns about somebody's disclosures or about somebody potential biases they're bringing to the table, or anything really at all, please come forward to NQF staff or the Chairs. Always better to deal with those issues in real time rather than finding out about them sort of much, much later when people are concerned that there was not really a robust and open discussion.

So with that, I'm just going to ask if you have -- based on everything you've heard, do you have any questions of each other about disclosures or any other issues regarding your introductions?

(No audible response)

DR. BURSTIN: All right. I think it's time for you guys to get to work.

CO-CHAIR WALTERS: -- staff?

MS. MARINELARENA: Hi, everyone. My name is Melissa Marinelarena. I'm the Senior Director now in the Hospital Group. This is my first year with MAP. I recently came back to NQF. I was here back in 2008, so it was the pre-MAP area. So I want to thank everybody for all of your hard work, the team, all the support staff that we have here at NQF working on this, and we're looking forward to the next two days.

PARTICIPANT: Talk about where you were before.

MS. MARINELARENA: Where was I before? I've been a lot of places. Well, I was in the hospital. I worked at Cedar Sinai. I worked with their measures there and did all the measure collection. And so, I went from here, from the policy side to the implementation side. So very familiar with a lot of these measures. And again, welcome.

MS. O'ROURKE: Hello, everyone. I'm Erin O'Rourke. I'm the Senior Project Manager supporting the Hospital Workgroup, and this is my I believe fifth year supporting the MAP. I've been here since the beginning and I'm excited to work with you all for another year.

MS. SHAHAB: Good morning, everyone. My name is Zehra Shahab. I am the Project Manager supporting this workgroup. I've been at NQF for about two-and-a-half years now and I've supported the readmissions project, care coordination, population health. I've been on a variety of projects, but this is my first time on MAP Hospital and looking forward to a great two days.

MR. TILLY: Hi, everyone. My name is Jean-Luc Tilly. I'm a project analyst supporting the MAP Hospital Workgroup. I've been at NQF for about three-and-a-half months. It's been great so far.

CO-CHAIR WALTERS: And I'll tell the new people; the people who've been here a while

know, we have excellent staff support. So feel free to talk to them about anything you may need. It's excellent.

So for the new people also, your job is to speak up, it's to get involved and get a buddy for someone that's been here longer, and if you have any questions, feel free to ask them. Don't be shy. This does not tend to be a shy meeting, by the way.

The objectives are very simple. We want to improve patient care and we want to make sure we know how we're measuring to do that. So let's not forget that it's all about measuring the improvement we make in patient care. And as a part of that, it's to deliver report to CMS about the proposed measures, the measures under consideration.

So that's the objective of the meeting. And we appreciate everybody's input prior to the meeting.

At this time I'm going to turn to over to Pierre, who's going to make some opening

remarks from CMS.

DR. YOUNG: Thanks, Ron. So it's a pleasure to be here. And just so folks know, we at CMS start thinking about the MUC list that we put together that you will be considering today starting in the spring time. So this is almost a year-long process for us at CMS.

And so, we always look forward to the MAP because, one, it's wonderful to see the diversity of perspectives represented on the Committee and the Workgroup, but also because it's a chance to see many returning members, but also to welcome new members. I always look forward to hearing Delores' comments and the perspective she brings to the table. But do want to thank all of you for taking time. I know you're all very busy, so taking two full days to participate and know that you spend many hours in addition outside of the two days at NQF to review the measures and provide your perspective.

I remember sitting here last year and somebody was asking a question checking that CMS

really does consider the input the MAP provides, and I want to reassure that we do take the MAP input very seriously and we want to make sure that we are here. And you'll see my colleagues coming to join me at the table, because we value your input and the diversity of opinions. So thank you for that.

I do want to thank also Ron, and welcome Cristie for chairing this particular workgroup, and also to thank Helen and her staff for all the work they've been putting in. And we've been really lucky to be able to work with them and certainly know that this meeting will proceed really smoothly in large part due to all the work that they've put in. So thank you.

CO-CHAIR TRAVIS: So we have just a couple of minutes. Does anybody have any questions they would like to ask Pierre before we get started? Yes, Nancy?

MEMBER FOSTER: Pierre, first of all, thanks for being here. It's been incredibly important throughout I think all of the years

that we've been doing the MAP to have CMS be a very vital presence at the table and be able to help us understand what's coming and why and so forth.

And in that regard I'd like to ask you if you could help us understand the set of measures that have come forward for the hospital programs this year. If one were to just sort of look at this blank slate, it might look like kind of a hodgepodge of measures. So is there a sort of framing thought or series of thoughts that brought these measures forward for this year that you might help us understand?

DR. YOUNG: Sure. So when we start thinking about putting together the MUC list, I think the thought, our sort of guiding principles and sort of goals are outlined in the National Quality Strategy. So I think that's the first place where we start. But then we also look at each program individually. And as you notice, each program has its own MUC list. So we look at the measures within each program, look at the

goals of those programs and look for particular gaps in the quality measures that are already implemented into those programs.

There are other considerations we also consider, so we also consider when putting together that list prior comments from the MAP. So we review prior MAP reports. We look for opportunities for alignment, because there are certainly concerns around burden and sort of misalignment between programs that we know is very real. So we want to be sensitive to that.

There are also priorities that we additionally have such as care coordination, improving care outcomes, patient and family caregiver, and improving that outcome space. So I think those are some of the priorities we also think about sort of that overlay some of the other considerations that we've put together.

So while the MUC list for each program is only a small subset of measures, you can imagine that those would be potentially implemented into a larger program which has

potentially many more measures. And so we think about the measure set as a whole, not just what you see on the MUC list. So hopefully that helps a little bit.

CO-CHAIR TRAVIS: Delores?

MS. MITCHELL: Well, I wasn't going to say anything right off the bat, but --

(Laughter)

MS. MITCHELL: -- Pierre's comment in response to Nancy's question made me think that I wanted to give CMS an admonition, if you will, which you can ignore or not as you wish.

But I have often been struck in these meetings by what is the appropriate focus on the federal programs. I understand that they're your programs and you pay for them and you want to have the best measures possible for working with them. But I think one of the considerations that I was listening for in your answer that I did not hear is the incredible ripple effect of everything that you decide on the rest of the healthcare world, or the medical world, or the

purchaser world, or the payer world, particularly given the increasing size, scope and magnitude of the federal role.

It may be a program that my agency, for example, has absolutely nothing to do with, but what you decide and how you run things and what rules you use and what measures you use has an incredible impact on us. And I hope that's always on your list of things you think about, because you should.

DR. YOUNG: So thank you, Delores. And I know that's been a topic of discussion, I think, also in discussions in the MAP, I think, at the Coordinating Committee level as well as in the individual workgroups that have been discussed. And so you're absolutely right that there are ramifications for decisions that CMS makes, and certainly CMS, beyond the work and the discussions here, is also involved with private payers, with like the Care Core Measures Consortium and other activities with other private partners in terms of thinking about and

sort of making headway towards potentially aligning measure sets, for example, and core measures across program. So certainly that is a consideration, but thank you for bringing that up.

CO-CHAIR TRAVIS: Ron?

CO-CHAIR WALTERS: Yes, I'd like to say also I'm sure I don't need to tell most of the people, or maybe all the people in this room, but as someone who does read the final rule every year and over years, you do get that very sense of appreciation, because they reference NQF Hospital Workgroup frequently in the final rule as rationales for either decisions they made or decisions they did not make. And it also gives you a very good feel, to the answer to Delores' question, as far as not only historically what's been the thinking process, but you get a pretty good feel for what's coming along in future pipeline and so on.

So it's all there. It's in a rather bulky document. But take the opportunity to read

it, if you don't.

CO-CHAIR TRAVIS: Okay. If you do want to make a comment, please put your tent card up. That'll help me be sure I call on you and can be sure that I get the right person's name. It's a large group.

So Marty?

MEMBER HATLIE: I just wanted to make a comment kind of building on what we've seen so far, because I have the good fortune to be able to listen to a lot of patients and family members. And I think that even though I find this MUC list every year overwhelming to look at, especially just given the time frame, and I always come here feeling a little insecure about whether I've got command of the material, even though I know I don't, I think there is an alignment that I'm seeing. So it can look like a hodgepodge to me, but there is an alignment that you see over time. And I think consumers increasingly are seeing that from CMS as a whole through the different projects that are being

focused on as transformation vehicles for healthcare.

So two or three years ago I remember having a conversation with Helen Haskell about how there was just no confidence that CMS was actually aligning with quality and safety going forward. And I think that's really, really changed in the last couple of years. So it makes me excited to be here and I think I want to just give CMS kudos for I think having a strategy to really drive not only improvement, but culture change in healthcare.

DR. BURSTIN: Okay. Well, seeing no more cards, I think we'll go on and get started looking at the measures themselves, which is why we're here today.

I'm going to turn it over to Erin O'Rourke and Zehra Shahab. And I just want to add my thanks to them. One of the biggest changes that we made in the process this year was to have some preliminary analysis done according to an objective rubric, and the staff took on

that responsibility. And I know it was extremely helpful to me in helping me kind of hone my thoughts, and I hope you found the same thing. So I want to thank Erin and her team for taking on that for us.

And I'm going to turn it over to them to talk about the pre-rulemaking approach so we'll understand how our work over the next couple of days fits into the bigger picture.

MS. SHAHAB: Thanks, Cristie. So good morning. I'm going to be providing an overview of the MAP pre-rulemaking criteria and the approach that we've taken including decision categories and describing the measure selection criteria for everyone as well.

So on this slide, first it's a three-step process how we've improved it. We have developed program measure sets like frameworks, which is in Excel, that you can see in the materials. And this is titled, "The MAP Hospital Workgroup Frameworks," and it includes the current measures in the program. And we put it

in an Excel so you can filter and look at it according to topic, priorities and the measure type. So also we've also looked at the measures under consideration for how they would affect the current program sets and we've also identified priority measure gaps for each of these programs and settings.

And on the next slide we also would like each of the MAP workgroups to reach a decision about each of the measures under consideration. And I will describe each of the decisions categories for the measures. Each decision should be accompanied by a statement or rationale that explains the decision by the workgroup.

On the next slide you will see -- so there's two types of pathway. One is for fully developed measures. And for fully developed measures the options are you can either support, conditionally support or do not support. And a few examples of conditions that could be are NQF endorsement, whether they require further

experience or further testing.

Okay. So the second option is for measures under development you can either encourage development if it addresses a critical program objective and promotes alignment, or you could do not encourage further consideration if it already overlaps with a measure that's in the program and if it doesn't address a critical program objective as well.

And the last option is insufficient information, which you can select if the numerator and denominator are not provided.

DR. PHELAN: Can you go back a slide?

MS. SHAHAB: Sure.

DR. PHELAN: You know in the past this conditional support has always kind of been kind of a nebulous category to me. What happens if we give conditional support? Does it automatically -- like for instance, in measures that aren't currently NQF-endorsed but they're in the process of being endorsed at NQF, is there an opportunity for the MAP to revisit that or does conditional

support mean once it's NQF-endorsed it rolls through the process?

MS. O'ROURKE: So technically MAP only needs to review a measure one time. CMS is not obligated to bring a measure back to us unless it's undergone a substantial change. Pierre can probably illuminate that a little bit more, but conditional support, you would not automatically review that again. It would be up to CMS to put the measure back on the MUC list and bring it back to MAP for review.

DR. PHELAN: And the reason I bring that up is because some of these measures are currently undergoing SDS testing and things like that I think it would be very valuable on -- I hate adding another category or something like that, but the idea that we really like the measure and it sounds like a great idea, but we'd really like to see what the final product is.

It has always bothered me on a couple of different levels because I'm like, well, we're kind of endorsing something that we really don't

know what the final product is yet. So I've always wondered if possible -- and that has given me great consternation because then it comes up with a decision of I really like the measure, but I cannot support it because I'm not going to be able to get another shot to look at it.

MS. O'ROURKE: Absolutely. And we recognize that's a grave concern shared by this workgroup and I think all of the MAP workgroups. And I don't know that I have a satisfying answer for you, but I did want to make sure that everyone knows we capture all of your discussions and concerns and put those in the rationale that goes along with each decision of the support, conditional support, do not support. So even if there's not a formal chance to review it again, all of your feedback does go to CMS.

DR. POLLOCK: Zehra, I wonder if you could just say what you mean by "fully developed measures." Are you using that concept interchangeably with NQF-endorsed measures, or is it something different?

MS. O'ROURKE: Absolutely. So the pathways are really determined by the level of testing. If a measure is specified but has not yet been tested for the setting or level of analysis of the program, that is how it ended up in the measure under development pathway, whereas a measure that's not NQF-endorsed yet but is tested and specified would be considered a fully developed measure.

DR. POLLOCK: I'm still a bit confused. If a measure is endorsed by NQF, it's typically endorsed for use in a particular type of healthcare location. So again, what is meant by fully developed measures? Are they measures that are indeed NQF-endorsed or is it some other category?

DR. BURSTIN: So typically anything that's endorsed obviously is fully developed. We still do have measures that come forward in which the developer has indicated a desire to continue testing, and I think in a couple of examples we put those in the continued development category.

But I think those are just a few examples that we can talk through.

DR. POLLOCK: So the essence is a fully developed measure can be one that may or may not be subject to further testing depending on what the developer seeks with respect to that measure?

DR. BURSTIN: No, but it may be endorsed and brought in potentially for one level analysis and at another level of analysis we would still consider that needing further testing. So it could be endorsed at one level of analysis or requires further testing for a different level of analysis or issues along those lines.

CO-CHAIR WALTERS: If I could add my two cents. If you show that slide and then the next slide, the really tough distinction which is being talked about here is that conditional support. And it can be subject to NQF endorsement, or encourage continued development. I mean, that's kind of the dividing line. And as

we go through the process I think everybody in the room is going to have to make a decision about the conditional support versus less than the conditional support. So this is a very pertinent topic and it's going to depend a lot on the measure, where it is in development, where it is in the testing, etcetera, etcetera. I mean, that's probably the best you can do.

DR. POLLOCK: And I guess it comes down to then without having another support category in that hat, it probably will fall to a do not support if you don't have enough of the information to make that decision based on socioeconomic factors that are being implemented. And that just has always bothered me because I want to say that we support it. Wait for the next round and the only thing that's really available in that category is do not support, unless you say conditionally support because no matter what comes out at the end of that NQF endorsement process, they're just going to accept it as a good measure, so to speak.

CO-CHAIR TRAVIS: Allen?

MEMBER NISSENSON: Yes, just to follow up on Michael's point. Do you have any data on what actually happens? What fraction of measures are in the conditional support and then what actually happens? So how many of those end up going forward and additional work is done and then they get adopted? So it would give I think a more realistic picture what it means to vote in that category.

MS. MARINELARENA: So most of the measures right now in the hospital are already endorsed. Some of them there may be updates, so it's just an update to the measure. But we also want to assure you, too, that here at NQF we are incorporating the CDP work with the MAP work. So all of the measures that were conditionally supported because they were not NQF-endorsed last year have come to us regarding projects and we reach out to the measure developers.

I know for example I'm leading the cancer work and cardiovascular work as well, so

even measures that were on the MUC last year and got conditionally supported based on NQF endorsement, we are reaching out to the developers to make sure and ask them if they're going to submit the measures. If it's a CMS measure, it does come to us.

CO-CHAIR TRAVIS: Nancy?

MEMBER FOSTER: So I know this has been a learning process over the several years that we've all been involved in -- at least some of us have been involved, so I'm just reflecting on my confusion in response to Michael's question earlier and the conversation that's ensued.

It seems to me, Ron, that your response is right. That is where the tension is. Do we conditionally support, do we encourage further development or do something else? But if a measure has been classified as, quote, "fully developed," we don't have that choice. So maybe part of our conversation should be around whether we think it actually is fully developed, is appropriately classified in that respect for the

program or use for which it is being proposed. Is that a fair conversation to have?

CO-CHAIR WALTERS: I think that's one of the factors that go into that decision for sure. And there is a certain element of trust, I would say, in the NQF endorsement process that it will make sure that a measure doesn't get through that isn't less than that. But it's going to be measure-specific.

MEMBER FOSTER: Okay. And then in response to Allen's question, I would say I'm in the trust but verify category.

CO-CHAIR TRAVIS: Tom?

MEMBER LUTZOW: Yes, it seems that throughout the measures one of the values that you kind of hit is meaningful comparison between providers. And I think the next generation is going to look back at this work and feel that that's too narrow.

There has to also be to what extent do these measures meet another criteria, and that is meaningful coordination between providers. And

one of the measures in this list speaks to that, and that is the smoking cessation. There are others that could be articulated along the lines of meaningful coordination, and that is readmission. But so much of the success in the total healthcare scheme is related to coordination of resources and our measures don't really get to that. Across the board they don't get to that. And what we have in fact is a siloing effect on many of these measures rather than a coordination effect.

And so collective impact has to be an important consideration in selecting measures. Smoking cessation can't be taken care of in three days, in a three-patient inpatient stay. There are others, too, especially with chronic conditions that linger beyond that touch period. The entire system, both in the medical side and the social service side, has to be aligned. And wherever Medicaid and Medicare dollars are spent there's an opportunity for coordination.

And so that has to be a value I think

going forward that needs to be addressed by these measures and the question has to be asked to what extent does this measure or that measure speak to coordination? And in some cases it will be zero, it doesn't speak at all. And in other cases it needs to speak to coordination. And maybe that's some other domain that needs to be spoken to, but I think as a general rule; and I'm glad CMS is here, we're too narrow.

CO-CHAIR TRAVIS: Thank you, Tom. And I may give Pierre a chance to kind of respond.

One of the aspects that I've seen develop over time in the MAP work is the desire and actually the implementation of measures, similar measures across programs, something like a smoking cessation, because there isn't just one -- it's not one touch in one setting that's going to have that kind of an impact. And so we have begun to see measures that cross all of these programs intentionally. So especially those that hold providers accountable for like readmissions. It's not just one provider that's impacting the

readmission.

And so we're beginning to see, I think, from an intentional standpoint from CMS that some of these measures do need to go across the programs. And of course care coordination is one of the priorities that CMS has identified.

So your point I think is very well taken that we need to begin to look across these programs and see how they're working together, not just independently of each other. And that is certainly something on the consensus development process side that we're beginning to see, because we see the measures, a lot of the measures before they get to the MUC list. And that rationale and that intent is beginning to take place.

But I agree with you, Tom, that we need to keep that kind of front and center in our mind. And sometimes it's hard to look across all these measures and programs and see the big picture.

But I don't know, Pierre, if you want

to kind of give us one final comment before we move on.

DR. YOUNG: Sure, Cristie. Absolutely. So we certainly do think about sort of -- care coordination is one of the priorities for us when we're thinking about measures for our programs, and also alignment between programs as we discussed earlier.

But I did want to go back for a second just to comment on the sort of fully developed measure and sort of how we think about that. Certainly the measures we put forward on the MUC list we believe are appropriate for the program. And there are particular reasons we may bring forward during discussions. Like for example, we'll talk about the tobacco measure, for example, just a little bit that we specifically want feedback on and we'll provide additional context when we have those discussions.

And I don't have a hard statistic, but when it comes to the endorsement process, I mean, the timing unfortunately is not -- there are

constraints, because from CMS' perspective in order to implement a measure into a program we have to go through rulemaking, through proposed rule and the final rule, which is a lengthy process. And then the endorsement process is also a lengthy process. So if we were to go sequentially from endorsement first and then bring it to the MAP and then put it through the rule and then add on the measure development time, we're talking like five years. And that's a long time to wait from our perspective to try and really meet our goals of improving healthcare delivered in the nation.

So oftentimes we may have what we consider a fully developed measure that has not gone through the NQF process yet simply because an appropriate project hasn't opened up and that may open up in the next few months. And so those measures we still believe are fully developed and we put them on the MUC list for your consideration at that point. But our intention is to submit them to the NQF's consensus

endorsement -- development process for consideration for endorsement to sort of when that appropriate project comes up. So I hope that helps.

CO-CHAIR TRAVIS: Zehra?

MS. SHAHAB: Thanks. Thanks everyone. So we discussed the pathways and I just wanted to give a quick overview of the measure selection criteria. And I won't read each of these, but I'll give kind of a high-level overview. So just keep in mind that these are not absolute rules. They're more of a general guidance on who the decisions should be made.

The focus should be to select high-quality measures that while NQF endorsement is not required, it is highly preferred. They also should address the National Quality Strategy three aims. They should respond to the specific program goals and requirements. They should include a mix of measure types. They should fill critical gaps. Also consider health disparities and cultural competency. And also increase

alignment.

So on this next slide you'll notice that, as Cristie was referring to earlier, the staff has conducted preliminary analysis for each measure under consideration. This is just to help facilitate the consent calendar. And you will find these in the discussion guide. And these are in the materials.

So the preliminary analyses are created using an algorithm which asks a series of questions about each of the measures under consideration. And this was developed from the MAP measure selection criteria and approved by the Map Coordinating Committee. So please note, though, that these are just intended to provide a brief profile and to be a starting point for discussions. And you can wholeheartedly agree or disagree with the staff's preliminary recommendations and vote accordingly.

And before I turn it over to Erin, I wanted to see if there were any other questions about the decision categories or anything I've

reviewed in the slides so far.

MS. MITCHELL: A quick process question. Do I assume correctly that the consent designation is used in the same way that it's used in most parliamentary venues, namely that unless somebody wishes to discuss it, it is in fact deemed to have passed? Is that correct?

MS. SHAHAB: Yes, that's correct.

MS. MITCHELL; Correct? Okay. Thank you. I just wanted to be clear.

MS. SHAHAB: Yes. Okay.

MEMBER FOSTER: Clarity on what's passed. It is the staff recommendation that's passed? Is that right?

MS. SHAHAB: Yes, that's correct.

MEMBER FOSTER: Thank you.

MS. SHAHAB: Okay. Erin's going to review the voting process and we'll also do a test voting slide after this.

MS. O'ROURKE: Thanks, Zehra. So I did want to do a few housekeeping items before we jump into the voting process. Does everyone who

is an organizational representative or a subject matter expert have a little blue clicker in front of them? That's what you'll be using to do the vote. If you don't, please raise your hand and Jean-Luc will come assist you.

And as Cristie mentioned, if you wish to speak, please put your tent card up vertically. And also to please have your microphone on when you're speaking so the transcriptionist can capture everything you have to say so that we have it all for our report. We don't want to miss anything. And on another note on the microphones, I believe only three can be on at a time. So if you're having an issue turning your microphone on, please make sure others haven't left theirs on accidentally.

Moving on to some key principles for our voting procedures. We'll be taking a vote on every measure under consideration either as an individual agenda item or as part of the consent calendar as I just described and Delores and Nancy clarified. So if you don't pull a measure

off of the consent calendar, the staff recommendation will pass.

We are asking the workgroups this year to reach a decision on every measure under consideration. This is a request from the MAP Coordinating Committee that we no longer pass things up to them without the benefit of a recommendation from the Workgroup. They recognize that the subject matter experts on hospital measurement are the ones around this table and it's difficult for the Coordinating Committee to make a final decision without the benefit of your input. So we'll be pushing to try to get to a decision on every measure. No more split decisions, if you will.

However, with that being said, the Coordinating Committee does have the option to continue discussion about a particularly important matter if there's a policy issue or a particular strategic issue they wish to discussion. So the measures still will be discussed with the Coordinating Committee.

They'll also have the chance to review the public comments that we received and react to those.

Next slide. So just to let you know a little bit of how things are going to flow, we'll have some introductory presentations from NQF staff and the Workgroup chair to give some context about the programmatic discussion. We'll then open the floor for discussion and voting.

The electronic discussion guide will be the main tool that we'll be using to go through the meeting, so please let us know if you're unable to get that up. That decision has all the information you'll need about the measure, the specifications that were on the Measure Under Consideration list, what public comments we received, as well as the full details of the staff's preliminary analysis. So please let us know if you're having any Internet issues and can't pull that decision up.

The discussion guide is organized as follows: The measure under consideration are divided into a series of related groups for

discussion and voting. Each measure under consideration does have a staff preliminary analysis. As Zehra said, that's really just our attempt to pull together what we could find about that measure and give you all a starting point for discussion. It's not binding in any way.

The discussion guide notes the results of this preliminary analysis, so a preliminary what staff would think it would be a support, do not support of a conditional support based on past MAP deliberations, research from the field, things like that, and provides the rationale of how we got to that decision.

Next slide. So the voting process this year is a little bit different for those of you who've participated in the past. We attempted to eliminate some of the voting that we did last year, so there will be no more voting to vote. And we're also going to attempt to take only one vote per measure. Last year we subjected you to voting if you supported it, voting if you conditionally supported it or

voting if you did not support it. So we collapsed it all. There will be one vote per measure with support, conditional support, do not support all at one time. Hopefully that moves us through a little bit faster.

So the first step is staff will present each group of measures as a consent calendar reflecting the results of the preliminary analysis that we used using the MAP selection criteria and the objectives of the program.

Next slide. The next step, the measures can be pulled from the consent calendar and become a regular agenda item that will be discussed individually. So the Co-Chairs will ask you all to identify any MUCs that you'd like to pull off the consent calendar. Every Workgroup member has the ability to ask that one or more MUCs on the consent calendar be removed for individual discussion.

And we did attempt to start this process via email. So we do have all of the ones

that you submitted to us ahead of time that you'd like discussed as individual agenda items. So the Chairs have those notes. But if you missed the email, you are still welcome to pull measures at this time. I did want to clarify that. So we have what has already been pulled, but don't feel like you cannot pull additional measures if you wish to discuss them.

Once all the measures that the Workgroup would like to discuss are removed from the consent calendar, the Co-Chair will ask if there's any objection to accepting the preliminary analysis and the recommendation of the MUCs remaining on the consent calendar. If there's no objections made, the consent calendar and associated recommendations will be accepted. So we will not be taking a formal vote to accept the consent calendar. So another change from last year and eliminate one more click.

Next slide.

MS. MITCHELL: Another procedural question?

MS. O'ROURKE: Yes.

MS. MITCHELL: Are we going to take each of these subject matter areas one at a time and go through this process, or do you expect to go all the way through the entire list for the pulling of measures?

MS. O'ROURKE: We're going to go consent calendar by consent calendar.

MS. MITCHELL: We're going to do what?

MS. O'ROURKE: We'll do one at a time.

MS. MITCHELL: Okay.

MS. O'ROURKE: So one area at a time. So we'll finish what was on one calendar --

MS. MITCHELL: All right.

MS. O'ROURKE: -- then move on.

MS. MITCHELL: That's just what I was going to ask to do. Thank you.

MS. O'ROURKE: We will not expect you to keep track of 40 measures and then come back.

So once we are done with what's left on the consent calendar, we'll move on to voting on the individual measures. So if you were the

member who pulled that measure for discussion, you are first up to discuss it. We'd ask that you explain why you pulled it and why you disagreed with the staff preliminary analysis.

We'll then turn to the lead discussants that have been identified to give their opinion. They are really welcome to say whatever they would like to say about the measure, if they agree with the staff analysis, if they agree with the person who pulled it, or if they have a completely different opinion.

DR. LEVY: I have a question. So a number of the measures appear on more than one program. Do you want one discussion on the measure or revisit it for each program?

MS. O'ROURKE: So right now we've got it for each program. I think that's maybe something as we get to those measures we can pause and ask the group if they feel a need to re-discuss it, if there's meaningful differences say between IQR and the HAC Reduction Program that they would like to discuss. But similarly

to years past we'd like to be as consistent as possible and have one recommendation for the measure across programs, but we understand there might be different issues a Workgroup member would like to discuss for a different program.

So once we've heard from the lead discussants, we'll open up the floor for the entire Workgroup and we'll discuss as needed. We ask that in the interest of time you refrain from repeating points that have already been presented by others. We've got an awful lot to get through today. And then after the discussion of each measure under consideration, we'll go to a vote on that measure.

For a fully supported measure, which I believe are all but one that we'll be discussing today, your choices are support, support with conditions or do not support.

Next slide. So another change from last year is in how we'll be tallying the votes. This is really how we were able to eliminate some of them. If a measure receives greater than or

equal to 60 percent for any one condition; so support, conditional support or do not support, that condition passes. Where the change is is this year we'll be summing the results of the support and conditional support to get to a conditional support decision.

So if 55 percent of you support it, 5 percent would also conditionally support it, it would default to a conditional support and staff will pause afterwards and clarify the conditions. So a little bit of a change from last year that those can be summed to get to a conditional support. If we don't get to conditional support by summing support and conditional support, the recommendation would be a do not support.

And finally, abstentions are discouraged, but they will not count in the denominator. We have built in some additional breaks and a little bit of a longer lunch time this year, so we'd ask if at all possible you not step away during the voting. We know life happens, but please try to participate in all of

the votes if you can.

So next slide. Just a few guidelines for public commenting. We had a public comment period on the measures under consideration. We have incorporated those into your discussion guide. If you see a little number of public comments received, say two for example, if you click that two it will take you so that you can read the full comments that were submitted. We ask that the Workgroup members read these through and consider them in your deliberations.

We'll have an opportunity for public comment before the discussion on each program. Commenters are asked to limit their comments to only the measures for that program and to limit their comments to two minutes so that everyone has a chance to speak.

We will have a global public comment period at the end of each day. This is a chance for the public to weigh in on everything that has been discussed. And if they want to provide comments on a Workgroup recommendation, that

would be the time. We'll also have our usual formal written public comment period that this year will be running from December 23rd through January 12th. And these public comments will be considered by the Coordinating Committee as well as submitted to CMS.

I think that is my last slide on voting, so I can take any additional questions.

MEMBER BENIN: Erin, were there updates to that discussion guide, or if I downloaded it a few days ago is that okay? Do we need to re-download it?

MS. O'ROURKE: We updated it yesterday. So there's a 12/15 version on the SharePoint site. The SharePoint site is public.qualityforum.org. So if you go there, you'll see a version dated 12/15 that has all the latest updates.

MR. TILLY: And just to be totally certain, that version we labeled 3.1 in the top left corner.

CO-CHAIR TRAVIS: Marty?

MEMBER HATLIE: So there's going to be no split voting, I get that, but suppose there's a very strong minority opinion? It doesn't rise to 40 percent, but it's 35 percent. How does that go forward to the Coordinating Committee, if at all?

MS. O'ROURKE: So that is really what the rational category is for. And we capture both sides of the discussion there when there are strong opinions on both sides or a substantial minority opinion. Staff will also be bringing issues like that to the Coordinating Committee. So we're trying to avoid any re-votes on the measures, but when there is some strong minority opinions about some key issues, those will be going to the Coordinating Committee for consideration.

So if there's no other questions, we're going to do a quick test vote. So on the top of your clicker you'll see the buttons that say 1A, 2B, 3C. Those are the ones that we'll be using today. So if you could all take your

clicker. Then our test question is how do you feel about testing our voting system?

(Laughter.)

MS. O'ROURKE: Do you support this test vote, would you support it with some conditions, or do you not support that we're taking this test vote? And if you'd point your clickers at Jean-Luc over there in the corner -- point them at him. I'm told it's not totally necessary, but it seems to work some magic.

MS. SHAHAB: I also want to add I'm going to be doing a proxy vote on behalf of Jennifer Eames Huff, who is going to be substituting for Helen Haskell until about 1:00 p.m. So I have that clicker and I'll be getting votes from here from chat.

(Voting.)

CO-CHAIR TRAVIS: Has everybody voted?

MS. O'ROURKE: There should be 26. If everyone could keep clicking.

And, oh, Jeff is out of the room. So there we go.

MR. TILLY: Oh, so that's just -- sorry. That little clock on -- that's just the timer on the right.

MS. O'ROURKE: Oh.

MR. TILLY: We actually have 23 responses so far, so I think we need two more.

MS. O'ROURKE: Okay. So keep clicking.

MR. TILLY: Yes.

MS. O'ROURKE: You'll see the red button light up. And your vote will not be counted more than once, so don't be afraid to keep hitting when we have these issues of getting everything tallied.

CO-CHAIR TRAVIS: And it will count your last vote if you change your mind, yes.

MR. TILLY: Okay. We just hit 25, and that's it.

MS. O'ROURKE: So we don't have consensus about testing our voting system. We'd have to sum this.

(Laughter.)

MS. O'ROURKE: Conditional support.

So if there's other procedural questions, I can turn it to Melissa to quick us off for IQR.

MS. MARINELARENA: So this is just going to be a very quick overview. We did this overview during the web meeting, so this is just a review for everybody.

Again, just as a reminder; and I'm sure everybody here is more than familiar with these programs as we sit around the table, the IQR Program is a pay-for-reporting and public reporting program. The incentive structure is; and we did correct this from the web meeting, that hospitals receive a quarter of the applicable percentage points of the annual market basket, or the AMB payment update. And for those hospitals who choose not to participate in the program, they get the same percentage in reduction in payments.

The goal of the program is to provide an incentive for the hospitals to report quality

information about their services and to provide consumers information about the hospital quality so that they can make informed choices.

Next slide. We are reviewing -- this year IQR and the EHR Incentive Program is together, so we're considering both measures for both programs. Again, this is a pay-for-reporting program. And the difference in this now as of 2015 there will be a reduction of three-quarters of a percentage of the applicable percentage of the annual market basket payment update. So the difference is there's no longer an incentive to participate in meaningful use. Now there is a reduction.

And the program goals here are again to provide widespread adoption of certified EHR technology to providers to incentivize the meaningful use of EHRs for hospitals. And of course by doing that we're looking to include quality, safety, efficiency in reducing health disparities and engaging patients and their family, improving care coordination and

population and public health, and of course to maintain privacy and security of patient health information.

Again this was just a quick overview. And now I will turn it over to Ron and we'll get started. Yes?

MEMBER BENIN: So what you're saying then is that if we are voting support for any of these metrics, we're supporting them both for the IQR and for meaningful use?

MS. MARINELARENA: Correct. It's just that now CMS is no longer requiring hospitals to submit two separate programs. It's just through one program.

CO-CHAIR WALTERS: Okay. Everybody ready? So as mentioned earlier, at the beginning of every program the first thing we're going to do is call for public comments about the measures, and this will be any public comments about any measure in the entire program. We'll do it first for in the room, but you on the phone can start to think about what you'd like to do.

Are there any public comments? Thank you very much. Go ahead and identify yourself.

MR. DEMIHIN: Morning. My name is Akin Demihin. I'm with the American Hospital Association. Thank you for the opportunity to share a couple of thoughts about the IQR Program. And actually this point was just raised as a part of this discussion about the differences and commonality between the IQR and the Medicare EHR Incentive Program.

And I guess my recommendation to the Committee would be to continue to consider those programs as parallel programs and not necessarily as the same program. We've begun to see more commonality between the programs over the past couple of years. There is a voluntary eCQM reporting option for the IQR now. There will be a mandatory eCQM reporting requirement that starts at the end of 2016.

Hospitals have expressed an enormous amount of frustration with the current state of eCQM reporting, especially with respect to

getting reliable and accurate data out of eCQMs, the extent to which different EHR vendors support particularly eCQMs. If their vendor doesn't happen to support one, it could leave them without the ability to report data.

We also have ongoing questions about the extent to which eCQMs have been tested across different EHR platforms and are quite concerned about a mandate that would have hospitals report on all of the same eCQMs.

And so as you think about how to recommend some of the measures on this list that are in fact eCQMs, you may want to make those recommendations conditional on their being used to support this kind of separate track for eCQM reporting rather than being something that would be a mandate to all hospitals. Thank you.

MS. BOSSLEY: Heidi Bossley. I'm consultant to the Federation of American Hospitals today. I'm just going to speak generally to a few comments.

I know all of you have already

discussed this, but again from the perspective of the hospitals I wanted to reiterate that it is important to look at the set of measures within a program and make sure that the juice is worth the squeeze, I guess I would say.

What we see with some of the measures that are proposed is a concept still, not quite ready for prime time. We're not sure that we actually know how these measures will be used, nor do we have information on reliability and validity, two critical pieces that we need to see before we see it moved into programs.

The other thing I would just note is even when we look at, for example, the cost measures, you can get that information from claims. So there is an assumption that it is easy for hospitals because there is little work, but actually when you look at the other side of this, there's still the quality improvement perspective as well as just the tracking that they need to do internally to make sure that this data is correct and that they're capturing

everything.

So just want to balance that perspective of looking at the claims. Oh, it's easy. It actually isn't. There's a huge lift. So if you can all be judicious as you think through, that would be very helpful.

CO-CHAIR WALTERS: Thank you very much. Are there any other comments in the room?

(No audible response.)

CO-CHAIR WALTERS: Okay. Thank you. Do we have any comments on the phone?

OPERATOR: At this time to make a comment, please star then the number one.

(Pause.)

OPERATOR: There are no public comments at this time.

CO-CHAIR WALTERS: Thank you very much.

So we will now move onto the consent calendar. As was mentioned earlier, we have grouped these into shorter calendars so that we're not dealing with 20 and 25 measures at one

time and flipping a bunch of pages. So the first Calendar 1, you should show has five measures on it. Four of them have been pulled for discussion. We'll get to them in just a second. One measure, Measure 2 out of the calendar, which was the harmonized SSI measure, is still on the consent calendar.

Is there anybody in the room that would like to pull that one?

MEMBER SCHULTZ: Yes, this is Leslie Schultz. I'd like to ask that that be pulled.

CO-CHAIR WALTERS: Okay. Measure 2 has not been pulled. That does not leave us a consent calendar anymore.

(Laughter.)

CO-CHAIR WALTERS: So we will now move to the Item No. 1 on the list, which is the adult local current smoking prevalence. And we have a presentation from CMS about that. Then we'll go with Andrea, who was the one who pulled that measure. Then we will go to the lead discussions, and then we'll open it up for

general discussion. Okay? And that's kind of the routine we'll go through for every one of the pulled measures. So first, we're open to the presentation from CMS.

DR. SANGHAVI: Thank you. My name is Darshak Sanghavi. I am a pediatric cardiologist and the Director of Prevention in Population Healthcare at the Innovation Center in Medicare. I'll just acknowledge I'm accompanied by several members of my team today.

I'll just review this measure summary in concept, which is a project that our group has proposed and it's something that has also been endorsed by our center director Patrick Conway, as well as Tom Frieden, the leader of the Centers for Disease Control.

The concept is an adult local current smoking prevalence as measured by the Behavioral Risk Factor Surveillance System, BRFSS, affectionately known as "Birfiss." This is NQF-endorsed at the state level, as you can see by given number 2020, which has also -- that data is

also collected at the county level in the identical manner. And this is going to be reported interesting not -- this information is actually collected by the CDC at the county level and reported by the CDC directly. We can talk about that.

Why a geographic measure for the IQR? And I'm going to try to limit my comments to two minutes so we can get to the discussion. Happy to discuss any of the research that underlies this if that will be useful to any members of the group.

The first question is why a geographic measure for IQR? We believe that smoking prevalence is a critical outcome measure for population health. We at CMS broadly are interested in quality measures that promote coordination and population-based health. Not only measures, but as some of you are aware, we have announced a national strategy that also tries to put our payment strategies behind that as well with gradually increasing circles of

population-based accountability for payment.

We believe that there is significant evidence demonstrating that the smoking prevalence is substantially impacted by multi-modal interventions that occur at the hospital level and also continue afterwards after those encounters as well. And there's substantial opportunity for improvement there.

To take one example, 18 percent of inpatients continue to smoke while they're in hospitals here. Significant community-based measures that can be endorsed by hospitals can have an impact on smoking to the point where last year the BMJ in 2014 reported that, quote, "Their findings by review suggest that delivering smoking cessation as a routine component of hospital-based care can have substantial impacts on prevalence of smoking." We believe this can be substantially also augmented by coordinated efforts across hospitals that are all in a county signaling the possibility of collaboration as well.

Next slide, please. Why the county as opposed to some other geographic denominators? Here we believe that county levels are easy to understand. We are striving for some basic concept of simplicity balanced with obviously an important outcome measure. Many other strategies can exist. Hospital referral regions. Those are derived from cardiac and neurosurgical referral patterns. Census tracks others. Each of those have issues. We believe the county-based level is the way to go because CDC has a methodology to collect that information through the BRFSS and reports it on a county level.

What about counties served by multiple hospitals? The key here, and I think one of the things we'd like to point out, is that the measure applies to all hospitals within a county. It connects them in some way. Hospitals, according to the CDC, have an enormous impact on the population geographically located around -- in which they are. Most Americans are in a county that is served by an acute-care hospital

and we believe that there is substantial possibility of coordinated activities. And we have also seen this activity already catalyzed in multiple health centers and also at large geographic centers including statewide in places like Oregon, as well as Maryland, through some of the other coordinated programs we are putting out there.

So I think one of the things that's been raised is what is CMS' strategic vision? This is a measure that in many ways starts to push that measurement strategy to go with that strategic vision. We could talk about that as well.

Our final slide is next. Some may legitimately ask, well, what do hospitals -- what powers do they have or what ability do they have to significantly impact smoking rates at the county level? We believe that there is substantial data that underlies this. CDC is developing a tool kit to assist with that. We know that inpatient care can be a critical

component there.

We know that best practices also at employers. One example is at Cuyahoga County, Cleveland Clinic serves, initiated substantial changes in employment practices and that was correlated with a specific potentially attributable reduction in the county-based smoking prevalence at that level.

We also believe that there's substantial opportunities for community partnership as well. And as many of you are aware, there is a significant body of evidence that community-based interventions, of which hospitals play a critical part because of the patient population that are served in those hospitals can fulfill -- and some of those are listed there. Tobacco 21. The effects on impacting price of tobacco as well as cessation campaigns more broadly.

And finally, we also believe that CDC can assist with developing a tool kit which will be distributed. And I had mentioned that.

I'm at time right now. I will stop there, but thank you for the opportunity to bring this to the Committee.

CO-CHAIR WALTERS: Thank you very much, Darshak.

Hold your cards. Now in this particular circumstance the person who asked that the measure be pulled happened to be one of the lead discussants. So, Andrea?

MEMBER BENIN: I think this is a really important area to look at and BRFSS is a really important epidemiological methodology for looking at smoking and how we impact smoking and reduce it as a society. So it's a critically important area. It's an epidemiological piece of work right now and I'm not clear how tying it to an accountability program for hospitals is the right thing as far as really thinking about how this can be moved.

There is only a certain amount that hospitals can impact around the people who come to them and are in contact with them, and so this

really strikes me as an epidemiological tool more than an accountability metric for a hospital. I think that there are lots of opportunities for CDC and CMS to come together and perform these analyses and be able to present out those analyses in order to begin to drive that conversation a little bit different, but this hasn't been used nationally. It's not been looked at nationally and as far as having people understand how it works and how it performs so that hospitals would know really how they're driving it.

So it just seems to me that it's premature for use as an accountability metric in a hospital-based program. It has potential and I think there's a lot of analytics that could be helpful in the future for hospitals to understand this better, but right now this strikes me really as an epidemiological function of BRFSS more than a true quality metric that hospitals are ready to be held accountable for.

CO-CHAIR WALTERS: Do you have a

recommendation about what that should be classified as?

MEMBER BENIN: I would recommend that at a do not support.

CO-CHAIR WALTERS: Now, we're going to come back to you for the other measures in a little bit. Leslie, you're the other lead discussant.

MEMBER SCHULTZ: Thank you. This is Leslie Schultz. This is the harmonized SSI measure.

CO-CHAIR WALTERS: We're still on the local current smoking measure.

MEMBER SCHULTZ: Okay. Great. I agree with both CMS and Andrea that this is a population health measure and we do encourage that, however, again the limitations as to a given hospital's ability to directly influence this measure, we think that's beyond their scope. And so I would support Andrea in the do not support.

CO-CHAIR WALTERS: Thank you very

much. Now get the cards ready. I didn't notice -- Jack, go ahead.

DR. FOWLER: Just two quick comments. One, I think we know there are a lot of demographic drivers of smoking and correlates that really trump almost everything else in terms of smoking prevalence. And so, it feels like this would penalize hospitals that happen to be located in the wrong places where the wrong kinds of people live.

And second, I do have trouble with the notion that when 15 percent of the population maybe gets hospitalized a year, the whole hospital is responsible for the smoking rate at a population. And this coordination rationale didn't impress me, so I support the against vote.

MS. O'ROURKE: I do want to make one procedural clarification before we go too far. This is our one measure that is on the under development pathway, so your choices are actually encourage future development or do not encourage further consideration. So they're on the small

screens to the side. It's fully developed at the state level, so this would be an application for the county level and it has not been tested at the county level.

DR. BURSTIN: In addition, in our conversations even if it is at the county level, there's probably an additional step to think through testing as it relates to hospital performance as well.

CO-CHAIR WALTERS: Ann Marie?

DR. SULLIVAN: I'm not sure how the person who developed this considers the big -- for example, in New York City, if you up the taxes on smoking or you ban it in certain parts of the city, it has a huge effect on smoking. That has nothing to do with the hospitals. And so it's not just the hospitals will be penalized for not doing it. I mean, you could have a society, a certain area where smoking initiatives are being made which would make the hospitals look very good and have nothing to do with what the hospitals are doing. So I'm not sure how the

developer of this tying it to what the -- if there's enough value for what the hospitals could do to impact it when big societal things can impact smoking almost in a much more aggressive way than others.

So for example, if you were to have a city that suddenly said you can't smoke any place; and that has cut smoking rates in the city, I'm not sure how that then impacts hospitals. How do you know that the hospital's done anything at all?

CO-CHAIR WALTERS: Okay. You can clarify an answer to that. Thank you.

DR. SANGHAVI: Sure. So that is correct that there can be impact if a city suddenly substantially increased the tobacco taxes. There are also many things that hospitals can do that also impact the smoking rate, though, however, as well.

As I pointed out, there are significant data that show that enhanced inpatient care actually does have substantial

impacts on local-based smoking prevalence. There's also substantial impact that in hospital employee hiring and other practices can have substantial impacts. And based on our information, looking at Trinity Health, St. Luke's Center, Kansas City, Partnership for a Healthier Carroll Hospital in Maryland, and numerous others, they have actually created large broad-based campaigns for the express purpose of reducing the smoking prevalence widely in partnership with other hospitals.

So this is true that, yes, major changes in -- you know, we passed the Affordable Care Act in 2010. That was something that was significantly outside the control of hospitals; may have improved quality in some places, damaged it in others. These types of things will happen. We believe that this should not impede our efforts to try and actually then realign our work and our payments at the population-based level.

CO-CHAIR WALTERS: Thank you. We got Sean, Nancy, Brock, Mike and Jeff. Sean?

DR. MORRISON: Yes, I mean, I don't think anybody would argue from a societal perspective that smoking has significant impact on public health, but what strikes me about this is that this -- our quality programs seem to be the only hammer that we have against the nail which tobacco use. And, yes, the data suggests that hospitals can reduce smoking, but the reality is the data suggests that increasing the tax on cigarettes is a much more effective approach to reducing smoking cessation, that public service advertising campaigns are a much more effective way of reducing --

And what strikes me about this measure is people are feeling very frustrated about it. This is the only program where we think we can make an impact, but quite honestly, as Jack pointed out, only 15 percent of Americans are hospitalized. Probably about 20 percent, less than that, are actually smokers. And this seems to put a tremendous burden on the wrong institution and the wrong program to address a

very important public health crisis. And I would suggest that we don't support this and we move efforts about smoking cessation outside of an accountability program and more into a public health perspective where they really belong.

CO-CHAIR WALTERS: Nancy?

MEMBER FOSTER: To keep this short I will just associate myself with all of the remarks that have been made by my colleagues on the Committee thus far. Important program -- or important issue, wrong program, wrong target.

I would also point out that hospitals have the annoying capacity to not be related to just one community, right? They serve broad-based communities. And you would decide which county to associate with Mayo Clinic or how to -- even looking at the hospitals here in the District, they serve Maryland and Virginia as well. It becomes very complicated in a way that just causes you to run down a rabbit hole to chase something that's not worth chasing.

CO-CHAIR WALTERS: Brock?

MEMBER SLABACH: I have two questions. First is how does the data get accumulated? And I'm concerned about small rural counties in remote areas. How does that data get put into a system that now is going to evaluate the hospital's ability to stop smoking in their community?

The second issue is is this in the ACO data set? And wouldn't this be more appropriate for those hospitals that have chosen to participate to be accountable for a community's health rather than affecting all the hospitals that haven't made that strategic choice possibly yet?

DR. SANGHAVI: So the answer to the first question is this is done on a county-level basis. There's a minimum number of individuals that have to be in a county for that to survey. There is methodologies used. It's essentially two survey questions. It's a telephone-based survey that are asked. And that's durable over time. It's been done since the early 1980s, and

again reported by CDC directly. So the reporting on the hospitals is not there.

To answer your second question, why IQR and not other areas? I think again we would say that smoking as the major and most important preventable cause of hospitalizations deserves a multi-modal strategy. We are not simply coming to the MAP Committee as the sole component of our anti-smoking strategy, but believe that this is part of a broader rubric in sort of thinking about the types of interventions that are most effective.

We also, for example, don't incentivize strategies that could reduce community-based infection, but we have programs here that certainly look at sepsis, for example. We are downstream to many of these areas, but I think that ultimately we do need to find ways to actually create those programs that have upstream impacts.

So I think that with that, having said that multi-modal strategy again, the strategy

here we could -- we are coming to IQR. There is also as I said a parallel strategy to use this in our Medicaid statewide redesigned programs as well as potentially in the ACO programs that we do.

So again, we would like to create -- one of the key things here is that the Committee here has an opportunity to say we would like to work with part of this broader public health effort along with other programs, the direction in which we're going, or the Committee can say that we would choose to sort of hold back and follow the rest of the organization.

CO-CHAIR WALTERS: We have Michael, Jeff and Marty. And I would probably ask that each one contribute incremental comments. Michael?

DR. PHELAN: I hate to be kind of the disagreer amongst the rest of the crowd, but I see this opportunity as the movement of where quality measurement needs to go towards the future. Wellness is the reason why we really

want to get into the healthcare arena, and to not incentivize in a way like this which brings the multiple partners -- it brings health systems together, it brings public and private cooperation, it would do so much around this arena of health wellness to try to improve the -- decrease the rates in communities. And hospitals, health systems and all the things that are associated with those health systems would be incentivized to cooperate, number one, which is one of the big things that we probably don't do a really good job at doing, and really meaningfully impact the lives of patients, not just in a one-on-one setting, but in a much larger broader sense.

So I kind of sense this is the direction of where healthcare quality measurements needs to go and the incentives that need to be put around something like a community-based smoking rate or community-based hypertension rate, or whatever rate you want to look at, or whatever metric you want to look at

for that. And I think this is an opportunity to do that. They could piecemeal pick every single incentive. Like there's some good data that just briefly discussing with patients in the emergency department has about a 10 percent reduction in smoking rate for that population. But to piecemeal do this instead of wholesale trying to get it from the very far end, which is the outcome.

We really want to see the outcome measure be what we're striving for and then let the communities decide however they want to do it, or the hospital decide how they can best impact through whatever programs CDC has or CMS. And the hospitals and hospital systems will go hog wild if there's a measure. And how I envision this is I imagine -- and I don't know how they would incorporate it, but maybe a reduction -- if your community has a higher smoking rate, there may be a reduction in some kind of payment by a percentage or however it goes.

But from a wellness perspective and a community perspective we definitely don't do enough to encourage our patients to not smoke. And it is a really heavy lift amongst -- if you're in a busy clinic and you're trying to move things along, but to meaningfully impact the patients' lives. The one and done doesn't do it, but to have a community working behind and rallying behind something like smoking -- and unfortunately the only way to get some of these incentives to this is with either a carrot or a stick.

I would much rather see a carrot, an increase in pay for every decrease instead of something to take away, which I think would get a lot more buy-in for the communities that you're trying to impact. Instead of taking it and saying, well, we're going to take some money away from you, well, we're going to encourage you because the up-front investment in this would be tremendous. Because at the back end is where you're going to be saving all the money, the

millions in COPD, cancer care and things like that, or billions down the road. And even in my small practice, I mean, I looked at how many people who actually come in and smoke with a significant disease like COPD, if they were ever given, at least in the medical record, any indication not to smoke. And it's almost negligible.

So when you review a medical record and you see someone who's been in the ED in the last six months four or five times for COPD and not a single provider actually meaningfully sat down and said have you ever thought about quitting? We have programs here at the clinic we can get you involved in. It's discouraging.

So I think I would ask the people in the group to think about this, but also from CMS' perspective the carrot works way better than the stick. So having incentives where it flips it from we're taking money away if your community is higher in smoking, well, we're going to give you money for significant reductions, not just the

fact that you have a 15 or 30 percent smoking in your community. If you show a three or four-percent reduction, we're going to incentivize you to get that.

So I would actually recommend we; what is it, continued development, but along those lines to incentivize hospitals to do that, because there are a lot of programs out there that can meaningfully impact patients' lives, and this is one where I think the carrot will work better than the stick. And I think it's something that we should be looking at strongly.

These health systems have a tremendous impact based on the community they work in. If it's the worker, employer population where you can say we won't hire you if you smoke, or doing things like actually meaningfully interacting with patients in an in-patient setting, in an ED setting or in an outpatient setting. I think it can significantly impact the smoking rates in the communities that these hospitals and health systems serve.

CO-CHAIR WALTERS: Thank you very much. I will remind everyone we're trying to get through our first measure.

(Laughter.)

CO-CHAIR WALTERS: So please keep that in mind as we move through a couple days here.

Jeff?

MEMBER JACOBS: Thank you. I'll try to be brief. I just wanted to comment, probably say something a little bit different from the majority of what the first speaker said.

It seems from what I understand that our options here are to encourage future development or not encourage future development. We don't have to fully endorse this at this point in time. And it seems that this measure is somewhat of a paradigm shift in the types of measures that are usually reviewed by this group; although I'm new to the group, but this is a measure that's putting hospitals responsible for the global health of the community.

And that's an interesting idea. It

could be debated whether or not that's the right or wrong idea, but I don't think we should shut that idea down today because it's an interesting idea that I think merits further exploration whether we should develop measures that put a hospital or a group of hospitals in a community responsible for the global health of the community.

And based on that rationale, I would encourage our group to encourage future development of this measure so that the measure developers can try to address some of the other concerns raised by the earlier discussants and come back to this group with a more polished measure that might address those concerns. This is a new idea and I don't think we should just shut down today.

CO-CHAIR WALTERS: Marty?

MEMBER HATLIE: I agree with the last two speakers. I think that we've underestimated the role that hospitals can play partnering with other community groups and public health groups

in trying to advance wellness. I think it is a paradigm shift. And I think the argument that hospitals shouldn't have accountability, it's unfair because they have a small part of the job, or they can't do it all is just not where we're going. And then the coordination strategy is community responsibility and I think I want to incentivize that.

So I'll vote certainly for continued development. Thank you.

CO-CHAIR WALTERS: Last comment. Nancy?

MEMBER FOSTER: Thanks. Just a very different point, which is that this is proposed for both IQR and EHR meaningful use program. Can we at least agree that since it is not an EHR-derived measure it should not be encouraged for further development for that program and then take a vote on the other?

CO-CHAIR WALTERS: Everybody ready to vote?

(No audible response.)

CO-CHAIR WALTERS: Thank you. So that's how it works, measure by measure by measure. And we'll now open it up for voting.

MR. TILLY: Okay. The measure's how open for a vote for the adult local current smoking prevalence. Encourage continued development, do not encourage continued development, and insufficient information are the choices.

MS. SHAHAB: Jennifer, can you please send me your vote?

(Voting.)

MR. TILLY: Okay. So we actually just need one more vote.

(Pause.)

MR. TILLY: Okay. And the results are 60 percent encourage continued development, 40 percent do not encourage continued development, 0 percent insufficient information.

CO-CHAIR WALTERS: So by our guidelines, 60 percent encourage further development.

Yes, Mitch?

DR. LEVY: I have a question. I'm not sure. So this measure is not fully developed and when -- if it's part of -- and the other three are. So if it's part of a consent agenda and we accept that it's not -- I mean, only --

I understand that, but had it been left, which I know this group's going to do with anything, but -- with any of them, but had we left it alone, what would be the voting on all for them? Would we be voting to support them?

DR. BURSTIN: Whatever the staff recommendations was remains.

DR. LEVY: Ah, I see. I get it.

DR. BURSTIN: So support --

DR. LEVY: All right.

DR. BURSTIN: -- continued development would have been --

DR. LEVY: That's great.

CO-CHAIR WALTERS: Just for your information, after about 25 minutes of discussion the staff recommendation was encouraged for the

development.

(Laughter.)

CO-CHAIR WALTERS: Let's move on to No. 2, which is the SSI measure that was pulled by Leslie. So you will be discussing why you've asked that to be pulled first.

MEMBER BENIN: Ron, is there a place where we're supposed to know what the staff position is? Is that obvious on here somewhere?

CO-CHAIR WALTERS: If you go to that previously referenced new discussion guide, that is 3.1 in the upper left corner, and you scroll down to the measures -- so right now we're on Measure No. 2 in the first calendar, that one was listed as encourage further development.

MS. SHAHAB: So if it's helpful, I can also note what the staff recommendation is for each measure, because that I have that at hand. So our staff recommendation was encourage further development for this measure. For the next measure, the SSI one, our staff recommendation is conditional support pending NQF update.

CO-CHAIR WALTERS: Okay. Leslie?

MEMBER SCHULTZ: This is Leslie and thank you for helping me get up to speed with process. I mean, I appreciate Zehra's comments there.

In reflection I do support what the staff's recommendation was. I do know that this measure is currently going to be in the process for periodic re-endorsement and review. I want to see the outcome of that first. And then do recommend that it be introduced into IQR, but not into other programs at this time.

CO-CHAIR WALTERS: Okay. The other lead discussant was Andrea.

MEMBER BENIN: I don't have a lot to add about this. I'm just not understanding at all whether this is the NHSN metric or the NSQIP metric, or whether it's -- because how can it be both because they have different sampling frames. And so I just have struggled to understand this and I assumed the idea was to figure it out and throw it in IQR and see how it worked, but I

would love some clarification on that.

DR. POLLOCK: So this is a harmonized measure in which ACS, NSQIP and CDC, NHSN agreed on the core measure constructs and the risk adjustment methodology. And the measures been in use in IQR since 2012, so the system for reporting purposes is NHSN. So we continue to enable both individual instances as well as sampling of the entirety of the denominated patient population being reported into NHSN.

MEMBER BENIN: Well, I think what you're saying is -- just to let me rephrase --

DR. POLLOCK: Sure.

MEMBER BENIN: -- make sure I understand, the NHSN metric has been in place for several years in IQR. We all know that. So, but then the idea here is that in lieu of submitting all of your patients, you could just submit the sample that you used for NSQIP.

DR. POLLOCK: You can submit a sample.

MEMBER BENIN: Okay. So that's what this is asking. Is it okay to update this to

be --

DR. POLLOCK: No, the staff will in part --

(Simultaneous speaking.)

MEMBER BENIN: So this is nothing new about this metric?

MS. MARINELARENA: The only thing that's new is the name.

MEMBER BENIN: The name?

MS. MARINELARENA: Yes.

MEMBER BENIN: This is a name update?

MS. MARINELARENA: Yes.

MEMBER BENIN: Okay. That's probably why I was confused.

MS. MARINELARENA: So it's already in the program.

DR. POLLOCK: I don't think the name is new.

MEMBER BENIN: So why are we voting on it?

DR. POLLOCK: Everything's the same.

MEMBER BENIN: I mean, I could not --

DR. POLLOCK: We haven't made any changes --

MEMBER BENIN: -- sort this out.

(Simultaneous speaking.)

DR. POLLOCK: -- since 2012.

DR. YOUNG: It's to allow accommodation for calculation of the SIR, the standardized -- or, excuse me, the ARM.

MEMBER BENIN: So it's an update to the ARM methodology that we --

DR. YOUNG: Correct.

MEMBER BENIN: -- voted on last year? There were a couple of other metrics, or whatever. But this is just to get this one up to date? Okay. I have nothing else to add.

CO-CHAIR WALTERS: We knew that was going to cause that very discussion. Sean, is your card up?

Michael?

DR. PHELAN: I'm confused on how this measure -- so there's an NHSN measure that is pulled from Holters? How is the data gathered

for that? From CPT codes?

DR. POLLOCK: No, it's an active surveillance where staff within hospitals identify instances of SSIs during hospitalizations or in the aftermath of hospitalizations. So it's not a claims-based measure. It's not purely a medical records measure insofar as there can be contact after hospitalizations. There can be information collected outside of the scope of what's in the actual medical record of care in keeping with the other approaches that are used in the NHSN healthcare-associated infection measures.

DR. PHELAN: And so this is a harmonized measure between NSQIP and NHSN? And how is it harmonized?

Okay. So why is it on the list?

DR. BURSTIN: Updated the methodology to the ARM. It's going to reflect the other NHSN-related measures.

DR. PHELAN: Okay.

DR. BURSTIN: It was a phenomenal

amount of work, so thank you to ACS and CDC for in fact doing this.

DR. POLLOCK: We'll be resubmitting for maintenance purposes this coming year.

CO-CHAIR WALTERS: Any other cards up? Nancy?

MEMBER FOSTER: Out of due respect for the NQF process I'm going to suggest that we continue to support the staff recommendation here. I think this is worthwhile doing, updating this measure. It continues to be a familiar and useful measure, but we do want to have NQF take a look at the update just to make sure everything works as planned.

CO-CHAIR WALTERS: Jeff?

MEMBER JACOBS: This is a very fast question. Does the ultimate results of the measure -- are they identical and use the same definitions whether it's done through NSQIP or through NHSN?

DR. POLLOCK: Correct.

MEMBER JACOBS: So the definitions are

completely harmonizing?

DR. POLLOCK: Correct.

MEMBER JACOBS: That's beautiful.

CO-CHAIR WALTERS: Any other comments?

MS. SHAHAB: I just want to remind everyone to speak into the microphones because people on the webinar are having a little bit of trouble hearing some of us.

CO-CHAIR WALTERS: Okay. To vote.

MR. TILLY: So the polling is now open on the ACS-CDC harmonized procedure specific surgical site infection (SSI) outcome measure, MUC15-534. The options are support, conditional support and do not support.

(Voting.)

MR. TILLY: We're just missing a couple responses.

(Voting.)

MR. TILLY: Okay. And the results are 52 percent support, 48 percent conditional support.

MS. O'ROURKE: So to clarify, this

would be a result of conditional support, and the condition would be pending NQF review of the update.

CO-CHAIR WALTERS: All right. So that happened again because support was less than 60 percent, but with the sum is certainly greater than 60 percent. That's how you end up there.

Okay. Let's move on to Measure 3, which is --

MS. MITCHELL: Question about that, Ron. I take it you guys who figured out this process considered the fact that if you add conditional support and support together, you got an overwhelming favorable vote for a measure, but because the one that's the strongest one didn't get 60 percent, it doesn't get the nod. There's something --

CO-CHAIR WALTERS: You're exactly correct.

MS. MITCHELL: There's something wrong with that.

CO-CHAIR WALTERS: No, you're exactly

correct.

MS. MITCHELL: All right.

CO-CHAIR WALTERS: It doesn't meet, it doesn't have the magic 60 percent to be fully supported. But you're exactly right, it clearly is supported. It's just that the only thing you can do is conditional support.

MS. MITCHELL: Yes, it's a sexist remark, but it's like being a little bit pregnant.

CO-CHAIR TRAVIS: Well, one thing I will point out; and Erin did it with this particular one, especially when it falls into something like this, the staff will put forth what they consider to be the condition. If for some reason we don't agree with the condition, we can have a conversation around the condition. It does fall into the conditional support category. And we may see some of this as we go through this agenda where staff will summarize what seems to be the condition and then we'll see what conditions we put on it. It was one I had very

early in the process, Delores, so I understand.

CO-CHAIR WALTERS: So when we do conditional supports, yes, make sure to spell out your conditions. Nancy mentioned one and then we talked about another one.

Okay. Item No. 3, INR monitoring for individuals on warfarin. And Nancy Foster pulled it, so she will be up first.

MS. SHAHAB: I just want to remind everyone the staff recommendation for this is support.

MS. MARINELARENA: And before we get started, this is a fully developed measure. It's AHRQ's IQI measure. No, I'm sorry. This is not -- I'm sorry. This is fully developed and it is endorsed. It got endorsed as of December 10th. So the staff recommendation is support. We didn't attach any conditions to it because it's already endorsed, but again you're welcome to have that discussion.

MEMBER FOSTER: Great. Ready? So this is again one of those areas where we have

this unique juxtaposition of the two programs here in one. I would suggest that this be a conditional support and that the condition be that the measure be used only as part of the IQR's eCQM reporting pathway rather than being required of all hospitals.

We surely agree that medication safety is an important area and this is a particularly potentially dangerous drug, so very good that we're looking at this. This measure is largely built on eSpecifications and we, as you heard from Akin earlier, have been very concerned about the reliability and validity of the eMeasures going forward. And we have as yet to see the accuracy of this one.

So we think it's a little premature and would recommend that in fact it be conditional support, conditional upon being demonstrated that it is effectively collected in all eCQM platforms and able to be reported and that in fact all vendors are willing to support this data collection.

CO-CHAIR WALTERS: Thank you. Clearly stated that.

Lead discussant, Leslie?

MEMBER SCHULTZ: Thank you. We disagree with the staff's recommendation, particularly applying this to the hospitals. We do believe this measure is better suited to accountable care organizations to individual physician measurement systems as hospitals in many cases are unable to track these patients and these INRs are done in on outpatient basis and they may not be on the same information system. So that's our rationale.

CO-CHAIR WALTERS: Andrea?

MEMBER BENIN: I don't have anything to add to those two conversations, but I do think that the -- it does seem as though the issues around being able to make this happen electronically seem untested.

CO-CHAIR WALTERS: Okay. Open for any other comments. Marty? No. Yes. Oh, I'm sorry. Greg.

DR. ALEXANDER: Yes, being new to this process I was reading this description and it seems like it says adult inpatient hospital discharges to home, that that's a little bit narrow. Some people go home; some don't. And INR measures are important in lots of different areas post-discharge, including nursing homes or other settings where people go that may not be a home. So I don't know how to address that other than I just sort of think the language is a little bit not complete there.

MS. MARINELARENA: So just a clarification. Discharges to home is actually an exclusion. I know it's in the denominator, the description discharges to home, but then you have -- well, inpatient discharges for which the individuals are monitoring INR at home is an exclusion, so they would not be counted in this measure.

DR. HAYDEN: Hello, this is Megan Hayden. So that was correct. I mean, they have to I believe look first to see if the patients

are monitoring INR at home. And I know we have our measure developers on the line that can speak to this exclusion if we need to clarify that.

INR DEVELOPER: Yes, the additional -- to address the question that was posed regarding discharge to alternate locations, the presumption was that the INR would be monitored in those alternate locations. The primary concern of this measure is going from a well-tracked condition where you are in the inpatient facility to going to home where there is less oversight and less availability. So the target of this measure is specifically for those who may not have that follow-up care in something like an nursing home, a skilled nursing facility or another post-acute care facility.

CO-CHAIR WALTERS: Yes, I'll remind everyone that under the discussion guide you can clearly click up the measure specs as an easy link. And to get back to the home page, you just click back.

DR. BURSTIN: And just one more quick

point. And it also links you to the evaluation and the endorsement process. Again, we're trying to link those more closely for you. So again, we don't want to have you feel like you have to dive into redoing endorsement. That's there for you to reference really what can you can do about it at the program set level? Is it applicable? Does it make sense?

CO-CHAIR WALTERS: Ann Marie?

DR. SULLIVAN: I just think this is a very important measure. I think it's very high-risk. I think it fits a lot of categories of why it should be supported. It's also one of those coordination measures which was mentioned where the hospital does very directly -- makes sure that the patients they discharge on something like this drug that the kind of follow-up care they need if they're not in another setting. I understand there might be some problems with collection, but I think sometimes when you make these measures, then the collection phenomena follows. So I would support it.

CO-CHAIR WALTERS: Yes, Sean?

DR. MORRISON: I'm sorry, Ron, could I just -- Nancy, could you just elaborate just a little bit more on your concerns about the HR collection, because I think that's what I'm having an issue with.

MEMBER FOSTER: So, Sean, thank you for asking. We did a study a couple of years ago. We continued to work with our members to helpfully try and understand what's going wrong with the EHR data collection. What we have heard consistently from them is that when they collect a measure using the eSpecified version, using their electronic health reporting tool, they get a different answer than when they do the chart abstraction. And it is in many cases a very different answer. So I mean, like 90 percent different in some cases. So getting to that accurate data point is what we want to make sure can happen. That was one of the conditions I was offering.

The other thing, as you may have heard

from Akin earlier, is that not all EHR vendors are supporting all EHR collection methods, or measures; excuse me, so if this gets put into an electronic program that is required, it still doesn't force the vendors hand at supporting it. And in some cases vendors have not been very responsive to the requests from the hospitals that they come up with a package to support it. So you are in a sense imposing a requirement on a hospital, but the EHR vendor will not support it. So you create that challenge. And I'm only asking that we make sure that all the vendors are supporting it and that the data can accurately be collected on all of those platforms before it's put into a required program.

MS. HAYDEN: Hi, this is Megan Hayden from CMS. So if I could just speak to maybe a couple of Nancy's concerns. And I think first and foremost this data was conducted a couple of years ago. If we can kind of touch on that first. And that would be we heard concerns as far as accurate data collection. I think the

question to the hospitals or the vendors would be how are they utilizing the specifications? Are they taking the human rateable and hard coating it? Are they consuming our electronic specifications, which would be our preference so that there's consistency. I think maybe that would have to be delved into a little bit further to try to figure out what the exact issue is.

And then when it comes to vendors as far as collecting and submitting on a specific measure, then I can understand there is that concern. CMS does have meetings with the vendor community on a regular basis, as well as obviously we would be putting forth any measure that would be potentially proposing for public comment and to alert the community as to what we are having come forth in the very near future.

So we would hope that this could move in the right direction and that they would be listening to the hospitals that need the measure to be reported to CMS and try to work through these types of issues.

(Off mic comments.)

MEMBER BENIN: -- this metric really potentially favors organizations where the labs and the inpatient and outpatient are all in one system. Like I can't even imagine, you know, it's complicated to know. Sometimes we discharge a patient from the location, if they're not your primary patient, whether or not they got the lab, you communicate that to the outpatient provider, and then whether or not the lab gets back to you as the inpatient doctor, if you're cared for by a hospitalist or whatever else is happening, and then you have the hospital.

So I think that there are some real challenges and that that conditional support should be really around working out the nuances and clearly whether or not it's possible for hospitals to accrue this kind of information. Because who then in the hospital -- you're not making the hospital potentially responsible for something that actually the primary care doctors are responsible for. And I think that that's a

tension. So in some environments it may be that they're hospital-based physicians and whether it's the cardiologist or whoever who's also hospital-based, but it may or may not be that way in all environments.

And so I think there are some nuances to this that deserve further exploration because this, you know, it heavily favors organizations where everything is really integrated including the laboratory and other things, because if you go to a laboratory that's not owned by your hospital, there's all of those challenges. So I just think that the idea of working out some of those nuances are --

CO-CHAIR WALTERS: Okay. Let's do Mitchell and then Pierre will give a response. Yes, he may have a response to what Mitchell says, too. So that's why I'm trying to -- and then we'll have a vote.

DR. LEVY: All right. Yes, so while I agree, I think that this is a philosophical issue because the fractured nature of EHRs is

going to be true for every measure we talk about. And I think it's a question of whether we think mandating something like this drives change or change is driven by the threat of it. And so from my view, even though I agree with what you're saying, Andrea, a measure like this will -- individual practitioners will not be able to change electronic health records, but institutions can drive it, especially when they're mandated to report something like this. So I think we're going to deal with this issue over and over again on many different measures.

CO-CHAIR WALTERS: Cristie also had a clarifying question.

CO-CHAIR TRAVIS: And then Pierre. Try to keep track of all of them.

I just want to have a feel for if this measure is recommended support and if CMS decides to move forward and put it in the program, when would it start collecting information? When would it be reported in IQR?

DR. YOUNG: So I just want to --

because I think these are important issues that Andrea and Mitchell raise. We just did want to clarify that this particular measure is a hybrid measure, so there is information that comes both from the electronic health record and from claims data. So whether or not the patient follows up and has an INR check comes from the claim system. So it's not that you would need information from an EHR for both the inpatient and the outpatient settings. So the information comes from different places.

MEMBER BENIN: So just to clarify that clarification then, so only CMS would be able to calculate it? You would not be able to calculate it yourself because you wouldn't necessarily get the claim for the lab?

DR. YOUNG: Right.

MEMBER BENIN: Perhaps. I mean, you can do all kinds of other things to calculate around it, but then the burden of measurement goes to CMS?

DR. YOUNG: And in terms of

implementation, I mean, I don't think we -- we haven't -- we want to get MAP input. We haven't made decisions about timeline for implementation. Obviously this would be -- potentially go into a program, would be -- would go into a rule, excuse me, in the FY '17 rule. But we also have other measures, so we're cognizant of burden. And so, it would probably be a year or two before we would ultimately be able to implement such a measure.

CO-CHAIR TRAVIS: I appreciate that it might not, but just helps me know what the earliest something could do, because there's time between now and then to perhaps have things move forward in such a way that it might not be as difficult once they're implemented.

CO-CHAIR WALTERS: Nancy?

MEMBER FOSTER: Thank you, Mr. Chair. One data point just to help people. I mean, hospitals are supposed to be collecting and submitting data using electronic health records now. They have the opportunity to either share

that data that they are collecting through their EHRs on the Hospital Compare web site, or not, or something attest to the fact that they are submitting. Ninety-five percent of hospitals currently attest to the submission because they don't believe the data that's coming in.

CO-CHAIR WALTERS: All right. Jennifer's on the line and has a comment.

MS. HUFF: Hi, I just wanted to make a couple of quick comments. The first is just again emphasizing that this is a really important patient safety issue and it addresses a couple of key things that are high priority, including the adverse drug events.

I also think this is a measure similar to other measures that we'll see where it's looking at not just the care that is occurring within the hospital, but the ability of bring providers together and doing more care coordination by having us look at the 14 days afterwards. I think hospitals are increasingly being responsible for care that is associated

with a hospitalization. That doesn't necessarily occur within the hospital. We've seen that in other measures. So I think this helps move in that direction again of where we seeing of encouraging work across different provider sectors.

In terms of the data issue, I think this really comes to the point of the balancing act. We've seen this with measures. It's not unusual to have challenges with the data. And then it becomes at what point do we start including it in accountability programs? We have seen in the past when the data hasn't been perfect you include it in an accountability program and the pace at which the data improves is much faster.

So I'd say one of my concerns about not supporting this measure is that it will be much longer for it to really be coming to fruition for the data to be improved. And this is an important measure to be looking at. Thank you.

CO-CHAIR WALTERS: Thank you very much. We'll have a vote now.

MR. TILLY: The polling is now open for INR monitoring for individuals on warfarin after a hospital discharge, MUC15-1015. The options are support, conditional support or do not support.

(Voting)

MR. TILLY: And the results are 50 percent support, 46 percent conditional support, and 4 percent do not support. So the result is a conditional support.

CO-CHAIR WALTERS: Dolores, so this is the second one that ends up for the -- the Dolores Rule we're going to call it now.

MS. O'ROURKE: So the conditions that we have at this time are that it not be a required measure. It would rather go into the optional eMeasure reporting pathway and that this be monitored for some of the data issues, the accuracy, reliability, validity and resolution of conditions that not all vendors would support

this measure.

CO-CHAIR WALTERS: Does that capture the conditions?

(No audible response)

CO-CHAIR WALTERS: Thank you. And we really do appreciate the rich discussion that's occurring about these measures. Those of you who have been on the Committee for a while, know that IQR is the one that takes a long time to get through.

Measure No. 4, vaginal birth after Cesarean delivery rate. This was pulled by Nancy and Andrea, so I think since Andrea is going to discuss it as a lead discussant, we'll go with Nancy first.

MS. SHAHAB: So the staff recommendation for this measure is conditional support pending NQF review and endorsement.

MEMBER FOSTER: So, gosh, I actually hated pulling this measure. I think it is critically important that we move the measures from what seem to be fairly heavily centered on

the conditions of the elderly; understandably so, since it's a Medicare program, to including more measures of young adults and the issues that confront children as well.

That said, to the best of my knowledge, as I looked at the specifications, this is driven off of claims data. And the last time we had a conversation with Pierre and his colleagues, the claims they have access to are Medicare fee-for-service for this kind of calculation. I just don't think VBAC in Medicare fee-for-service is going to be telling.

So I would recommend either do not support or conditional upon getting a broader sampling of a population of -- that might work.

CO-CHAIR WALTERS: Pierre, we can wind up your response in a second.

Andrea?

MEMBER BENIN: Thank you. This is obviously an important issue. There are a couple of problems with this metric. I think the first one is that it's not NQF-endorsed and it's not

been submitted for NQF endorsement. The second one is that it's based on claims. And there are times when it's appropriate not to have feedback, and it's not really known what is the correct rate of feedback.

And so the idea that we could measure this using claims data with appropriate exclusions I think is a little bit lofty. This I think is more useful again as an epidemiological understanding of what are our feedback rates looking like and not really as hospital accountability metrics.

When I pulled the ACOG guideline this is not the metric that's recommended in the ACOG guideline. The recommended metric in the ACOG guideline is more around was the trial of labor discussed with the mother? And I do think that different people will value -- one to five, or depending on what percent chance you find in the literature, chance of uterine rupture, which is close to a death sentence in many ways, will value that differently.

And so I am not in favor of this metric as a part of IQR and I think that the reasons that the Nancy mentions adds to that, the fact it may not be appropriate data set regardless of all of those things.

I think that it is nice to be able to try to get some issues for women and children into some of these things, but there are probably other venues for that.

CO-CHAIR WALTERS: Leslie?

MEMBER SCHULTZ: To be incremental, I have nothing to add. I agree with both of my colleagues.

CO-CHAIR WALTERS: Thank you. Other comments? Wei Ying?

MEMBER YING: First of all, I want to say it's great to see that there is --

DR. BURSTIN: Could you please get closer to your microphone?

MEMBER YING: Oh, I'm sorry. I was saying it's great to see that we have a measure in the IQR set for discussion that it's can

beyond the older population. Like Delores mentioned earlier, whatever CMS put out, it has the ripple effect downstream. So for the commercial population that we look at to the CMS measure set, these type of measures is very appealing. And on the topic of C-section there's definitely one thing that we heavily focus on on the woman population during that age range.

And my question is there is another C-section measure which covers broader -- well different set of population but similar topics, a primary C-section measure. I think CMS already publicly reporting it. It's not in IQR Program, but the data is available. So I'm just curious why CMS is proposing this measure versus the PC-02, the primary C-section measure. That's one question.

And another comment. If there is a solid reason why PC-02 is not actually as good as this one, then the concern of the claims data -- again, it seems just like the discussion on EHR, there is never one data source that's perfect,

but if it is using a data source capturing the data for a very important topic and the performance threshold or performance target being measured on that imperfect data universally I think is doable.

CO-CHAIR WALTERS: Okay. We'll see if Dolores can add to Pierre's list of responses. Delores?

MS. MITCHELL: Well, I'm very supportive of this measure. I do not consider the claims data are not reliable sources of information. From all the complaints I've heard from my physician friends about some of the electronic health record systems, they leave a lot to be desired, my most recent visit to my own physician having shown me two contradictory drugs which that particular record system didn't recognize and suggested that my doctor go ahead and do both of them. So I now will associate myself with skepticism as to all the data sources rather than focusing on the shortcomings of the claims system.

But more importantly, although I would like to hear the answer to the question that was just raised from CMS about why they chose this one rather than whatever; I forget the number, the other one was, in which case I'd be happy to switch my allegiance -- but I really do think that the enormity of the overuse of C-sections is of epidemic quality in this country. And I know from previous years; if you've been around long enough, you know this, that C-section rates plummeted 25 years ago. And there they are, right back up again. And I think this is a societal problem. It's a fiscal problem. It's a health problem.

I was concerned that a lot of people thought that there were countervailing concerns about the risk of a vaginal delivery after C-section going bad, but as I read the measure, it did say without complications. And it is my understanding that these deliveries do take place in hospitals that are only supposed to take place in hospitals that do have surgical staff nearby

in case they go south during the course of the labor. And so I strongly support this measure.

CO-CHAIR WALTERS: Pierre?

DR. YOUNG: Thanks, Ron. Thanks for saving them all up for me.

(Laughter)

DR. YOUNG: So I'm going to respond, but also just a quick request because there are a couple of CMS staff on the phone with me and they're having a little bit of a hard time hearing, so just to reiterate the request to please speak into the microphone when you're speaking.

But certainly we appreciate the feedback that this is an important topic, that there is a desire to see conditions or measures added to the program which expand beyond conditions highly prevalent in the elderly population. And certainly we also appreciate that the issue of C-sections is a high-priority condition for CMS to tackle.

Certainly because it's a claims-based

measure, we only have access to Medicare claims. We don't have unfortunately access to all care claims, though we certainly are interested in including measures that have all the aspects as the denominator. And we certainly do have those measures in the program, but that is a limitation, as several folks have noted, for this particular measure.

There are some differences between PC-02 and this particular measure, and I was going to ask Megan -- are you -- can you address that?

MS. HAYDEN: Sure. I apologize. I am one of the individuals on the phone that was having a little trouble hearing the exact questions that were being posed about PC-02. So I apologize if I am not answering your questions, but please let me know.

So I guess potentially the question was why IQI 22 is on? I know you've seen PC-02 at the MAP in the past. And so, PC-02 would be a different denominator. So if PC-02 is not looking at a vaginal birth after Cesarean. It is

looking at individuals that receive a Cesarean when the baby is in a vertex position. So it is a different measure. You did I think see it last year.

It is still under development at this time and anybody that may look at our measures development and then the web site could see we've been out for public comment recently. So that is still in the works at the eQCM. And I hope that answers your question, but it hasn't, then please let me know what additional questions you have.

MS. SHAHAB: Jennifer, you had a comment as well?

MS. HUFF: Yes, thank you. A couple quick comments again. I think, one, what people have said, really important measure and an important area to have attention to, and both consumers and purchasers are really interested in seeing more information on this.

I will say to the point of it not being an NQF-endorsed measure, but this is an AHRQ IQI measure, which is in widespread use. I

think we're familiar with AHRQ and how it develops its measures. And it's really transparent in terms of the information it provides on the measure. So I think there's a lot available to be able to make decisions or assessments that would have occurred during the NQF process.

I think this is also an area that is ripe for consumer decision making, and with IQR being a place for public transparency and using Hospital Compare I think we would all agree there's a lot of information that sometimes go up in public reporting, some that grabs the attention of consumers and others and others, consumers in particular and others that doesn't. This is one that really consumers are looking for this information.

In terms of ACOG, I will say in their comments they were one of the organizations that comment during the week time period and they indicated their support for the measure. I think their only concern is just how the measure is

classified in terms of they want to move it to an intermediate outcome. So there is support and ACOG has come forth with being strongly supportive of the measure.

Since I'm also channeling Helen in terms of sitting in for her, I do have a couple comments from Helen, particularly from the patient safety standpoint. And she wanted to raise both for C-sections and VBACs, there are patient safety issues. And VBAC I think we've heard particularly the uterine rupture, while it's rare, it does have a high consequence in terms of what would happen. And so she wanted to make the point about a concern about unintended consequences about this measure and being it out.

She also had one suggestion. She thinks there needs to be balancing measures; that is, complementary measures that are about the outcomes. For example, looking at maternal mortality or infant mortality as well.

CO-CHAIR WALTERS: Thank you. Pamela Owens is on the phone from AHRQ.

DR. OWENS: Thank you very much. AHRQ feels that this is actually quite a strong measure as it's applied to all payer data. So that would include Medicaid and private insurance and the uninsured.

We have not submitted it for NQF endorsement. We certainly could. We don't feel that there's anything wrong methodologically with the measure. And then we can talk about some of the issues that were just raised in terms of the patient safety issues, et cetera.

We have seen this applied, this measure applied in state reporting. We applaud consumers for wanting to be able to help them report out in terms of both making a choice around VBAC, but also choosing the hospital to go to if they're choosing VBAC. This measure was not intended to be applied to Medicare fee-for-service data, however. That calculation is 65-plus or those with disability. And in terms of our reliability and validity of the measure we have not explicitly tested it on Medicare fee-

for-service data.

We feel it's a strong measure as applied to all payer data, but -- to Nancy's point.

CO-CHAIR WALTERS: Thank you very much. Comments around the room? Michael?

DR. PHELAN: I mean it sounds like it would be a great Medicaid measure. And I mean, I understand why CMS -- and I don't understand what measures actually apply to Medicaid. And I'm sorry I'm ignorant on that, but are there are -- because it's a shared program with the states, are there measures that CMS says we really want you to have this measure? Would this measure fall into that category then?

DR. YOUNG: I mean, for this particular considerations it's just for IQR, which is focused on the Medicare Program, but certainly we have discussions with the Medicaid colleagues and have had discussions about program priorities including VBAC.

DR. PHELAN: Because clearly this

doesn't fall into a Medicare -- I mean, I don't know what the numbers could be, but it's got to be almost negligible, because -- maybe the disability, but if you're 65 and older or you're disabled, those two kind of -- the 65 and older automatically eliminates you from pregnancy. The disabled might, but I can't imagine that's a huge, huge population.

DR. YOUNG: The numbers are very, very -- are small, yes.

DR. PHELAN: Right. So I guess, I mean, I think it's a good measure to have out there and to be promoting, but it would definitely not to me fall into the IQR Program and it would be something that I would encourage going into the Medicaid side, or wherever that can be promoted on that direction.

CO-CHAIR WALTERS: Okay. Let's vote.

MR. TILLY: So for the measure IQI 22, vaginal birth after Cesarean delivery rate, uncomplicated, MUC15-1083, the options are support, conditional support or do not support.

(Voting)

MR. TILLY: So the results of the vote are 28 percent support, 28 percent conditional support, 44 percent do not support. The result of the vote is do not support.

CO-CHAIR WALTERS: Okay. In case anyone's been wondering and getting a little bit antsy, we are going to take a brief break after this measure so that we at least complete Calendar 1 of 3 of one program.

The fifth measure is NHSN antimicrobial use measure, and that was pulled by Nancy and Andrea. So, Nancy, go first.

MEMBER FOSTER: Thank you again. This measure is an important first step in getting us to a good measure of actual effective antibiotic use. CDC developed this so that they could get the baseline of information, is my understanding; and, Dan, please correct me if I'm wrong. But they wanted the baseline of information about how antibiotics are currently being used so that they could take the next step and really look at

what's appropriate use and what's not appropriate use so that we can get to a measure of; however you're going to develop it, either the positive appropriate use or the maligning inappropriate use of antibiotics.

But that's what we want to focus on, not just this generic use. There's no risk adjustment here, there's no nothing. This is just collecting the baseline data around use, is my understanding. And for that reason I think it's not ripe for public reporting right now. It's ripe for measure development, it's ripe for perhaps quality improvement as hospitals begin to look at their own usage of this. And we're fully supportive of hospitals looking at that usage, but I don't know what a measure strictly of use without any risk adjustment, without anything else tells the public about antibiotics.

CO-CHAIR WALTERS: Also pulled by Andrea.

MEMBER BENIN: So the antimicrobial stewardship community is very excited about this

metric and I think very excited about working with NHSN about developing a way to understand the utilization of antibiotics. And I think that the purpose of this work has really been around getting that group to collaborate around starting to think about these issues. I think the metric just had NQF review maybe last week or something. It's very fresh, very hot off the presses.

(Off mic comments.)

MEMBER BENIN: Right, I mean it just literally --

DR. BURSTIN: It really was endorsed, not just reviewed. It was just endorsed like a week ago.

MEMBER BENIN: Last week, right? Like it just came through the cycle last week. Do I finish the endorsement?

(No audible response)

MEMBER BENIN: Okay. And so, I think that people are very excited to start to be able to use this as a way to understand how antibiotics are being used, but it's definitely

not ready for a hospital accountability level program, and I think actually that that has the potential to negate some of the collaboration and the ability for people to enthusiastically work together around what this looks like.

The way the metric is set up it's not clear that if you have a hospital with higher acuity where you need more antibiotics for good reason -- but that's going to look like you're using more antibiotics, because you are, because maybe you have more patients with bad cancers and things where they need antibiotics, or maybe you're capturing your septic patients earlier, like you should be, I don't know.

And so, I think that until this antimicrobial stewardship community really has the time and is given the space to really work through this and use this metric in a way that it's been developed with all good intent to do the right work for patient safety -- it's not time to put it in the accountability programs. And the higher levels of terror as it stands

right now will clearly look worse on this metric. And it's just not the right time for this and I think we need to understand this better and hear about it more at some point in the future.

CO-CHAIR WALTERS: Leslie, you're the other lead discussant.

MEMBER SCHULTZ: Yes, again, we completely support these efforts to assess antimicrobial use and to work on the appropriateness, however, this is a brand new measure. There is minimal national experience and there are challenges in the collection and reporting. Moreover, the measure developer has stated that this measure ought to be used for several years before it's used in public reporting and accountability. So I would suggest that we heed their advice in that manner.

CO-CHAIR WALTERS: Okay. Any other comments? Mitchell?

DR. LEVY: I'm amazed. I actually completely agree with Nancy on this. I'm surprised this is endorsed in that -- and I am a

strong proponent of metrics, but I'm not sure I view this as a metric. It's such a broad brush that I'm hard-pressed to really understand -- and, Andrea, you already alluded to it, that -- where it's -- I don't even know how you would risk adjust a measure like this, but it just paints a broad brush of how many antibiotics. It's almost to me as if in order to reduce hospital admissions we just count the number of admissions. And I really -- I understand the desire for antibiotics stewardship, but this feels honestly misguided to me.

CO-CHAIR WALTERS: Let's go to Dan first as almost the natural Pierre for this situation.

DR. POLLOCK: Thank you. So the measure that we have proposed and that has -- that we proposed submitted to NQF in April has, as we said, just been endorsed by the NQF Board. For those of you who are not familiar with the actual measure submission form, a measure developer is required to indicate to state

explicitly the intent of the measure, how it's supposed to be used. And we were very explicit that we see this measure as a valuable measure for internal and external benchmarking and for public health surveillance, but for public reporting and not for accountability for an incentive payment program. Very explicit.

Now we've done numerous presentations, public presentations on that score, so it should come as no surprise to anyone that we are advocating use of this measure, but not for public reporting and accountability purposes.

Why are we advocating use of this measure? Because the measure and of itself does provide an important indicator of potentially overuse of antibiotics in certain patient payer locations where we have other information to indicate there is indeed a performance gap here that amounts to an overuse of antimicrobial agents. So the metric itself is actually a set of 14 specific combinations of patient care locations and antimicrobial categories.

Without going down into the weeds too far; I'll just poke in there for a second, if you have a hospital that's reporting three times or more what would be predicted -- and we do have predictive modeling in this measure. If the hospital's use of, for example, broad spectrum agents predominantly used for community-acquired infections is three, four, five times what the national aggregate would be using the national aggregate data what would be predicted for those patient care locations, there's a potential problem there that warrants investigation.

And that's what this measure is intended to do. That's what benchmarking is about. You benchmark against nationally aggregate data that are presented to you in an actionable form that will require further evaluation to determine whether there has been appropriate or inappropriate use at three, four or five times what would be predicted for that hospital and patient care location.

So I just want everyone to understand

we're not proposing this measure to collect more data and improve the measure itself. Certainly more data can be used for that purpose, but first and foremost we've got a serious problem with not only antimicrobial resistance in this society, we've got a serious problem of misuse of antimicrobial agents in this society. And if we're not measuring it and if we're not looking at the data, we're not going to be in a position to address those problems.

This is a first step, but I don't want the point to get lost in the shuffle here that this is a measure that's ready for use by hospitals right now. And CDC is encouraging its use by hospitals right now. This is a measure that is included in Meaningful Use Stage 3 as an option for reporting to public health registries. It is a purely electronic measure. The data are captured as a byproduct of the record keeping that's done using electronic bedside medication administration systems.

So it's a measure that helps us move

in the direction of using electronic data that are increasingly available. It's a measure that connects with the antimicrobial stewardship community and helps drive patient care practices in a positive direction. But again, although we're not advocating use for public reporting or accountability purposes at this time, we are certainly advocating use of this measure and we're working very closely with several large healthcare systems and hospitals already that are using these data in their stewardship programs and are using these data in operational purposes to drive change.

CO-CHAIR WALTERS: Before we get to Pierre to answer the question why it was proposed, Shek and then Michael.

MEMBER MEHTA: Yes, thanks. I didn't want to take up too much time. I just have a question about the process. And in the list it says "pending additional use." In terms of like the condition, if your vote's on conditional support, what does that mean exactly? Would it

be reviewed next year for inclusion, or is the additional use just some other requirement?

MS. O'ROURKE: Sure, I can take the first pass at what staff was thinking and Helen will clarify.

I think we were trying to address some of the concerns that Dan just raised, that while this is an endorsed measure, at this point it seems more ready for benchmarking than public reporting. However, perhaps this measure could go into the IQR program at this time and have a slower path on Hospital Compare and allow hospitals to gain some experience with the use of this measure rather than immediately putting the results publicly.

DR. BURSTIN: Perhaps I wouldn't have been direct, but we very clearly heard from Dan and CDC as part of this, the endorsement process that this measure -- I think the Committee agreed completely was very, very important, very early stages, and they wanted further experience, although they also made it very clear, back to

Mitch's point of why it was endorsed, this measure is ultimately intended for accountability, but it felt like additional experience was needed prior that happening. So that was the logic of potentially wrapping that in the conditional recommendation.

CO-CHAIR WALTERS: Michael?

DR. PHELAN: And I guess this is a critically important question, and I mean I couldn't imagine CDC putting the amount of time and effort to doing this. Hospitals I'm sure would want to see this data. But I think it's promoted in the IQI. And after hearing Dan say a number of times we did not want this for reporting, we did not want this public reported, I guess I'd like to hear what the response is going to be if we say, yes, this is a critically important question. We need to have a measure on it. What's going to happen with the data? Is there a category in the IQI that says not for public reporting, but just for hospital use to make improvements in this area of care that is a

critical question?

So I guess my question is if we support it -- because, I mean, this is a critical question that needs to be answered. It's affecting hospitals across the country. If we say we support it, what kind of assurance do we have that it's not going to end up in a public reporting arena, I guess?

CO-CHAIR WALTERS: So that's teed up for you, Pierre.

DR. YOUNG: Thank you very much. I'm going to say thank you a lot today. But so, one -- I think we're heartened to hear how much support there is for this particular -- to address this particular topic. I think we all -- what I've heard from everybody who's spoken is that there is a big issue here that needs to be addressed, and that's reflected not just in your comments, but also initiative ongoing within the Federal Government such as the White House's Combatting Antimicrobial-Resistant Bacteria Initiative.

In recognition of that we were interested in trying to fill that gap in the space. As several people have mentioned, we thought this could potentially be a first step forward in terms of trying to address this particular issue in the IQR Program. But also understanding that there are limitations to this measure as a number of people have pointed out. Certainly the intent isn't to undermine any ongoing and vigorous efforts to combat antimicrobial resistance and antibiotic overuse, but rather to support it.

I think I would just say that CMS is aware that there are issues relating to potential public reporting, that it may not go far enough and address actual appropriate use of antibiotics. These are all important considerations that we are thinking through and it's helpful to hear feedback from you on.

In terms of the specific question about sort of public reporting, certainly if measures are implemented into IQR, the general

expectations that they will be publicly reported on their results, there's no separate category that says this is just for -- not public -- you have to submit data, but we're not going to publicly report it.

I mean, if we were to pursue putting this measure into the IQR Program, I think we are trying to internally figure out what potential options there could be in terms of the public reporting issue, but I think the general expectation is if a measure is in IQR, it would be publicly reported. And that's been the goal.

CO-CHAIR WALTERS: Okay. Looking around, ready to vote. I think we've heard all the issues, all the concerns.

MR. TILLY: Okay. For the measure on national healthcare safety network antimicrobial use, MUC15-131, the options are support, conditional support and do not support.

(Voting)

MR. TILLY: We're missing about four responses. Just go ahead and scan your clicker

and --

(Voting)

MR. TILLY: Okay. The results are in. Twenty-five percent support, forty-percent conditional support, thirty-three percent do not support. So the measure has conditional support.

CO-CHAIR WALTERS: We may need to clarify those conditions a little bit after all that discussion.

MS. O'ROURKE: I was afraid of that.

(Laughter)

MS. O'ROURKE: So from what we've heard from the discussion I would say it would be pending the resolution of some of these issues we've heard that the measure is not ready for broad scale use in public reporting.

DR. POLLOCK: That's exactly right. It's not ready for public reporting, but if there's an opportunity for voluntary reporting in a program, we're fully supportive of that. But if there's no opportunity for voluntary reporting in a program, we're not supportive of it. You

can't be any clearer than that.

The measure from our perspective at CDC is ready for wide use, voluntary use. By voluntary we mean no associated incentive or penalty, willingly reported and with the expectation that the data by virtue of being willingly reported and voluntarily reported are going to have value for the institution. And we fully support that idea, but we can't support use for public reporting.

CO-CHAIR WALTERS: Mitchell, you have conditions?

DR. LEVY: Yes, and I completely support what Dan's saying, but I'm just trying to separate the measure from what we're voting on. Are we voting on support to include an IQR?

(No audible response)

DR. LEVY: Right. So --

CO-CHAIR WALTERS: That's the program it came under.

DR. LEVY: -- if all of us are saying it's not ready for public reporting, I'm not sure

how we could -- I mean, we're --

DR. BURSTIN: Trying to spell out the conditions for which it would be --

DR. LEVY: Right. So I guess to me the condition would be not being in IQR.

(Laughter)

DR. LEVY: Not public reporting. I just want to make sure we all understand that we're voting when we say support to be included in public reporting.

CO-CHAIR WALTERS: So the problem is that got 33 percent of the vote, so -- or whatever it is. Thirty-eight. Do not support did not win.

DR. PHELAN: I mean, hearing that from Dan and -- I mean, these are two large federal organizations here, you've got a program -- and I don't know how malleable CMS is when we have a critically important measure like this that people want to support for a number of different reasons and you have the measure developer, a pretty reliable measure developer saying --

(Laughter)

DR. PHELAN: Pretty reliable. Very reliable, actually. But saying that it's not ready for public reporting, I think taking that as our condition, that we recommend that it can be part of the measure -- but until we have better data, more information, more comfort with its use, not to be public reported until a reevaluation by this body, by the MAP again may be something to consider as a condition of support.

CO-CHAIR TRAVIS: One thing that I guess hit me as I was talking -- and really to follow up on what Michael said, what I thought about was condition upon CDC's recommendation that it is now ready for public reporting, because I don't really know that we'd be in a better position to reevaluate that in the future. So to me, I would like to suggest at least that we consider that as the condition.

CO-CHAIR WALTERS: Marty?

MEMBER HATLIE: I'm really just

agreeing with the last two speakers. I mean, I thought I was voting for its use on a slower pathway after further use and testing.

DR. BURSTIN: Do people feel comfortable with what Cristie just raised as the condition to move forward with, that it would be conditional upon CDC's agreement that it is ready to move forward?

MEMBER BENIN: CDC's agreement and coming back here.

DR. POLLOCK: So also part of the very astutely revised NQF submission process, if the developer does not specify a public reporting or accountability purpose, the developer needs to describe a strategy for getting to a public reporting and accountability purpose. And so our strategy is really several-fold: We're going to work with hospitals and antimicrobial stewardship programs to better understand how the measure can be honed in ways that dovetail as effectively as possible with stewardship efforts.

The AU, antimicrobial use reporting to

NHSN is part of what we call our AUR module, antimicrobial use and resistance. And so the resistance part of that is only now available. And what the resistance part enables is electronic reporting, capture of pathogen information, including resistance. And that pathogen information is a likely candidate to include in our predictive modeling that addresses the very important fundamental of there are reasons to administer antimicrobials. And pathogens are the reasons to administer those antimicrobials.

So when we have pathogen data in hand, when we have antimicrobial stewardship experience, we will be in a much better position to say that the measure in its next iteration can be used as an appropriate indicator of judiciousness or injudiciousness of antimicrobial use. That's the point we want to get to. But we don't want to throw out the fact that right now the measure itself can have value in terms of having an impact on injudicious use.

So we're very fine with the status for the next duration of the endorsement period: non-publicly reporting, not using for the accountability. We're directly opposed to that, just to be as clear as possibly can be. But we're not opposed to voluntary reporting and we're not opposed to using any and every means that we can to encourage voluntary reporting. There is a lot of competition out there for capturing and delivering measure data. We happen to think that this particular arena, given where we are right now with resistance to antimicrobial use, is a very, very, high priority for quality measurement and improvement purposes.

CO-CHAIR WALTERS: So the last proposed condition, because the vote is what the vote is -- the last proposed condition was that again support for the measure, but CDC has the final say as to when the data is mature enough to move into IQR.

DR. POLLOCK: Well, we don't have the final say. We have a role as the measure

developer of factoring in all the very valuable input; and we've gotten lots of valuable input, and will continue to get valuable input, and put forward a next generation. Iteration sounds perhaps too minimal. It's going to be a next generation when we get to the point of being able to include in the predictive model the burden of infectious disease. That's going to be a next generation.

CO-CHAIR WALTERS: So representation of the data back to MAP, which is what was mentioned over on this side anyway.

MS. O'ROURKE: So I have that we conditionally support this measure pending that it's not public reported until better data is available and reevaluation by the MAP and recommendation by the CDC that it's ready for public reporting.

DR. POLLOCK: Could we say "additional data" rather than "better data?"

MS. O'ROURKE: Additional? I can --

(Laughter)

CO-CHAIR WALTERS: Thank you very much. And thank you to everybody for what has been a long couple hours, but a lot of good input.

We're going to take a five-minute break, because we have to get to Calendar 2. So get up and do what you need to do.

(Whereupon, the above-entitled matter went off the record at 11:54 a.m. and resumed at 12:05 p.m.)

CO-CHAIR TRAVIS: Okay, please take your seats. And, if we can ask the people in the back of the room to kind of have softer conversations?

Okay, the reward, if we can get through the rest of what we're supposed to do as quickly as possible is that we get to have lunch at 1:00.

Now, you know that that is going to be a challenge because we just took a significant amount of time, although I think it was very valuable conversations that we had, on our first

calendar. And we actually got about three calendars to cover before lunch.

We do still want to be sure that we have good conversations, though, as we move forward.

So, we are going to go on and get started with the goal that we can eat at 1:00. And, we're going to go to Consent Calendar 2. And, we're going to do this calendar a little bit differently than we did the first calendar because there are some common themes across some of the measures that have been included in this calendar.

So, just to kind of set it up for you how we would like this part to work for Calendar Number 2 is that there are four measures that are clinical episode-based payment measures.

And, we feel that there's a common theme around the clinical episode-based payment approach.

So, what we would like to do for those four measures is to have a conversation first

around the payment approach that essentially would be impacting all four measures.

If there are issues relative to the particular clinical aspects, we will, after we've had a general conversation around the approach, we will come and address any particular issues there are relative to the clinical conditions.

So, hopefully, that will help us have the conversation once about the payment approach and not have the conversation four times about the payment approach.

We will then after those first four, we will come back and cover Measure Number 3 which is the hospital level risk standardized 30-day episode of care payment measure for pneumonia and it is different than the other four measures.

So, hopefully, that will make sense to you all. We will see how this goes, but let's try during the first part of the conversation to focus on the payment approach and then we will move to any concerns around the individual clinical conditions.

And, we'll try to kind of correct ourselves if we get diverted.

As you will see, the other thing we don't have to worry about for this measure -- for this set is whether or not there's a Consent Calendar.

All of these measures have been pulled so we will be discussing all of them in the format that I just laid out.

So, we're going to start with the four clinical episode payment measures and we're going to start with the people who pulled the measure, just like we did the last time. And, that kind of makes it easy to have our new approach because some of the same people pulled all these measures.

So, I am going to start with Jennifer Eames Huff who did pull -- asked to pull all four of these clinical episode-based payment measures. And then, we will move on to the others that wanted to pull the measures.

But, Jennifer, if you can please start

us off and if you will, kind of focus your comments around the payment approach at this time.

MS. HUFF: Yes. Thank you.

So, I think we're all well aware of the health care spending in the United States is a problem. We've seen it $3 trillion for 2014 and it continues to eat up the gross domestic product.

And, we also know that about one-third of health care spending goes to things that aren't making us healthier. They're going to things that actually do not provide added benefit to patients.

Even with this higher spending, though, we still have quality issues with mortality, issues related to patients' experience with care and other things. And, we've made progress, I would say, but we still, particularly in the affordability realm, have a ways to go.

Cost resource use and the spending payment measures are badly needed, help us get

to, I think, the overall goal which we're trying to get to which is understanding what is high-value care and who our high-value providers.

The NQF endorsed measure portfolio has assembled a large portfolio of quality measures, way more preponderance of quality measures than measures related to cost resource use and spending. So, we really applaud the effort of bringing these measures forward.

In regards to the group of the episode-based measures, the clinical episodes, they represent a substantial portion of payment. And, I mean like a relative substantial portion of payment when looking at how much is spent on this.

And, the hospital care can influence near term outcomes for these procedures or conditions. It also shows that post-acute care payments are high.

And then, there is sizable variation in payment. Those were the requirements for determining what measures to look for in

developing measures related to payment and affordability for the clinical episodes.

So, I think those are all important issues and good reasons that make these measures important for us to be looking at.

It also so happens that this calls attention to conditions and procedures that are known for overuse and waste. And from both cost and a patient safety and quality perspective, both consumers and purchasers are really concerned about unnecessary treatments and how they're happening.

Let's say these clinical episode-based payment measures also address efficiency of care over a relevant time period. So it, again, like was mentioned previously, encourages hospitals to work together with other providers.

It looks at more of instead of a discrete experience, starting to look at more of the continuum of care, the patient as a whole. It's a more patient centered approach.

There was one of the rationales for

not supporting these measures was that there is an overall Medicare spending per beneficiary measure in the program. I actually don't see that as a negative issue. I see it as a positive and I think it's important for areas that are really important to prioritize them. And, by having measures that may have some overlaps that does it.

I also think it's good to have an overall measure. It doesn't get at, though, the variation that is happening at the condition and procedure level. So, this provides a little bit more information in terms of what's doing -- what's happening and what's driving that Medicare spending per beneficiary.

Thank you.

CO-CHAIR TRAVIS: Thank you, Jennifer.

So, the lead discussant for this is Nancy Foster, so I'm going to turn to her in a moment.

I just want to let you all know that Kelly Trautner won't be here until this

afternoon, so unfortunately, she won't be able to comment on this particular calendar.

So, Nancy, do you have some issues relative kind of to these four measures from the payment approach standpoint?

MEMBER FOSTER: Sure, thank you, Cristie.

We actually thought that the staff recommendation was exactly the right one, that while cost is an important thing to be measured and having good measures of cost would be useful, these are not yet NQF endorsed. My understanding is they haven't even come to the NQF yet.

We've never seen these measures. We don't know about the -- what the variation is. We don't know anything about sort of how much of this is variation in utilization of post-acute care services.

If it's predominantly hospital services that are being used, it's kind of odd for Medicare to portray something as being overpayment because the only thing that they're

portraying is what they paid us, right?

So, it's as if they're saying well, we've paid them this but it's too much but they determine how they're going to pay us, so that's just a really freaky thing.

So, you know, really understanding what's here, what's in the measures, what's causing the variation is critically important and that occurs when we see things as they come through the NQF process and we get a little experience with them.

So, you know, maybe right direction, but, you know, far too little information here for us to think that supporting this at this time is the right thing to do.

CO-CHAIR TRAVIS: Thank you, Nancy.

And, Jennifer, I failed to ask you what your recommendation would have been in terms of when you pulled them. What would be your alternative recommendation?

MS. HUFF: Yes, yes, and that actually flows very nicely from Nancy's comment of the

recommendation would be conditional support pending NQF review.

And, I would agree that there is not as much information. For example, like on the IQI measures available publicly on these measures. So it would be helpful as a part of the NQF process to get more information on that.

I will say there is some public information and there is some public information on how much the average payment per hospital for these episodes and looking at variation from the 25th to the 75th percentile. And, it does show, you know, high cost and there is variation in looking at the payments.

So, I think that the identification of the areas are right in terms of looking at the conditions and procedures. And, the NQF review would provide more information that people look at in terms of like reliability and validity of measures.

I do also want to add, I do have a question for CMS. As these areas typically cover

areas that are related to appropriateness and as it's an episode-based measure, it's getting at only the payment of the episode.

And, like I said, I think the significant cost and the variation is a rationale for these being important and looking at them.

But, it doesn't address whether or not the episode should have happened. So, I'd like to hear from CMS in terms of comments around plans for maybe a supplemental or a complimentary measures on actual appropriateness.

Though, I don't think that should hold it up in terms of the conditional support.

CO-CHAIR TRAVIS: Pierre, would you like to respond?

DR. YOUNG: So, thank you for that comment.

Certainly it is appropriateness of care, overuse, under use of services is an important topic.

I'll just say that, you know, it is an area that is specifically called out in MIPS and

so, something that we're thinking about is we're thinking towards MIPS.

Thank you.

CO-CHAIR TRAVIS: Okay. We would like now to open it up to the committee for discussion kind of around the basic approach. And then, after that, we'll see if anybody has any comments in the particular clinical areas.

So, Michael?

DR. PHELAN: And, I guess this goes to what my question was with the first comment that we had about how do we support these? Is it going to be conditionally support where, I'm going to say it again, at the MAP, or do we do not support knowing that full well that the next iteration will make it back to the MAP?

I think the one thing I'd worry about and with all of these kind of episode group of things is matching it with some type of quality outcome, to me, is very important to these -- not just the raw financial aspect of it.

So, I always want to see some kind of

quality measure because there may be a place where they have a much higher spend but they're outcomes are much more -- they're getting better care for whatever reason.

So, I always worry that when you just say, well, we'll just look at the cheapest denominator, so unless these are kind of care or some kind of quality outcome associated with it, whether it's patient satisfaction or an actual outcome, you know, a functional outcome or whatever you want to look at.

I just worry when these just care episode group what we're able to.

CO-CHAIR TRAVIS: Thank you, Michael.

Leslie?

MEMBER SCHULTZ: Thank you.

I agree with the staff's recommendation. The condition specific payment measures overlap with the Medicare spending per beneficiary measure that is currently in both HIQR and the VBP. Adding segments of this creates unnecessary duplication in the programs.

And, while the payment measures would create alignment with the physician value modifier in later MIPS, MAP requires establishment of patient relationship categories and codes to attribute patients and episodes.

This significantly changes the way the episode groupers are implemented and could lead to a lack of alignment between the hospital and the physician specifications.

And so, it would suggest that the measure not be added to the hospital programs in the advance of finalizing the measures with the physician programs.

And, additionally, in general, we have ongoing concerns about these measures. As measures of federal spending, they're not necessarily true indicators of value from the perspective of the beneficiary.

Because now they're capture the quality of care or are paired with measures that so do. Moreover, they don't give the beneficiary a real sense of their financial obligations so

they're not -- the payment reporting and beneficiary engagement purposes and the crosscutting measures that are not appropriate for evaluating care exclusively in the inpatient setting.

Most use a various range in differences in both the market availability of these services and some of it is not with real control.

CO-CHAIR TRAVIS: Thank you.

Dolores?

MS. MITCHELL: Thank you.

First of all, I'm moderately, maybe very moderately, pleased that the issue of costs and price, that all is beginning to percolate into the discussion in the quality community.

And, I understand and I will comment on this issue about where does quality fit in?

But, let me say, I left Massachusetts yesterday to come down here while we are -- because we're on a fiscal year that begins in July, in the middle of rate negotiations. One of

my most favorite activities because I'm basically a bully and I like to bully the health plans into lowering their premium requests.

But, you know, quite seriously, it's scary. It isn't just irritating or upsetting or annoying, it's scary.

After a number of years in which utilization was down and prices moderated a little bit, it's gone right back up. Last year, I had to go to the legislature with a $190 million shortfall in my spending.

Now, in Washington, that may be chump change, but let me tell you, that in the Commonwealth of Massachusetts and as an agency head, that huge personal, professional embarrassment to have to go back and say, oops, I overspent by a $190 million.

The concern that I have is in thinking about this because this is my problem, not your problem. But, I think it's very important to separate what I think are the basic components and how they affect the quality agenda.

There's the issue of resource use which I suppose you could say has partly to do with waste or unnecessary duplication. And so, that's different from appropriateness of care, though related. And I think we have to do more and more and more in that. I think we have huge gaps in that area.

I separate the words price from the word cost. Cost doesn't tell you very much. It's my beef with actuaries. They can tell you what something is going to cost, they don't tell you what it might cost if you did a better job or what it ought to cost.

And so, we have not just a cost problem, we also have a price problem. And, I think that it is an issue that this society has been extremely reluctant to address with the exception of the recent Mr. Turing -- how do you pronounce his name -- who sort of maybe pushed that envelop a little further than even his supporters thought was reasonable to defend.

But, except for that one, I think the

issue of cost and, excuse me, of price has been -- we've all been too polite with one another and in the public press about saying that people or institutions are charging more than is appropriate or ethical or reasonable.

And, I think we've just got to stop being so polite and address those issues.

But, closely related to price then and most egregiously unfair is disparities in price. I mean that's an ethical question in my view.

The people least -- the people, the institutions, the communities, the organizations least able to pay are the ones who are over and over and over again charged the most. There's just something basically wrong with that. And, I think we've just got to address that. That is a quality measure. It's an ethical measure or issue.

And then, finally, I think there's a point after which cost and price begin to become a quality issue. And, I think those who say, well, cost isn't our problem, cost isn't our

issue, quality is issue, I think maybe that was true 20 years ago. I think it no longer is true.

And, in what way is it true? If cost and price begin to affect access, then you've got a quality measure and I think we need to keep that higher up in our personal and professional agenda.

And, I don't know how many years it takes for people to understand that when the cost gets too high what people do is not just cut out the unnecessary, not just cut out the duplicative, they cut out and abstain from taking necessary preventive care as well as stuff that is optional.

Going all the way back to I don't know how many years ago the Rand study was, I don't know, probably 20, 30 years ago.

But, you look at the data about high deductible plans and the experience is universal. People don't use necessary as well as unnecessary care.

So, the notion that people are all of

a sudden going to become prudent shoppers and know whether or not they need an MRI or they need 25 or 30 or 40 rehab or physical therapy sessions versus three is just, I think, it's a fantasy.

And, yes, we should let people know what things cost and, yes, we should be transparent about prices. And, yes, we should make judgments about quality. But, I think to put the burden on the patient rather than to solve the problem is just an evasion of our professional responsibilities.

So, I will get off my pulpit. But, I really think those points need to be issued, excuse me, need to be kept on the agenda and on the agenda of the quality community, not just those of us who are penny pinching Simon Legree's who are trying to deprive our patients or our enrollees of their just desserts.

I think it's untrue, unfair, even of insurance companies, the evil insurance companies. Most of them these days, you know, their customers are largely self-insured anyhow,

so the notion that they're the evil ones and that everybody else is a saint, I think is a bit of self-deception that we ought not to indulge in.

CO-CHAIR TRAVIS: Thank you, Dolores.

And, Andrea, I'm going to call on you and, I apologize, I realize you also pulled one of these measures and but thank you for your patience.

MEMBER BENIN: Oh, that's okay, no worries.

Dolores brings up the question about appropriateness and I think that it would be helpful to have some understanding from CMS maybe not necessarily today but as part of the evolution of these types of metrics, a little better understanding about how we think any kind of risk adjustment really is working.

Because, as best I can figure out from the limited materials I could sort through, there's not really any risk adjustment, so you can't tell. Is there some -- I mean they call it risk adjustment but it's like about dollars, it's

not about severity of illness. I can't sort it out.

So, you know, I think that's like if I look at the hospitals in Connecticut, the ones that take care of more acute care, you know, sicker patients, the higher level of care hospitals seem to have the higher, you know, dollars attributed to them on the metrics that we have so far on Hospital Compare versus the smaller, you know, community hospitals that don't have the sicker patients.

And so, I'm just not sure that -- I think that before we could do anything other than, you know, the do not support that's been recommended, that we would need to understand that a little bit better in a more robust way and understand how that evolves and how that methodology on each evolve over time.

I think that that's the -- that to me -- I think there is also potential that I do not understand around geographical differences. And, as Nancy mentions, how the pricing gets worked

and how the payments get worked is not necessarily uniform, is my understanding, different organizations will have different agreements. And so, I'm not sure how that works out.

So, those are kind of the types of questions that I have that make me feel as though these metrics are -- I mean we have some of these payment metrics but we need to understand the ones we have better before we layer it with more of them. That's where my mind was.

Thanks.

CO-CHAIR TRAVIS: Would CMS like to respond kind of to the methodological issues that Andrea brought up? Because that may influence some of the other questions.

MS. SPALDING BUSH: Yes, thanks for the opportunity to respond to that.

I'm Kim Spalding Bush from CMS. I'm the lead on these measures and I'm sorry, I don't have my placard.

So, there is risk adjustment for all

of these episode-based payment measures. We actually sent a detailed methodologies document. I'm not sure whether that made its way, but we can provide that after this if you didn't get it.

The risk adjustment follows along with the existing Medicare spending per beneficiary measures construct in that it takes into account the diagnoses built during the 90 days that precede the episode and as well as the patient's age.

So, it does look at the beneficiaries clinical picture as well as the MS-DRG for the admission to the hospital because these are all -- we'll talk about IPPS hospital episodes.

So, it is risk adjusted and I think that's separate maybe what you're thinking of, too, is the payment standardization that we do which removes geographic payment adjustments, differences in wage index, geographic practice costs index so that you can make those comparisons across geographically different areas.

The standardization also removes things like if you have teaching hospitals that get an additional payment for IME, those come out so they don't look more expensive just by virtue of receiving that add-on payment or if they serve a disproportionate share of uninsured patients, we take the payment out.

So, the standardization, you know, serves to kind of level the playing field in those respects and all of the measures are risk adjusted at the facility level.

I hope that helps.

CO-CHAIR TRAVIS: Thank you.

Wei?

MEMBER YING: My comment is the previous comments that of these set of measures are sort of a duplicate of the total expenditure measure. I think the opposite.

I think the total expenditure measure is more of affordability measure. Actually, for these set of procedure-based measures, does get into quality because if there is major

complication or readmission happens post-hospital discharge, then the cost will go up.

So, it's definitely implicitly there is a quality component procedure-based measure.

But, I do have a question for CMS. So, just like hospital readmission measures, there is this overall hospital wide and there is a specific condition readmission measure for a procedure. If we go down this path, there will be endless procedures that you can pick.

So, these four procedures you put out here, I assume you have done some analysis. These are high-volume, maybe even see -- we have already seen the variation in the highest on the top of the procedure list, how you pick them? And, the question for CMS.

And, another comment is probably more for the NQF endorsement, is if this measure ever come up to NQF consideration is there are many procedure groupers out there.

If CMS approach is very different from what is out there either on the market or other

organization has developed by themselves, it will cause some disruption, let's put it that way, because if CMS put out it, it becomes sort of the gold standard. But, if it's very different from some of the procedure groupers that have been in existence for a long time, it will cause problems.

CO-CHAIR TRAVIS: Would you all like to respond about why these particular conditions were selected?

MS. SPALDING BUSH: Yes, thank you.

So, they were based on analysis as you had suggested about high prevalence, so they have to represent a high proportion of Medicare payment, being that they're, you know, Medicare payment measures. So, just to narrow down, we did look at high cost conditions and high prevalence conditions.

They also have to have significant variation within the measure so that there is an opportunity to gain efficiencies here. Whereas, if it's an episode where we didn't see a lot of

variation, we didn't select those.

There's also a high proportion of post-discharge care that happens with these. So, I think that also gets at one of -- Leslie or Nancy raised that concern. Oh, Nancy, yes, about whether or not these were really drive by CMS's set, you know, IPPS payment system which they're not. So we made sure to pick episodes that had a lot of post -- high proportion of the included costs are post-discharge payments.

And also, they were selected because the clinical panel determined that they were conditions over which the hospital had a lot of influence on the downstream charges.

So, that's how we went about selecting these measures. And, they do, as people have noted, they overlap in a sense with the spending per beneficiary measure.

I think that the key difference there is that these measures are -- when we say clinical episode-based, we mean that we've only included charges that are related to the

admission in these and they've had a lot of clinical panel reviews, CMS doctors, Acumen, Stanford doctors.

So, the clinicians have agreed that these are the services that are related. So, that's a key difference between these clinical measures. And, I think that was responsive to some of the public comments we received when we proposed the original overall MSVP measure that since become NQF endorsed but, at that point, wasn't and the public had said, you know, we feel like we need some measures that are more clinically oriented and clinically cohesive.

And so, that's what these measures are as well as that the public felt we should really expand our measure sets that we use for resource use measurements so that it's not kind of all dependent on this one.

CO-CHAIR TRAVIS: Thank you.

Nancy?

MEMBER FOSTER: So, I'm also curious about the grouper methodology. It's very

different than what's been used before. We haven't had a chance to kick the tires on this nor has NQF. So, we really don't know how it behaves very well.

And so, I'm curious as to why we've gone down a path that's a very different grouper methodology than used before. We're using a 90-day look back period when previously in other measures that CMS has developed or contracted to develop, they've used a year, two year look back period in order to get a more accurate assessment of the underlying diseases and disorders of the patients.

So, this is a very different approach and I think it's that difference without an understanding of why that, in part, makes me nervous about whether this will do what it's supposed to do.

And, the other thing I don't' know about this methodology, but I think it is important when we talk about all cost methodologies, all cost outcomes, is to look for

whether there are socio-demographic factors that will really affect the total cost here.

And, one could easily imagine that a patient who comes from an impoverished condition and has not -- to Dolores's earlier comments -- not accessed the health care system previously would have higher costs in many respects, even with the ongoing treatment in order to address all of those problems.

And, you know, to what extent has this begun to address that SDS issue?

CO-CHAIR TRAVIS: I'll give you just a brief response to that and then we'll see if anybody has any clinical specific questions.

MS. SPALDING BUSH: Thanks, I'll try to talk quickly.

So, with respect to the methodology here, it is more aligned with the Medicare spending per beneficiary measure that's in the hospital VBP program. That one uses the 90-day look back as well.

And, I think the rationale there

that's different than like an annual total per capita measure is we were looking for the conditions that most directly affect the hospitalization rather than like if you have a total per capita cost measure that spans a year, you might want to look at just the CMS score for the year that preceded it where that, you know, may not actually accurately reflect the conditions that have occurred more closely to this inpatient hospitalization.

And, we also use the MS-DRG for the hospitalization which the total per capita measures don't need to do it because they're just sort of looking at the costs over the course of the year.

And, there was another part to that, yes. So, we are cognizant of the work that's underway that NQF is currently working on, the tier project to look at SDS adjustments and also the Assistant Secretary for Planning and Education has undertaken another analysis that's required under the IMPACT Act.

So, we are aware that those are going on. We're certainly open to future refinements once we get the outcomes of those projects that are underway with NQF currently.

CO-CHAIR TRAVIS: Thank you.

Before we move to a vote on these four measures, does anyone have any questions specific to any clinical area or comments, not just questions?

So, Leslie?

MEMBER SCHULTZ: Just in regards to the aortic aneurysm repair. That strikes me as a heterogeneous population. I can see a little bit more homogeneity from certain cholecystectomy and stuff like that.

But, the triple-A kind of -- I don't see that as clinical on here. There's very different patients involved. So, just to kind of --

MS. FEINBERG: Hi, I'm Laurie Feinberg and I'm with Physician who works for Acumen and we're in measure development working with CMS.

There are really two subgroups in the triple-A's. There's the thoracics and the abdominals and that, we thought, were there relevant ways of separating them.

And, if you look at the data which here on page 25 of the 37-page document you hopefully should have gotten, it shows that indeed they are different.

Does that answer your question?

CO-CHAIR TRAVIS: Thank you.

Are there any other questions about any specific clinical conditions?

Michael, do you have a question?

DR. PHELAN: It was regarding the spinal fusion episode grouper for that. I remember seeing it when it first came out last year or not last year, maybe earlier in the spring, and I never follow up, but there was some concerns about that measure specifically with the group of patients that were going to be selected for evaluation.

And, I thought -- I cannot remember

the detail now, but did they change their specifications that they were going to look at? Because there's some that are pretty straightforward like the spinal fusion versus more complex patients. And, I didn't know how they addressed that question.

MS. FEINBERG: Hi. Based on the negative comments from the American Congress of Neurosurgeons, we actually had them give us some neurosurgeons to work with us and we developed a methodology that we think is far superior.

What we did is eliminate the cases where there was trauma and the large spinal deformities which we think are quite different and actually maybe not.

But what we were looking at now is focusing on CPT codes that looked at the elective surgeries of which there were lots for degenerative diseases.

And, we had the neurosurgeons help us pick out the right codes. I happen to be a physiatrist and it looks right to me and it looks

like our data showed that they're right.

So, we actually did quite a bit of refinement here.

CO-CHAIR TRAVIS: Andrea?

MEMBER BENIN: So, these kind of metrics, what's the relevance around IDC-10 stuff? So, do they have to be redone for ICD-10? Because all of these metrics will come into play in an ICD-10 environment. So, how does that --

MR. FEINBERG: We will crosswalk them.

CO-CHAIR TRAVIS: Okay. I don't see any other cards at this point. So, what we're going to do is we're going to vote on each measure because that's our process.

And so, I'm going to turn it over to staff to lead us through the vote on each one of these measures.

DR. PHELAN: Is this about the vote again?

CO-CHAIR TRAVIS: Yes, Michael?

DR. PHELAN: So, these are -- it goes back to that initial question we had. These are

fully developed measures or are these --

CO-CHAIR TRAVIS: Yes, they are fully developed.

DR. PHELAN: So, they don't have the -- it's not that middle category that we can select? Either can select conditionally support which means they're no NQF endorsed or that -- but there's no middle ground?

CO-CHAIR TRAVIS: It's support, conditional support or do not support. So, thank you for helping us clarify that. They are not NQF endorsed at this point, though.

Okay, so I'll turn it over to Jean-Luc.

MR. TILLY: Thank you.

So, for the first measure, Aortic Aneurysm Procedure --

CO-CHAIR TRAVIS: Sorry.

MEMBER FOSTER: So, I'm less than clear on what the condition would be if we were voting to conditionally support. Is it pending NQF endorsement or is it something more?

MS. O'ROURKE: So, I think we can take them one at a time. NQF endorsement seems to be the one that we've heard. Are there additional conditions we'd attach to the aortic aneurysm measure?

CO-CHAIR TRAVIS: And, we will get a chance, let's see where it ends up and if it is conditional support, we'll just reaffirm that it would be NQF endorsed meant as the condition.

And, if it's not, then we'll talk about what that would be for each measure.

MR. TILLY: And so, the three choices are support, conditional support and do not support.

MS. SHAHAB: This voting is open.

MR. TILLY: And we're just missing one more, so if you guys just want to give one final shot.

MS. SHAHAB: Is everyone voting?

CO-CHAIR TRAVIS: How many votes have been cast? Okay.

MS. O'ROURKE: We have one vote

missing it looks like, if everyone could click one more time.

CO-CHAIR TRAVIS: Ready to vote again?

MS. O'ROURKE: Just one second, please.

MR. TILLY: And so, polling is open again.

CO-CHAIR TRAVIS: Still on Aortic Aneurysm, vote again.

MR. TILLY: Okay, so the results are in.

Eight percent for support, 32 percent for conditional support, 60 percent for do not support.

So, the recommendation is do not support.

CO-CHAIR TRAVIS: Okay. Thank you all. Thank you for your patience and trying to be sure everybody gets their vote in.

We'll go to the next measure, Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure.

MR. TILLY: Okay, the voting is now open on Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure, 115-836.

The options are support, conditional support and do not support.

The results are 20 percent for support, 28 percent for conditional support and 52 percent for do not support.

So, the result is do not support.

CO-CHAIR TRAVIS: Okay, we're going to skip down to number four which is Spinal Fusion.

MR. TILLY: Okay, the voting is now open for Spinal Fusion Clinical Episode-Based Payment Measure 15-837.

The results are 16 percent support, 36 percent conditional support, 48 percent do not support.

So, the recommendation is do not support.

CO-CHAIR TRAVIS: Okay, and now Measure Number 5.

MR. TILLY: Okay, the polling is now open for Transurethral Resection of the Prostate for Benign Prostatic Hyperplasia Clinical Episode-Based Payment Measure, 15-838.

So, we're actually just missing one more, if you'd all try again. And we got it.

Okay, so the results are 20 percent support, 24 percent conditional support, 56 percent do not support.

So, the recommendation is do not support.

CO-CHAIR TRAVIS: Okay. Well, thank all of you. Now, we have experience with just about every possible voting outcome, I think. So, that'll help us as we move forward to understand how this works. So, thank you very much for that.

We have one final measure that's in this calendar. It is the Hospital-Level Risk Standardized 30-Day Episode of Care Payment Measure for Pneumonia.

This was pulled by Nancy, Andrea and

Jennifer. Since Nancy is the lead discussant, we'll go to Andrea first then Jennifer and then Nancy.

MEMBER BENIN: You know, I don't have any particular concrete things, I just felt as though this needed a little bit of discussion and explanation about how this metric was thought that it would perform as well as the, you know, what do we need to know about this type of metric. And so I just wanted to make sure we got all the information proper.

CO-CHAIR TRAVIS: Well, maybe, Andrea, what might work is for us to have a conversation and then if you have a specific question still outstanding we can come back to that. Would that be okay?

Okay, Jennifer, in terms of why you chose to pull this measure?

MS. HUFF: Yes, I think so a lot of the comments we made for the clinical episode apply here. So, I'll just focus on some that are different.

So, pneumonia is the leading cause of hospitalization for the older population. They're costly and have variation.

The pneumonia measure has a complimentary outcome measure. It has a mortality measure. But, I think the discussions around the linking the two together, CMS has been doing a good job in moving in that direction with some of the measures and this is one of them.

So, the improvements and the relative resources can also be viewed in terms of the quality of care that is being provided.

And then, I would also say -- let me see -- this measure is currently in use in this program. It's only that it's changing the population and then it's expanding it, the population, to make it more similar to the mortality measure.

So, for me, it didn't seem like this was a significant change and it's nice to bring alignment between measures. I saw it more modest alteration, so I would suggest changing the

recommendation from conditional support to support.

CO-CHAIR TRAVIS: Thank you, Jennifer. Nancy?

MEMBER FOSTER: So, thank you.

I am going to make a recommendation that we add an additional condition on the conditional support that was the staff recommendation.

But, before I do, I would note that I continue to be a little bit surprised that the previous measure did not undergo further NQF review because this is a substantial change in the population that's included in the measure. It basically doubles the size of the patient population and that, to me -- and it incorporates a lot of patients that never would have been in the measure before.

So, I see this as pending NQF review as a conditional support and that would be appropriate as far as I'm concerned.

The other issue for us continues to be

socio-demographic factor adjustment. We understand that when this was submitted to CMS under the trial period that, in fact, there were some SDS factors explored with this one.

What I would say is that we thoroughly agreed with the task force that NQF had on socio-demographic factors that suggested that race should never -- probably never, that almost always never, should ever, ever, ever, never be a potential adjustment factor here.

And, yet, when this came forward to NQF for review, it was proposed as an adjustment factor. I can think of no conceptual reason why race should be an adjustment here. But, I can think of a lot of reasons why the differences in the poverty rates in the communities, the access to ongoing care and other such factors would create differences in performance that should be considered for adjustment.

So, we are supporting this with NQF review and deep consideration of SDS factors that do not involve race.

Thank you.

CO-CHAIR TRAVIS: Thank you, Nancy.

And, I'm just trying to be sure I've gotten everybody who pulled it. Yes, I have.

So, now we'll open it up to those on the committee.

Wei?

MEMBER YING: My comment here is very similar to one other comment I made about the procedure-based measure.

When it comes to NQF assessment of all these measures, it's not only endorsing this particular measure, it's probably also endorsing the grouping as knowledge.

There is an industry standard, probably more than one out there, that either health care -- the providers or the insurance company have been using, especially on the clinical condition.

Procedure-based is relatively new, but condition-based on episode has been going -- has been in the market -- on the market for quite

some time.

If CMS knowledge is very different from the sort of quote, unquote standard out there on the market, then it really will cause problems, especially for those, let's say insurance companies serving different population then there will be a lot discrepancies in between.

CO-CHAIR TRAVIS: Thank you, Wei.

Any other -- Marty?

MEMBER HATLIE: Excuse me, Sean.

I'm concerned about Nancy's additional condition. I don't know that I understand it.

My concern is that I think there are situations, I'm not sure if this is one of them, where racial bias is a determining factor where if you adjust for education level or socio-economic status, you still see outcomes differing because of color of skin.

And so, I don't like -- my knee jerk reaction is, is I don't like taking that factor out of the equation. But, I'll admit that I just

don't really have granular knowledge about this particular condition.

MEMBER FOSTER: So, Marty, I hope you are wrong in that assessment. I fear you may be right. But, the adjustment factor would essentially take it out of the equation. It would never illuminate differences as a result of race. But we are talking about analyzing things by race, I would say to you, yes, let's do that.

In fact, we have a major effort underway to encourage hospitals to break down some of their measures by what we call real data, race, ethnicity and language data to look and see if there are any disparities in care despite whatever efforts they have underway to make sure that there aren't, we know there possibly can be.

But, this is an adjustment factor that would blend that out and I don't -- we don't see that as a legitimate adjustment factor and that's what I'm saying

CO-CHAIR TRAVIS: Leslie?

MEMBER SCHULTZ: Thank you.

I agree with the staff's recommendation on this one, that it go back through the process. They've really changed the population when they introduced aspiration pneumonia and the subcohort, it's radically different as Nancy alluded to.

You double the populations of something meaningful. It has changed clinically.

CO-CHAIR TRAVIS: Thank you.

Michael?

DR. PHELAN: I'm just wondering, because there seems to be a concern for some of the other people, I'm wondering if CMS can comment on why that was done and why it matters?

CO-CHAIR TRAVIS: Which particular part?

DR. PHELAN: The double the population.

CO-CHAIR TRAVIS: The change in the population?

DR. PHELAN: The change in the metric which I don't -- I'm not, as a clinician, too

concerned, but I just wanted to hear what CMS thoughts were on that.

CO-CHAIR TRAVIS: Okay. That sounds good.

DR. YOUNG: So, we discussed this on a couple of the other pneumonia measures that we have in the IQR program last year, last year's MAP.

So, this is an update to -- a substantive change to the payment measure to align it with the other pneumonia measures which is essentially to update it to attempt for, you know, some -- what we've noted in terms of coding practices, in terms of coding of severity of pneumonia to capture folks who are now designed as sepsis with the primary -- as their primary diagnosis on a discharge with a secondary condition of pneumonia as well as to capture those patients that have aspiration pneumonia.

So, we believe overall this is a more comprehensive assessment of the pneumonia population that a hospital treats.

I would also turn to Suzannah Bernheim who helped developed this measure and led those efforts if she has additional comments.

But, the other thing I think we just want to clarify was also that, while we looked at race as part of the SDS trial in NQF, race is not part of the risk adjustment methodology.

CO-CHAIR TRAVIS: Thank you.

MS. BERNHEIM: I mean I'm happy to add more, although I think Pierre basically covered it. Right? We brought, you know, to this committee both the mortality and readmission pneumonia measures last year with this cohort expansion on a pretty extensive discussion about why the cohort was being expanded.

That went into last year's rule and we actually, in response -- you can see, Nancy -- okay, just hold it a bit closer, okay, sorry.

So, the expansion of the cohort for the mortality and readmission measure came to this group last year in response to some great stakeholder input. We actually narrowed the

expansion so the mortality and readmission measures have been finalized and moved forward with a cohort that is expanded from the previous one but actually somewhat narrower than what came in front of this group last year.

This work is now to bring the mortality measure cohort expansion to the payment measure so that those two measures stay aligned.

And, yes, we -- the payment measures were one of the first to go through the SDS trial as an ad hoc review and we looked at a wide range, not that wide a range, but as wide a range of SDS variables as we could to see the impact on the measures.

So, we looked at race but we in no way proposed race being infiltrated into these measures and don't intend to do so.

CO-CHAIR TRAVIS: Okay. Thank you.

MS. SHAHAB: Cristie, Jennifer has a comment as well.

CO-CHAIR TRAVIS: Yes, Jennifer?

MS. HUFF: Hi, I have a question for

clarification and it's around the addition of the conditional support regarding looking at SDS.

I'm on the NQF Cost and Resource Use Standing Committee, so have some knowledge about what's been going through that process and this pneumonia measure, the current pneumonia measure and the IQR program has gone through that endorsement process and also gone through the SDS trial process of being reviewed.

The committee's given feedback to the measure developer that has led to what different measures to look at.

So, I'm wondering is it like is it -- is that suffice for the condition that's being put forward? Is it being looked at since it has had some review already? And, I think it may have gone to the Board recently.

But, I know it has completed the Standing Committee review.

CO-CHAIR TRAVIS: I'm going to ask NQF staff to kind of answer that for us so that we get the right answer.

MS. O'ROURKE: Sure. I can attempt to take that and I may look to Helen or Taroon who are also involved in this project.

So, the current version of the measure that is used in the program has been NQF endorsed and was looked at by the Cost and Resource Use Standing Committee for consideration of adding SDS factors in the risk adjustment model.

The committee, at the time, did not recommend that those factors be included in the risk adjustment model. So, that measure has undergone the Standing Committee's review and will be going to CSAC as the Board for finalization in the coming months.

However, this update to the cohort has not been reviewed by the Standing Committee for either the change to the population included in the measure and if that change in the measure should be also again considered for SDS adjustment.

CO-CHAIR TRAVIS: And, just to be sure I'm on the same page, assuming that this measure

comes back in for the update and the review, potential review and re-endorsement during the SDS trial period, they would go through the SDS review at that time for this measure.

So, I think that will happen if, assuming those things I just said.

MS. O'ROURKE: And, I just wanted to be explicit about it, that's my only thing.

CO-CHAIR TRAVIS: Right.

All right, we'll let's take a vote.

MR. TILLY: The polling is now open on Hospital Level Risk Standardized 30-Day Episode of Care Payment Measure for Pneumonia, MUC 15-378.

The options are support, conditional support and do not support.

Okay, so the results are support, 32 percent, conditional support, 60 percent and do not support, 8 percent.

So, the result is conditional support.

MS. O'ROURKE: Sure, so I think the conditions I've heard is that it's NQF review and

endorsement of this update to the cohort with particular attention paid to inclusion of social demographic factors.

CO-CHAIR TRAVIS: Okay, well, not hearing any opposition to that, that's the condition that will go forth.

And, I know I said I was going to try to get us through all three of these calendars before lunch, but I'm personally very hungry.

So, we will take a break, but before we do, I'd like to see what Tom would like to share with us.

MEMBER LUTZOW: Yes, as you follow through on those convictions, do you actually look at raw data? In this case, are intercity hospitals at a disadvantage to suburban or rural are dually eligible patients in the fee-for-service system actually costing more than non-duals? Do you look at the hard data? Can you see a difference and what is it?

MEMBER FOSTER: I was going to say, there have been a number of studies that look at

socio-demographic effect on readmissions, on cost, on anything else.

These particular conditions, I'm not -- pneumonia yes, people have looked at that. And, yes, there is clearly an effect of poverty, if you will. So, whether you're measuring that by dual eligibility, which gets a little funky because some states have expanded their Medicaid population and others have not. And so, you've got sort of a strange confounding factor in there.

Or, you look at it by Census track which is probably a more rigorous way to look at it. Or zip code, some people have suggested.

You can find a poverty factor in there that affects total cost, total number of readmissions, I'm not aware of the mortality, but somebody can correct me if I'm wrong.

MS. BERNHEIM: So, when we brought these measures back again, it was much later and the current version of, not the version that's in front of you, we did exactly that.

So, we looked at hospitals with high proportions of dual eligible patients, hospitals with high proportions of patients coming from neighborhoods indicated by our SES index. I think we did that one for payment, we've done this for a lot of measures right now as you can image because they're all coming back. And, we looked at race.

And, what's surprises people with these payment measures, because they are looking at an episode and because, unfortunately, sometimes patients in poor communities are less likely to get procedures or are less likely to get follow up care and sometimes they are more likely -- at most, it comes out in the wash. You see much less difference than you might expect with these actual measures and those factors.

And, all of the stuff that we did is public. It's on the NQF website because we brought it back to the committee. So, you can look at it in detail.

But, I think it surprised the

committee how little in the case of these measures and the versions of SDS that we can feasibly include, how little difference it made.

MR. AMIN: So just a few clarifications. So, I just wanted to provide -- take a step back from this question and just sort of articulate a little bit of what we're doing in the SDS trial and the approach that we're asking measure developers to undertake.

I think it might help to provide a little bit of clarity and hopefully some confidence about, you know, what happens with these measures when you ask -- well not even when you ask us to look at the SDS question because this is being implemented across all NQF projects in the next -- for the next few years.

By the way, my name is Taroon Amin, by the way. I'd just like to introduce myself. I'm the Staff Support for the MAP Coordinating Committee and also Staff Support on the SDS Trial Period along with my colleague Karen Johnson here and others.

So, with this change, NQF convened an expert panel to look at the question of the appropriateness of including SDS factors in risk adjusted models.

Many of you were on that panel and the main summary statement there, while it was a very extensive report and I highly encourage you to take a look at it if you haven't seen it yet, the main operational impact was that it removed this consideration that SDS factors should just not be included in risk adjusted models which was our prior guidance.

And so, we lifted this ban, if you will, but that, I want to be clear that lifting that ban means a few specific things.

The question of whether SDS factors should be included in risk adjusted models is dependent on each individual measure and should follow a pretty defined process within our NQF endorsement process.

The first is that there is a conceptual analysis on whether and how these SDS

factors influence the outcomes of interest.

So, there should be sort of an underlying conceptual rationale for the way that's low income, for instance, or the dual eligibility variable influence the outcome of interest.

That is a critical element of how one should decide whether or not these factors should be included in risk adjusted models.

The second is once you have that conceptual understanding, to then be able to test it empirically to understand how much these factors are influenced in the outcome.

Now, there are clear challenges in the field about how well the data that we have, the individual variables represents the underlying conceptual construct.

And, that's a discussion that's going to be well beyond our two year trial period and, quite honestly, well beyond what many measure developers can do with the current state of the data that they have to test this.

So, this is going to be a learning process for us as a field to continue to understand, you know, I think some interesting findings so far in the context of these measures.

And then, as this measure expands to expand the population, you know, we'll have to go back and take a look at this question and I'm sure Suzannah and the CMS team are going to do that.

But, I wanted to provide context in the fact that we're looking at these measures individually. Every single measure starting this past calendar -- well, 2005 is in this trial period. There were -- 2015, I'm ten years off -- 2015 are in this trial period.

The NQF Board asked that certain measures that were in 2014 to go back into the trial period, so that's where these measures -- these three measures that Suzannah talked about of large number of readmissions measures went back into this trial period and then all, you know, all these measures in the next few years

will have to go through this conceptual analysis and then an empirical analysis.

But there are going to still going to be underlying data challenges, you know, my summary statement.

And so, we can go into a discussion about how well dual eligibility represents underlying SDS factors or low income or how that data can be collected. And those are definitely conversations that need to be had and we are convening a Disparities Standing Committee to really address some of these more long term issues that we're going to need to grapple with that are going to require many of us to, you know, help advise the field in where we need to go forward.

So, Cristie, I just wanted to provide this background of what we're doing and hopefully that addresses the question that was raised.

CO-CHAIR TRAVIS: Thank you.

And, I'm sure that'll be an ongoing conversation as it goes on.

Michael, did you have a question?

DR. PHELAN: You know, I'm sure you're familiar with the Barnett's paper that internal medicine with the different patient characteristics.

Because I heard someone from CMS say that they didn't really see this kind of a wash out, but there's other studies out there showing that some of the, for at least for the all cause readmission, there's a Barnett, I think they had a paper that looked at 29 different factors that may be contributing to the differences in readmission.

So, whether or not the data coming out from CMS actually explored each of those, I don't know if they did or not, but there are factors that are there. I just I got this impression that it was kind of being minimized --

CO-CHAIR TRAVIS: Trust me, the review process -- participating on that side of it as several people around here do, it is thorough. So but, there are these challenges that, you

know, this trial period is actually helping to uncover which is why it is a trial period so that we can learn what it takes to do it the right way.

So, your comments are right on target in terms of what is going on in the trial period. So, thank you for that.

And, I'll go to David for the last comment before lunch.

MEMBER ENGLER: Thank you very much.

So, I don't want to stand between us and lunch.

But, to your point, what we have done in the last couple of years at America's Essential Hospitals and it's a resource that we'd like to offer all members of MAP if you're interested in, we've published the results of at least 18 or 19 different studies looking at the impact that SDS has on outcome measures. And, that's all available on our website.

And, to generalize from those 19 studies or so, it has a significant impact on

selected metrics. Okay? In particular, pneumonia, in particular, stroke, and in particular, of the admissions as a general theme.

So, we offer that as a resource to all members of MAP and as you're looking at the impact that socio-demographic factors have, we've published also race, ethnicity and language tools that are available through our site as well.

So, I just wanted to offer that.

CO-CHAIR TRAVIS: Well, thank you, David.

MEMBER ENGLER: Thank you.

CO-CHAIR TRAVIS: Thank you very much.

Okay, well, like I said, we had a reward for three. We only got through one, but we're doing continuous improvement and adjustment.

So, we're going to have lunch right now and I'm going to staff, though, as to what time we need to come back.

MS. O'ROURKE: 1:45, 30 minute lunch.

CO-CHAIR TRAVIS: Are people up for a

working lunch? Okay.

MS. O'ROURKE: Maybe we can take 15 minutes to get your lunch and decompress a little and then come back at 1:30 for a working lunch.

CO-CHAIR TRAVIS: That sounds good. Thank you all.

(Whereupon, the above-entitled matter went off the record at 1:17 p.m. and resumed at 1:35 p.m.)

CO-CHAIR WALTERS: Okay, Helen Haskell, one housekeeping thing for you, would you just tell the group about your conflicts or lack thereof?

MS. HASKELL: Hello, I'm Helen Haskell for Mothers Against Medical Error and Consumers Advancing Patient Safety and I have no conflicts to report.

CO-CHAIR WALTERS: Thank you very much.

Okay. We're moving into Consent Calendar 3, the 11:00 item. And so, I'm pleased to inform you that when we started to put

together these Consent Calendars, we purposefully did that in kind of groupings to facilitate some of the discussion that, like you just saw on the last Consent Calendar, so we knew might be able to catch up a little ground.

And, this one almost naturally groups into numbers two, three and four because they are all about ischemic stroke mortality. And, I'm sure we'll need --

And then, the first one has to do with the excess days which is a different type concept.

But, before we get to two, three and four and then one, let's talk about number five which is the RPSI composite. That, to this point in time, has not been pulled by anyone. So, I want to see if everyone wants to leave it on the Consent Calendar which was recommended by staff for support?

Is there anybody in the room that wants to pull that from the Consent Calendar?

Good. Okay, thank you.

We will now go over two, three and four which is those group of measures regarding ischemic stroke mortality.

They were pulled by a combination of Nancy, Sean and Andrea, either two at a time or three at a time.

So, who doesn't have food in their mouth? Let's see, Sean, no you're not there.

DR. MORRISON: I'm here.

CO-CHAIR WALTERS: You have food in your mouth yet.

DR. MORRISON: No, not yet.

CO-CHAIR WALTERS: Andrea, do you have -- okay, Sean, you go first.

DR. MORRISON: Okay.

CO-CHAIR WALTERS: And, this is taking two, three and four kind of as a group because I suspect where we're going end up is talking about the three measures together and what's the same about them and what's different and so on.

DR. MORRISON: Right. So, these are the three measures around adjusted stroke

mortality. And, I had a couple of concerns about those and let me just preface by the data that are out there.

The first element is that there, particularly related to stroke, there are a number of data point -- or a number of studies out there that demonstrate that there really is something that patients consider a fate worse than death and that is living with either profound cognitive or functional impairment and that is often a result following a severe stroke.

The second data element out there is that we know that patients goals of care are not discussed well by physicians in the acute care setting.

And, the third point of data is that it is very easy, or relatively easy, to keep somebody alive for a prolonged period of time following a severe stroke if you place a tracheostomy into their larynx and then put a gastrostomy tube into their stomach.

And, many of us who work in this area

are very familiar with the comment by our neurosurgeons and our neurologists, it is time for a trach and PEG. Trach, PEG and send them home.

So, the idea of putting a mortality measure out there without any consideration as to whether (a) goals of care were discussed, (b) whether there was any consideration as to whether patients were enrolled in hospice following a severe stroke means that we are not protecting our most vulnerable patient population and, indeed, may be placing many of them in a situation which they would consider to be a fate worse than death.

And, I think unless there is some accountability for either goals of care discussions, patients preferences, that mortality in and of itself for this measure is a poor measure and I would vote either (a) to support continued development with that indicated or (b) not move it forward at all.

CO-CHAIR WALTERS: Thank you.

Nancy, you asked that it be pulled, too?

MEMBER FOSTER: Thank you.

And, I appreciate Sean's comments very much that very important concerns.

My question was really about why three measures? What's it going to tell us if we endorse all three of them? What's the difference between the three of them?

I appreciate the fact that you have -- that CMS and its measure development team has taken the step of trying to adjust these for stroke severity which is clinically the most important thing, I understand, in determining stroke outcome.

So, great step, but help me understand why three are on the MUC list.

CO-CHAIR WALTERS: The spec to that came up and I think we're going to get a response to that as the discussion unfolds. That's why they're kind of grouped together.

And, Andrea, you had a problem with

three and four. You asked that that be pulled, those be pulled.

MEMBER BENIN: No, my comments were similar and I think Sean made some excellent points and I think we need to understand what the differences are between these three and why there's three and what the implications are around them.

CO-CHAIR WALTERS: Okay. Let's head into the response. That was anticipated to be the number one question. So, let's head into two, three and four as a group. Why all three of them are there, what their differences are, why all three of them should to be important or not and then we'll get into comments after that.

DR. YOUNG: Sure, so thank you for the comments and if there are specific comments about the technical specifications, though, I'll ask Suzannah to help answer those.

But, we felt as we were developing these measures with Suzannah and her team, we wanted to move forward but were also cognizant

that the landscape of data sources and movement towards use of electronic health records as a data source for quality measures was also happening.

And, as I mentioned before, usually take several years before CMS can implement a measure into a program.

So, the main difference between the different versions, if you will, of these measures, is essentially the data sources we essentially have one claims-based measure.

We have a hybrid measure which uses data from claims information as well as data from EHRs and then an EHR version.

So, the reason we included all three was really because we were cognizant that, you know, we want to move forward with ultimately achieving this vision of having quality data pulled from EHRs.

And so, we wanted to have some -- thought it would provide some flexibility if we had different versions that we may consider

appropriate for the program at different times depending on what data source was -- and what the stage of development is with EHRs.

CO-CHAIR WALTERS: Yes, open for discussion.

MEMBER FOSTER: So, Pierre, if I could say that back to you in a slightly different way, it is not your intent to implement more than one of these at a time, in essence. You are looking for guidance on whether to move a measure forward and, if so, whether one of these is preferred. Is that right?

DR. YOUNG: Certainly that would be valuable input. I mean sometimes we have had two versions. Right? We've had paper measures and the voluntary ECQM version of that measure. So, certainly we've had that situation in the past.

So, there are possibilities that you may have different versions of the same measure in the program at the same time. But, I think the goal here is really to have a measure in the program.

CO-CHAIR WALTERS: I'll address it before I get to David. Greg as the lead discussant.

DR. ALEXANDER: Thank you.

So, I've reviewed all the comments on these and the only thing that I have to add is there was one comment about the sort of usability, human computer interaction components of EHRs.

And, since I have some experience with that, I thought it was an interesting comment in that different users, the different EHRs and the ways EHRs are designed should be considered in relationship to this measure because the measure is only as good as the data underlying it.

And, if the data isn't collected consistently and reliable across different vendors, then you're not really measuring the same thing across different settings.

And so, this was a concern that was raised and I think it's a valid concern that should be considered.

So, I guess I would recommend conditional acceptance based on this.

CO-CHAIR WALTERS: And, the other lead discussant, Heather?

MEMBER LEWIS: I have to say that in concur with Sean's comments and I do have a question regarding risk standardization and selectively with this stroke mortality measure, it selectively disadvantages of hospitals as we've seen in some of our experience.

CO-CHAIR WALTERS: And, I'll go back to David.

MEMBER ENGLER: So, thank you very much.

So, I had both a comment and a question.

So, when we looked at the metric itself, we were very supportive. American's Essential Hospitals was very supportive in the sense that the adjustment was going to be made for the stroke severity scale. So, thank you for doing that.

But the follow up question for that is whether or not in the collection of the data both claims-based and EHR, if those data elements are routinely collected for the purposes of the scale, if they are not, then we would withdraw our support for it. If they are, then we would continue to endorse it.

CO-CHAIR WALTERS: Pierre?

DR. YOUNG: So, with this switch to ICD-10, there is -- we now do -- or will be collecting eventually NIH Stroke Scales as part of the claims data, so that's how we can include that as part of the risk adjustment model with even just the claims-based measure.

CO-CHAIR WALTERS: Leslie?

MEMBER SCHULTZ: Very similar theme, applaud the inclusion of the adjustment for the stroke scale. However, unsure if those elements can capture consistently across EHRs.

And CE HTR requirements need to be incorporate the elements prior to the implementation.

CO-CHAIR WALTERS: Jack?

DR. FOWLER: I'm on Sean's team, I guess, that the notion of having a quality measure that encourages hospitals to keep people alive given the fact that we know there's an awful lot of over treatment at the end of life, it doesn't strike me as rational.

CO-CHAIR WALTERS: Sean?

DR. MORRISON: I would just add that I would suggest that mortality is not the right measure here but it's cognitive and functional outcome and that mortality is just -- it's just a wrong outcome for this condition.

DR. LEVY: Yes, I was about to say the exact same thing that Sean said. I'm not sure that mortality is a measure of quality here because the outcomes of stroke could cognitive. I think that's much better.

But, the relationship between stroke and mortality in terms of quality is very unclear to me.

CO-CHAIR WALTERS: I have kind of a

question myself. With three measures of kind of different sources, mixture of sources, et cetera, it's kind of a version of the one that someone asked earlier.

And, if they're all in the program, and if it all happens to be at the same time, how's that work for an individual hospital?

DR. YOUNG: So, I don't know -- so, from the CMS perspective, we, I don't think we've made any formal decisions in terms of which measure or all measures to potentially propose for IQR.

So, certainly if all three are in, we recognize that there would be these complications because then it becomes, well, which one would a hospital submit?

What I can say is, you know, in the past, we have had paper -- we've had two versions of the same measure in the IQR program. We've had, you know, a paper -- like a chart extracted measure and a voluntary ECQM version of that same measure that hospitals could voluntarily submit

data on instead of the paper of the measure.

So, that could be one possibility for how we could have multiple versions of the same measure in there.

As far as I know, we've never had three versions of the same measure in the program. I think just to emphasize our thinking here, I think we want to encourage the movement towards EHR based a type of clinical quality measures but also recognize that based on, as we've heard in some other discussion earlier, there are concerns about the data quality and how reliable that data quality is at this point. So, we recognize that's a moving target.

But so, but these are very good questions that we need to fully think through before we would make any proposals through a notice and comment rulemaking about how to include these measures.

CO-CHAIR WALTERS: Mitchell?

DR. LEVY: Yes, so, based on your comment, I think this is another one of those

times before we vote that we're really sure and clear about what we're voting on because this -- the conditional support that's recommended by the staff is conditional support for public reporting into patient quality as opposed to conditional support for further development of the measure.

So, to me, we need to clarify -- be sure of what we're -- what one of those is.

CO-CHAIR WALTERS: Did you have another comment?

MEMBER ENGLER: Yes, thank you.

I need more clarity on whether or not it's all three metrics. I wouldn't wish three metrics on my worst enemy on the same measure.

So, and particularly as we try to adjudicate the differences across the three, so again, while we support it given the fact that there's a stroke scale in it and given the notion that the EHRs will eventually catch up with humanity, but I do need some clarity for purposes of the vote as to which of the three we're voting on.

CO-CHAIR WALTERS: So, Nancy's going to give us that clarity.

MEMBER FOSTER: Well, listening to the comments, I think the NQF review is really the ideal place to address the question of are these there equal measures, is one superior to the other? Which one should be endorsed? Or is one simply the electronic equivalent of the paper-based measure and there are really two sides of the same coin?

I'm not sure we are constituted to do that or have the time to do that given how much time we've taken already.

But, so I leave that question to NQF review. But, I'm seriously concerned about the questions that Mitch and Sean and others have raised about how this aligns with what are the real outcomes of interest and how it aligns with patient preferences and DNR decisions and so forth.

So, I'd love to hear CMS's response on whether any or all of these measures have taken

into account patient decision making and whether -- why you thought these were the outcomes of interest for stroke.

DR. YOUNG: So, thank you.

And so, we -- these are really important questions about sort of patient preferences and engagement of patients, particularly in our measure development process.

And, I just want to ask Suzannah actually to talk a little bit more specifically about how we did that with this particular measure.

MS. BERNHEIM: Can people hear me okay?

So, these are really important questions and, remember that CMS has in the IQR program right now a 30-day hospital stroke mortality measure. So, these are coming forward as a revision to that measure if you stick with the claims-based measure to respond to one of the key criticisms of that measure when it first came out which is that we did not have a way to

accurately account for patient severity.

That is not the same in any way as end of life desires, but it is related because those issues are going to come up much more in these severe strokes.

So, it's not a solution to a problem that, as a measure developer, I've had for a long time which is I would love for you to tell me who, based on their condition when they come into the hospitals makes end of life decisions? And, we can't tell that.

So, we can't tell the difference between patients who have had terrible aspiration pneumonia because of poor care and ended up ventilated and had mortality issues that were related and hospice decisions that were related to poor care versus based on the time they enter.

So, just a plug for hospitals to help resolve this problem.

In the meantime, what we do for this measure is we account for hospice on the day of admission. So, if hospitals are proactively

identifying this, that's something we can do with the claims measure.

So, that's an exclusion for all of these measures, patients who are hospice prior -- any time in the prior year or on the day of admission are out of the measure.

And, now, we have the ability at least to account for how severe the stroke is which helps us get better.

So, that's the story of this measure. And, the true story is that it started as an EHR measure because we didn't know how to get stroke severity any other way. And, in the process of developing it, a new ICD-9 code came forward, an ICD-10, excuse me, which would allow us to do a claims-based only measure.

And, I think you're right, Nancy, we need the neurology committee and all of these measures are going to the neurology committee in January to tell us about validity. But, they're all pretty strong measures based on my biased viewpoint.

What you guys can reflect back to us is, is the effort to start pulling the clinical data out of the EHR and the NIH Stroke Scale out of the EHR important enough to the stakeholder community that leading with an EHR risk adjusted model is more valuable or is it better to just bring the claims data from the NIH Stroke Scale in and stick with a claims-based measure which is lower burden?

Although I heard well earlier comments about the fact that it's not that these claims measures are no burden.

CO-CHAIR WALTERS: So, the last statement was clear about what they were looking for out of this. So, as we vote on measures two, three and four, I would say take into consideration what you heard from Sean and from Nancy.

Take into consideration that if you vote three supports, take into consideration all permutations of the vote on three different measures and vote the way that you think

describes these situations.

But, you heard what they were looking for. They were looking for direction about which way to go with which one of these preferred.

MS. O'ROURKE: So, before we vote, while Jean-Luc is cuing that up, could -- Kelly, could you -- would you mind introducing yourself and disclosing?

CO-CHAIR WALTERS: Yes, Kelly, we need your disclosure.

MS. TRAUTNER: Hi, my name is Kelly Trautner, I'm the Director of AFT Nurses and Health Professionals. Do you need me to say anything else? I have no conflict of interest and no disclosures to make.

CO-CHAIR WALTERS: Start this out with measure two.

MEMBER BENIN: So, I don't know, who I'm going to ask to answer this, but the -- so, if these metrics are based on ICD-10 codes, how are they possibly even validated because nobody's been using ICD-10 except for like a month?

So, they're not validated at all for ICD-10? No, she just said it only became possible because of ICD-10, sorry.

MS. BERNHEIM: So, great question. So, the way these measures were developed, because, as you note, we don't have the data, is that we used registry data as a proxy and we combined registry and claims data. So, we created a data set that was made of claims data with the NIH Stroke Scale as it came from the registry data.

So, it shows that the measure works with the NIH Stroke Scale, we can't say 100 percent that what they put in the registry is what they would have put in the claims, but they're pulling it from the same place as the chart.

CO-CHAIR WALTERS: Okay.

DR. PHELAN: So, I have a question.

CO-CHAIR WALTERS: I'm sorry.

DR. PHELAN: So, number two is a measure that is currently endorsed by NQF but has

some modifications? Which is the measure -- is that the correct one that's in the IQR?

MS. BERNHEIM: Number two --

CO-CHAIR WALTERS: It's in administrative claims.

MS. BERNHEIM: Right, and it is in IQR. This is a refinement to one in IQR. It is not NQF endorsed.

No, the current version of number two, without the NIH Stroke Scale is used in IQR. We're bringing to the MAP a revision of the current measure that would incorporate the NIH Stroke Scale and we reselected variables in that. That is number two.

Okay, so three is a measure that uses claims data to identify the cohorts with an identical cohort and it uses claims data for the outcome. It has an identical outcome but we used a combination of data elements that could be pulled from the EHR, primarily labs and vital signs, and claims data and the NIH Stroke Scale and we chose the strongest risk model. And that

new risk model has a combination of claims and EHR data elements in the risk model.

Number three is similar to that, it only uses EHR-based variables in the risk model.

CO-CHAIR WALTERS: And, you say that again in number four, right?

MS. BERNHEIM: I'm sorry.

CO-CHAIR WALTERS: Yes, so let's go -- again, this has to be perfectly clear because it's muddy enough already.

MS. BERNHEIM: Yes, and I really apologize. I'm going to look at the screen while I say this.

CO-CHAIR WALTERS: Describe two, three and four again.

MS. BERNHEIM: Yes.

Measure number two is a refinement to the current IQR measure. It is claims-based and it includes the NIH Stroke Scale.

Measure three is a hybrid measure, meaning that it uses both claims and electronic health record data and it's risk model, the risk

variables come from both claims and electronic health record data.

Number four is still considered a hybrid measure in that the cohort is defined through claims data, but it only uses elements that would come from an EHR including the NIH Stroke Scale for the risk variables in the model.

I apologize.

MEMBER ENGLER: Thank you, Ron.

So, I've just got one more question. I apologize.

As the developer, if you list down those three, could you tell me what the receiver operator curve is for each one of those three and whether or not it got better as you added EHR data, please?

MS. BERNHEIM: I can't tell you them off the top of my head. If you want to know the actual numbers, somebody can pull them up for me.

I can tell you they are quite close and that the third one, the one that has both claims and EHR data is the strongest, but not by

much.

If you want real numbers, I can provide them.

Number three.

CO-CHAIR WALTERS: Is there everybody clear on what they're voting on?

Mitch?

DR. LEVY: So, and I assume when you say EHR data it's been validated on across platforms in the EHR?

MS. BERNHEIM: So, what we've been able to do is validate all of the elements that are in there except for the NIH Stroke Scale. Hospitals do not standardly have the NIH Stroke Scale now in a structured field. But, all the other elements are part of what is CMS's four clinical data elements.

CO-CHAIR WALTERS: Are we ready? Okay, tee up number two.

MR. TILLY: All right. So, the polling now open for Hospital 30-Day Mortality Following Acute Ischemic Stroke Hospitalization

Measure, MUC 15-294, what we were calling number two.

And the options are support, conditional support and do not support.

All right, so the results are in, 24 percent support, 44 percent conditional support, 32 percent do not support.

So, the verdict is conditional support.

CO-CHAIR WALTERS: And?

MS. O'ROURKE: Thanks, Ron.

So, again, this is a little bit of a tricky one, but just to summarize what we've been hearing, so I would say the conditions I've heard are NQF review of this update, that CMS consider which version of this measure to require at a given time and to consider a phased approach to not require three versions of the same measure in the same program and for strong consideration that from the patient perspective, mortality is not the most meaningful outcome and to consider moving towards measures that would address

patient goals and quality of life.

MEMBER FOSTER: So, while CMS will certainly have to consider that, I was hoping we were also going to hear that the NQF Steering Committee would be asked to review all -- two or three of the measures, how many CMS really wants to advance simultaneously to make recommendations about whether the juice is worth the squeeze, to borrow a phrase from this morning.

MS. O'ROURKE: I think that makes sense that the three would be submitted and reviewed together.

CO-CHAIR WALTERS: Doing it too, measure number three on your list.

MR. TILLY: The polling is now open for Hybrid 30-Day Risk Standardized Acute Ischemic Stroke Mortality Measure with Claims and Clinical Electronic Health Record Risk Adjustment Variables, MUC 15-1135.

The options are support, conditional support and do not support.

So, the results are 17 percent

support, 54 percent conditional support, 29 percent do not support.

The verdict is conditional support.

CO-CHAIR WALTERS: And now, number four. Conditions, sorry.

MS. O'ROURKE: I just wanted to confirm that the committee would have the same conditions for this measure as the previous.

CO-CHAIR WALTERS: Okay. The fourth measure on your list, the third of this group.

MR. TILLY: Okay, the polling is now open for Hybrid 30-Day Risk Standardized of Acute Ischemic Stroke Mortality Measure with Electronic Health Record Extracted and Risk Adjustment Variables, MUC 15-1033.

Okay, and the results are 8 percent support, 36 percent conditional support, 56 percent do not support.

So the verdict is do not support.

CO-CHAIR WALTERS: So, if anybody who voted do not support would like to clarify why they voted do not support for this one

specifically and may have voted either support or conditional support for the other two. You know, well, that's the only way I can word it, I mean, you know. I don't see any takers on that.

MR. AMIN: Ron, it seems like maybe that it might be related to Suzannah's comment about the one that performed the most was the hybrid or performed the best might have been the hybrid measure and so, focusing there might not be the best place.

CO-CHAIR WALTERS: So, happy for feedback on that without identifying the --

MR. AMIN: Is that a fair feedback on why it was do not support?

CO-CHAIR WALTERS: So, I hope that gave you your direction and guidance.

MEMBER FOSTER: I know this is supposed to be part of the NQF process anyway, but if you -- when this comes up to the NQF Steering Committee for review, if you could make sure to include the comments that Sean and Mitch and others made about concern that this is

perhaps not the right thing to be looking at, it would be I think a useful thing for them to probe on.

MS. O'ROURKE: Absolutely. Just to step back for a second, we are continually developing the processes and trying to improve them of how we feed feedback from the MAP to the Standing Committees and from the Standing Committees to the MAP. So, we are working to make sure that everything you say goes along with these measures when they come along for endorsement review. So, staff will be -- not everything -- a summary of the most salient points.

CO-CHAIR WALTERS: Greg?

DR. ALEXANDER: Thank you.

So, there -- so I came here from the NQF Health Information Technology and Patient Safety Panel that reviewed and made recommendations for measures about EHR at patient safety.

And, I kept that in mind as I was

thinking about this and I think it would be good for NQF as they review these measures to think about those measures in that panel that are now being commented on as recommended measures because they will affect, you know, some underlying assumptions made about EHRs in this measure.

CO-CHAIR WALTERS: Okay. We now move to measure one in Calendar 3 which only has one version of it, that's the good news, which is the excess days hospitalization for pneumonia.

It was pulled by Nancy Foster and Andrea. Nancy, would you like to go first?

MEMBER FOSTER: Okay. We're actually fairly concerned about this measure and would recommend do not support for it.

One, because of the need to look at SDS for this. We believe that this would be exclusively sensitive to the lack of other resources in the community for care as patients come back to the hospital if they have no other source of care and think that that needs to be

carefully looked at.

And, you know, this measure in large part should be duplicative of the existing hospital readmission measure.

So, I wonder if we really need to have this additional focus on the same issue.

So, those were our major comments.

CO-CHAIR WALTERS: Thank you.

Andrea?

MEMBER BENIN: I would agree with Nancy's comments around the readmission. You know, the readmissions are a portion of this and the duplicative aspect of it.

The other piece of this for me is that there are, I guess, last time around, there are a couple of other excess days metrics that are going to start to play out I think in '18 -- of fiscal '18, the other two metrics.

And, to my mind, I think understanding how those metrics perform and how they play in this space is important before adding in new ones. I think that adding in the new ones seems

to be before we're really added in the other ones it seems a little bit in advance of things.

And so, understanding how the other ones I think it's DMI and heart failure it looks like, seeing how those actually play out once they come into play is relevant for understanding how these metrics really work.

MS. O'ROURKE: And, I did want to clarify for the committee, MAP has reviewed this measure previously. This is another one where the cohort is being changed to include aspiration pneumonia and sepsis. So, just to focus on that this is another update for the pneumonia cohort and we've reviewed this measure previously.

MEMBER BENIN: What did we say previously?

MS. O'ROURKE: I believe we conditionally supported it pending NQF endorsement.

CO-CHAIR WALTERS: Lead discussant, Greg?

DR. ALEXANDER: The only comment that

I have on this was that the three categories that are going into the calculation of this measure including PD treatment and release visits, observation stays and readmissions are all pretty distinct measures and observation stays are a little bit of an ambiguous kind of a measure.

And so, I don't know that I felt comfortable with how this complete operationalized.

CO-CHAIR WALTERS: And, Heather?

MEMBER LEWIS: I have nothing to add to the previous comments.

CO-CHAIR WALTERS: And Dolores?

MS. MITCHELL: I'm about to give another one of my pious sermons.

But, I do so not with the expectation that it will affect or should affect how anybody votes on this, but again, one of those concerns that I think tie us into knots sometimes over some of these issues.

I have been supportive and am supportive of the responsibility of hospitals,

particularly as they grow into larger delivery system organizations where I think there is an ongoing responsibility for what happens to the patient not just inside the walls of the hospital.

Nevertheless, I think it's not quite fair to the hospitals to assume that they are responsibility for picking up the societal burdens that create those conditions in which socio-demographic criteria are involved and should be considered in some cases.

But, I think you don't want a hospital responsibility creep and that's what I see happening. To go without thinking about, well, wait a minute, what are the other alternatives and who's responsibility is it to deal with those other alternatives?

I don't think that one can expect hospitals to be in charge of solving poverty, war and injustice. Those are our responsibilities as citizens.

And, without sounding, you know,

without making the hospital -- I'm looking at you for obvious reasons -- for once I'm on your side.

So, again, as an organization which isn't just bean counters and has a social agenda, I think we need to sort of start suggesting other alternatives.

And that gets us into tough territory because you may be talking about how we spend our tax dollars and how decides.

Nevertheless, I don't think we ought to be guilty of saying that everything is the responsibility of the hospital because, at some point, not only is it probably not fair, but it's also outside of their area of expertise. They are not social workers, they have some, but they are not themselves basically social workers, they are not economists who are responsible for solving economic injustice.

And, I think, you know, those are the kinds of issues that we as citizens need to be thinking about over the next decade. Otherwise, we're going to find ourselves asking the

hospitals to do things that they are neither competent to do nor equipped to do nor is it fair to ask them to do.

CO-CHAIR WALTERS: Does that take it that encompasses most of your -- of these two? Okay.

Michael?

DR. PHELAN: I think we have to look at this measure as the next iteration of a quality measure around pneumonia readmission.

So, I think this brings more clarity of what actually is happening. Are these patients showing in a outpatient setting? Are they going to an ED or are they getting admitted under observation?

So, we already have a readmission measure for pneumonia. I think this just gets it a little bit more granular and will provide data for hospitals or hospital systems to better understand what's actually happening with their patients. Are they just showing up in the ED? Are they coming back within two days and getting

readmitted to observation and then getting a full admit?

So, actually, I think this is the progress of quality measures that we've got. We have a really, you know, raw one on pneumonia readmissions. The addition of a couple extra patients as CMS has mentioned before, patient categories, the aspiration pneumonia and the sepsis one, I don't think really changes the measure in itself. It's more additive.

And, from that perspective, everyone's going to be affected equally. So, if patients have aspiration pneumonia or sepsis related to that, I have a feeling that that's going to just wash out in the end anyways.

But, I don't see it as Dolores sees it as the ills of society being put upon us. I actually just see this as a better measure for hospitals to be able utilize to try to figure out what actually is going on instead of just a raw readmission measure.

DR. SULLIVAN: Yes, I agree with

everything you just said.

So, then I have a question for CMS. If this were to happen, would you then drop the readmission or what happens? Now you have two measures or --

CO-CHAIR WALTERS: I knew you were going to have a question so that's why I held Pierre for answering -- dealing with everything. What is the strategy about excess stays and what's the answer to Ann Marie's question and anything else you can think of?

DR. YOUNG: Right, so as several folks have noted, we do have condition specific readmission measures already in the IQR program.

The idea behind -- but those only capture readmissions, but that doesn't -- is not the entire universe of acute care following a hospitalization. So, that's why the thought was to try and capture that more fully by including ED visits and ops in addition to readmissions in a single measure.

The other big difference between this

measure and the readmission measure is that the readmission measures are expressed as rates, so readmission rates.

These are actually expressed as a period of time because the thought was this would be a more patient consumable, patient friendly way to present the information about how much time they are spending in acute care after a hospitalization.

It is not intended to replace the readmission measures. We think the readmission measures provide very useful information and is intended to compliment and expand the information that's provided by that particular measure.

CO-CHAIR WALTERS: Are there any other comments or questions for CMS?

Go ahead.

MEMBER LUTZOW: Yes, I think this is a general question as to whether care transitions are really appropriately funded within the system and whether there's a real investment.

And, I know that we don't have the

right people here to answer that question, but it seems to me that more could be done here if -- in strengthening transitions if they were properly funded.

Medicare, unless you're homebound, there's no extension and reach into the home really. I know there's some experimentation about educational visits and so on, but I think this whole area of readmission prevention is not properly funded. And, we're trying to squeeze the turnip to get more blood out of it but the very structure is getting in our way.

And so, you know, as part of a review, you know, these transitions, yes, we want them to be sounder, but are we really structured to support them? And I think not.

CO-CHAIR WALTERS: Thank you for the comment.

Looking around, are we ready for a vote? Okay.

MR. TILLY: The polling is now open for Excess Days in Acute Care After

Hospitalization for Pneumonia, MUC 15-391.

The options are support, conditional support and do not support.

The results are 23 percent support, 42 percent conditional support, 35 percent do not support.

So the result is conditional support.

MS. O'ROURKE: So, for this one, I would say the conditions we heard are NQF review and endorsement as well as a particular attention to socio-demographic factors in the risk adjustment model and being cognizant that measures like this test what really is the role of the hospital and to be cognizant of what is a hospital problem and what is society's problem. I'll find a more elegant way to say that for the report, Dolores.

DR. SULLIVAN: And, can we also maybe also recommend that there be some thought given to having one measure even if they are looking at different things? It's like piling measure upon measure I think is a problem and we talked about

parsimony, so maybe put that in, too, that perhaps there should be some thought about not just adding this one on top of the previous one.

That's all.

CO-CHAIR WALTERS: All right, are you teed up? Is she going to make her presentation now? This is from the 1140, yes, the measure concepts. Right. It was on the --

MS. O'ROURKE: So, if none one pulled the measure, we do not have to --

CO-CHAIR WALTERS: That's why I asked again before we started that whether anybody wanted to pull that. You did? Oh, it went by all of us.

Hold that presentation a second.

Okay. It went right by us.

All right, the PSA, the composite patient safety measure. Leslie, why would you --

MEMBER SCHULTZ: I just want to softly disagree with the staff recommendation and take it down a level to conditional.

The reason I do that is we strongly

encourage and support the changes in the recently endorsed version which is a vastly improved measure, to be sure.

But, version 6.0 has not been out. It hasn't been used nationally yet. So, our recommendation would be rather that the current measure be replaced with this new version 6.0 in the IQR program and only then after we gain experience with this brand new measure, essentially, should the measure then be moved into other programs such as VBP and the hack reduction program.

CO-CHAIR WALTERS: Thank you.

Greg?

DR. ALEXANDER: I have nothing to add.

CO-CHAIR WALTERS: Heather?

MEMBER LEWIS: Nothing to add.

CO-CHAIR WALTERS: Comment?

Mitchell?

DR. LEVY: But, it sounds like you're not pulling the measure off of IQR.

MS. O'ROURKE: So, can I just clarify?

So, this would be for IQR, that could be a condition that you could use because it's also for VBP and Hacks. So, for IQR, it would go into RQR the form, the most recent form, correct.

MEMBER SCHULTZ: And the most currently endorsed version 6.0, yes, that that be in IQR and then -- so it replace the current version.

MS. O'ROURKE: Right. So, the condition would be for a different program. So, right now, you are in agreement of the staff's recommendation which is full support for IQR?

MEMBER SCHULTZ: For IQR version 6.

MS. O'ROURKE: Yes.

CO-CHAIR WALTERS: Vote?

UNKNOWN PARTICIPANT: So, if everybody's okay with it, we can leave it on the Consent Calendar if we all agree with that.

CO-CHAIR WALTERS: For the --

UNKNOWN PARTICIPANT: I guess Leslie rescinds her pull for IQR and we'll discuss the conditions when we get to this for VBPN and Hack

RV.

CO-CHAIR WALTERS: Okay. Good. Now, we can tee up for a presentation?

MS. LEMONS: Okay, so the purpose -- I'm Tara Lemons, sorry, with CMS one of the measure leads.

And so, I'm here today to just give you a little bit of -- some background information on the episode-based payment measure concepts under consideration for the hospital value-based purchasing program which we are about to embark upon.

The clinical episode-based payment measures are designed to assess the resources used for clinically related services provided in the treatment of an episode of care.

These types of measures allows for meaningful comparisons between providers based on resource use and certain clinical conditions or procedures.

The principle goal of episode cost reporting is to encourage efficient patterns of

care. This creates identified opportunities for care coordination and improved health care affordability.

The Affordable Care Act requires measures adopted into the hospital value-based purchasing program to include efficiency measures. And, currently, MSPB or the Medicare Spending Per Beneficiary Measure is the only cost measure in the program.

CMS is considering the role of additional cross measures for the value-based purchasing program, so we, therefore, would appreciate the MAPs careful consideration of various episode-based payment measures.

And so, the next slide, what we provided for you is a chart for you to review some of the episode-based payment measures that will be discussed and some of the complimentary quality measures that are in the value-based purchasing program or another hospital quality program.

And then, we also have measures to ---

and we can speak more directly to some of the questions.

MR. AMIN: Can I ask a quick question? I think Wei mentioned a bit earlier when we were talking about the episode payer measures, if the CMS and the measure developer can just clarify whether these are as a result of an episode grouper or they're just designed as episode-based cost of care measures?

MEMBER HATLIE: I couldn't hear the question.

MS. O'ROURKE: So, I can try to paraphrase for Taroon.

If CMS could clarify if these measures are the result of an episode grouper or they're episode-based cost measures?

MS. SPALDING BUSH: Thanks.

Kim Spalding Bush from CMS.

So, these are episode-based cost measures. I think the distinction really with the terminology about episode grouper is generally that those are episode-based cost

measures that are developed on the physician side.

But it's a really similar construct here where we're looking at clinically related services when we define an episode as opposed to one that is more of an all cost during a given window after a condition or procedure.

MS. O'ROURKE: So, hearing no further questions, at this time I can just begin by giving you a brief overview of the hospital value-based purchasing program.

This is a pay-for-performance program. Medicare bases a portion of hospital reimbursement on performance through the VBP program. Medicare began withholding a portion of its regular hospital reimbursements to form a pool of VBP incentive payments. These are increasing over time.

So, for fiscal year 2016, it's 1.75 percent. For fiscal year 2017 and the future, it will be 2 percent.

Hospitals have a chance to either earn

a penalty or a reward through this program. So, to be clear, that it's not a strict reward program that you might not earn back what you put in to fund the payment program.

And hospitals are scored on their performance relative either to each other or to their performance over time. So, there is a component for improvement.

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

CO-CHAIR TRAVIS: Okay, well thank you.

Since we're entering into a new program, we will, operator, like to open up the lines for public comment.

And, I would first like to see if there are any public comments in the room?

PARTICIPANT: Thanks for the opportunity to comment again.

At this time, on the slate of measures that you have in front of you for the VBP program, this particular comment doesn't relate to any of the measures on the list, but it's a concern that's been on the minds of our members very much over the past couple of years.

And, that relates to the pain management questions that are a part of the HCAHPS survey that constitutes part of hospital score on VBP.

And, just to be specific about what I'm talking about, there are three questions that get at pain management that ask whether patients receive medicine for pain, whether they felt their pain was well controlled during hospitalization and whether hospitals did all they could to control pain during the hospitalization.

In raising the concern about this, I want to be very clear that the AHA has been and will remain a strong supporter of the HCAHPS survey and of assessing hospitals on whether they

are adequately controlling the pain of patients.

That being said, there have been important questions that have been raised in the past couple of years about the interplay of these pain management questions and the increasing epidemic of prescription opioid abuse in this country.

And, just to underscore just how big a problem this is becoming nationally, the rate of drug poisoning deaths related to opioids quadrupled between 1999 and 2013. There were -- the CDC estimates that 44 people die each year as a result of opioid overdoses.

So, where does the HCAHPS fit in here?

Our members have communicated to us that the questions included on the HCAHPS measure, and in particular, the question that asks whether hospitals are doing all they can to manage pain may create some unintentional but potential pressures to prescribe opioids.

And, since opioids do carry just by dint of what they are, the potential risk for

abuse, we are concerned about whether these questions are creating these kinds of incentives.

We think responding to the opioid abuse epidemic really does require a holistic approach that involves patients, that involves all stakeholders that have a hand in all of this.

And, we also know that there are patients that benefit enormously through the use of opioid pain relievers and we want them to continue to be able to do so.

But, we also think that given the severity of the epidemic, that it would be wise to examine those questions and see whether they need to be recrafted and to assess the potential unintended consequences of it.

And so, we would encourage you to think about making a recommendation to the CMS about reexamining these pain management questions in the HCAHPS survey, and while that happens, to consider suspending the use of the pain management questions from scoring hospitals in the VBP.

Thank you.

CO-CHAIR TRAVIS: Okay, thank you. Thank you very much.

And, just to kind of remind those who are making public comments, we appreciate all comments, but given the agenda that we have today, we really need to focus the public comments on the measures that are before us to make a decision today.

There are other opportunities for public comment around some of these issues such as this and it is an important issue, but we need to be able to get through these particular --

We will have opportunity for public comment, a global public comment at the end of the day today and at the end of the day tomorrow.

So, thank you for that and we appreciate that thought process but if the others can think about trying to keep your comments to the measures under consideration for today, that will help us get through it.

So, operator, would you please see if

there are any public comments under the measures -- for the measures under consideration for value-based purchasing program that are on the line?

OPERATOR: Yes, ma'am.

At this time, if you would like to make a comment, please press star then the number one.

There are no comments at this time.

CO-CHAIR TRAVIS: Thank you, operator.

Okay, so we are going to go to our first Consent Calendar which, as you will see has four measures in it, all of which have been pulled for discussion, so we no longer have a Consent Calendar to approve.

They all are dealing with hospital level risk standardized 30-day episode of care payment measures.

One is for pneumonia, one AMI, one heart failure and one for primary elective total hip or total knee arthroplasty.

This reminds me a little bit of our

previous conversation where we tried to group our thoughts into looking at the approach or the payment model first and then addressing any of the particular condition specific issues after we've had that broader conversation.

I'm sure that that will probably work out pretty well because Shelley is the one that pulled all four of these measures.

So, if we, Shelley, can talk first about pulling them from the payment methodology approach and then later on if you have any clinical specific issues, we can bring those up when we get to the second part.

MEMBER FULD NASSO: Great, and I don't have -- they're not clinically based, it's more of the principle of, you know, I just wanted to have a little bit more discussion about the rationale for pulling these because it would be, I guess, double-dinging.

And, you know, I think some of these are really important in terms of, I guess my question is, for discussion is, is there a value

in really important measures in pulling them out in addition to having them as part of these other measures.

And, obviously, the staff recommended that you to not support them, but I think that there is some value to having them reported separately and included separately in the measure in addition to as part of the more composite measures.

CO-CHAIR TRAVIS: Thank you.

And, just to clarify, to be sure I'm on the same page as you. Is part of your discussion around the fact that the staff indicated that it overlapped with the current Medicare spending per beneficiary --

MEMBER FULD NASSO: Right.

CO-CHAIR TRAVIS: -- measure? Okay, I just wanted to be sure in my own thinking.

So, thank you for that, Shelley.

So, we're now going to go to our lead discussants.

David Engler?

MEMBER ENGLER: Thank you.

So, Marty and I drew the discussant straw here. And, you know, when we started looking at the measures themselves, there are now four suggested measures to be added to the one existing measure that's already out there on Medicare beneficiaries spend.

So, there are four additional measures to be added to this particular domain. The domain in this value-based purchasing category has 25 percent weight. So, it's significant.

I would also note for the committee that three out of the four measures are diagnosis-based. Okay? So, we're accumulating costs across the episode of care for 30 days from admission to 30 days later.

So, there is a cost accumulation that's done in the calculation on it.

I would also draw the committee's attention to the fact that there is the overlap between the current one measure that's in there which gave us some pause and we agree with

staff's assessment that that can cause a double, triple or quadruple dinging effect if we were to add these additional four measures to value-based purchasing.

I will agree strongly with Dolores that the issue now and there was just a great study that was just featured in yesterday's New York Times, that the issue is really about price, much more so than particular cost or payment, at least in the non-Medicare population.

The study showed that their analysis which features very specifically on Medicare data may not always lead to the right result. But, as we do have markets out there that are dominated predominantly by large hospitals and large systems that have prices that will throw off the average price considering in comparison to what Medicare is showing on their data.

So, I just want to add that additional feature because that's a brand new study that was just released yesterday.

So, for both Marty and myself as

discussants, we agree with the staff's nonsupport for these metrics given the fact that it overlaps with the existing measure and given the fact that since they are diagnosis-based, they don't add any additional to the equation and may, in fact, wind up penalizing hospitals even further double and triple penalizing them because of the cost variation.

And, one other fact is that historically, I think this committee has looked at this metric before and has said that we should not over extend or add additional measures to this one particular cost measure.

Thanks.

CO-CHAIR TRAVIS: Marty, do you have any additional comments?

MEMBER HATLIE: Yes, I'm actually torn about this measure. I do certainly agree with David that I'm worried about double dinging. I mean if this -- for a reporting program, it's fairly easy for me to weigh in because I'm in favor of more, faster, in general.

Here, I am worried about the impacts on hospitals, especially the hospitals that David's organization represents. I mean, I live in Chicago. Hospitals there have not been reimbursed for Medicaid since June. And there are 600 hospitals that are just running on fumes. So, I really get that.

The question here, I also know that this is a major transformation vector for Obama Care, for the Affordable Care Act. And, I want to support the program, but I am concerned about the double dinging that David mentioned as, you know, maybe not being necessary if it's already an incentive for hospitals to be paying attention to these issues. Do we really need another set of incentives?

So, that's where I am. I'm really interested in hearing discussion from others here because I don't really know how I'm going to vote yet.

Thank you.

CO-CHAIR TRAVIS: Okay. So, this is

when we open it up to the full committee. Any comments or questions?

Pierre?

DR. YOUNG: Thank you.

I just want to -- just teeing off of what Tara presented earlier, we would also like to hear the MAP's input. And, I think it's -- there's a grouping -- two groupings of resource use measures under consideration with this calendar and the second one.

One of the distinctions between them is this particular set, they do have accompanying quality measures. And so, that's, you know, an issue that came up earlier in the discussions of resource use measures for IQR.

So, we were also wanted to hear the committee's feedback about, you know, if we were to implement additional resource use measure into the program, what kinds of resource use measures would be appropriate?

Thank you.

CO-CHAIR TRAVIS: Okay, thank you.

Nancy?

MEMBER FOSTER: So, sorry, Pierre, I'm not going to get at your specific questions, but I have to say that it makes me nervous to think about endorsing measures for use in a value-based purchasing program before we've seen them in real life in the IQR program.

That, in fact, I believe, in part because I was part of the conversations, that when Congress passed that two-step process, they really meant for people to take a look at the function of the measure when it got into the IQR program, understand whether there were unintended consequences as there can be from some measures, understand whether there is an SDS -- a need for an SDS adjustment or other kinds of things before putting them into a program that tied measures to money.

Which, you know, one can argue that the money is not that much and, in some -- most hospitals the VBP money isn't really moving a whole lot around.

But, it's this notion that the government is saying, we really, really want you to focus on this one or this aspect of care because we've included it in a payment measure or a payment program.

So, I think we really need to think about that as we bring measures to the MAP for inclusion in a value-based purchasing program that we really do need at least some experience with it before this group can effectively comment on whether it should be included or not.

CO-CHAIR TRAVIS: Pierre, can you clarify that for me because on prior years, serving on this work group, I guess I had interpreted it that it did need to be in IQR before it comes into value-based purchasing. So, can you clarify that, please?

DR. YOUNG: Sure, and that's correct, Cristie.

So, for HVBP, hospital value-based purchasing programs, specifically, we have a statutory requirement that the measure be

publicly reported in Hospital Compare for at least a year so meaning it's in the IQR program before it gets implemented into the HVBP program.

CO-CHAIR TRAVIS: So, are these measures already lined up to go into IQR?

DR. YOUNG: So, right. So, these measures are in IQR already.

CO-CHAIR TRAVIS: Okay. So, they are already and have they been publicly reported or do you know? And they have been publicly reported?

And, is there some response to Nancy's concern over how these measures have performed since they are in IQR and have been publicly reported? Do you have experience with these measures in terms of their performance and what you're learning from that and as to how then it would fit into the value-based purchasing program?

PARTICIPANT: Well, I was just going to comment that this measure is -- has been -- is on Hospital Compare, has been reported on. It's

on the list for the updated cohort.

So, I'm not sure if your question is, Nancy, that you want them to go back through IQR before they come to VBP with the updated cohort?

CO-CHAIR TRAVIS: Okay, thank you.

I get it now, maybe.

MEMBER FOSTER: And, when we get to the second set, we can talk about whether they every publicly appeared or not.

CO-CHAIR TRAVIS: Okay. So, in my own mind, we were thinking about all of these measures at once. When you say this measure, you're talking about pneumonia, correct?

MEMBER FOSTER: Right, sorry.

CO-CHAIR TRAVIS: Okay, okay, I just wanted to be on the right page.

MEMBER FOSTER: Well, actually heart failure, AMI are also reported on the Hospital Compare.

CO-CHAIR TRAVIS: Okay, so all three are currently reported to the point that we know like on pneumonia that we're looking at a

different version of that measure. It's not the new version that's out there. I would assume it's the existing version. Okay.

MS. HAYDEN: Hi, this is Megan.

So, the version that is under review is the updated cohort for the pneumonia payment.

And, just to add on to what my colleagues are stating, the pneumonia, AMI and heart failure payment measures are already reported on Hospital Compare on last year's rule that went out, you were -- you could have seen the GI and urinary tract infection payment measures as well as the THA and TKA were just adopted.

So, these have not been publicly reported as of yet, but they will be in the near future.

So, I hope that just provides a little bit more clarification and I'm happy to answer any more questions that you have.

CO-CHAIR TRAVIS: Thank you.

That helped me. I hope it helped

others.

Wei?

MEMBER YING: One comment on the cost measure. I just actually, the comment on the resource use measure, there are other measures out there that basically take out the price as a factor, basically standardize the price and it becomes a sort of a utilization versus outcome ratio measure.

I'm just curious, for CMS when they develop -- when they think about resource use and knowing the price is a factor in the total cost, can they instead of bring the unit price into the picture, but actually, you're just looking at the frequency of the utilization and then pair it with the outcome. That becomes more fair and more reasonable for hospitals to look at. So that's one comment.

And the other is, in the commercial market, there is a quest for us and for consumers to see is the condition specific or procedure specific cost because they, as consumer, they

have the copay. They have the deductible. So, they have to make these decisions. They can make these decisions based on this information.

So, it becomes the transparency becomes true for consumers to make these educated selections in their where or what type of care they should be given.

I'm just wondering for these type of measures, from CMS point of view, you put it on the public reporting. If a consumer looks at it and they don't have those pressures under the copay type of arrangement, what is tell the consumers? What's the value of there for public reporting?

CO-CHAIR TRAVIS: We'd be glad to hear any comments that CMS wants to make.

This particular, and just to kind of reorient myself here, but this particular calendar is for the payment, is for hospital value-based purchasing program.

So, it is in a payment program our consideration of this at this point. These

measures are already in IQR at different levels of having been publicly reported. But, they are in IQR.

So, you know, certainly, we might want to come back to that kind of question about the value for IQR. But, they're already in that.

So, just kind of focusing on the fact that now we're thinking about should they go into the payment program.

Mitchell?

DR. LEVY: I'm going to ask another question. So, it would help, if you're looking for the committee to support the move from IQR into VBP, it would be helpful to know what are the data that should drive that move?

First of all, what do you -- what data do you use to want to move it into VBP? And, is it a bell curve? What are you seeing so that we would have a sense of is it a valid -- has it proved to be a valid measure and, therefore, we would support it being in VBP?

I don't know if that's a clear --

CO-CHAIR TRAVIS: Pierre?

DR. YOUNG: So, thank you for the questions.

So, I think when it comes to, this sort of references back to, I think, Nancy's question when we first opened thinking about, you know, what measures are appropriate for any particular program. I know those are made on a program by program basis.

The way we look at HVBP, we certainly don't put every measure that's in IQR into HVBP. That would not be appropriate as there are like 70 measures in IQR.

But, we want as parsimonious a set of measures as possible in HVBP that reflect the priorities that we have identified as we discussed before including patient safety, resource use, clinical care and care coordination. And that fit within the national quality strategy.

We do look at -- want to use measures that we believe add value to the program as a

payment program that stimulates additional quality improvement by providers. Meaning that there is variation in care or variation in the quality of the providers in that measure, that we believe that there are no significant unintended consequences from using that measure.

But, that being said, you know, new information emerges as we gain more experience with the measure in a program. And, we certainly are receptive and are always looking for feedback as those experience and feedback on those measures that we use in our programs emerge.

In terms of the question about sort of assessing utilization versus price or cost, I mean I think that's -- we appreciate that feedback. Certainly, there is a statutory requirement which for a resource use measure in hospital value-based purchasing, so that's why we have the MSPB measure currently in the program.

But, it is definitely an interesting thought to sort of take out the price and really focus on the utilization.

I think there is this bigger question that I think many folks are struggling with which is how you assess value in health care which is a difficult question to struggle with. And, I don't know that anybody -- any single person has the -- has figured that out yet but certainly there is this sort of idea of quality and price/cost and perhaps sort of outcomes as well in how you sort of factor all of those in in sort of assessing value.

But, those are, right now, the measures we have for utilization look at resource use in terms of cost but also we have utilizations such as, you know, readmissions and other types and other measures.

CO-CHAIR TRAVIS: David, is your card still up?

MEMBER ENGLER: Yes, thank you.

So, I would strongly suggest, and I'd love the opportunity to engage in the conversation about looking further into price in particular. So, I'm really heartened to hear

that CMS is interested in looking at that as well.

The issue of the overlap between these four measures relative to the existing measure continues to sort of plague me. And, I think it historically when it was brought up before in front of MAP, there was this issue of if you are double-dipping that we were responding to, and perhaps the staff is responding to as well.

So, I wonder if you could give us a little bit more clarity if you've looked at -- I'm sure you have -- if you've looked at this, given that you have AMI, heart failure and pneumonia as three of the highest volume drivers in Medicare payment, given that you have those three in these separate measures, are we really going to be picking up more cost variants or are we truly duplicating?

So, I guess I'm trying to get to whether or not you can validate the assumption that at least this person here is operating under that there is a lot of duplication and potential

multiple penalties because of adding these additional measures to VBP?

Thank you.

CO-CHAIR TRAVIS: Any response, Pierre?

DR. YOUNG: I mean, we have heard from stakeholders before about desire for -- and I think there are people on both sides, I think we've heard that there are concerns about overlap as we've discussed here.

We've also heard a desire for additional sort of granularity that we find a little more condition-specific procedure, specific measures.

So, that's why we wanted to bring this forward and wanted to get that input from the group.

CO-CHAIR TRAVIS: Okay, Ron?

CO-CHAIR WALTERS: Just trying to make sure I have my facts straight here.

So, the first three measures are endorsed and have been in IQR and they're coming

up for value-based purchasing. Okay, I think that I get.

Then, knee one, the knee and hip one, is scheduled to go in IQR, has never been endorsed, never submitted for endorsement and was submitted for value-based purchasing. That's what I'm looking at here.

And, I mean I didn't think that was the way it was supposed to go.

Now, I understand you have a knee and hip program now, so it'd be darn nice to have an endorsed measure that goes with that. But, it seems to me that, again, for statutory purposes, they should go through IQR -- they should be endorsed, they should go through IQR then, after being in IQR should go to value-based purchasing.

And, yet, the knee and hip one is already slated for -- it says for IQR for 2018's measure set.

Could you explain some of that?

MS. HAYDEN: Hi, Ron, Megan Hayden here.

So, we would, of course, follow the statute and understand that the measure is not being moved into VBP until it's publicly been -- it's been publicly reported on Hospital Compare for one year. We would definitely follow that.

This is just a request for MAP to weigh in on the measure concept for HVBP and that would be the purpose.

And, it is -- and Suzannah can correct me if I'm wrong, but it is slated for interest submittal for an open project or has been submitted at this point, I'm not sure. Suzannah could probably state whether it has at this point.

But, that's just to provide a little bit more clarification.

MS. BERNHEIM: We're just waiting for a project. The measure is ready, but NQF, as efficient as they are, can't evaluate every measure all the time. So, we're just waiting for the hip and knee project to bring it forward.

CO-CHAIR TRAVIS: And, just one more

clarification for me. There is a pneumonia hospital level risk standardized 30-day episode of care payment measure in IQR, but this one that we're thinking about today, this is the one that has the updated or changed, broadened specifications to bring in the other pneumonia cases that are associated with aspiration and sepsis.

So, it's not the one we're looking at here is not the exact same one that's been on -- in IQR and on Hospital Compare. It is the same one we thought about in an earlier program for IQR.

MS. BERNHEIM: Yes.

CO-CHAIR TRAVIS: So, I do want to -- so two and three that are on here, the specs aren't changing from the IQR to value-based purchasing, but the specs are changing on one from what's currently in IQR into value-based purchasing.

So, I'm hoping that I got that right. I see a lot of nodding heads. I'm getting

affirmation from my colleagues here. But, it can be a little confusing.

And, number four has not gone through NQF endorsement at all. And, is slated for IQR in 2018.

So, do we have our facts right? Okay. I just wanted everybody to at least have the same --

MS. HAYDEN: Okay, let me see if I can answer all of your questions.

CO-CHAIR TRAVIS: Okay.

MS. HAYDEN: So, the measure that you are looking at for VBP, the pneumonia payment measure, is the updated cohort. It is the one that you just reviewed for IQR. This is the version that we would prefer to go into VBP but, of course, we understand that it would have to be publicly displayed on Hospital Compare for one year prior to that.

And then, I think the second question you're asking whether number four is slated for NQF endorsement. That is correct.

And, I apologize, was there an additional question?

CO-CHAIR TRAVIS: Just that it's also the hip and knee is -- has already been approved to go into IQR in 2018, I think it's --

MS. HAYDEN: Okay, sure. Let me also just comment on that.

So, in the rule that was published last year, we did adopt this measure for IQR. I believe this one is going to be publicly reported in July of '17, at least that was -- that is the plan at this current point in time.

So, you are correct, everything on the MUC list for VBP has been adopted for IQR and it is -- some of them are pending public reporting. Those would be the ones that were adopted in rule last year for IQR.

CO-CHAIR TRAVIS: Okay, I think we've got it.

MS. HAYDEN: And, AMI and heart failure and pneumonia have all been publicly reported on Hospital Compare already. Those are

the ones that have been and, again, that pneumonia would have been the older cohort. So, we would have had -- we will have to wait for the updated cohort to be publicly displayed.

And, I know that's all very confusing and hopefully everyone is on track now, but if not, I can repeat myself.

CO-CHAIR TRAVIS: So, but you did say something I think that was very important around the pneumonia measure is that assuming everything moves forward with the new specifications, that would be publicly reported on Hospital Compare one year, collected and reported that way under the new specs prior to moving into a value-based purchasing?

MS. HAYDEN: That is correct. And, again, that was the measure that we just reviewed so that version of the measure has not been adopted into IQR at this point. So, we would have to wait on that.

CO-CHAIR TRAVIS: Okay, thank you. That was helpful to me.

So, let me go back and see where we were.

Andrea, you were next.

MEMBER BENIN: You know, I think Mitchell brought up a good point and something that I think we have struggled with as a group over the years here with these programs.

And, I don't know whether this is a task for our group or whether it's a task for CMS, but the, you know, we don't have agreed upon principles for what necessarily moves things from one program to the next.

I mean, I think we've heard a couple of different things bantered around, right? Mitchell says, well, the distribution of the data or we have, you know, understanding what the IQR performance looks like for a year or we have, you know, not double-dipping as principles that any one of us might adhere to.

But, we don't have an overarching, you know, comprehensive mental model that we all share about how to think about these things.

And, I think that that presents itself with some struggle.

And so, some kind of a framework that says, you know, this is our mental model for what moves things from one program to the other would make this feel a little more cohesive and a little like every time we do this, it's like this scattershot thing and then kind of you just vote because you got tired.

And, I think that there's -- and I think we do this like kind of year after year and these things move from one program to another without any sense of rhyme or reason. Perhaps there is rhyme or reason, but I'm sure CMS spends a lot more time thinking about it than we do.

But so, I have, as part of that comment, I would also say that, in my mind, it being in IQR for a year and so people to understand it, should be more than just it's on IQR for a year, check the box, move it to VBP.

The concept behind that, for me, would be that it's on IQR for a year so we could review

it. So, I ask that there's a little bit of time so that you could -- we would make this decision informed by being on IQR for a year, that seems to me the spirit of that concept, not like let's just check the box and move it through, because you know, we can just fill out a spreadsheet up to 2021 at this point.

And, so, I just think that a little bit of attention to thinking about a more comprehensive mental model would make this process feel more satisfying and potentially build a better product.

And, I don't know whether that information really comes from CMS, comes from NQF, comes from us as a committee, I don't know how we think about these things.

CO-CHAIR TRAVIS: Mitch?

DR. LEVY: It's kind of a natural follow up to Andrea's question. Can you help me understand how -- so, some of these measures are already in IQR, some of them are about to go into IQR. And, yet, you're asking for all of them,

for us to support going to VBP. And, yet, and you don't do that with all the measures.

So, I feel it's the same question, like some of them you're looking for the go ahead in IQR and go to VBP. And some of them are already in IQR but we're not reporting it.

So, I just would like a little more insight into how are you -- what's driving your request, all of them at once, to go into VBP as opposed to waiting until they've been in IQR and you have a sense of it and then making the request?

DR. YOUNG: Right, so in terms of implementation, we would not be able to implement a measure into HVBP until it had been publicly reported for a year in IQR.

But, I think what I hear from the comments from the MAP is suggestion to CMS that, you know, we bring forward measures for IQR and then wait until if we want to consider them for HVBP to bring them back at a later point once they've been publicly reported. That's what I've

been hearing from folks.

CO-CHAIR TRAVIS: I think you're definitely hearing that.

But, I will also -- so I want you to -- yes, I confirm that you've been hearing that.

But, I guess -- and I'll take my chair hat off for a moment -- I guess where I struggle with that, because that sounds rational to me and I understand why we would do it that way, what I struggle with is how far out in advance we have to -- you have to, actually, think about when measures will come on.

And so, if things are not publicly reported for a year until 2018 or 2019, and then we've got to take it and we've got to look at it and see whether or not it makes sense to put it into hospital -- into the value-based purchasing, I mean we are talking like 2020, 2021.

I mean I'm just -- and I think where I struggle with that is that that's a long way away from now to being able to use what I think are some pretty strong levers that CMS has to

help see improvement.

And so, you know, what I think would be helpful to me is to understand maybe it's in your backpack, this is the way I would look at it, that it's in your backpack and you can use it but that there'd be some way to say, it's not ready to be used yet, you know, or the data shows there's not as much variation as we thought there was going to be so it doesn't make any sense to come into the program.

And so, I just struggle with how long, if we do a linear approach to all of this, it just pushes it so far out that we miss lots of opportunities where there are improvement opportunities.

So, you know, trying -- if you can help me understand kind of -- and it goes back to what Andrea was saying, having a mental framework and, you know, how do things progress through this, but don't take 50 years to get where we want to go.

DR. YOUNG: So, thank you, Cristie,

because I think that is one of the issues we struggle with on the I think implementation side because of the way the HVBP program is set up, there is a scoring methodology and there are benchmarks that need to be set and met in order to earn or earn potential incentives or to -- or not incentives, but essentially, there are benchmarks which need to be set. We need to be able to provide notice of those benchmarks in advance before we actually then score those measures and count them in the performance score.

But, when you play that out, that does put us out to 2021 even though, you know, we're now in 2015.

But, Megan, do you have any additional details that you want to share about sort of the time line issues that we face?

MS. HAYDEN: No, I mean I think care really has captured it and we do have to, of course, propose a good ways out.

And, your input does provide us with that ability to plan and to, you know, factor in

all the time lines that we work with.

So, that is why we have requested this input early in and that is helpful to us. I mean I think that also requesting you to look at, you know, multiple payment measures at the same time is really trying to get your input on, you know, if you like a particular type of measure or not, it just it does help us moving forward with the program and for planning purposes.

So, that is kind of why we are asking it even though we know that some of these measures have not been displayed on Hospital Compare, we're just trying to provide you with an overall picture of the measures that, you know, could be potentially put into the program.

And so, having that input with a whole picture would be helpful to us.

CO-CHAIR TRAVIS: Okay.

Nancy?

MEMBER FOSTER: So, Cristie, if I can bring this back to a discussion we had in the early fall or late summer, whenever we had the

conference call.

I think Andrea's comments about having a mental model make a whole lot of sense and would be very helpful to us.

But, it also speaks to the need, I think, here to get more input up front about what should be produced that would then roll into programs. And, for me, the vital signs report from the IOM, back when it was still IOM, provides some of that direction which could be further illuminated by a group such as this with a coordinating committee of the MAP.

But, I kind of end up where, I think, some people report they are this election season, which is a really -- these are the things I get to choose from? You know, where's the really good choice?

And, so helping all of us to think through and to get input from particularly patients, consumers and other payers as well as providers, but around, you know, what is it we really want to be measuring? How do we get

there? And, you know, get us all teed up so that when things are coming to us for the IQR and then for the VBP or other programs that we understand the purpose and how it links to not only what's going on in the hospital programs, but what's going on in physician and the post-acute care and the other programs because there's this sort of coordinated purpose driven set of measurement.

And, I'll get off my soapbox.

CO-CHAIR TRAVIS: Thank you, Nancy.

Michael?

DR. PHELAN: Just, you know, piggybacking on what Cristie had said, it's getting late.

Not even a mental framework, but just a framework for taking and, you know, we're saying that some of these are good for IQR. The next step should probably be the responsibility of the MAP to say, okay, it's passed the IQR, we're going to request data from CMS. Show us what it is and why you think it's still valuable to move into VBP.

I think we do a disservice by kind of piggybacking on all these things hoping, you know, well, if it's good for the IQR for a year then it's just fine.

So, I think having that idea from NQF at least and the people in NQF to say, hey, we submitted this for an IQR, we really shouldn't be piggybacking on it three years from now, we should really be looking at that data. And, it may not be this group, you know, it may be new members, but people should say, oh, they submitted that for the IQR back in 2015, oh, it was a good idea. Well, what does the data show? And is it valuable data? Does it make sense to put in the value-based purchasing not just to be this kind of follows down a path of, you know, least resistance so to speak?

CO-CHAIR TRAVIS: Thank you.

Marty?

MEMBER HATLIE: I mean, I saw a rhyme or reason to these four measures. I mean they all -- I think they were high prevalence, the

measures seemed really well developed.

I mean, I think there is something to a plan there. But, again, if we don't have it, if there's not a roadmap or something that we can see, then I think we get into the situation that you mentioned, Cristie, and that is just kicking this down the road for years and years and years and we don't want that.

So, I think a plan, a map, a framework, something like that would be really helpful to be moving things like this forward.

CO-CHAIR TRAVIS: Brock?

MR. SLABACH: Well, I think that clearly the MAP has some previous conversations advocating keeping the parsimonious set of measures for the VBP program.

And, to that end, I'm wondering why we couldn't consider a family of measures around this type with a composite being that the top line and then the dropping down to the various disease specific points.

And then, have it one measure but with

three or four different roll ups into that one measure? Because then it's not double-dinging or triple or quadruple-dinging hospitals, number one.

And, number two, it gives me, as a manager of a hospital, an understanding better about what the problems are that I'm addressing in my facility and where I can make improvement.

And so, I think that kind of ingenuity I think is what I would like to see applied to these kinds of measures.

CO-CHAIR TRAVIS: I'm trying to remember, I think there's a readmission measure that kind of does it that way where you actually can see -- it's the all cause, actually. I think you can actually see down at the clinical level so that it's actionable for the hospitals but it's a build-up measure.

So, thank you for your thoughts on that.

Taking off my chair hat and asking one other question to the data point which actually

we have addressed that in prior MAPs where we've wondered if things were topped out, whether there is variation.

In other words, if all these were to move into the program, would it really help the program from that perspective?

And, I think you alluded to this earlier, but for any of these four measures, is there data such that we realize there is an opportunity for improvement?

In other words, there's a gap in the performance and that there is a performance variation across facilities that would make it something we would want to incentivize improvement around?

I mean, if every is already performing at the top of their game, it's not really, from my person perspective, appropriate for this type of a program because we want to incentivize improvement.

So, I don't know if you all know that data or the results. I think you alluded to it

earlier, but if you do, if you could share that with us, I think it would be helpful.

DR. YOUNG: So, that's a great question and certainly it's something that we look at not only when we develop measures, but also when we consider potentially implementing them, what is the opportunity for improvement?

It's also, you know, one of the things that the CDP process looks at, too, when they consider endorsement.

And so, the measures -- three of these measures have already been through endorsement, so that have been through that scrutiny and we're waiting for another -- the project to open to submit the hip and knee, so it will get that scrutiny, too.

But so, we believe that there is opportunity. There is variation and opportunity for improvement.

CO-CHAIR TRAVIS: I do think it would be helpful if we start making a list of things that next year would be helpful would be to bring

the data.

And, we've done that a couple of times in the past, but I do think that, especially when we get into these programs, we want -- I mean marrying the right measure with the right program is critical if you want to have the desired result of improvement.

So, just maybe file that away in your head that it might be helpful to have some of that data next time.

Okay, I don't --

MS. O'ROURKE: Cristie?

CO-CHAIR TRAVIS: Yes?

MS. O'ROURKE: Can I just clarify, there is data here. If you go into the preliminary analysis, you can look at a high value measure. They do provide the range on the episode of care and it ranges from 12,000 to 37,000 and they provide the mean, and they do it for all of the measures.

CO-CHAIR TRAVIS: Well, thank you very much. Another way for us to remember that we

need to use all of the resources that are at our fingertips.

So, maybe while I'm trying to get us to a vote, you all can be taking a look. And, you get to that off of the electronic guide direct.

Okay, thank you, thank you for that.

Okay, I don't see any other cards up. So, before we go to a vote, though, we did indicate that if there were any clinical specific comments or questions that people had that we would give you an opportunity to bring those up as well.

So, does anybody have anything specific for pneumonia, AMI, heart failure or hip and knee?

Okay, well, seeing none, then I think we will tee this up for a vote.

MR. TILLY: The polling is now open for Hospital Level Risk Standardized 30-Day Episode of Care Payment Measure for Pneumonia, MUC 15-378.

The options are support, conditional support and do not support.

And the results are 31 percent support, 15 percent conditional support, 54 percent do not support.

So, the verdict is do not support.

The polling is now open for Hospital Level Risk Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction, MUC 15-369.

The options are support, conditional support and do not support.

The results are 27 percent support, 15 percent conditional support, 58 percent do not support.

So, the verdict is do not support.

The polling is now open for Hospital Level Risk Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure, MUC 15-322.

The results are in, 27 percent support, 8 percent conditional support, 65

percent do not support.

So, the verdict is do not support.

The polling is now open for Hospital Level Risk Standardized Payment Associated with an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty, MUC 15-295.

MS. SHAHAB: We need two more votes please.

MR. TILLY: The votes are in, the results are 19 percent support, 12 percent conditional support, 69 percent do not support.

So, the recommendation is do not support.

CO-CHAIR WALTERS: Okay, what we're going to try to do before a short break is to get the Calendar 2 done.

There are three measures, as you can see and that they are all episode-based payment measures. So, as we have done, we'll talk about the concept in general and then we'll go into any specific clinically relevant issues.

They were all pulled by Andrea and/or

Shelley. So, Andrea, would you talk about your pulling of the three measures under Consent Calendar 2?

MEMBER BENIN: I'm just thinking, I didn't really realize -- I don't know what the staff recommendation was for these metrics.

CO-CHAIR WALTERS: Do not support.

MEMBER BENIN: Do not support, okay.

I will support the do not support. Sorry, I thought that all the Consent Calendars were all supports.

So, anyway, I will support the do not support. I feel extremely strongly that these are in IQR for 2019. We won't see the metrics until then.

There's high likelihood when I went through the details of these measure sets, we could end up penalizing places that have more severity when you look at the different, you know, the cellulitis.

When cellulitis is not cellulitis is not cellulitis, when you look at the list of

codes that are on there, it's quite a range of like, you know, two cellulitis to, you know, severe massive, really bad cellulitis.

And so, the costs are going to be very dependent on the type of cellulitis and what is going on.

And so, I did not feel at all that for any of these three metrics that it was appropriate to move them into a payment program until we had really watched them play out in a more of a just understanding of the way first.

So, that's what it was and I'm real sorry I pulled them out now that I realize the staff had already said do not support.

DR. PHELAN: Can we revisit that if the Consent Calendar is all do not support? Can we -- it's not that? Okay.

MS. O'ROURKE: Sorry, yes, for these. I thought you meant in general. Yes, with these, it's all do not support.

DR. PHELAN: No, but if it's all do not support, can we -- and none of these are

going to be pulled out, so I don't want to pulled it out and say that we --

CO-CHAIR WALTERS: It would have been nice if nobody had pulled any out.

Shelley, would you comment about your pull out?

MEMBER FULD NASSO: I pulled it for the same kind of discussion that we just had so I can -- if we can rescind our pulling it out, I would do that.

DR. PHELAN: And then, the Consent Calendar vote would be for do not support, correct?

CO-CHAIR WALTERS: You're exactly correct.

DR. PHELAN: I may save you some time here on that. I mean, unless there's someone who had one of these pulled out and wants to discuss it, just a thought.

CO-CHAIR WALTERS: The two people that have done that have withdrawn. So, does anybody -- thank you.

Does anybody else wish to pull any of these measures out of the Consent Calendar which is do not support?

Okay, I might mention, none of the measures are endorsed.

Okay, that was a very quick Consent Calendar.

Short break, I mean like five minutes. That means ten minutes, I know.

(Whereupon, the above-entitled matter went off the record at 3:30 p.m. and resumed at 3:40 p.m.)

CO-CHAIR TRAVIS: Okay. We're going to go on and get started. And now we're looking at Consent Calendar 3 for Value-Based Purchasing.

And just a couple of housekeeping items beforehand. Unfortunately LaDonna was not able to be with us. So, one of our lead discussants won't be here.

Jeff is our other lead discussant. But because we've been delayed so significantly on the time from when this was supposed to come

up, Jeff does have to step out at 4:00.

So, we're going to -- wherever we are in the process, if he hasn't had an opportunity to make his comments, we will just kind of stop and let him make his comments before we proceed.

And I'm sure you all will appreciate that. And we'll do the same for you under any similar circumstances.

So, these are three different measures. And so, we're going to take them one at a time.

And they've all been pulled from the Consent Calendar. So, they're all up for discussion and for a vote on each measure.

So, let's start out with Measure Number 1. Which is the ACS-CDC Harmonized Procedure Specific Surgical Infection Outcome Measure.

And this was pulled by Nancy. So, Nancy?

MEMBER FOSTER: Sorry, getting myself reorganized here. So, we have discussed this

measure for inclusion in the IQR Program. And I believe endorsed or approved it for inclusion in the IQR Program.

But again, we're now at a point of whether or not it should be included in value-based purchasing without us seeing the data to know how it works.

So, there were modest modifications here. But, just sort of on principle, wondered if someone could explain to me what data differences we should expect to see.

And will hospitals be able to see the results and understand how this has affected the measure they -- the measurement that they have known and loved for the last year, around this measure before it would go live if you will.

CO-CHAIR TRAVIS: Is that in the form of a question?

MEMBER FOSTER: Sorry, yes. That was in the form of a question about procedure. The second was in the form of a question about procedure, yes.

CO-CHAIR TRAVIS: Okay. Any response from CMS on that?

DR. YOUNG: Sure. To -- the reason we put SSI on the MUC list for HVBP was similar to why we put it on IQR. Which may be some of the ARM.

And certainly if we were to move from the SIR to the ARM, that would -- we're trying to -- we're just having internal discussions about, you know, the present concept of doing that.

But, certainly anything that we can make do that, we would have to go through, that would be substantive change and would go through public comment.

CO-CHAIR TRAVIS: Okay. Jeff, do you have any comments?

MEMBER JACOBS: For this one the only thing I would say is I think it's good to see collaboration between the CDC and the American College of Surgeons. And I think that represents a very important collaboration when it comes to measuring surgical site infections.

And therefore, I'm supportive of this initiative. On that principle alone I think it merits support.

CO-CHAIR TRAVIS: And if you all will allow me, just because I'm not sure how long the discussion and the vote may take on this measure. Jeff, do you have some comments relative to measure number two and measure number three that you want to be sure we have before you have to step out?

MEMBER JACOBS: Measure number two was the one I was really hopeful I could be involved in the dialog with. Because there's potential dialog about -- about the measurement of 30 day mortality that is similar to the dialog related to 30 day mortality that took place earlier today for management of brain injury.

So, I think that's a potentially important dialog. And the other issue related to that measure is a discussion about the fact that there's this administrative measure that looks at outcomes after CABG.

There's also a clinical measure that's been developed by the Society of Thoracic Surgeons, which is used by 96 percent of the adult cardiac surgical programs in the United States.

So, I think there's some fairly important discussion that needs to take place regarding measure two, around those two topics.

And then measure number three, I really don't have anything important to say. I'm supportive of measure number three.

CO-CHAIR TRAVIS: Okay. Well, let's see if we can help Jeff out and see if we go back to measure number one, which is where we started.

Are there other comments or questions from the Committee?

MEMBER FOSTER: I'm sorry, I'm not sure if I quite understood Pierre's response. So, was your -- was that an indication that in fact hospitals would be able to get and the public would be able to get some sense from CMS about how this reconfiguration of the measure

might be expected to affect the values that get displayed on Hospital Compare?

So that they have a sense of, you know, this may have gone up. But that's -- it's to be expected because we changed the measure? Or something of that nature?

DR. YOUNG: Yes. So, I think -- and again, no decisions have been made about whether or not to make a switch.

But certainly, if there is a switch, we would -- one thing we are cognizant of is that it can impact the -- probably impact the rates. And essentially just distribution of hospitals and where they're classified.

So, there would be a lot of, I think, education and outreach we would need to do. And we acknowledge that.

CO-CHAIR TRAVIS: Thank you, Nancy. Mitch?

DR. LEVY: Pierre, so it's just in this measure, the only change is from SIR to ARM, is that correct?

DR. YOUNG: It is to accommodate. So, the measure is currently calculated using the SIR. But when CDC did measure maintenance, they allowed an alternative way to calculate the rates. Which is the ARM methodology.

So, this is to accommodate that. Because that would be a substantive change.

DR. LEVY: And so, -- and that's what I understood. But you're saying CMS hasn't made the decision yet whether to go with that?

But this is -- this measure is saying the decision's been made, because it's a different measure. I'm not sure I -- am I making sense?

Are we voting on the measure and then you still haven't decided at CMS whether to use it or not? Is that the idea?

DR. YOUNG: Right. Because -- well, the measure itself is already in the program.

DR. LEVY: Right. Right.

DR. YOUNG: Right. So, I think the -- there is still ongoing discussions internally

about whether it would be beneficial to change the calculation methodology.

And that's -- but, if we do do that, we want to be as consistent as possible between IQR and HVBP.

DR. LEVY: And so are we voting on -- is this measure already in VBP? And all we're voting on is the change from SIR -- the reporting methodology? Right. That's what I thought. Okay.

DR. YOUNG: Yes. It's already in SSI. The NHS and SSI measures are already in the program.

CO-CHAIR TRAVIS: Thank you for that clarification. Any other comments or questions?

(No response)

CO-CHAIR TRAVIS: Okay. I'm going to take that, that that means we're ready to vote on this measure.

MR. TILLY: The polling is now open for ACS-CDC Harmonized Procedure Specific Surgical Site Infection Outcome Measure, MUC 15-

535. The options are support, conditional support, and do not support.

It looks like we need just three more. So if you guys want to give it another shot.

Okay, so the results are 58 percent support. Thirty-three percent conditional support. Eight percent do not support.

So, the recommendation is conditional support.

MS. MITCHELL: We have a late voter.

MS. O'ROURKE: We're not ready yet.

MS. MITCHELL: Yes, give Jean-Luc a minute to reset the poll and we'll --

Oh, okay. We knew -- we have another rejoining. So, we'll revote. We've got another vote, so. We'll revote on --

MR. TILLY: So, the polling is back open for ACS-CDC Harmonized Procedure Specific Surgical Site Infection Outcome Measure, MUC 15-534.

And we're missing just three responses. And now we're missing just one

response. Oh, there we go.

Okay, so the results are 58 percent support. Thirty-five percent conditional support. And eight percent do not support.

So the verdict is conditional support.

MS. O'ROURKE: And just to make sure I heard the conditions correctly. So they would be pending NQF annual update.

And that the measure is put in through the program all in the proper statutorily path -- or statutory path versus the IQR. Then publicly reported. And then to VBP. With education.

MEMBER JACOBS: Yes, I know that there's two NQF endorsed measures regarding mortality after coronary artery bypass grafting. One -- and they're actually developed jointly between the Society of Thoracic Surgeons and CMS as a collaborative initiative.

So, my disclosure is that I was involved in the development of both of them. Because they were developed jointly.

That being said, it surprises me that

one of them is here and one's not when they're both NQF endorsed companion measures. And it seems that they both should be there.

The second issue that may come up is that I've heard previously criticisms about after coronary artery bypass grafting, a 30-day mortality measure is problematic because it perversely incentivizes providers to keep a patient alive until day 31.

And that topic may or may not come up. But, I think one of the advantages of the measure from the clinical registry, from the STS Registry, is that it eliminates that as a problem.

Because the end point is not 30 days. But operative mortality, which is defined as the union of 30 days plus survival, or lack of survival at discharge.

So, the measure then becomes is the patient alive at the time of going home? And eliminates potential incentive to keep somebody alive to day 31 just to meet the metric. And

it's a matter of being alive and well enough to be discharged.

So, I think those are two potential topics. The main issue is, I wonder why only one of those measures is here and not both of them?

CO-CHAIR TRAVIS: Thank you, Jeff. Any thoughts, Pierre, while he's in the room?

DR. YOUNG: Sure. And thank you for those questions. And thank you also for working with the collaboration on development of those measures.

And I just want to confirm, but I believe the STS version is a registry-based measure. And so that was a big limitation for us on the hospital side.

Because we do not have the ability to permit registry-based reporting for hospitals. So, we are limited to claims-based measures, the HR measures and chart abstraction.

MEMBER JACOBS: So this is a registry that has 96 percent penetrance in the country. The only hospitals that don't participate are a

few VA hospitals.

So, it was surprising. But I guess registry-based measures even with 96 percent penetrance are not a candidate for utilization.

I'm sorry, I've said -- I said it -- the registry is a registry used by 96 percent of the hospitals in the country. And only not used really by VA hospitals.

But, I guess if the issues are that registry-based measures, even if they have complete -- almost complete penetrance in the country, are non-candidates, then that issue about why that's not here is really a moot point.

The other issue though remains with the challenge of using an endpoint of 30 day mortality. And I don't know how to address that.

Because I've heard the issue raised that that creates an incentive to keep a patient alive until 31 days to comply with the measure. And you can do that after a coronary bypass with a tracheostomy and a peg and a variety of other things.

That's why an endpoint of operative mortality, which is survival to discharge from the hospital eliminates that perverse incentive. So, that's kind of a problem with an isolated 30-day mortality measure versus survival to discharge that, you know, as a cardiac surgeon, I'm fairly sensitive to that.

And I'm not sure how to address that if the endpoint is just 30 day mortality.

CO-CHAIR TRAVIS: All right. Other thoughts or comments from the work group on this measure? And Sean was the one to pull it, so you're next.

DR. MORRISON: Yes, I just wanted to echo what Jeff said for -- and two data points. The first is actually data from two very large programs, including one of mine.

Where the average time to palliative care consultation and serious complications following discharge for all surgeries except for cardiothoracic runs around ten days post op. For the cardiothoracic group, it's in the mid 30s.

So, if you want a look at what's the perverse incentive, it's significantly longer in the cardiothoracic group, which this measure is. And when you look at focus groups with the cardiothoracic surgeons, they are very concerned about that. It is -- this is what's driving it.

The second is, the Joint Commission just came in, certified our group yesterday. And when the comment that came out over and over was, this is a national issue when every palliative care program they are certifying, where does palliative care not get involved? It's in cardiothoracic surgery.

Now one can argue that there's something very specific about cardiothoracic surgeons versus the other surgical world. But I would also suggest that it is this issue, the 30-day mortality.

Jeff, I don't know what to do about it. I think this really -- mortality following -- bypass surgery, is a big issue. It's one we should be doing.

But I think we should be aware that there really are perverse incentives around the 30 day number.

MEMBER JACOBS: Yes. I'd like to make one more comment on that. I think if the endpoint has changed to survival to discharge from the hospital, it eliminates the perverse incentive to keep somebody alive until 31 days.

And there's no doubt that mortality after heart surgery is an extremely important metric. Because risk adjusted mortality after heart surgery has substantial variation across programs.

For any form of heart surgery. Whether it's coronary artery bypass grafting, or pediatric heart surgery. And therefore, it's a very important metric to follow because there's variation.

And there's opportunities for improvement. But, if the endpoint is just 30 days, it's problematic.

Most heart surgeons track 30 day

mortality, discharge mortality, and then use a term called operative mortality, which is the union of both. And that term, operative mortality, is a form of mortality that eliminates incentivization just to keep somebody alive for 31 days to meet a metric.

And that's the answer. But that answer's not part of this measure. And that makes it somewhat challenging.

I'm supportive in general of the administrative measure from CMS because we helped develop it. But, I think that the 30-day endpoint is somewhat limited.

And I'm sorry I have to step back because I have a 4:00 p.m. phone conference with a patient's family that I just cannot miss.

CO-CHAIR TRAVIS: Thank you, Jeff. Michael?

DR. PHELAN: I think all these measures can potentially be perversely incentivized. Survival to discharge from the hospital, well, they'll just move people to a

SNF, and then that could happen.

So, I think they all have that. I would really love to see multiple measures in there. And end up being a composite. But as a first step, I think this is not a bad way to go to support the move forward with it.

Just my thoughts.

CO-CHAIR TRAVIS: Any other comments? Yes, oh Jeff -- that's Jeff's card. Would somebody put that down so I won't keep looking at it? Thank you.

I'm going to take my chair hat off for just a moment. And I have a feeling that I've said this in prior years at the MAP.

I guess I find it extremely disturbing and disappointing to think that the provider community would actually react to an incentive, and actually keep a patient alive one extra day in order to have their metrics look better.

And I hear that type of comment every year when we come in here. And quite honestly, I really question whether it's true.

I know that there's -- where Jeff was saying there is some evidence, maybe it's just that I don't want it to be true.

But, I think that what that shows for us isn't necessarily that the measure is wrong, but that there is something wrong in the provider community. Because their first responsibility is to the patient.

And I think that we always are kind of trying to take it away from the measure, when I think the reality of the situation is if there are providers who are treating their patients in this way, I can't think of anybody who would agree with that. Even probably the providers who it appears must be doing that.

So, that's my soapbox. Of course, which I think I can be counted on once a year at least, to bring up in front of everybody.

But, I think that it's not assigning -- it's not making the measure a bad measure. I think it's actually reflecting on the provider community.

And if indeed this is what is happening in the provider community, I would expect the provider community to do a better job of policing itself. And shining the light on people who are doing this.

And it's not appropriate. Because I can't imagine keeping somebody alive, and say okay, well, it's 31 days. You know, the hour's hit. You know, now we can let them die.

I just -- that entire thing just disturbs me and disappoints me. So, enough said. I am sure.

So, thank you for letting me say that.

(Laughter)

CO-CHAIR TRAVIS: I think it is time. I think that was -- Wei, did you have something to say?

MEMBER YING: Yes. This is not the first standardized mortality measure for VBP, right? Currently is there a similar measure in there already?

This is not the first standardized,

risk standardized measure mortality to be considered for VBP Program, right? Currently in VBP, do they already have a same type of measure just for different clinical condition?

MS. HAYDEN: That's right. We have a -- the AMI and pneumonia mortality measures in the program.

MEMBER YING: Right. So, that's what I thought. If we didn't -- well, the 30-day issue didn't become an issue at the time I think for this round.

Understanding it will be some desired reaction from the provider community. Even maybe isolated. But still then it should not be an issue preventing us from thinking this is a measure, important measure to be included into the VBP program.

CO-CHAIR TRAVIS: Thank you, Wei. Tom?

MEMBER LUTZOW: Yes. My question has to do -- and certainly, I mean, I am against perversity wherever it exists. Whether in

measures or in human behavior.

But, we have pretty much control over the measure, don't we? I mean, isn't it -- can't it be redesigned so that we don't have to worry about perversity in human behavior?

Is it so sacred that, you know is it one of the Commandments and we can't take it out? Or is it something less important than one of the Ten Commandments?

CO-CHAIR TRAVIS: I'm going to assume that was a comment, not a question.

(Laughter)

CO-CHAIR TRAVIS: Sean?

DR. MORRISON: Cristie, I look forward to that comment every year. But, as somebody who monthly meets with the surgeons and goes through every single mortality, I do -- I wish that was the case.

I wish that providers would do that. But the reality is, they're under so much pressure that this is just -- the lightbulb goes off at 30 days.

And you know, what's the difference between 14 days or 30 days or 35? You know, and in their mind well, 30 days is a realistic amount of time.

And I would argue that for some patients it is. For some it's not. And this is going to drive their behavior whether we like it or not.

But, I do appreciate the comment every year.

CO-CHAIR TRAVIS: Thank you. And I think you make your same response to me every year.

So, this is our discussion, Sean. Thank you so much for having that. Nancy?

MEMBER FOSTER: So, a measure not yet on Hospital Compare. So, not up for a year. We can't really look at variation in performance and know what it means one way or the other.

And I'm -- I was trying to glean, and I'm sorry Jeff had to leave the room. Though his priorities are in the right spot.

I'm trying to understand, are there outcomes that are more important? Is there a better construct of the outcome that would give us more valuable information?

And give patients and families who are trying to understand these data, more important information than 30 day mortality. Which 30 day is an arbitrary cutoff by anybody's tally.

So, I don't know that. I would appreciate clinical input on whether there is something better.

And I suspect Jeff would probably be the best clinician to give that to me. But, I'm -- but Sean, you have your fingers deeply into this.

And Mitch? Michael? I -- you know, somebody help me here, please.

CO-CHAIR TRAVIS: Oh, come on. Somebody needs to help Nancy. Any answers to her concerns? Or comments around them?

PARTICIPANT: If I may, just to clarify. The measure was publicly released or

publicly reported in July of this year.

So, it is on Hospital Compare. And it --

CO-CHAIR TRAVIS: Thank you. And Mitch?

DR. LEVY: Yes, I mean, this has been publicly reported for a long time. I do think in this case mortality is a good quality indicator.

I think, Nancy, I think there are others. Long term functioning, et cetera, et cetera. There's no question that there are other measures.

But, if I were going to a cardiac surgeon, I would definitely want to know what his 30-day mortality is. Given the fact -- and I work in a medical ICU, and at 31 days, I get these folks.

Because then they don't -- well, for reasons that Sean knows. But I still think 30 day mortality is a really good quality indicator.

MS. MARINELARENA: And I think what Jeff was saying, one of the measures is the one,

the STS measure, which he talked about, you know, survival at discharge. Which that measure exists.

But, because of the data source, it can't be used in this program. So, if we want to make a statement about that, maybe encourage a different data source or something like that.

That's certainly something that we could include in our report.

CO-CHAIR TRAVIS: Michael?

DR. PHELAN: I agree, it's what we got. You know, it's a measure we got.

But, I don't think it's unreasonable to put a comment in there that there are other measures out there in good data registries that according to Jeff and every other surgeon I know, the STS Registry, I mean, that is the gold standard of registries that I'm aware of.

And to not use it for whatever reason, and there may be, you know, data quality issues and stuff like that. But, I'm like really? We got a phenomenal data registry that's got 96

percent penetrance.

Maybe we can get 100 percent if they mandated it. But, to use that data registry for other measures like the survival to discharge and the -- what was the other one he mentioned? So the mortality and the survival to discharge.

But, having a composite measure of all the things that revolve around that, I think patients -- I think it would benefit patients to see that.

CO-CHAIR TRAVIS: Leslie?

MEMBER SCHULTZ: Well, this pales in comparison to the perverse incentive to keep people alive. The current measure I don't believe is fully adjusted for SDS either.

CO-CHAIR TRAVIS: Thank you. Oh, Ann Marie put her card down. I forget who -- oh, did you want to say something Ann Marie?

DR. SULLIVAN: Yes. Just to add that I think we could make a recommendation that the other measures that the physician was recommending could be added to this. If you

think that would be some kind of precautionary measure that would stop people from just spreading the mortality out for 30 days.

And then we have many measures that have like one or two things associated with them. So, we could make a recommendation that you add something like survival to whatever, discharge. That kind of thing.

So, I think that, you know, you could make that recommendation. And then if you have that, you kind of can still see what the, you know, you could prevent the kind of perverse incentives.

So, maybe we could make that recommendation in addition.

CO-CHAIR TRAVIS: You all are capturing some of these thoughts?

MS. O'ROURKE: Yes.

CO-CHAIR TRAVIS: Thank you. Thank you, Ann Marie. Heather?

MEMBER LEWIS: Just to state something quite obvious. We have other measures where

we're using ER -- EHR information.

Is there any reason why we couldn't use EHR discharge status as an indicator? Rather than the SDS data point?

CO-CHAIR TRAVIS: I think that was a question for CMS to think about. I don't know if you have a comment now or whether it's just something you want to consider.

DR. YOUNG: Yes. Thank you. We'll take that under consideration.

CO-CHAIR TRAVIS: And I apologize. I may not be getting everybody in order. But, I had Andrea next.

MEMBER BENIN: I mean, what I'm hearing from this conversation really is that the, you know, the metric is in IQR, which satisfies I think Mitchell's comment and Michael's comment that we would, as consumers, be able to see the data.

And then I think in order to avoid the financial penalties that cause some of the problems with the metric, it makes sense in my

mind not to put this into value-based purchasing, which adds these additional financial penalties, which are real for the hospitals and for the providers involved.

So, to my mind, this is one of those situations where if we understood really well what our criteria were for one program versus the other, it would be helpful.

But, we already are in a situation where there's complete transparency around this metric. So, that's not up for discussion.

What's up for discussion is, do we add another financial penalty to a metric that we've already ascertained is being perversely impacted by just transparency alone, let alone adding financial penalty.

So, I think that to my mind, it seems pretty clear that that's maybe not the best idea based on this discussion.

CO-CHAIR TRAVIS: Mitchell?

DR. LEVY: So, two things. One, a lot of these recommendations, we're bordering on

trying to create another measure.

And so I just want to -- I would -- we're not talking about making this conditional. Because our suggestions are suggestions for other measures to be developed.

Right? So, because we're weighing in on this measure.

And then the second thing I would say, is I guess I disagree. Although I understand the perverse incentives that this creates, I do not feel it outweighs the benefit of making this in VPB.

I think that drives -- I think that drives quality. And I do think that this is a good measure.

And there is always going to be gaming that goes on. But I don't think that outweighs the value of holding people accountable and keeping their feet to the fire by putting them in VPB.

CO-CHAIR TRAVIS: Helen?

MEMBER HASKELL: Yes, I just -- I

think, you know, from the beginning, the heart surgeons have always said that they shouldn't be measured because they will game the measures.

And I think that I assume, I've always assumed that one reason for the 30-day measure was because that's a little more difficult to game then survival to discharge. Because you did use discharge to a skilled nursing facility.

So, I think it's fine to suggest, you know, additional measures. And look at them as composites.

But I certainly don't think getting rid of 30 days is any kind of answer.

MS. MARINELARENA: And if you look in the preliminary analysis summary, the last bill that impacts on quality of care for patients, we do provide a summary of the performance rates from Hospital Compare.

So, if you look, what we have is that there was a mean rate of 3.2 percent with a range from 1.5 to 7.9 percent. And then the developer found a median rate of 3 percent.

So, that the 25th and 75th percentiles are 2.6 and 3.6 respectively. So, we do have data on the performance of this measure.

CO-CHAIR TRAVIS: Thank you for pointing that out, of course. I'm taking my co-chair hat off for a moment. I'm not seeing any other cards.

I too kind of, you know, think that no matter what the measure is, there's probably a way to game it in some form or fashion, to Helen's point.

And I also though do support us giving some commentary to CMS around some of the things that we've talked about today that could perhaps ultimately result in a better way of doing this.

But, given, you know, where we are in this measure, my tendency is to support it. But, I think we would have an unintended consequence discussion around every measure that could come up.

I mean, you could discharge somebody early out of the hospital to get to discharge

them while they are alive. So, I mean, and then we'd be having that discussion, that that's a perverse incentive to discharge people early.

So, you know, that's just kind of where I'm standing on the measure. So, any other comments before we move to a vote?

(No response)

CO-CHAIR TRAVIS: Okay. I think we're ready.

MR. TILLY: All right. The polling is now open for Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery, MUC 15-395. The options are support, conditional support, and do not support.

So the results are in. Seventy-six percent support. Eight percent conditional support. And 16 percent do not support.

So, the recommendation is to support.

CO-CHAIR TRAVIS: All right. Thank you all very much. And now we'll move to the third measure in this Calendar.

And it's the Patient Safety for Selected Indicators/AHRQ Patient Safety Indicator Composite, affectionately known as PSI-90. And this was originally pulled by Nancy Foster.

So, Nancy?

MEMBER FOSTER: We have just talked about this for the IQR Program. And so, the question of whether the revised version ought to be moved into VBP or not, was what was on my mind.

And, you know, understanding exactly what's the difference here. And the other thing is, and I've spared you this stump speech this far, but PSI-90 is not our idea of a reliable measure when done on the Medicare data.

This version of it seems to be slightly better. But the real problem with the measure is in what would -- I'm sure Dan would tell me, is case finding.

It is that you cannot identify in any of these things through the claims data. There is plenty of evidence out there to that effect,

including probably the seminal article by David Klassen and colleagues written several years ago that appeared in Health Affairs.

I have seen recent data from one of our major systems that suggests that when they looked at their claims data for one of these measures, they identified one event. When they went back and used their electronic health record to look for those events, they found many, many more of the same events, as in more than tenfold more.

So, it is that level of inaccurate. And we need to get to a better measure. We just simply need to get to a better measure.

So, this is a step forward. A small step forward in making a better measure. But, it's still not where we need to be.

CO-CHAIR TRAVIS: And just to be clear, what would be your recommendation?

MEMBER FOSTER: I would recommend conditional support for this. And that condition would be that hospitals be given information on

the difference between this measure and the old measure.

And be able to understand the impact prior to it going live in the VBP Program.

CO-CHAIR TRAVIS: Thank you, Nancy. Jeff's not with us. But I think he indicated his support for the measure.

So, I'll open it up to the work group. Helen?

MEMBER HASKELL: Well, I think the consumer group strongly supports this measure. It's the basis for most public reporting that's done on hospitals.

The measure has been considerably revised. It -- and I would say, you know, the components in it are much weaker than they have been.

I think the issue that people are not honestly or accurately billing Medicare, is a whole different issue from whether this should be measured on that. I think the problem is elsewhere.

So, that's my comment. And also, the -- you know, people are now beginning to game this measure as well. And have been for a while so that they are going through the records and, you know, and looking at things that could be construed as something that would be part of PSI-90.

So, I think you will soon find that the records will agree more with the claims. Whether that's a good thing or not is up for debate. But, I think that's what's happening.

CO-CHAIR TRAVIS: Thank you, Helen. Leslie?

MEMBER SCHULTZ: I'm going to concur with Nancy. And would recommend conditional.

I think we need to see it and get experience with it in IQR before we put it into VBP. Because we don't know what kind of information, actionable information variation we're getting yet. Too soon.

CO-CHAIR TRAVIS: Thank you, Leslie. Mitchell?

DR. LEVY: So, I would speak out strongly in favor of this. I totally understand what Nancy's saying about the difficulty in identifying some of these.

But, I think that would be true across the board. I think these -- each of these represents where safety is.

There are iatrogenic conditions, I think the addition of the exclusion criteria for present on mission really helps this metric. It has to go into IQR first anyway.

And this is the kind of measure that I would like to see facilitated. So, recommending it now for VBP, knowing that it has to go into IQR first, there's so much face validity to the -- to the individual elements in this measure in terms of avoidable complications and patient safety that I find it very compelling to support this.

CO-CHAIR TRAVIS: Thank you. Yes?

DR. POLLOCK: So, to Mitchell's point, I would say there are many different adverse

events of course that are included in this composite I think that speak to -- there's one associated blood stream infection component of this composite.

And there are numerous studies of under ascertainment in the use discharge diagnostic data to identify some of the associated blood stream infection events.

So, while I think we would all agree that the events included in this composite measure merit quality reporting, there are alternative ways for at least some of these adverse events in terms of ascertaining whether an event occurred.

CO-CHAIR TRAVIS: Thank you. Any other thoughts? Andrea?

MEMBER BENIN: I mean, I will say that I have been bothered by this metric for years for all of the reasons that are stated. That any time you really dig into it and either try to validate it in your own place, or look at some of the studies that have been put out there, the

individual components don't validate well.

And then the idea that by somehow combining them together makes it mathematically stronger, I've never entirely understood. But, I think in addition to that, this idea of transitioning to ICD-10 with a set of -- with a metric that we're already not 100 percent clear of how well it actually foots to reality.

And then we're now going to change up our entire coding bases that is based on -- and are we just going to do that on a cross walk? Or is that going to need to be revalidated, is suspect to me.

Especially for this purpose. I think that until it's really been properly vetted in an ICD-10 environment, until some of the considerations that Dan had mentioned are taken into consideration, I find it hard to support this at least for years.

CO-CHAIR TRAVIS: Marty?

MEMBER HATLIE: I mean, this measure's been talked about for so long, it's taken a long

time to get it here. I think it's just a really important statement to the hospital community about where safety is now important is all.

And I think it's just very important we build it into this program in particular. It's a very strong recommend.

And it's never going to be perfect. But I think it still has value. Great value.

CO-CHAIR TRAVIS: Thank you. Michael?

DR. PHELAN: I still conditionally support the metric. But I continue to have grave concerns about some of the methodology that the data is attributable to.

And whether or not it actually has any valid quality programs that come out of it. I like the pressure ulcer measure.

But, I think there still needs to be work done around some of the undifferentiated pressure ulcers that -- how they categorize them. But, it is really difficult not to have a measure in this space on patient safety.

And there currently isn't anything

better. That they're kind of stuck with the person they brought to the dance, so to speak.

But, I would like to make sure that there is more work done on the waiting and the understanding of some of the biases associated with the measure.

And whether or not it's impactful or not, really concerns me. Because from what I hear from the hospital communities that I deal with, is yes, we just do it to report that.

That's not where our focus is. We're focusing on improving DVT prophylaxis. We're focusing on this.

So, I'm wonder if the measure themselves, although they look good and it's important to publicly report them, if it's not having the impact that we actually need to have, I think we need to put some serious consideration in what are the next generation of measures going to come out there.

And, does it need to be in a composite format the way this is? Are there more

individualized measures that we can select from that could replace or be a better -- that actually addresses some of the concerns that people have around patient safety in a hospital setting.

CO-CHAIR TRAVIS: Dolores?

MS. MITCHELL: Just a small point on the issue of composite measures. In a way we're trapped with wanting to have our cake and eat it too.

Everybody has said, oh, people don't use the measures because there are so many of them. And there are so many that are so highly technical that they don't give you the big picture.

We've got to have families of measures. We've got to have composite measures. The fact of the matter is, if you're going to have composite measures, they are going to include some things that you like less well then you like other components.

It's just an inevitable outcome of

having composite measures. So, since we -- most of ours are in fact rather discrete. It seems to me appropriate to have some that are composites.

And in the safety field, I think that's particularly acute. So, I'm in favor of supporting it.

CO-CHAIR TRAVIS: Thank you. Oh, I can't tell, is that yours, David? Okay.

MEMBER ENGLER: Yes. So, I've had some practical experience about doing this. A number of years ago, I published a paper in a community in Columbus, Ohio that put together a community of harm index based upon composite measures.

And all the hospitals in that community are placed into the index, these various measures of harm. And it -- in addition, they worked on the individual measures for the quality comparison purposes in performance improvement.

And it was incredibly impactful. The medical leaders and the infection control

practitioners got together and started really paying a great of attention to the level of harm in the community. This is community based.

So, imagine a situation where you could spread that kind of view of composite harm across the country. And you know, I'm a very big believer and have spent a long time in my career moving harm down to zero.

And I think it can occur. And I think this is yet a wonderful tool. And I'm not usually very supportive of multiple measures.

But, I think this is a very interesting opportunity to do that. And I've seen it work.

CO-CHAIR TRAVIS: Thank you. Nancy?

MEMBER FOSTER: So, I want to join with David and respond to Dolores' comment. This is really not about it being a composite per se.

In my ideal world, we'd be at an all cause harm measure generated out of electronic health records. Where you have sufficient data to really look at what happened to the patient.

Know -- and know better whether it was caused during the hospitalization, something the patient came in with. Something much more reliable then what we've got right now.

There are such things under development. Some in testing. I'm really looking forward to the day when we can talk about that kind of measurement.

But, when you -- with regard to this measure, it's really ten things that don't test out very well as individual components that get rolled together in a sort of the kind of ten wrongs make a right kind of philosophy.

And that -- it just doesn't quite work. And the lack of validity and reliability when people go back and do it, Andrea was talking about, and try and match this to their clinical records, means that it doesn't have the kind of credibility among the clinical world that is needed to really generate quality improvement.

And so, for me this -- and it's also data that are now two years old by the time you

get them. So, it's trying to drive safety, the critically important issue of safety, by looking in a rearview mirror a couple of miles back.

And it's just not working right. That's my issue with this measure.

CO-CHAIR TRAVIS: Dolores?

MS. MITCHELL: I just have to say, you know, it's been 15 years or going on to 16 since To Err is Human was released. And my understanding is that the data show that in fact our statistics have not gotten any better.

In fact, they've gotten worse. So, it seems to me anything we can do is worth the shot. Even if it's imperfect, as is life.

It's my brain at this hour of the day.

DR. OWENS: This is Pamela from the Agency for Healthcare Research and Quality. When everybody's spoken in the room, I'd like to say something about the measure.

CO-CHAIR TRAVIS: Okay. Thank you. Wei?

MEMBER YING: I haven't looked at the

details of this new measure. In the previous version, two of the -- two indicators among this whole set was heavily weighted.

At the time for us, we had concerns, I mean, for our organization, we had the concern that if only two out of say, seven or eight indicators were heavily weighted, then there -- basically hospitals can cherry pick.

They basic -- if they say, oh, I do -- I can pick up a couple of measures that have the greater impact of the composite, then we just work on that.

But, then because it's a composite measure, and when the consumer looks at it, they basically say, oh, this is a safer hospital. That may not be the truth if they are only good at those two heavily weighted ones.

So, I just wonder, can the developer or CMS comment in this newer version whether this is still an issue?

CO-CHAIR TRAVIS: Well, perhaps that's a good segue to Pamela on the phone, who just

indicated she did want to have an opportunity to make some comments.

So, if you can take that last question into account in your comments, we would appreciate it.

DR. OWENS: Absolutely. So, in terms of Andrea's comments regarding the conversion to ICD-10, I think this applies to all claims-based measures.

In terms of the comments regarding two year old data, again, this applies to all claims-based measures. And so, you may have a larger issue with those things. But, it's not specific to PSI-90.

I will tell you this, PSI-90's building blocks are largely the same as the previous PSI-90. Which is in HPVP as well as in the HAC reduction.

This one has been redesigned. And we would consider this a substantial change, which is why you're seeing this now.

It has been substantially changed

based on user feedback and stakeholders that are involved in NQF. And now is a composite of ten indicators.

The previous version was eight indicators. And no longer includes PSI-7, so to the point of the -- measure that there are other ways of measuring it, that's true.

And CDC does have a PSI-7 measure that in the HAC reduction is part of the composite. And -- or Class C is part of the HAC reduction composite.

And so we've taken PSI-7 out of it. We have significantly looked at PSI-12 and PSI-15 to state specifically, I believe, to what Nancy is talking about, and Andrea is talking about, regarding validation.

And going back to what the medical records and our own studies of medical records versus the claims data, and specified the indicators so that it is much more precise.

There, you know, in terms of PSI-12, we respecified to omit the isolated calf vein

DVTs from the numerator. We omitted patients with any diagnosis of acute brain and/or spinal injuries in the denominator just to give you some indication.

The other significant -- one of the most significant differences between the pervious version of PSI-90 and the current version of PSI-90 is the harms weighting. So, there are two components to the weight now.

It used to be just volume weights. And now it's harms weights. And the harms weights are based upon estimates of excess harms associated with patient safety events.

And we gather this information specifically from CMS, Medicare fee-for-service data. And then we have the volume weights as well.

In terms of how the weights turn out, I think where you were concerned particularly about PSI-15 had a large component of the weight. Which is -- it has been redesigned. But it was the accidental puncture measure.

It's now unrecognized abdominal pelvic accidental puncture laceration rate. Just -- detailed there.

And, I think your other one was the concern was PSI-12, which is the perioperative pulmonary embolism and deep vein thrombosis. And as I mentioned, we respecified those particular indicators so that they're much more precise.

The weights now for PSI-15 is less than one percent. And the weight for PSI-12 is only 18 percent in the new weighting scheme.

The new composite includes three additional indicators that were not in the previous one. That includes perioperative hemorrhage and hematoma rate, post-operative acute kidney injury, and post-operative respiratory failure rate.

In terms of the overall signal to noise ratio reliability, it is computed to be .768. I don't know what it is in the Medicare fee-for-service data.

And I know Nancy, you are particularly

interested in it. The memo that I think you're thinking about, is actually pretty dated now. I know those measures are not at all what the measures are that are in the composite.

We have recalibrated PSI-90 so that it is calibrated to Medicare fee-for-service data in terms of the parameter estimates that go into it, et cetera.

I hope that gives a broad brush stroke of the indicator. If you have questions, I'm happy to answer them.

CO-CHAIR TRAVIS: Thank you. Any questions or any additional comments from the Workgroup?

MEMBER HASKELL: I have a question Pam. Maybe I missed it.

But, what percentage of the weighting is pressure ulcers now?

DR. OWENS: Pressure ulcers is now 3.6 percent. It was 3.3 percent. So, it didn't change that much.

CO-CHAIR TRAVIS: Okay. Looks like

we're ready for a vote.

MR. TILLY: The polling is now open for Patient Safety for Selected Indicators/AHRQ Patient Safety Indicator Composite, MUC15-604. The options are support, conditional support, and do not support.

(Voting)

MR. TILLY: And the results are 68 percent support. Twenty-four percent conditional support. And eight percent do not support.

So, the recommendation is support.

CO-CHAIR WALTERS: Okay. How's everybody holding up? We are going to move cancer to tomorrow and just finish out the day with HAC.

So, Zehra will give an overview of the HAC Program.

MS. SHAHAB: So, I'll be brief. But, I just wanted to give a quick overview.

So, HAC provides incentives for hospitals to reduce the number of HACs, which are Hospital Acquired Conditions. This is both a pay

for performance and public reporting program.

HAC scores are reported on the Hospital Compare website since December 2014. The incentive structure for this program is that 25 percent of hospitals that have the highest rate of HACs will have their Medicare payments reduced by one percent.

And the measures in this program are classified according to two domains. One is the PS -- Domain One, which includes PSI-90. And then Domain Two, which includes CDC's National Health Safety Network.

The HAC program goals include to increase the awareness of HACs, eliminate the incidents of these HACs, and improve patient outcomes and the costs of care by reducing the HACs.

And there's two measures on the Consent Calendar for this. One is an update to a measure currently in the program. And one is PSI-90 that we just discussed.

So, before we go into the Consent

Calendar, we're going to open for public comment on this program.

CO-CHAIR WALTERS: Is there any public comment in the room?

(No response)

CO-CHAIR WALTERS: They're asleep. Is there any public comment on the phone?

OPERATOR: Okay. At this time, if you would like to make a comment, please press star then the number one.

(No response)

OPERATOR: There are no comments at this time.

CO-CHAIR WALTERS: Okay. As you can see, there's two measures. One of them is the -- so far a lot discussed, the SSI measure, which is being applied to this program.

That was not pulled by anyone. And so currently would be the only measure on a consent calendar for support.

That was -- staff was conditional support pending the NQF Annual Update and a lot

of the issues we've talked about all day long.

Is there anybody that wants to pull that measure?

(No response)

CO-CHAIR WALTERS: Good.

The second measure has also been discussed a few times today. And it's the PSI-90 again. Was pulled by Nancy.

So, Nancy, would you comment on that?

MEMBER FOSTER: I actually have no different comments than previously. But, I would just ask that if we do move this forward, that indeed relative to the conversation we've just had and the information from Pam, I suspect there will be significant shifts in how hospital performance appears on this measure, versus the old PSI-90.

And that, as we have discussed previously, it would be very useful if CMS would provide some educational information, both for hospitals, and then subsequently for all the rest of the public who will be watching this measure,

to understand what those shifts mean.

And whether they are actually reflect a difference in performance at the hospital, which would be hard on this one to know.

Or are really reflective of the differences in the measure itself.

CO-CHAIR WALTERS: First lead discussant is Mitchell.

DR. LEVY: So, we just finished talking about both of these. I don't have anything to add.

Certainly they qualify as HAC measures. And the recommendation from staff was conditional support and support.

And I agree with both of those for the reasons I stated on the previous measures in discussion.

CO-CHAIR WALTERS: The recommendation from staff on this one was support.

DR. LEVY: The first one was conditional support, no? And then the second one was support.

CO-CHAIR WALTERS: Yes, that's correct.

DR. LEVY: Yes. I'm sorry, that's what I said, but --

CO-CHAIR WALTERS: Yes. Brock?

MEMBER SLABACH: Yes, I just echo some of the things that Nancy said. I mean, the degree difficulty here is increasing as we move this into a program that's going to have increasing penalties for hospitals.

And I think that by having this reported in IQR and then the information related to hospitals for training and improvement, would be very important before it's put into a penalty program.

CO-CHAIR WALTERS: Okay. Open for comment. Andrea?

MEMBER BENIN: So, I guess I'm wondering, does this metric even really qualify as the same metric? Can it just be the same metric with all of these changes in addition?

And just get the same name? And -- I

mean, is that --

MS. MARINELARENA: They did change the name as well.

MEMBER BENIN: It's not called PSI-90 anymore?

MS. MARINELARENA: No, now it is called -- they've changed it to the Patient Safety and Adverse Support Events Composite.

MEMBER BENIN: But, I'm just saying, it's getting treated like it was there all along. But, it's actually a totally different metric that we think is going to have totally different performance.

I'm just not super comfortable with this anyway. I think that it's a different metric. And we're just treating it like it was the same metric.

It has different components in it. It has different weighting. I mean, it's not really --

CO-CHAIR WALTERS: PSI-90.

MEMBER BENIN: PSI-90 -- I guess it's

PSI-90 point whatever. But, it's -- I mean, it's like PSI-90.

I think that there is some -- it's sort of inherent unfairness to just calling this thing PSI-90 and passing it through as it were. I mean, we can vote on it like it is.

But I think that CMS should take into consideration perhaps rebranding it. Or whatever it is, in a way that kind of makes it clear that this is different.

I mean, if I were going to do this in my place, you wouldn't just show this on a run chart or whatever. And say, oh, here's been our performance.

And now whoopsie, here's our performance. And you put all those little arrows on it that explains to the board why the thing is now totally different.

I mean, this is like it's a different metric is what I'm hearing. And so, it's not how I would use it.

I mean, I wouldn't -- we don't use

this metric anyway because of it's sort of lack of value. But, regardless, if I were to use it, I wouldn't just try to -- and try to bill it to a bunch of doctors as the same old metric.

It just doesn't -- there's nothing about it that has sort of face validity to me. So, I guess I would just say maybe there's a way in the packaging of it that can address the fact that it is a little bit different.

CO-CHAIR WALTERS: Mitchell?

DR. LEVY: Again, my understanding from the last discussion is this does go back into IQR first. Is that correct?

And so, that's not what's happening, Andrea. I think it's being repackaged and retested in IQR.

So, what we're voting on is whether after it goes through IQR again, whether we're recommending first DPB, and now the HAC program.

So, I do see that as very different than just passing it off as the same old thing.

MS. MARINELARENA: And I think one

thing to take into consideration is that right now there are two versions of PSI-90 floating around. So, maybe the end goal would be to get all versions into all the programs.

Because the first one had, I believe, eight components. Then it went to eleven. And now we're at ten.

So, think of that as the goal as well.

CO-CHAIR WALTERS: Would you clarify too, I don't -- I think that while it has to be in IQR and for a year to go through value-based purchasing. Is that true of HAC also? I don't believe so. No.

MS. MARINELARENA: And again, it's already in HAC, so you would be reporting a different version of this measure.

MEMBER FOSTER: To Andrea's point, it's not in HAC. It's not in IQR. It's not in VBP.

It will be in IQR. Because this is a different measure. It has some of the same components, but it's a different measure.

CO-CHAIR WALTERS: Michael?

DR. PHELAN: To the same question that we had about another previous measure. If we support it for going into IQR, then evaluating it, it seems like we're doing multiple tasks on a measure before we have the actual data to support moving forward with some of the other programs that it belongs into.

Because we don't have any data to base it on. And I agree 100 percent with Adrian -- Andrea, the same --

MEMBER BENIN: I think one of these days you'll get it.

DR. PHELAN: One of these days I'll get it.

MEMBER BENIN: Maybe tomorrow.

DR. PHELAN: But, the same issue of this, repackaging -- these repackaging of metrics where they completely change the whole -- I keep on thinking of it as PSI-90.

But, it's not PSI-90 anymore. From what we've heard, there's five or six new

measures that are in there.

The weighting is completely different. So the idea that this just the same measure and we need to support it and move forward, concerns me.

CO-CHAIR WALTERS: I think that's the first time that's come up all day. Renaming it.

Any other discussion?

(No response)

CO-CHAIR WALTERS: Ready for a vote? So, what would you recommend it be? Support, conditional support, do not support?

Either one of you, or anybody that wants to talk.

DR. PHELAN: Do not support until we have the data.

MR. AMIN: Ron, can I just get one piece of clarification here, Erin actually? Can you clarify if this is a version that's been reviewed?

This updated version is the one that was reviewed by the Patient Safety Committee just

this last year. And just confirm?

Because this version in question that's come up, just what is the endorsed version? And what was the conclusion of the standing committee on this particular version?

Because, you know, there are updates to measures. That does happen. That is something we see. It's not limited to just this issue.

But, we need to at least get clarity on what it is that's endorsed in terms of version.

MEMBER BENIN: I mean, I think the bigger burden --

DR. OWENS: So, the sense -- the pending indicator I know is the endorsed version. The indicator item -- the indicator composite is no longer endorsed.

So, the one you're voting on right now is the endorsed version that went all the way through CSAC two weeks ago. Or one week ago.

MEMBER BENIN: I think the bigger

problem then, and this is probably what Pamela is thinking about, is that the -- then it leaves you with HAC, with what we all agree to be a substandard PSI-90 in it.

And we've always felt it to be substandard PSI-90. So, if we don't have this version, then we leave HAC in its debilitated state versus sort of adding this measure.

You know what I mean, it's like we're saying that this other measure is not as good as the new one. I mean, it's a little bit of a catch-22, unless -- because I don't think we have the ability to say that we don't want the old.

Like it's a little bit complicated. And I don't know whether our job is just to vote straight on that since we don't have the ability to go back to the old one.

Unless we're saying, I do not support this PSI-90. Does the old one go away, too? Or the old ones stays, right. Because it's a different metric.

So, the problem is that it's not so

clear what to vote -- do you see what I'm getting at here? Does that make sense?

So, I don't know about --

MR. AMIN: Well, the vote in front of you is, let's just be clear, I mean, the vote in front of you is clear.

It is to decide about this composite for this program. What CMS does with the old composite is another question.

And that's not really in front of you at this moment.

MEMBER BENIN: Right. That's sort of a problem.

MR. AMIN: I mean, you should vote on this one for this program. That's the question in hand.

MEMBER BENIN: So, but if we don't support this, the old ones stays is the problem.

MR. AMIN: Well, that's up to CMS.

MEMBER BENIN: We don't know. That's up to CMS. Okay. All right. Okay.

MR. AMIN: We're not commenting on

finalized measures that are currently in the program. I mean, that -- we could have a whole conversation about that.

But, yes, that's, you know, let's all -- the principal question at hand is this measure, as this version two, or whatever we want to call it, of PSI-90, for this program. That's the question.

And it is the version that was reviewed by the NQF's Patient Safety Committee. And it was just most recently -- most recently went through CSAC.

So, I just wanted to give you that update because it is updated based on what was in your discussion guide.

MEMBER FOSTER: But I think, Taroon, rather that Andrea's point was performance on this will shift a great deal. It will have both the effect of meaning that hospitals who thought they were very safe before at -- will now discover that they have -- they're in the HAC penalty area and looking bad.

More importantly then getting the penalty, they'll be on the list of the hospitals that CMS considers the worst in the country. Which is how all the headlines read.

Which is devastating to a hospital. So, you can't just tell them 30 days in advance, hey by the way, you know, all that performance you thought you knew about, well, we've got a new version of the measure. And now you look really bad.

You need to give them more opportunity to see how the measure functions, what it means for them. What they can do about it so that they can respond more effectively to the new measure in ways that -- it's to the reason you have a public reporting before you pull it into a payment program.

Is you want to be able to give people an opportunity to understand and use the measure. And I'm with you, Andrea.

I don't -- if this is a better version of what used to be PSI-90, I think I kind of want

it used in HAC more than I want the old ugly version. But, I don't want the surprise.

So, that's the dilemma.

CO-CHAIR TRAVIS: Ron called on me. He might not know it. No, I'm just kidding. He did call on me.

So, I -- you know, I think that that is a good question. Because any time you essentially swap out, that's what we're doing, we're swapping out a measure. Then the performance on that measure could change -- that part of it could change substantially for individual hospitals.

So, to that point, what would be the earliest state that you think this -- if you all decided to move forward with it, what would be the earliest state?

And why type of preparation would you be providing, what kind of information in advance? And not just 30 days in advance, but in advance, for hospitals to be able to understand the differences so that -- and I don't know

whether they're probably given everything.

There's probably not enough time for them to go around making changes to everything. But, I guess I'm just trying to think about the -- how they would have an opportunity to know far enough in advance to where perhaps they could begin to tweak some of their internal improvement efforts to understand, you know, where they're going to be on this measure.

So, just kind of understanding that sequence would be helpful to me.

DR. YOUNG: So, I always need to draw this out. Because the timelines are never quite -- I'm sorry? Oh, I'm sorry.

Yes, the time line question's a good one. But, it's complicated as you know.

So, theoretically, we could propose it in this upcoming rule cycle for the FY17 IPPS rule. But, we've already finalized the measures for FY16, and I believe FY17 as well.

So, I would have to double check. But, probably FY18 or beyond is my guess. But I

would need to double check those timelines.

CO-CHAIR TRAVIS: Just as a follow up. Is there any process for doing, I guess you all might call it a dry-run or something, against -- with the new specs early?

So that hospitals could have the benefit of understanding at least, you know, if you'll be using the new specs, where they would have fallen? And they can see the difference between the existing measure and that one?

I'm just trying to understand how far in advance they could actually understand how they would perform on these measures. So they could do something for improvement.

DR. YOUNG: Right. And so thank you for that suggestion. We can definitely talk about this internally and think it through what the options might be in terms of educating hospitals and sort of sharing the results with -- under the new calculation of the composite.

CO-CHAIR WALTERS: Dolores?

MS. MITCHELL: Well, I don't mean to

do CMS's work for them. But, it does seem to me, or I should say, I find it very hard to believe that the measures that are changed, are changed to go in an opposite direction.

So that the concerns that Nancy has raised, which, you know, might be reasonable, should not really worry her that much. In other words, if cutting off the wrong leg last year was a terrible thing to do, but this year it's fine, go right ahead, then you've got a real problem.

Because that -- but, if they are in fact gradations of, or changing the formula so that the cut points were a little different, or I would assume, some of the changes came as a result of what happened in the past year or two.

And that were brought to their attention by the hospitals themselves, so that they would, from their point of view in fact, see that it was a net gain.

So, could you give us some kind of an idea when you say -- you or Pam or whoever, that this isn't your old PS, whatever it -- 90, or

whatever it is. But, it's a newer, better, and you're going to like it better?

Or, you know, if you were a C minus last year, you're going to be an A plus this year, or vice versa?

DR. YOUNG: Pam, are you on? Do you want to address that?

DR. OWENS: Well, from a sort of a methodologic approach, I mean, we can sort of say -- do that. Because that is an interesting scenario.

But, it's just that each of these indicators within the composite are basically -- we took away the noise in terms of making it just a much more precise measure.

I would expect hospitals to shift. How they shift within the HAC reduction, that's actually quite a complicated question.

Because, remember PSI-90 is just one component. I think it's Domain -- is it Domain One or Domain Two?

But, it's only a small percentage

relative to the entire composite. But then there's the whole other domain.

So, it's hard for me to assess which way hospitals are going to go. I know that's something we are looking at carefully.

I'm sure CMS is looking at it carefully. We don't, you know, we don't typically run it on Medicare fee-for-service data ourselves.

But, I don't know, Pierre, if you want to think about it from a program standpoint.

DR. YOUNG: Right. So, we are certainly from the CMS. So, we do look at the -- and are cognizant that there can be changes in sort of the hospital -- the distribution in where hospitals are classified.

And we do do internal analyses as we are thinking about implementing measures and updates to measures. In the program, we're looking at how that affects, you know, which hospitals get penalized and how that affects the distribution.

So, I mean, we do do those analyses and sort of think about them before implementing them.

CO-CHAIR WALTERS: Dolores?

MS. MITCHELL: -- performance of -- evaluations of physicians. And we have very carefully, as we make each year's changes, tested to make sure that there isn't motion -- movement from Tier One to Tier Three, or from Tier Three to Tier One.

Understanding that there will be changes between Tier One and Tier Two. And between -- to that, Tier Three and Tier Two. But that going from an A plus to a D minus is just not acceptable.

And if we can do it with our bench strength of -- well, we don't have any actuaries. That's where we're ahead of you.

But, sorry if I insulted anybody. But, I mean, I just don't know if the scenario that Nancy's worried about is in fact a likely outcome.

And I gather from what you've both said, that that's not in fact likely to happen.

CO-CHAIR WALTERS: Marty?

MEMBER HATLIE: Dolores, it's actually been 16 years since the IOM Report. It was November 30, 1999.

And I think as a country, we have just dragged our feet in coming up with a composite measure. I think that the fear of hospitals being embarrassed is just not enough of a rationale to drag our feet anymore.

I mean, CMS got serious about eliminating HACs. They're expediting action.

I would hope that if this composite measure is so bad, it will just incentivize all of us. Especially the hospital who needed to work on coming up with a better measure.

I just don't think we can afford to drag our feet anymore on this. It's just been too long.

We've been too tolerant of too much harm in our healthcare system.

CO-CHAIR WALTERS: It sounds like your recommendation is a support?

MEMBER HATLIE: It is a support. Thank you.

CO-CHAIR WALTERS: Did I see Nancy over here? Oh, Ann Marie.

DR. SULLIVAN: You know, I -- before I was in the position I'm in now, I was running a couple of hospitals.

And I think one of the problems is that the hospitals work very hard on the quality measures for what they're going to either get dinged for, or what they're going to get praised, you know, money for.

But the reality is if you're really going to -- which is I think partly why we haven't moved so far. Because I think hospitals have to get used to the fact that they're going to have to do quality across the board.

And it's not just the particular indicators. That we have to use something to measure and something to pay for.

But, you can't depend on that. You've got to say that my quality agenda has to be wide and broad and deep.

And I think we're getting there. But, we're not there yet. So, I think the panic that hospitals still have when something changes, is yes, I'm not going to look so good.

But, ultimately, if they're not looking good in whatever is now the new thing, then there's a problem. And they should be facing that and thinking of it in an ongoing basis.

So, I think we're at a point of evolution here for hospitals. Hopefully, we will get to the point where quality in everything is kind of important, so we move that agenda.

Which it has not moved. Partly I think because we still get too bogged down in the very specifics. Right now that's where we are. Good.

But, that's why I'm not too much in favor of saying, you know, this is going to be

too hard for hospitals. I think they have to face the facts that if they have serious problems with these issues, they've got problems with these issues and whether they've got to fix them and fix them relatively quickly.

CO-CHAIR WALTERS: What is your recommendation?

DR. SULLIVAN: For.

CO-CHAIR WALTERS: Jack?

DR. FOWLER: Yes, it seems like also, we're not here to micromanage with CMS, which we can't do anyway. And I mean, mainly my understanding is there are -- what we're supposed to do is say whether we think it would be a good idea to have this measure as one of the measures that was figured into the HAC program.

And that will count about three percent, I think that she said, of the final score. So, it seems to me I could vote on whether this is a good idea or not from that context.

And I think it is a good idea.

CO-CHAIR WALTERS: All right. Any other comments?

(No response)

CO-CHAIR WALTERS: Okay. Let's vote.

MR. TILLY: Polling is now open on Patient Safety and Adverse Events Composite, MUC15-604. The options are support, conditional support, and do not support.

(Voting)

MR. TILLY: And the results are 73 percent support. Twenty-three percent conditional support. Four percent do not support.

The recommendation is support.

CO-CHAIR WALTERS: So, at this time, we want to open up the lines again for public comment. And take any comments from the room in general, about anything discussed today.

(No response)

CO-CHAIR WALTERS: How about on the phone?

OPERATOR: Once again, to make a

comment, please press star then the number one.

(No response)

OPERATOR: There are no public comments.

CO-CHAIR WALTERS: Thank you. Thank you again, for everybody for their patience. We've actually made up a lot of ground this afternoon.

Looking forward to tomorrow again, breakfast is at 8:30. We'll start at 9:00 unless that's changed.

We'll redo the agenda probably a little bit. But, this is what you do, right?

Cancer, probably -- it probably will be first. There's five measures of which one's been pulled. Then Renal has seven measures of which three have been pulled.

All except one now. It changes hourly, yes. OQR has two measures. Both of which have been pulled.

ASC has one measure which was pulled. And the psychiatric core measures has two. One

of which has been pulled, unless that's changed.

We've had a -- we'll see how time goes. We had a request to do psychiatric maybe a little different timing -- or a little different sequence as some people are going to be leaving.

But, I think as long as we come prepared to get through. I think, as everybody knows, the bulk of the work was today.

And a lot of good work and discussion went on today. There was a lot of good views about some very important things.

So, thank you again. And I certainly appreciate all your involvement. Cristie?

CO-CHAIR TRAVIS: Oh. Nothing other than thank you from my perspective. And I look forward to seeing you all tomorrow.

Please do come back.

(Whereupon, the above-entitled matter went off the record at 5:04 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership Hospital Workgroup

Before: NQF

Date: 12-16-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter