National Quality Forum
Measure Applications Partnership Post-Acute Care/Long-Term Care Workgroup 2022 Measure Set Review Meeting
Thursday, June 30, 2022

The MAP PAC/LTC Workgroup met via Videoconference, at 10:00 a.m. EDT, Gerri Lamb, Co-Chair, presiding.

Present:

Gerri Lamb, PhD, RN, Co-Chair
Dan Anderson, PhD
Larry Atkins, National Partnership for Healthcare and Hospice Innovation
Alice Bell, American Physical Therapy Association
Jill Cox, National Pressure Injury Advisory Panel
Elissa Charbonneau, Encompass Health Corporation
Nicole Fallon, LeadingAge
Andrew Geller, Centers for Disease Control and Prevention
Aparna Gupta, National Hospice and Palliative Care Organization
Jolie Harris, SNP Alliance
Jim Lett, National Transitions of Care Coalition
Dheeraj Mahajan, AMDA, The Society for Post-Acute and Long-Term Care Medicine
Paul Mulhausen, MD, MHS
Pamela Roberts, American Occupational Therapy Association
Debra Saliba, American Geriatrics Society
Michelle Schreiber, Centers for Medicare and Medicaid Services

NQF Staff:

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Joelencia Leflore, Associate
Jenna Williams-Bader, MPH, Senior Director
Susanne Young, MPH, Manager

Gus Zimmerman, MPP, Analyst

Also Present:

Ihsan Abdur-Rahman, CMS
Alrick Edwards, Abt Associates
Beth Godsey
Morris Hamilton, Abt Associates
Nicole Keane, Abt Associates
Julie Malloy
Cody Mullen
Rebekah Natanov, CMS
Gerald Nebeker
Mary Pratt, CMS
Gequincia Polk, Indefinite Delivery/Indefinite Quantity Contracting Officer's Representative, Interim TO COR, CCSQ, CMS
Joan Proctor, CMS
Shequila Purnell-Saunders, CMS
Mikhail Pyatigorsky
Kimberly Rawlings, Task Order Contracting Officer's Representative, CCSQ, CMS

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Proceedings

(10:04 a.m.)

Welcome, Introductions, Overview of Agenda, Disclosures of Interest (DOIs) and Review of Meeting Objectives

Ms. Williams-Bader: Okay. Good morning, everyone. This is Jenna Williams-Bader from the National Quality Forum. Thank you very much for joining us this morning and for this discussion today about measure set removal for PAC/LTC programs.

Before we get started, a few quick housekeeping reminders. You can mute and unmute yourself with the system and you can also turn your video on and off. Please feel free to have your video on throughout the event.

Please, if you are on the web platform, raise your hand and unmute yourself when called upon. And if you are a call-in user, please state your first and last name when talking. You may also use the chat feature to communicate with NQF staff throughout the meeting.

Next slide, please. Also, a few meeting ground rules. Really, here, we're asking you to be respectful of each other and of all voices here. Please try to remain engaged and actively participate. We know this is a full day and we appreciate you staying engaged throughout the meeting.

Please base your evaluation and recommendations on the criteria we've provided and the guidance we'll provide during the meeting. Keep your comments concise and focused. We have a few measures to get through today. So we need to keep an eye on the time.

Please be respectful to others and allow others to contribute, but we also -- your experiences are really important, so we want to hear from you and

just if we could all approach this meeting with a learning mindset and learn from others.

Next slide, please. I am sure many of you are familiar with the WebEx platform. But in case you need a couple of reminders, the way to mute or unmute yourself, there's a button along the lower left-hand side you can see here, No. 1.

If you want to see the participants or chat, there will be -- there's a participant and chat -- a couple of buttons on the lower right-hand side.

And then to raise your hand you -- there should be a little Raise Hand or you can -- there might also be a little Reactions tab. And then if you click that, you'll see a Raise Hand option.

Next slide, please. So as I said, I am Jenna Williams-Bader, Senior Director of the Measure Applications Partnership here at NQF, and we are really looking forward to the discussion today. We look forward to your feedback on these measures.

We'd like to thank CMS for participating and for funding this work and we'll go ahead and jump in.

Quick review of the agenda. We'll start with introductions, disclosures of interest and a roll call and a review of the meeting objectives. We will ask CMS to give some opening remarks. Then we'll do a review of the process and the measure review criteria and voting categories we'll be using today.

Then we'll spend the bulk of the time talking about the measures under review and the Home Health Quality Reporting Program. There are opportunities for public comment at a couple points in the day; first before we actually start walking through all of the measures individually, and then once after we've had the measures discussion.

We'll then have an opportunity to discuss gaps at the end of the day, and the last meeting agenda

item is getting feedback on the Measure Set Review Process from all of you. We really hope you can stay for that portion and give us feedback as this is the first time that we are rolling out measure set review to all of MAP.

Next slide, please. And one more. So I'll now turn it over to Tricia Elliott for opening remarks.

Ms. Elliott: Thank you so much, Jenna, and it is my pleasure to welcome you to today's MAP Measure Set Review Post-Acute Care/Long-Term Care Workgroup Meeting.

NQF is honored to partner with the Centers for Medicare/Medicaid Services to convene the Measure Application Partnership. MAP brings together multi-stakeholder groups with representatives from quality measurement, research and improvement, purchasers, public community health agencies, health professionals, health plans, consumers and suppliers.

Last year, NQF collaborated with CMS and piloted the Measure Set Review Process to offer a holistic review of quality measures.

The 2021 Measure Set Review Pilot considered input from the MAP Coordinating Committee on 22 measures with the output being a set of final recommendations and rationale for measure removal. During the pilot, CMS and NQF prioritized programs within the hospital setting.

The 2022 MSR process has expanded beyond the pilot bringing the three setting-specific workgroups and two advisory groups into the process.

MAP members will review measures from the hospital, clinician and PAC/LTC settings as this will be the first year that we involve all MAP members in the Measure Set Review and we expect to learn quite a bit, and we welcome your feedback on the process.

Today's meeting will focus on discussing measures under review from post-acute care, long-term care, including those measures nominated from the Home Health Quality Reporting Program.

During today's meeting, the PAC/LTC Workgroup members will decide on the extent to which each measure contains challenges regarding data collection and/or reporting for PAC/LTC providers, contains any methodological problems calculating performance, or contains any negative consequences relating to the removal of the measure in the specified program.

We would like to thank our workgroup members and federal liaisons for their time and effort. Thank you also to our colleagues at CMS and to the program leads who have joined today's call and who have been extremely helpful during this process. We would also like to thank all of you in advance for providing important feedback that will help us hone the MAP PAC/LTC Workgroup activities.

Lastly, I want to extend a special thank you to our co-chairs, Gerri Lamb and Kurt Merkelz, who, unfortunately, is not able to attend today, for their leadership and dedication over the course of the MAP PAC/LTC Workgroup.

I would like to specifically recognize Gerri Lamb for her contributions to this workgroup as this will be her last workgroup meeting as a co-chair.

The MAP PAC/LTC Workgroup appreciates -- was that a sigh of relief, Gerri -- appreciates your thoughtful facilitation, commitment and engagement throughout your time as our co-chair.

At this point, I'd like to hand things over to Jenna.

Ms. Williams-Bader: Thank you very much, Tricia. We can go to the next slide, please. Yes. So we'll now have an opportunity for welcoming remarks.

As Tricia said, Kurt was, unfortunately, unable to join us today. He may join for part of the meeting, but is mostly unavailable. So Gerri will be leading as our lone co-chair today. And so you might see NQF staff helping to support her in facilitating the discussions in order to give her a little bit of relief.

So, Gerri, let me turn it over to you.

Co-Chair Lamb: Thanks, Jenna. And thanks, Tricia, for that lovely comment. Nope, it wasn't me sighing. It probably was some of our committee members.

So good morning everybody. I'm really happy to see you and thanks so much to everybody for taking time -- lots of time to be here today and prepare for today.

It's just -- it's such an important opportunity especially since we're doing a different type of review for the first time today together. And so being able to tap into your expertise and your advice is really critical here. So I am so glad so many of you are here today.

And as always, thank you to the NQF team -- remarkable NQF team who always helps us with outstanding preparation for our meetings and to CMS.

So I would just say let's have a great discussion throughout the day and please, everybody, feel free to participate actively, share your ideas. This is really important work.

When we do MUC, we're talking about making recommendations for measures coming in. This time, we're talking about removing measures. Equally important. Different process. So looking forward to talking to all of you.

Ms. Williams-Bader: Great. Thank you so much, Gerri.

All right. Next slide, please. So now we will turn to

disclosures of interest. As a reminder, NQF is a nonpartisan organization.

Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendoes or humor relating to, for example, race, gender, politics or topics that otherwise may be considered inappropriate during the meeting.

While we encourage discussions that are open, constructive and collaborative, let's all be mindful of how our language and opinions may be perceived by others.

We will combine disclosures with introductions. We will divide the disclosures of interest into two parts because we have two types of MAP members, organizational members and subject matter experts.

We'll start with organizational members. Organizational members represent the interests of a particular organization. We expect you to come to the table representing those interests.

Because of your status as an organizational representative, we ask you only one question specific to you as an individual. We ask you to disclose if you have an interest of $10,000 or more in an entity that is related to the work of this committee.

Let's go around the table beginning with organizational members only, please. We will call on anyone on the meeting who is an organizational member.

When we call your organization's name, please unmute your line, state your name, your role at your organization and anything that you wish to disclose. If you do not identify any conflicts of interest after stating your name and title, you may add I have nothing to disclose.

If you represent an organization that is a measure steward or developer and if your organization developed and/or stewarded a measure under discussion today in the past five years, please disclose that now and then we ask you to recuse yourself from the discussion and poll for that measure later in the day.

I will now turn it over to Susanne to run us through the organizational disclosures.

Ms. Young: Thanks, Jenna. Okay. We will start with organizational members first. Do I have someone on the line from the Society for Post-Acute and Long-Term Care Medicine?

Member Mahajan: Yeah. Hi. This is Raj Mahajan. I'm from Chicago. I represent AMDA, The Society for Post-Acute and Long-Term Care Medicine. I'm glad to be here. Looking forward to the discussion.

Ms. Young: Thanks, Raj. Do you have any disclosures?

Member Mahajan: Yeah, no conflicts.

Ms. Young: Thank you. Next, the American Academy of Physical Medicine and Rehabilitation.

Okay. Next, American Geriatric Society.

Member Saliba: Good morning. I'm Deb Saliba and I'm representing the American Geriatric Society. I have no conflicts to disclose.

Ms. Young: Thanks, Deb. American Occupational Therapy Association?

Member Roberts: I'm Pam Roberts and I'm representing American Occupational Therapy Association and I have no disclosures.

Ms. Young: Thank you, Pam. American Physical Therapy Association?

Member Bell: Good morning. My name is Alice Bell. I am a physical therapist and a senior specialist in health policy and payment representing the American Physical Therapy Association, and I have nothing to disclose.

Ms. Young: Thank you, Alice. ATW Health Solutions?

Okay. We will circle back. Encompass Health Corporation?

Member Charbonneau: Good morning. My name is Dr. Elissa Charbonneau. I'm the Chief Medical Officer of Encompass Health and I am filling in for Mary-Ellen DeBardeleben.

So I apologize. This was kind of a last-minute substitution for me, but I have been on the Standing Committee for the Patient Safety Task Force.

So I am somewhat familiar with the NQF process. So my only disclosure is that I am employed full-time by Encompass Health.

Ms. Young: Thank you, Elissa. I'm glad you could join us. Kindred Healthcare?

Okay. Next, LeadingAge?

Member Fallon: Hi. I'm Nicole Fallon. I'm the Vice President of Health Policy and Integrated Services with LeadingAge and I have no disclosures.

Ms. Young: Thank you, Nicole. Just FYI, you're a little quiet.

Member Fallon: Thank you. I'll try and talk louder.

Ms. Young: That's perfect. Thank you.

Member Fallon: Thanks.

Ms. Young: National Hospice and Palliative Care Organization?

Member Gupta: Good morning, everyone. I'm Aparna Gupta. I'm the Vice President of Quality representing National Hospice and Palliative Care Organization. I have nothing to disclose.

Ms. Young: Thank you. National Partnership for Healthcare and Hospice Innovation?

Member Atkins: Hi. I'm Larry Atkins. I'm the Chief Policy Officer for NPHI and I have nothing to disclose.

Ms. Young: Thank you, Larry. National Pressure Injury Advisory Panel?

Member Cox: Good morning. My name is Jill Cox. I sit on the Board of Directors for the NPIAP and I have nothing to disclose.

Ms. Young: Thank you, Jill. National Transitions of Care Coalition?

Member Lett: Good morning. I'm Jim Lett. I'm the President of the Board of Directors of NTOCC. I'm a post-acute and long-term care physician retired from practice of more than 30 years.

I just retired beginning this year from being associate medical director of a quality improvement organization. So obviously a relationship with CMS at one time, but no longer.

Since I've retired, I am on the board of a private company and one branch of the business is being a quality improvement organization. So relationship with CMS from that standpoint, but not direct. Only through the Board oversight. Beyond that, nothing to disclose.

Ms. Young: Thank you. SNP Alliance?

Member Harris: Good morning. I'm Jolie Harris. I'm representing Skilled Alliance, Special Need Plan Alliance. I am a VP of Clinical Services and COO for ISNP (phonetic) in Louisiana. Nothing to disclose.

Ms. Young: Thank you. Let me pause here, and have any organizational members joined since we started with roll call or DOIs for organizational members?

Okay. Next slide, please.

Ms. Williams-Bader: Okay. Thank you very much for those disclosures. Now, we'll move on to disclosures for our subject matter experts.

Because subject matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities. When you disclose, please do not review your resume. Instead, we are interested in your disclosure of activities that are related to the subject matter of the workgroup's work.

We are especially interested in your disclosure of grants, consulting or speaking arrangements, but only if relevant to the workgroup's work.

If you are a measure steward or developer and if you developed and/or stewarded a measure under discussion today in the past five years, please disclose that now and then we ask you to recuse yourself from the discussion and poll for that measure later in the day.

Just a few reminders. You sit on this group as an individual. You do not represent the interest of your employer or anyone who may have nominated you for this committee.

I also want to mention that we are not only interested in your disclosures of activities where you were paid. You may have participated as a volunteer on a committee where the work is relevant to the measures review by MAP. We are looking for you to disclose those types of activities as well.

Finally, just because you disclose does not mean

that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

Please tell us your name or organization you're with and if you have anything to disclose. Susanne will call your name so that you can disclose. We'll begin with our co-chairs, and so I'll turn it over to Susanne.

Ms. Young: Thanks, Jenna. So we will start with Gerri Lamb.

Co-Chair Lamb: I'm Gerri Lamb. I'm a professor at Arizona State University, and I do consulting in care coordination. I also receive royalties for books that I've written or edited in care coordination and I am an expert in care coordination on advisory committees at NCQA.

Ms. Young: Thanks, Gerri. And I don't think Kurt has joined us, but just pausing here to make sure.

Okay. Dan Andersen?

Member Andersen: Yeah. Hi, everybody. My name is Dan Andersen. I work at the RELI Group. I think the only disclosure I have is the same as on previous meetings.

In my work at RELI, one of our -- a contract that I -- a subcontract that I manage is actually validating some of the data that's on the PAC QRP sites, you know, which includes some of these measures once they are endorsed or pushed to the public websites. So I do want to disclose that.

Ms. Young: Thank you, Dan. Paul Mulhausen?

Member Mulhausen: Hi. I'm Paul Mulhausen. I am a medical director with a health plan in Iowa called Iowa Total Care. I'm a geriatrician and have a lot of experience in long-term care and quality improvement in the Medicare program.

I don't believe I have any conflicts of interest, but I should disclose I'm on the Board of Directors for the American Geriatric Society, but not representing them in my role on this workgroup.

And I am a paid employee of Centene Corporation, which administers a number of Medicare Advantage plans, but I'm not involved with any of those plans. So those are my disclosures.

Ms. Young: Thank you, Paul. And forgive me, is it Sarah -- is it Livesay?

And Terrie Black?

We'll keep an eye out and, Jenna, I'll turn back to you.

Ms. Williams-Bader: Thank you very much, Susanne. At this time, we'd like to invite our federal government participants to introduce themselves.

They are nonvoting liaisons of the workgroup, and I'll start with the Centers for Disease Control and Prevention.

Okay. Move on to Centers for Medicare/Medicaid Services?

Member Schreiber: Good morning. This is Michelle Schreiber. I'm here from CMS. We have a number of other CMS colleagues on the phone as well. Thank you.

Ms. Williams-Bader: Thank you.

Member Geller: And this is Andy Geller from CDC, Division of Healthcare Quality Promotion. I was muted. Sorry, I don't think I was heard before. Andy Geller, DHQP, CDC.

Ms. Williams-Bader: Thank you so much. And then the Office of the National Coordinator for Health Information Technology?

Okay. Just one more time, have any organizational representatives joined or subject matter experts?

Okay. Well, thank you all so much. I'd like to remind you that if you believe you might have a conflict of interest at any time during a meeting, please speak up. You may do so in real-time at the meeting or you can also message your chair or go directly to NQF staff.

If you believe that a fellow committee member may have a conflict of interest or is behaving in a biased manner, you may also point this out during the meeting, approach the chair or go directly to NQF staff.

Do you have any questions or anything you'd like to discuss based upon the disclosures made today?

Okay. Well, thank you all. Let's go ahead and move on. So I'd like to introduce our MAP staff starting with Tricia Elliott, who is our senior managing director.

As I said, I am Jenna Williams-Bader, Senior Director of Measure Applications Partnership. We have Katie Berryman, who is our Director of Project Management; Ivory Harding and Susanne Young, who are managers; Ashlan Ruth, who is our Project Manager; Joelencia LeFlore, who is our associate; and Gus Zimmerman, who was recently promoted -- very recently promoted to Analyst.

Next slide, please. We then also have Kim Rawlings from CMS joining us today. She's our Task Order Contracting Officer's Representative, or COR. And then we also have Gequincia Polk, who is our IDIQ COR.

Next slide, please. Oh, and also -- apologies. We also would like to introduce Taroon Amin. He has a lot of experience with MAP. He has been working on MAP since its inception and used to work at NQF. He's now an NQF consultant. You'll hear his voice

quite a bit as he will be facilitating a large part of the meeting today.

So the meeting objectives. We will be reviewing the Measure Set Review Process, Measure Review Criteria and voting categories, as I said before. We'll then be providing you with an opportunity to discuss and recommend measures for potential removal.

And then, as I also mentioned, at the end of the day we'll be seeking feedback from you on the process and we think this is a really valuable opportunity to learn what's gone well and what can be improved in the future.

CMS Opening Remarks

Okay. Next slide, please. I will now turn it over to Michelle Schreiber, from CMS, to make some opening remarks.

Member Schreiber: Jenna, thank you very much. You and I have spent a great deal of time together recently. And so I want to say thank you to you because this has been a tremendous amount of effort.

Welcome, too, everybody. We are just delighted that you are on the call today and we thank you for the time that you are taking out of your personal lives to spend to provide comment to CMS about measures removal.

As you know, this is a relatively new process. Last year, it was the Coordinating Committee who actually looked at some measures for removal and this is the first time that we're involving the committees directly.

And we thought who better to really comment on measures in the programs than the actual committees, the Hospital Committee, the Clinician Committee, the Post-Acute Care Committee, because you've come to know these programs very

well.

And so this now becomes, you know, closing the cycle where the committees get to recommend on measures to include potentially in CMS programs as well as to remove from these same programs, which really over time we think will make significant progress in helping to shape these various value-based programs into something that is even more meaningful and useful for the community and for all individuals.

We have so far had meetings from the Rural Committee, from the Equity Committee, who have looked at all of the measures, not just a select subset of them, and have made comments.

The Hospital Committee has met and the Clinician Committee. So you are really wrapping up the committees before we go to the Advisory Committee as a whole.

So far the conversations have just been so informative and the comments have been so thoughtful. And we know that the same will be today and look forward to everyone's comments.

I do want to say some special thanks first again to NQF and to the staff who are leading this. I already mentioned Jenna in particular, but, you know, NQF does a lot of work in organizing these and has been wonderful hosts to CMS.

There are a number of CMS colleagues on the phone today. If you see their names as participants, I will just share Rebekah Natanov, Ihsan Abdur-Rahman, Joan Proctor, Kim Rawlings, Mary Pratt, Shequila Purnell-Saunders. Hopefully I didn't miss anybody. They are really the experts in these programs and it's Joan Proctor who will be leading the conversations for CMS today.

Who is not here, unfortunately, and I just want to take a note of thanks even though he's not here,

many of you know him, Dr. Alan Levitt, who has been on these post-acute care committees for a long time and is really an expert in post-acute care.

This is his last week at CMS. He's actually retiring effective tomorrow. Well-deserved, we wish him well, but his absence will be felt by all of us today.

We certainly thank our co-chairs and, Gerri, thank you for carrying the load today singlehandedly. That's quite a great deal of work, but to the co-chairs who really helped put this together.

And then, again, to each and every one of you for spending your time in trying to improve these programs and making recommendations to CMS this time around, measures to be removed.

We look forward again to today's conversation. In advance, I wish all of you a Happy 4th of July weekend. And with that, Jenna, I turn it back to you.

Ms. Williams-Bader: Thank you very much, Michelle. Very kind words. Appreciate that.

Okay. So before we do a review of the process, I'd like to check has anyone from the MAP Workgroup joined?

Mr. Mullen: This is Cody from the Rural Health Group.

Ms. Williams-Bader: Oh, hi, Cody. Okay. We'll circle back.

Susanne, I will turn it over to you for review of MSR Process.

Review of MSR Process and Measure Review Criteria (MRC)

Ms. Young: Thanks, Jenna. Now we want to do a review of the MSR process and the Measure Review Criteria. For those of you who joined us for our

education meeting, which seems like so long ago, months ago, some of this might be a review for you.

Next slide. So this is a visual overview of the 2022 MSR process and its four steps, which are prioritize, survey, prepare and discuss.

So starting with the first one, so CMS and NQF prioritized programs for discussion. And then, you know, we started with a large group of measures. The NQF staff refined the list of measures and then created a survey for MAP members to review.

Second step, survey. The workgroup and advisory group members nominated measures to discuss for potential removal.

And again, they were nominating those measures to bring them to the table so they could be discussed for further review using the Measure Review Criteria's rationale. And we'll go over that Measure Review Criteria in the next couple slides.

And then, of note, we do want to note that when MAP members -- when workgroup and advisory group members were nominating those measures for discussion, they did not have the full amount of information that you see today and that you have on your measure summary sheets as we started with a very large group of measures.

NQF then compiled the survey results selecting the measures with the most votes to determine the list of measures for discussion.

So when we talk about post-acute care and long-term care, actually hospice and home health were both on that survey.

They were only talking about home health measures because those are the ones that rose to the top. We did not have any measures that rose to the top on the survey in hospice.

The third step is prepare. And after compiling that

list of measures, those measures were presented for public comment.

And that public comment is on those measure summary sheets and you also will maybe hear reference to the public comment that was made by our lead discussants today.

NQF staff then prepared the measure summary sheets for review by advisory group and workgroup members.

And fourth, discuss. That's where we are here today. A couple weeks ago the advisory groups met and today, as was mentioned earlier, this is the last of our workgroup meetings.

Workgroups will vote to recommend maintaining or removing a measure and we will review those categories on the next couple slides.

The workgroup will hear feedback from the advisory groups. I know we have some volunteers here today that will reference any discussions that were made during the advisory groups, and then come forth in a couple months.

In August, the Coordinating Committee will discuss all the measures and the Coordinating Committee will vote to uphold the workgroup recommendation.

These recommendations will be published in early fall and is one factor in CMS measure evaluation.

Next slide, please. This slide, this is the first of two slides. This is the 2022 MSR Measure Review Criteria. These are the first seven of which there are ten.

For the MSR pilot here, NQF created a set of Pilot Measure Review Criteria. And then based on feedback from the Coordinating Committee after the pilot, additional clarifying language was added to the criteria.

Next slide, please. These are the last three criterion. As we move ahead, we anticipate the criteria will continue to evolve as we gain experience from the MSR process.

And then speaking of process, I know Jenna mentioned earlier that at the end of today there will be an opportunity for member feedback as we want to hear your feedback on the MSR process.

Next slide, please. Now, we want to go over the four MSR decision categories. And we will go into detail on the next couple slides, but we have four categories; Support for Retaining, Conditional Support for Retaining, Conditional Support for Removal and Support for Removal.

Next slide, please. Okay. Let's start with Support for Retaining. So this definition is that MAP supports retaining the measure, as specified, for a particular program. Again, today we'll be looking at home health.

After discussion, MAP determines that the measure does not meet review criteria for removal or the measure meets at least one review criterion, but MAP thinks that the benefits of retaining it in the program outweigh the MAP criterion. Additionally, MAP has not identified any changes for the measure.

So some examples of this would be the measure is a PRO-PM that is associated with reporting burden, but it is an important measure to patients.

Another example is the measure is not reported by some entities due to low volume, but it is a meaningful measure for those entities who can report it.

Next slide. The next decision category, Conditional Support for Retaining. So MAP supports retaining the measure for a particular program, but it has identified certain conditions or modifications that

would ideally be addressed.

The measure meets at least one review criterion, but MAP thinks the benefits of retaining it in the program outweigh the MAP criterion; however, MAP supports retaining of the measure is based on certain conditions or modifications being addressed.

So some examples of the conditions or modifications would be receives CBE endorsement, is aligned to the evidence, is respecified as an eCQM, or is modified so that it no longer meets review criteria.

Next slide, please. And the third category, Conditional Support for Removal. MAP supports removal of the measure from a particular program, but has identified certain conditions that would ideally be addressed before the removal of the measure.

The measure meets at least two review criteria, but MAP thinks that removing the measure would create a measurement gap. Therefore, MAP does not support the removal until a new measure is introduced into the program.

So some examples of that would be the measure is integrated into a composite or the process measure is replaced by an outcome measure or a PRO-PM.

Next slide, please. At our fourth category, Support for Removal, MAP supports removal of the measure from a particular program.

This measure meets at least two review criteria and MAP does not think that the removal of the measure will create a measurement gap.

This is where the workgroup determines that the measures no longer meets the program priorities and removing it will not lead to measurement gap; for example, the measure is topped out.

Next slide, please. And the workgroup review meetings and key voting principles, again, this will

be similar to (audio interference) process.

Quorum is defined as 66 percent of the voting members present for live voting to take place.

NQF staff establish quorum -- we did that earlier today -- prior to voting. And if quorum is not established, the members will vote via electronic ballot after the meeting.

And MAP has established the consensus threshold of greater than or equal to 60 percent of voting members voting positively and a minimum of 60 percent of the quorum figure voting positively.

And if there are any abstentions, they do not count in the denominator. And every measure under review for MSR will receive a decision category today.

Next slide, please. Let's go over the process for today's discussion starting with the NQF staff is going to describe the program.

Again, we're talking about home health today in which the measures are currently included.

2, the co-chair will open the discussion for public comment on measures under review within the home health program for today.

Step 3, we will have lead discussants offer any initial thoughts about retaining the measure in the program.

4, we will have advisory group volunteers and NQF staff summarize the advisory group's discussion of the measure.

And then 5, co-chair will ask for any clarifying questions and open the measure for discussion.

We do have CMS leads on the call with us today. We appreciate that. The CMS leads will respond to clarifying questions about the measure and NQF

staff will respond to clarifying questions about the process.

Next slide, please. And then 6, we will have workgroup discussion of each measure and provide feedback on data collection and/or reporting challenges for PAC/LTC providers, including hospice, inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities and home health care, methodological problems of calculating performance measures and potential unintended or negative consequences related to removing the measure from the program.

And then 7, co-chair will put forward a decision category. So as the discussion is happening, co-chair, Gerri, will summarize the major themes of the discussion and will determine what decision category will be put forth to a vote today based on potential consensus emerging from this discussion.

If the co-chair does not feel there is a consensus position to use to begin voting, the workgroup will take a vote on each potential decision category one at a time.

The first vote will start with conditional support for retaining, then conditional support for removal, then support for removal, and then finally support for retaining.

Next slide. And finally our last step, Step 8. NQF staff will tally the votes. If a decision category put forth by the co-chair receives greater than or equal to 60 percent of the votes, then the motion will pass and the measure will receive that decision category.

If no decision category achieves greater than 60 percent, the measure will be assigned the decision support for retaining.

Next slide, please. And let me pause here for any questions on the 2022 MSR process. Feel free to raise your hand. Or if you are on the phone, feel

free to come off mute.

Keep me honest, team. I don't see any hands.

Ms. Williams-Bader: I don't see any either.

Ms. Young: Don't hesitate to ask us if there's any process questions that come up in the future.

Next slide, please. So speaking of voting, at this time we do want to do a test vote. Yesterday, voting members received a link -- or you should have received a link via email for the Poll Everywhere platform. And that is what we will use today to vote. It's the same platform that we have used for the MUC process.

We'd like you to find that email and use that link to open the platform, and please let us know if you're having trouble locating the link or opening the platform. We are going to bring up a test question.

Okay. And our test question today is do you like tea? And, again, let us know if you're having trouble locating that link or any trouble with that platform.

Member Roberts: Do you mind resending it, because I'm trying to find it in my email.

Ms. Young: And I'm sorry, I missed your -- is that Pam?

Member Roberts: Yes, please.

Ms. Young: Team, can we send Pam that link, please?

Member Roberts: Never mind. I found it.

Ms. Young: Perfect. Thank you.

Okay. Looks like we have 14 and I think that is what we have on the back-end, how many we should -- the count we should have.

So do you like tea? And when we do voting, we will

close the vote. And we have 13 members who like tea and 1 who does not.

Again, if you have any problems throughout the day with that platform, please let us know.

And now, I think I will turn it back to you, Jenna.

Ms. Williams-Bader: Susanne, we might have had one more than we expected during that last vote based on someone stepping away.

So just -- it might be that everyone was available, but, just as a reminder, this is just for the MAP members, organizational reps and/or subject matter experts.

And also if you've -- I guess I'll pause here and see has a MAP member joined since we did roll call at the beginning of the meeting?

Member Lett: Well, I apologize. This is Jim Lett. I saw the question, but I couldn't find a way to take action with a vote on that question.

Ms. Young: When the vote was open, were you able to click on a response?

Member Lett: It did not capture my response, to my knowledge.

Ms. Young: Okay.

Member Lett: I mean, if you all have a way of checking from your end to see if mine came through?

Ms. Young: We are checking on the back-end.

Ms. Williams-Bader: If we can just pause here for just one second, we'll see if we can work this out.

This is just the best opportunity for us to make sure that voting is working correctly. So we'll check that quickly.

Ms. Young: And while we're paused here, do we have -- any questions come to mind on the process and what we discussed earlier?

Ms. Williams-Bader: So, Jim, maybe we can circle back to you. We'll let you know if your vote came through or not and work with you before the next vote.

And I see a hand raised from Jill Cox?

Member Cox: Yes, hi. Just a quick question.

So in the voting I -- I'm not identified as to who I am; is that correct? We're supposed to be anonymous?

I did not sign in as a name -- I don't know if that makes a difference -- or my organization that I represent.

Do you want that?

Ms. Young: Correct me if I'm wrong, team, but if someone has voted in the past, they may not have to enter their name the next time?

Member Cox: Meaning in a past meeting? In a previous --

Ms. Young: Meaning in a past meeting.

Member Cox: Okay.

Ms. Young: Jill, we can see on the back-end who is voting.

Member Cox: Okay. Fine. Okay. Thanks.

Ms. Young: Thank you.

Ms. Williams-Bader: Okay. I think we can go ahead and move on. It looks like we do have someone voting -- or we have a name showing up for someone that doesn't look like they're signed into the meeting. So we're going to keep working on the

back-end on that.

Maybe it's a name that's saved somehow from a prior vote. We will try to look into that.

Okay. Let's go ahead and move on to the next slide, though. So today we'll be looking at measures from the Home Health Quality Reporting Program.

One thing to note, is that we also included the Hospice Quality Reporting Program in this year's measure set review; however, none of the measures received enough votes on the survey to be discussed today.

So that is something to keep in mind that that program is considered to be part of this year's measure set review.

Next slide, please. And the next one. So the Home Health Quality Reporting Program is a pay-for-reporting program.

Section 484.225(i) of Part 42 of the Code of Federal Regulations provides that HHAs that meet the quality data reporting requirements are eligible to receive the full home health market basket percentage increase.

HHAs that do not meet the reporting requirements are subject to a two-percentage point reduction to the HH market basket increase.

Alignment with the mission -- or, sorry, the program goals are alignment with the mission of the National Academy of Medicine, which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety and timeliness.

Another thing to note is that of the measures selected by the Committee, several are statutorily mandated within this program.

The IMPACT Act mandated the reporting of quality

measures, as well as resource use and other measures, across four post-acute care settings; home health agencies, inpatient rehabilitation facilities, long-term care hospitals and skilled nursing facilities.

The measurement domains mandated under the IMPACT Act included functional status, skin integrity, injurious falls, medication reconciliation, transfer of health information, Medicare spending per beneficiary, discharge to community and potentially preventable hospital readmission rates.

Measures falling under the IMPACT Act cannot be removed from the PAC programs unless directed by Congress.

We will be discussing those measures that were nominated in the survey today despite the statutory mandate because CMS would like feedback from MAP about whether the measures in the programs are the right measures, and CMS welcomes feedback on these measures.

So next slide, please. And then one more. So I'll now turn it over to Gerri for public comment on the measures in the Home Health Quality Reporting Program.

Opportunity for Public Comment on Home Health Quality Reporting Program (HHQRP) Measures

Co-Chair Lamb: Thanks, Jenna.

So we're pleased to have an opportunity for public comments on the measures under review.

We're going to have two opportunities to do that; once now at the beginning, and once as we complete the measure reviews.

I would ask before we open up the lines or you put your hand up, to please, in the interest of time, keep your comments to two minutes, or less, and please focus your comments on the measures under

review today, the ten measures that we are reviewing. So thanks so much.

Jenna, do you want to take a look and open it up for either hands up or calling in?

Ms. Williams-Bader: So I'm not seeing any hands immediately, but we will leave this open for a minute here.

Currently, I'm not seeing any hands. I'm not seeing anything in the chat. Is there anyone on the phone who would like to make a comment?

I'm still not seeing any hands and no chat. I think we can probably go ahead and --

Co-Chair Lamb: Move on? Okay.

Ms. Williams-Bader: -- close public comment.

Co-Chair Lamb: Thanks, Jenna.

And so, again, there will be another opportunity for public comment at the end of the review.

HH QRP Measures

00187-C-HHQR: Improvement in Dyspnea

And now, we're going to move into our first measure review, which is 00187: Improvement in Dyspnea, and just a quick review.

Taroon, I'm not sure if we have the slide, but quick review of our process. Okay. There is a very tight sequence of presentations.

So Taroon will be introducing the measure and you're going to see this over and over throughout today. So just kind of go with the rhythm here.

So Taroon will introduce, then our CMS project person will have a chance to comment. Then we will have the lead discussants as well as our advisory volunteers from Rural and Equity, and then we will

have a chance to open for discussion.

Did I get that right, Taroon?

Dr. Amin: That's exactly right, Gerri.

Co-Chair Lamb: Cool. All right, Taroon, you're on.

Dr. Amin: Let's get started.

Thank you, everyone, for joining today. We'll start with 00187-C-HHQR: Improvement in Dyspnea.

This is a percentage of home health episodes during which patients become less short of breath.

The endorsement status is Remove. Endorsement was removed and the selection count was six.

If we go to the next slide, this includes the rationale that was selected by MAP members for discussion today and additional feedback that was provided.

I will turn it over to Joan for a one-minute introduction of any contextual comments from CMS.

Joan, are you on the line?

Ms. Proctor: Yes, I'm here.

Can you --

Dr. Amin: Great.

Ms. Proctor: -- hear me?

Dr. Amin: Yes. Absolutely.

Take it away, Joan.

Ms. Proctor: Sure. Clinically, dyspnea is a useful proxy for heart failure, COPD and other chronic diseases that have shortness of breath as an indicator of stability.

The median performance score is 83.5, and the mean is 78.4, and trend data showing national

averages suggests that HH scores are still improving over time.

To address specific questions on the Medicare measure summary sheet, we would like to note there is no exclusion for diagnosis of a terminal illness for OASIS QMs.

The measure is currently reported on Care Compare and is part of the Home Health Quality Reporting Star Rating and the Home Health Value-Based Purchasing.

Through the Improvement in Dyspnea measure, endorsement was removed by the 2012 Pulmonary and Critical Care Consensus Standards Committee. It was due to the consideration of a stronger QM to replace it.

The preference was to defer decisions to determine if another stronger measure would be presented that could replace the existing measure and no measure currently addresses this area of clinical quality as the dyspnea QM.

CMS would like to retain this measure as dyspnea is associated with increased hospitalizations and is a symptom of a myriad of diseases. It is an important outcome to monitor and assess improvement in symptoms.

Our goal of the Home Health Quality Reporting Program is to encourage processes and care which would reduce home health beneficiaries' rehospitalizations. Thank you.

Dr. Amin: Thank you, Joan. And for the lead discussants, I believe we're still waiting for Nicole to rejoin.

Dan Andersen, can I turn it to you on any introductory comments from a lead discussant perspective?

Dan, are you still with us?

Okay. So in terms of other additional comments here, I think the criteria and rationale for why the measure was pulled for discussion is on the screen in front of you. So I will not repeat it.

If Dan or Nicole rejoin or have additional feedback -- that is Nicole from LeadingAge -- I would welcome that.

Okay. It sounds like Dan is having some audio issues. Dan, if you are able to just rejoin, let us know.

I'll go ahead with the Rural Advisory Group volunteer. Cody?

Mr. Mullen: Good morning. Our discussion of this measure, we had one yes, five no, and one unsure.

Amongst our discussion, a lot of the discussion focused around the loss of approval from NQF -- or endorsement, pardon me, from NQF on this measure.

Dr. Amin: Thanks, Cody.

And from the health equity perspective, Beth, are you with us?

Ms. Godsey: Yes, I am.

Dr. Amin: Great.

Ms. Godsey: Thank you for having us and good morning.

With respect to health equity, the conversation really revolved around sort of the broader question around patients receiving referrals for home health, not necessarily specifically stratifying by race or historically marginalized groups for this measure, but just the broader concern that the patients that are in this population are already reflecting some level of inequity.

And so there was conversation about, from a home health perspective, looking at those referrals and evaluating the stratification from that perspective. Thank you.

Dr. Amin: Thank you, Beth.

And one other note that I would make in terms of -- and, Beth, you may want to elaborate here from your recollection of the discussion from the Health Equity Group, but broadly the Health Equity Workgroup discussed just challenges with functional status measures and the challenge with access to home health broadly.

Obviously, this is not just related to the measure in front of us; however, challenges with certain disadvantaged populations with just access to home health, in general, remains a concern.

Anything else that you want to add on that, Beth? Otherwise, we can leave it there for now.

Ms. Godsey: No, that's my comments.

Dr. Amin: Okay.

Ms. Godsey: Those align exactly with my statements. The concern was the lack of access to home health, in general, not necessarily specific to any measure.

And for the remaining measures you'll hear a similar theme, so appreciate you reiterating that. Thank you.

Dr. Amin: Thanks, Beth. Dan, were you able to rejoin?

Okay. Jenna, let's make a note of Dan at the discussion point -- at the discussion section. If we are able to recapture him, we can get him at that stage of the discussion.

So I'll turn it over to Jenna to just acknowledge the

raised hands, and Gerri to help facilitate the discussion at this point.

So we'll invite general conversation of the workgroup on the measure and we will go from there.

Jenna, I'll turn it to you for any clarifying questions or discussion.

Ms. Williams-Bader: Thank you very much, Taroon. So, yeah, at this point we can start with questions. Does anyone have any questions for CMS about the measure?

All right. I see Gerri's hand raised -- actually, I see a few hands now. So, Gerri, I'll start with you.

Co-Chair Lamb: Sure. A question for CMS.

The -- in 2012 the endorsement was removed by Pulmonary and Critical Care due to the inadequate evidence for showing impact on outcomes. That's ten years ago.

Do we have more evidence now that shows that impact?

Member Roberts: I'm going to ask our measure developer -- measure support contractor to address that question because I'm not even sure I was here at that moment. So I'm not sure. To address or answer your question.

Alrick, are you online?

Mr. Edwards: I am. Sure. I can take a stab at this question. Thanks, Gerri, for asking that.

That is a while ago and I think what we've done since then, especially in the home health side, is we've -- one, we've resubmitted quite a number of other measures within the suite of home health measures and also have done a fair amount more in terms of monitoring and comparing these measures

to other measures.

And I would say that similar to other measures, Improvement in Dyspnea is related to and associated with some of the other strong outcomes that we're concerned with. I think in Joan's statement she mentioned rehospitalization, hospitalization.

Another that I would mention that has been introduced since then, distress to community. We looked at results related to that as well.

And so though at the time in 2012 there is an interest in potentially having another measure, I think part of the issue is in terms of priority of measures, we focus on one of the critical aspects of that which since a few years after that was cross-setting measures.

So we have not circled back to dyspnea just as yet, but we still value this measure.

Ms. Keane: And it's Nicole Keane, one of the measure developers as well, who was probably closest to that time period and a home care nurse by training.

I think some of the problems in 2012, there wasn't a lot of publications from home health agencies, clinicians, et cetera, that could necessarily be pulled into that endorsement process for that criteria of importance.

I don't know that that has changed so much since then. It remains a problem for home health, quite frankly.

Co-Chair Lamb: Thank you.

Mr. Edwards: So what we have is what we produce in our natural process of comparing our measures and looking at their outcomes. So, yeah, thanks, Nicole.

Ms. Williams-Bader: Thank you very much for that.

I'll go to Nicole next. Nicole Fallon?

Member Fallon: Thank you. And I'm sorry, I missed my opportunity to be the lead discussant. I was running from a meeting with your colleagues at CMMI, so I apologize.

We had a couple of questions just -- one was -- I think one of the challenges that home health agencies face is just the simple question of when do we evaluate this particular shortness of breath?

You know, what is the experience the patient is going through when we're measuring exertion, et cetera. And then, so I don't know if it's possible to get more clarity on that.

I don't think anybody denies the importance of measuring this, but it feels like there's a couple of things missing; and one is a little more clarity about when that data gets collected and then the populations it's being applied to. So I don't know if folks can talk about that.

It seems like there's opportunity to maybe make some improvements to this versus just eliminating it outright, but I'm trying to figure out if that's been evaluated before.

Ms. Keane: Yeah, sure. It's Nicole, Nicole, the measure developer from Abt.

And again, I, in a previous life, was a home care clinician, so just -- I think a lot of you already know this, but maybe some of you might not.

In certified home health, which is a program for skilled intermittent need, clinicians go out and assess the patient in their home on admission using a survey instrument or item instrument called the OASIS.

So there are items that feed into this measure,

Improvement in Dyspnea, that you assess, as a clinician, both at the start of care of that admission, at the end of care, and then some other time points, for instance, if they're transferred to the hospital setting. So there's the opportunity to improve or assist the patient to improve.

That is kind of the point of the measure. What have you done during that episode to help the patient improve and lessen shortness of breath?

Does that help?

Member Fallon: So, yeah, it does, but it doesn't. So I wasn't clear in what I was trying to get at.

Ms. Keane: Okay.

Member Fallon: So I understand the time points, but then the question is, what's the activity that's occurring when you're assessing that, because -- well, I'll be honest. I'm out of shape and going up stairs sometimes I have shortness of breath. I shouldn't at my age, but -- so I think that was one of the concerns.

And then, of course, there are also those with maybe COPD that are always going to have shortness of breath. So, you know, how are we evaluating that and their ability to improve, too?

Ms. Keane: Yes. So what I would say is, again, as a clinician, a licensed clinician who's trained as either a nurse or a physical therapist, you're using your clinical judgment, when you go into that home, based on whatever the referring physician has entered for the diagnoses.

So I guess that's what I would say is the approach.

Member Fallon: I don't want to dominate the conversation. So I know there are other people that have questions. I'll follow up if there's time.

Dr. Amin: Nicole, one other note -- Committee

Member Nicole -- feel free to also just note any additional questions that you have in the chat as we continue to go forward.

So that may elucidate any measure specification questions that are unclear just for the rest of the Committee to also capture as we continue the discussion. Thank you.

Jenna, back to you.

Ms. Williams-Bader: Thank you.

Before I go to the hands that are raised, Dan, it looks like you were able to rejoin and we just wanted to see if you had any other comments, as a lead discussant, that you wanted to make.

Member Andersen: Yeah. I think I'm on, If you can hear me.

Ms. Williams-Bader: Yes, we can.

Member Andersen: I apologize. I had to get kicked off and restart and all that. And I'm not sure what all I missed, but based on what I've heard I think we're up to date.

I don't know what I would add other than kind of restating what's been said.

Ms. Williams-Bader: Okay. Thank you.

Jolie?

Member Harris: Yes. Good morning.

I think my question was also seeking some clarification on the data used, whether this was subjective and/or objective data that combined in order to give the result for this measure.

And, you know, is it just a self-report-type question as the level of improvement or is there some physical assessment that's combined to give that measure?

As I'm familiar with MDS, OASIS and different-type tools, generally it's driven by certain questions that are answered that drive that comparison. Thank you.

Ms. Williams-Bader: Thank you.

Jim?

Member Lett: Oh, thank you. Part of it --

Ms. Williams-Bader: Oh, and actually, sorry, you did ask a question, Jolie. So let me pause there and see if CMS would like to answer that question.

Member Harris: Thank you.

Ms. Proctor: Again, this is Joan.

As a nonclinician, I'd like to look to Nicole if she could --

Ms. Keane: Sure.

And so the measure is based on specific items within the OASIS that the clinician goes in and uses their clinical abilities to assess.

There isn't a specific if the patient has COPD, this is how you assess. If the patient has heart failure, this is how you assess.

You're going in there as a clinician and using your learned assessment skills. And, again, based on the referring diagnoses from the physician, that's how you're making your determination about how you're going to assess that patient.

Dr. Amin: So just one quick note -- this is Jim -- as it relates to two additional comments in the chat on this specific thread related to, I guess, sensitivity or inter-rater reliability of the assessment -- clinical assessment.

Nicole, any other feedback on that or do your comments stand in response to those two chat

messages as well?

That was a question for the developer.

Ms. Keane: Oh, sorry. You know, and actually we are pulling up the OASIS assessment tool and it would be great to be able to actually share this.

I don't know, Morris, if you're able to copy/paste it into the chat, but there is an actual, I guess, somewhat standardized way of approaching it and that, again, you got four choices.

And you're going to start when is the patient dyspneic or noticeably short of breath? And, again, you're going to start with patient is not short of breath.

And then it does have the, when walking more than 20 feet, climbing stairs with moderate exertion. And it gives you some examples like dressing, commode, et cetera.

With minimal exertion, again, eating, talking, performing ADLs. And then at rest, which would be during day or night.

Is that helpful?

Member Harris: Yes, that is helpful. Thank you.

Mr. Edwards: And I would also note that when we first introduced these measures, dyspnea and other items based in the same M section (phonetic) of the OASIS, these items have consistently been tested a lot in terms of inter-rater reliability.

I think that was the other question that was -- and so even at the time when this was brought to the -- up for renewal of NQF, the issue was not whether or not the items themselves were valid or reliable in terms of assessing this area of dyspnea.

Dr. Amin: Okay. Thank you. And that was coming from the developer, correct?

And then, Jenna, we'll turn it back to the Committee discussion.

Mr. Hamilton: That is correct, Taroon. That was from Alrick at Abt.

Dr. Amin: Thank you.

Mr. Hamilton: This is Morris at Abt.

Dr. Amin: Thank you very much.

Jenna, thank you.

Ms. Williams-Bader: Yes. Thank you.

I see Jim has his hand raised.

Member Lett: Yes. Thank you.

Morris Hamilton's comment in chat was very helpful. It answered part of my questions because I was worried about the subjectivity of how that's being reported.

I would ask, No. 1, is there any self-report when the patient will open this or it's all observational?

Secondly, I -- what has really piqued interest here is about a high level of reporting burden, and what Morris Hamilton put in the chat does not seem like a high burden, to me, to respond.

It would be just as a comment worthwhile to know if there is any readmission data around those who are judged to be or self-report to be dyspneic.

And I also agree with the previous commenter that dyspnea is a terrible thing to have.

So I do think our reporting or assessment of this would be a worthwhile thing to retain.

Ms. Williams-Bader: Thank you very much, Jim.

It sounds like there's a question there about patient

self-report. So I'll turn it over to the measure developer.

Ms. Keane: No, it's Nicole. I'll just clarify.

I think in the traditional sense of like a PROMs or a PRO measure, you know, that's not what this is, but, again, a clinician is going into a home and having a conversation with the patient and making that assessment for the OASIS item.

So, you know, I don't think that I would say that it's not no self-reported information because, again, the assessment is happening.

So you are getting information from the patient, but, at the same time, you should also be following through those steps where you're getting the patient up, walking them around, seeing what they can do.

Ms. Williams-Bader: Okay. Thank you.

Elissa? I hope I said that correctly.

Co-Chair Lamb: Elissa, you're on mute.

Member Charbonneau: Thank you. Sorry about that.

I should just clarify that I'm a rehab physician by background. So my question about this measure is that, as you're rehabilitating somebody, you're actually going to increase the challenges that you're giving them physically.

So it's not necessarily a bad thing as you get somebody up and walking that has not been walking previously, that they're going to become more dyspneic with that increased challenge to their mobility.

And I guess that's my problem with the explanation here -- which thank you very much for showing that in the chat -- but I hope I'm expressing myself adequately that if you have a patient that, you

know, let's say, has had a stroke and has not been walking and, as the therapist continues to increase their challenge to their mobility, it's not necessarily a bad thing that they're going to be -- you would expect them to be more dyspneic as you're challenging them.

So that's my problem with this scale.

Mr. Edwards: I think, Elissa, that's a good point. But if you think about what Nicole Keane mentioned about clinical judgment, you're the same clinician who initially may have only had them dyspneic while at rest.

And so you're coding them both at the start of care and understanding if they've made improvement now that they have short of breath because you're giving them more challenges.

You're not coding them as a worse state at the end. You've seen the improvement because you're able to challenge them more.

That's why it's not ultimately a self-report measure. It's a measure based on clinical judgment or in terms of the coding. This is Alrick Edwards from Abt.

Dr. Amin: Great.

Other comments from the Committee?

Ms. Williams-Bader: I see Paul has his hand raised.

Member Mulhausen: I do. I don't have a comment. I have a question.

I heard in the presentation about why we're reviewing this measure, I think, that the rate has been improving over time since reporting this measure.

Did I hear that correctly? Performance rates have been improving over time in OASIS, is what I thought I heard.

Mr. Edwards: That is correct.

Member Mulhausen: I wanted to confirm that.

Mr. Edwards: It is.

Member Mulhausen: Okay. Very good.

I'm with Jim. Dyspnea is horrible. I think it's easy to miss for all the complicated reasons we've talked about. Focusing on it makes perfect sense to me.

And although I realize causality is problematic in a circumstance like this, I'm impressed by the fact that rates have been improving since CMS started measuring this, which, to me, is progress. So thanks for answering my question.

Ms. Williams-Bader: I also wanted -- I see that there's a couple of comments from Pam in the chat.

Pam, did you want to make those comments verbally so the rest of the workgroup can hear?

Member Roberts: Yeah.

I guess I still think that there's some subjectivity in here although I appreciate the feedback that was provided here. That helps.

I don't know if that's consistent across people, although I do understand the importance of this and, you know, that this is something horrible.

But -- and then my other question is, is this captured in readmissions if they're sent back to the hospital or to the ED?

But, on the other hand, if we can keep somebody in the home and not going back, that's a good thing.

Mr. Edwards: This is Alrick Edwards.

I would say that this is not completely captured by readmissions. Part of what you want to get for home care is improvement in a range of different

clinical areas.

And as you noted in your last portion of your statement, you want to keep them in the home where possible.

So as we're going to see with the other M-based (phonetic) improvement items that we'll review, there likely could be captured by readmission measure, but we also want to note improvement within the episode of care as well.

Mr. Hamilton: This is Morris Hamilton from Abt Associates.

I also want to clarify that this measure has an exclusion of inpatient transfers so that if you end your care by being transferred to an inpatient facility, you are not included in this measure.

So you would only be in terms of, like, how that compares to the readmission measure that we're really measuring a different population here.

These are patients who are discharged to the community that we're looking at here.

Dr. Amin: Jenna, one other comment in the chat from Nicole.

I'd just ask, Nicole, if you can -- Fallon -- the measure accommodating maintenance, I think that was the only chat of the remaining here that has not -- well, there's a few that just jumped in that have not been addressed, but, Nicole, do you mind just addressing that question or the comment here around accommodating maintenance? Nicole Fallon.

Member Fallon: Oh, okay. I wasn't sure which one.

Dr. Amin: I'm sorry. I'm sorry.

Member Fallon: Just call me Fallon from here on out and I will answer.

Dr. Amin: Okay.

Member Fallon: Yeah, I was just trying to get at -- so, you know, and I go back to my own experience. We all do, right?

My dad had COPD. He was short of breath pretty much doing everything. So discharged from the hospital, getting home health, you know, what would be considered improvement in that circumstance?

Are there -- I mean, there's going to be certain individuals that we care for that have dyspnea that aren't going to improve, and are we capturing them as nonimproving in this measure? That would be a concern.

Dr. Amin: Okay. Great.

Any other comments of the Committee? Anyone else that's hand raised? Otherwise I'll turn it to Gerri in terms of where we might go from here.

Co-Chair Lamb: Sure. Thank you, Taroon. Thank you, everybody, for the discussion.

So we're looking at 00187: Improvement in Dyspnea. I'll start with what I'm hearing as kind of the general themes and then make a recommendation of which category to vote on that we can kind of get our process down.

So what I'm hearing is that several people have spoken to the importance of this measure that dyspnea is a tough symptom and is important to look at and to deal with.

That most of the questions were related to the subjectivity and how this is being measured.

And the comments have been that this is part of the standard OASIS, and thank you to the measure developers for putting the actual measurement in just as a side note.

For our review process, I think it would be helpful to have this detail related to measurement detail because it could have been handled that way, but we do have questions about the subjectivity, that there is not a self-report; however, it is part of a long-term standardized OASIS tool.

There was also the other issue that was raised in the 2/12 loss of endorsement, was differentiating the home health as -- in terms of other causes of dyspnea and that was also addressed.

So in terms of the criteria and rationale, most of these have been addressed. This measure is not currently endorsed and it has been -- it has been shown to result in other outcomes like readmissions.

Reporting burden, it is found in OASIS and I don't -- I think we addressed that it's not topped out, Paul's question, that it is shown to be improving.

So with all of that, I think the theme I'm hearing leads to a conditional support to retain this measure and with the conditions being to relook at endorsement and also revisit the measurement within OASIS, and to evaluate the reliability and the conditions under which the dyspnea is measured.

So how's that sound to everybody? Does that capture the discussion? Conditional support for retention.

I'm seeing some nodding, but I can't see everybody's -- if -- okay. Seeing some thumbs up.

Anybody want to speak to another category -- oh, I wanted to add one thing, too, while I've got the floor here.

Part of our accountability, in terms of our MAP group, is to look at alignment across the different programs.

We're doing home care here, home health, but we

also have other settings and symptom management is one of the alignment and this is one of the few measures.

So another reason I think we should look at maintaining -- or retaining it and conditional support.

Okay. Was that a question? Jenna, can you help if hands are up?

Ms. Williams-Bader: Yes.

I see a hand from Alice Bell. She also has a question, it looks like, in the chat.

Dr. Amin: The only other observation I would just make is right before I turned it over to Gerri, Elissa also had her hand raised.

I know you've put it down since, but I just want to acknowledge that I may have missed that as well after Alice, if you have any additional comments.

Member Bell: Thanks so much. This is Alice Bell. I apologize for kind of the last minute. I've just kind of been working through this in my head. So in the -- I did write in the chat.

I guess in terms of the question of subjectivity, I do think that a score of 3 or 4 can be established based on observation only; but a score of 0 could be assessed based on the conditions of observation of 3 or 4 only.

Meaning that a clinician is talking with the individual, but might not put them through the demanding requirements of conditions 1 or 2.

So is there a way to ensure that a score of 0 is based on actually having placed those demands?

Does that question make sense?

Ms. Keane: It does.

Do you want me to answer? It's the measure developer Nicole Keane.

Member Bell: Sure. That would be great. Thanks, Nicole.

Ms. Keane: Sure. So OASIS has guidance -- a guidance manual that goes along with the instrument. And best practices are put in there as well as errata or updated to sort of see new scenarios that have come along, you know.

Every clinician can be different, but best practice is as you're saying.

Member Bell: Okay. Thank you.

Co-Chair Lamb: Okay. Any others up? Otherwise I would suggest, Jenna, Taroon, we go to a vote.

Dr. Amin: Elissa, are you good or do you have any --

Member Charbonneau: Well, I wrote my comment in the chat box and I guess I just don't understand what -- wouldn't measuring respiratory rate doing a consistent activity be a more objective way of measuring dyspnea?

Ms. Keane: I'll take that one. It's Nicole again -- Nicole Keane. It's a fair point.

As a clinician, you know, I think what my understanding of this meeting is CMS is looking to get everyone's input. You're the experts in this area.

This measure did lose its endorsement. So it's not endorsed. I think if CMS would like to go forward, that is a suggestion that could definitely be incorporated into a respecified measure if that is what the decision should be.

Mr. Hamilton: Elissa, this is Morris Hamilton from Abt. Just a question for you if you're willing to

answer.

What consistent activity do you have in mind given kind of the variability of the patient population?

You have some stroke recovery patients versus others who are post-surgical.

Member Charbonneau: Right.

So, you know, I think that you could measure dyspnea at rest. You could measure dyspnea rate during transfers, you know.

I think that just having an objective rate doing the same structured activity would be a more valid and objective way of measuring a patient's dyspnea because, you know, there's so much variability in patients subjectively looking short of breath depending on how they're feeling a specific day or what they're doing.

I just -- this just seems, to me, to be a very subjective assessment.

Mr. Hamilton: Thank you.

Ms. Williams-Bader: And I know it's not a question, but, Julie Malloy, you've got a comment in the chat.

Did you want to make that -- and then I also see Deb has her hand raised, but I'll go to her in a second.

Ms. Malloy: This is Julie.

Just a reliability statement because there's so many people contributing to OASIS and the different -- how the patient's doing.

I just heard it mentioned earlier that, you know, the same clinician would look and often it isn't the same clinician.

So just something to think about if the vote is, you know, made conditional.

Dr. Amin: So, Gerri, the reliability point here and the issue around the objectivity of the assessment, I think, can both be added into the comments that are around the conditions.

Co-Chair Lamb: I think it will be really important. I think the, you know, the group here is asking to relook at some of the components of OASIS, and I think that is why we're here. So I think that's really, you know, it's great feedback.

Dr. Amin: Great. Debra?

Member Saliba: Thank you. As Gary pointed out, this is based on symptoms and the respiratory rate is only one component.

Recently, a piece in JAMA pointed out that everyone seems to have a respiratory rate of 20 in the medical record, that there's a problem with the reliability even of reporting respiratory rate.

And part of dyspnea is getting at the air hunger sensation that the individual is having.

And I think that's why you're hearing some people be very passionate about the need to continue some measurement of this distressing symptom for patients and families.

As we think about it, I do agree that, you know, improving the reliability of how we measure it is certainly important, but the reversion to a respiratory rate alone is not likely to accomplish that.

Co-Chair Lamb: Thanks, Deb. Any more comments?

Okay. I think we have a list of things related to conditional and I think that, in my view, given this discussion, that still holds that this is, you know, overall hearing consistently important measure (audio interference).

Co-Chair Lamb: Excuse me?

Dr. Amin: I think we might have had some feedback from somebody's line.

Co-Chair Lamb: Ah, okay. Can we go to vote then?

Ms. Williams-Bader: We might actually need one more minute. We're just resolving some technical difficulties with the voting.

Co-Chair Lamb: Okay. Jenna, do we have quorum?

Ms. Williams-Bader: I believe we do, yes.

Co-Chair Lamb: Okay.

Ms. Williams-Bader: I think we should. So let us check. Just one second. I would just say that if anyone has made a comment in the chat and you want to -- sorry, I muted myself -- this is your opportunity while we are just working on --

Dr. Amin: Gerri, do you mind just repeating kind of where we are in terms of the vote?

And then I can just do some introductory comments on the next measure while we're waiting.

Co-Chair Lamb: Sure. So where we're at is the vote being put forward is Conditional Support for Retaining Improvement in Dyspnea, Measure 00187-C.

And it is related to the -- it does contribute to the goals and objectives. It is important.

Condition is that it has lost endorsement for many of the reasons that we have discussed; however, the link to patient outcomes has been improved since it lost endorsement and it is not topped out. It has improved over time.

Big issue for review is the reliability of the measure and how dyspnea is reported, and we have lots of comments and ideas about that to go to CMS.

How's that, Taroon?

Dr. Amin: That's remarkable.

Co-Chair Lamb: All right.

Well, let me just add as we -- you give us an overview, I would suggest, in the interest of kind of consistency and time, if the folks that are doing the discussion, the lead discussants, if you could also hit if there is any difference between the criteria and what your review showed so that we can just deal with that up front.

Remember that we did these reviews without all of the information. So that would be helpful so that we're not repeating it.

Taroon, back to you.

Dr. Amin: Yeah. And the only other point I would make, and I'll look to the team to let us know if we're ready for voting, is as we continue with the flow for discussion going forward, it would be extremely helpful in terms of moving the facilitation and also, quite frankly, for transparency.

If there are measure specifications -- if there's measure specifications clarifications -- sorry, measure specification clarifications for the developer as we do the introduction, please note them in the chat.

That allows the developer a little bit of time to review and add any -- sort of any text into the chat and allows all the members of the workgroup to be able to review it in addition to cutting down a bit of time.

So we will go with that and I'll turn it to the team to see if we're ready to go ahead with a vote.

Ms. Williams-Bader: We are ready to go to a vote.

Dr. Amin: Great.

Mr. Zimmerman: All right. Voting is now open for

Measure 00187-C-HHQR: Improvement in Dyspnea. Do you vote conditional support for retaining?

Ms. Williams-Bader: So the technical issue we're having is that this Poll Everywhere account is being used for a couple of different meetings today.

So I believe we have more than we need at the moment. We're just going to -- we have members not on MAP who are voting.

We're going to need to check the list here and we are going to try to separate these at the lunch break so that we do not continue to have this problem all day.

But if you can give us a minute to check who's voted --

Dr. Amin: Deb and Alice, just a quick note. You're on deck for lead discussants for the next measure.

Co-Chair Lamb: Jenna, while you're checking, can we move on to the next measure or no?

Ms. Williams-Bader: Yeah, we can circle back to voting on this. So if we want to move ahead to the next one -- well, I don't think -- I think what I'd like to suggest is that we go ahead -- we're only eight minutes ahead of schedule -- seven minutes ahead of schedule for the lunch break.

So I'd like to go ahead and, if we can, call the lunch break now instead because we do -- I think we do have to display the votes for purposes of, you know, documentation.

And if we keep moving ahead and then move back, I don't know how that will affect that.

So I think it's just better to give staff a chance to touch base offline and figure this out. So let's go ahead and do that.

Is that --

Member Mahajan: Hi, everyone. This is Raj Mahajan.

If you do need to borrow a Poll Everywhere account, I am happy to share my university account.

Ms. Williams-Bader: Oh, thank you very much. We will let you know if that is the case. So are we --

Dr. Amin: What time will we return? What time will we return?

Ms. Williams-Bader: It's a 30-minute lunch break. So we'll return, let's say -- let's just make it 12:15 Eastern Time.

Dr. Amin: Okay. And we'll start with Timely Initiation -- well, we'll finish this voting, hopefully, and then we'll move on with Timely Initiation of Care, again, with Deb and Alice on deck for the lead discussants for that measure, then turning to Cody and Beth from the advisory groups.

Jenna, anything else that you wanted to cover?

Ms. Williams-Bader: No. Thank you all so much and thank you for your understanding as we work this out. It's a very, very busy committee day at NQF.

Dr. Amin: Gerri, are we good?

Co-Chair Lamb: I think we are.

Dr. Amin: Okay. Thank you all. We'll talk in half an hour. Enjoy your lunch or breakfast, depending on what coast you're on.

(Whereupon, the above-entitled matter went off the record at 11:44 a.m. and resumed at 12:15 p.m.)

Ms. Williams-Bader: Okay. Welcome back everyone. I hope you had a good lunch. We've been able to work through our technical issue and we've sent out a new link to the workgroup members.

So for all of the voting moving forward, please make

sure that you are using that new link. Just looking here to see if it seems like we have enough -- I think we'll just have to try the vote to see if we have enough people back from lunch.

So first of all, does anyone not see the new link?

Okay. Great. Well, let's go ahead and try the vote. We can --

Member Andersen: Just to be clear, if we already cast a vote, do we still need to do something?

Ms. Williams-Bader: Yes. We have to clear everything out and restart. So we will be asking everyone to vote. And let me put this in the chat as well.

Mr. Zimmerman: Voting is now open for Measure 00187-C-HHQR: Improvement in Dyspnea. Do you vote conditional support for retaining?

Member Andersen: So sorry, this is Dan. I'm having an issue now where it will not let me go back to that site.

It says page not found. Then it says pollev.com/username to join the presentation again.

Mr. Zimmerman: Sorry, Dan. I think you joined a little late. It's a new link.

Member Andersen: New link.

Member Saliba: It's a new link? Did you all email it to us? I apologize. I'm lost, too.

Mr. Zimmerman: Yes. We sent it via email over the lunch break.

Member Saliba: Okay. Thank you.

Ms. Williams-Bader: So those of you just coming back from lunch, we sent an email at 12:11 Eastern Time with a new link for voting. This should resolve the issues we were having earlier.

Please use that link for the rest of the voting today. And for this first measure, we will need everyone to resubmit your vote. We had to clear out the votes from before.

We will need 14 for quorum. I believe we have 14 on, but we will check on that.

Is there anyone who hasn't been able to find the new link yet?

Okay. It looks like we don't have quorum at this time. Let's go ahead and have a discussion of the next measure and we'll check to see who we're expecting to have on at the moment and we'll do a vote with the next measure.

Dr. Amin: Okay. So I would encourage the group to, you know, jot down your votes as we go and let's keep moving in terms of the discussion.

00196-C-HHQR: Timely Initiation of Care

So we have -- the next measure in front of us is 00196-C-HHQR: Timely Initiation of Care.

This is a percentage of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC or ROC date, otherwise was within two days of the referral date or inpatient discharge, whichever is later.

This measure -- endorsement status, endorsement was removed and five members selected it for discussion.

If we can go to the next slide on the criteria or rationale for why this was pulled for discussion and additional survey feedback that was provided?

Our lead discussants are the American Geriatric Society with Deb, and the American Physical Therapy Association with Alice and Sarah Livesay, who I do not believe is on the call today.

So we'll start with Deb.

Member Saliba: Okay. So this measure is -- I'm not sure why, but the measure developer did not resubmit it for maintenance in 2016 and that's why the endorsement is not active at this point. And perhaps the developer can speak to that.

I think, you know, the challenge with this one is that there is a big disconnect here between the science and the measure.

So in the science and the logic we believe home health really matters in the health of people, and the timeliness of home health would follow from that as being an important thing for improving health.

There's also evidence that supports the importance of timely delivery of home health. There's a paper in JAMA Network in 2016, that showed that folks that had a longer period after hospital discharge between the initiation of home health and -- had worse outcomes than people that had earlier initiation of home health.

So that kind of recognition that it matters is part of, I think, what drives this measure. Nonetheless, when we look at the measure, it appears to be topped out.

So that 2016 paper, for example, said only 54 percent were seen within 14 days of discharge from the hospital. But when we look at these measures, they look like there's a much higher rate.

And I think part of that issue is the receipt of -- that it's contingent on the receipt of a -- what starts the time clock is the receipt of valid referral.

And it's the definition of valid referral that's getting, I think, some of the challenges in actually having this capture the real amount of time.

CMS has increased training around how to code that

and how to follow up on it, according to the papers that we received, and it wasn't clear whether there's been additional auditing on that measure.

Nonetheless, I think the concern has been -- I took it to my own Policy and Quality Performance Committee and people were very strong about the idea that this concept needs to be included, the idea of timely referral; however, they were also, you know, pointing to that topped out as a matter of concern.

So if the developer could address why it wasn't resubmitted and any measure -- any attempts to try to validate that coding of that item, that would be helpful.

Dr. Amin: Thanks, Deb.

My apologies to Joan in terms of the contextual comments from CMS. So there have been one or two questions that Debra has posed, but I would also turn it over to Joan and the measure developer for a one-minute introduction.

And if there's any of those responses to those questions that you would like to provide, which I know that you started to provide some of the specification answers in the chat already, but, Joan -- and my apologies for passing over you.

Ms. Proctor: Oh, no worries.

You know, I agree with you totally, Deb. Research consistently shows that outcomes have improved when compared to the time frame start of care with an established condition of participation.

While the measure can -- may appear to lack sufficient variation, it represents an important aspect in the continuity of care for Medicare beneficiaries.

It is worth noting that at the tenth percentile of HHAs, they were not initiating care in a timely

manner in 17 percent of their episodes.

So the measure is currently reported on Care Compare and is a part of our Home Health Quality Reporting Program Star Rating. And as we mentioned before, it is a condition of participation.

Increased hospitalization subsequent admissions to long-term care facilities in which higher levels of care are received are associated with difficult transitions from a hospital environment to a beneficiary's home.

Ensuring Medicare beneficiaries receive timely care as they transition from an acute care setting into their home is important to mitigating potential risk as experienced by this population. For these reasons, CMS would like to recommend this measure be kept within our QRP.

And in terms of a validation, you are correct that we do not, at this time, have the availability or the process in place to do that, that data validation for this program, but I think we can look to trend in other programs to assume that, you know, hopefully Congress will see fit for us that they have that type of leeway.

I'm going to turn it here to Nicole or to Alrick to discuss the endorsement process and why it's not endorsed and do a history for us. Thank you.

Dr. Amin: Thank you, Joan.

Ms. Keane: Sure. It's Nicole Keane from Abt Associates.

So what happened, it was due for NQF endorsement in 2016. We felt, as the measure developers, it did have current limited variability. We thought it probably would fail the 1b performance gap section of the NQF documents. That said, it is an important measure.

As a home care -- previously -- it's been a while,

but when I was a home care clinician, it was important to get into the home as timely as possible and this is one way of holding agencies accountable for that.

Dr. Amin: Okay. Thank you, Nicole.

Deb, any outstanding questions to the developer? I think they addressed the topped out question and the endorsement status, and then we'll turn it to Alice.

Member Saliba: Yeah. I think those were very helpful insights. I will point out again in that setting in 2016, there were significant differences for dual eligibles as well as black patients and Hispanic patients.

So there are some -- I see some slight -- in the data that was sent to us, some slight differences that probably achieved statistical significance given, you know, the number of people.

But in this other report, there were big differences when you just looked at the time, you know, as opposed to that referral date.

Dr. Amin: Thanks, Debra.

Alice?

Member Bell: Thanks so much, and Debra covered pretty much the majority of questions.

I guess the one thing I would just continue to kind of follow up on is given that what seems to be the greatest issue with this measure is that confusion around a valid referral, does the developer or does CMS have any ideas on how we might be able to tighten that up, because that seems to be what's leading to the issue of this measure being topped out.

And I agree, I think it's an important measure. I think that the timeliness of the initiation of care can

be, and has been shown to be, a predictor of outcomes and mitigation of risk and risk for rehospitalization and other adverse events.

So I think the issue really is, how do we figure out that the measure is actually measuring what we intended to by addressing that issue of a valid referral, because that was the statement as well by the National Association for Home Care and Hospice that this confusion has kind of persisted since the original use of the measure and we're not seeing resolution.

Member Roberts: I think the best response I can give you is, you know, no one has contacted us directly and we haven't heard this in our training when we've surveyed and we've done training sessions on our new OASIS things; however, now that I'm aware, (audio interference) to our training contractor in developing the necessary resources and education outreach to be able to ensure that providers are clear on what represents a valid referral.

Dr. Amin: Thanks, Joan.

Cody, I'll turn it over to you from the rural perspective, and then we'll go to Beth next.

Mr. Mullen: Okay. On the rural perspective, we had a long discussion on this measure. There's concerns of the lack of endorsement that's already been discussed.

We are also concerned, on the rural, about the amount that had already met the measure and the concern it was topped out.

We didn't know if other measures within the bundle may make sense to get at these components.

We voted not -- advised not to pass this measure. 78 percent of those attending our meeting a few weeks ago.

Dr. Amin: Thanks, Cody.

Beth?

Ms. Godsey: Yeah. From a health equity perspective, there certainly were some concerns again going back to the original or previous measure and comments around home health and the general overarching concern that there was not referral for home health in historically marginalized populations. And so that remains and continues for this measure as well.

As mentioned earlier, Debra mentioned that there are -- it is shown in the reports that there are differences that are shown for black patients compared to white patients and other types of differences that need to be understood a bit more.

So from a health equity perspective, I feel that it would be important to continue to evaluate and further explore.

Dr. Amin: Thank you, Beth.

And as we've done in the past, feel free to raise your hand and Jenna will start to collect the list.

And, Gerri, we can certainly facilitate conversation based on workgroup input on these. We heard from all of the -- we've heard from the lead discussants, the rural group and the equity group on this measure.

I'll turn it over to the workgroup for general discussion. And, again, if there are any measure specification questions for the developer, please throw them in the chat and we'll take it from there.

Ms. Williams-Bader: Thank you very much, Taroon.

Okay. So I see -- Jill, you've got your hand raised. Go ahead.

Member Cox: Yes. Hi.

So just a point of observation as my primary practice is in acute care and I don't know how relevant this is to this, but this is a problem that we face on a regular basis.

So patients will have a discharge order for home care from a physician; however, the ability to find a reliable agency has been difficult.

I live in the New York metropolitan area and that is especially true in the Medicaid population, finding actually home care agencies to take the cases.

And sometimes there is a delay because of those home care agencies because of actually finding them and then actually going out to do services.

So it's sort of like an operationalization and I don't know what -- how much of affect that is on the physician who actually writes the order in terms of discharge.

Well, anyway, just an observational comment.

Ms. Williams-Bader: Thank you.

Elissa?

Member Charbonneau: I would echo that and also just add that during the public health emergency, staffing was a particularly difficult issue for home health agencies.

So that also -- I don't know if that is something that can be considered as well.

Ms. Williams-Bader: Thank you.

Okay. I'm not seeing any other hands raised at the moment.

Co-Chair Lamb: So, Jenna, I think what I'd like to do is summarize because I have questions for the Committee.

Would that be okay?

Ms. Williams-Bader: Yes. Go ahead, Gerri.

Co-Chair Lamb: Okay. So let me summarize what I'm hearing in the discussant reviews as well as comments.

One, is that timely initiation matters. It's important to patients and stakeholders in home health.

There's also here the potential for disparities in terms of the data that's available. So we've got those, you know, that it matters that there are disparities.

There are the issues that it's not endorsed and the endorsement, or the lack of endorsement, is due to questions about variability and being topped out.

And part of that is the way that this is being measured, was suggested, that there is confusion about the start/stop.

There's also the system issues about -- and I think our equity volunteer advisory has emphasized that now in terms of just access to home health, in general, as well as other system issues affecting that. That certainly, you know, is important feedback to CMS and in gaps.

So I'm, you know, I am thinking in terms of the criteria that we've been given -- and here's my question to you all and I think I will -- I'd like to start with the lead discussants, is -- I'm hearing conditional.

What I'm questioning is are we talking conditional support to retain which, in my understanding, is that the benefits outweigh the problems and that, you know, that some changes need to be made, but it needs to stay versus conditional support to remove because removing it would create gaps.

And so that we would recommend conditional support to remove waiting for a better measure, but this is important enough that it needs to be

measured.

So, Deb and Alice, can you just help in clarifying where you landed on this?

Member Saliba: Yeah. And, Gary, you know, I struggled with what the best response was given that tradeoff that you just excellently summarized.

I decided that conditional support would be the way to go and it's -- because this is an important signal and we'll be able to look across agencies.

And as somebody just noted in the report -- I'm sorry, in the comments, Jolie just noted that it's from the date of accepting a referral.

So I don't know if I should hand it over to her to round out that comment.

Co-Chair Lamb: Deb, before you hand over -- and I'd actually like to hear from Alice first, you said conditional, but which direction? Retain or remove?

Member Saliba: Support. Retain.

Co-Chair Lamb: Retain. Okay.

Member Saliba: Retain. Sorry. Apologies.

Co-Chair Lamb: Alice?

Member Bell: Yes. I think I would agree conditional support to retain, but I guess I have a counter question and this is probably a little bit more process. So -- and if it's inappropriate, let me know that.

So if we would be -- would there be a greater move to resolving the challenge with a conditional support to remove versus a conditional support to retain?

And what I mean by that is, we really have identified that the primary issue here is in clarification of that definition.

So would we get that resolution faster with the conditional support to retain or to remove or does it not impact --

Co-Chair Lamb: So, Alice, your question is what's going to get us the best mileage in getting us the measure we think is important.

Member Bell: Correct.

Co-Chair Lamb: Jenna, can you help us with that or guide us to who we should ask that question?

Ms. Williams-Bader: So what we've heard from CMS in the past is while the vote does matter and I think that the direction -- I'll talk about the framing of that in a second -- CMS is also really looking to the comments and the feedback that the group provides.

Again, as we've thought about it before, really the difference between the two conditional support categories is that a conditional support for removal means that this particular measure is not a good fit for the program anymore.

And it's -- you don't think that there are small tweaks that could be made that would -- or conditions that the developer could meet that would make the measure a better fit, that the measure is not meeting the needs of the program.

Whereas, if you do think that there are tweaks to be made to the existing measure, some conditions that could be met like taking it through endorsement, then that is where I think you'd want to use conditional support for retaining.

I hope that helps, but let me know if you still have questions.

Member Bell: No, it helps significantly and thank you, Jenna.

And with that clarification, I would say conditional

support to retain because I do think there are opportunities that might even be just in the training of the use of the measure that could resolve some of the issues.

Ms. Williams-Bader: Gerri, you're on mute.

Co-Chair Lamb: All right. We had to have at least a couple people do that.

Jenna, I'm going to give it back to you to see if there's any more questions or comments.

Right now, I think that, you know, we're moving towards a vote on conditional support to retain.

Ms. Williams-Bader: Yes. I see Jim has his hand raised and then Nicole.

Member Lett: Yes. Thank you. And I would support the conditional support to retain.

A comment, and this, I guess, involves CMS as well as I'd like some feedback from you all, but, in my experience, there has been a problem in getting the order set for home health signed, No. 1, by hospitalists in the hospital because they say, I don't want the nurses calling me. I don't practice outside of the hospital.

And we saw the same thing in skilled nursing facilities where I would sign them because what -- the patient needed it, but there are a lot of folks who don't want to sign them because they don't practice in the community and they don't want to start getting calls from home health about that patient because it's no longer their patient since he or she has shifted to a different site of care.

So in a rural area, it is hard to even find a physician or a nurse practitioner or a PA to assume the care of a patient who leaves the hospital or nursing facility.

So this is more, I suppose, of a gap type of issue that we have in healthcare and the lack of a warm

handoff as these people transition through the system.

So I don't -- I'm not sure what I'm asking us to do as a result as much as allow CMS to understand that there is indeed a gap in care and it's no one's fault, but there is no solution to a significant problem particularly in inner city and rural areas.

Member Saliba: And, Jim, you know, I completely agree with you about that issue. And I think, though, from the healthcare -- the home health agency's perspective, they're not getting dinged for those, and pardon the euphemistic language, but they're not being held accountable for those instances where there's not, you know, it only starts to count once there is a valid referral.

So for this measure you may be right that that may explain a lot of the discrepancy between what, you know, Rachel Warner's group found in that JAMA Network paper and what's showing up in the actual quality measure may, in part, be that delay in getting that signature.

Ms. Williams-Bader: Okay. I'm going to go to Nicole next and then I see Pam has her hand raised.

Member Fallon: Thanks, Jenna.

So I think I'm in support of the -- well, I'm in support of retaining something. This obviously is an important measure.

Where I'm struggling is -- and want to know if there's feedback that can be provided on this.

So if we clean up or clarify the valid referral, do we think that we're going to see kind of different results?

So it's kind of a two-part question, right, in the sense of are we topped out and the way we're measuring this is no longer helpful.

And if that's the case, if we're topped out, is there a better way to look at this issue where there is more variability and we can get more consistency and a better outcome.

Maybe that doesn't help. I'm just vacillating between, you know, retain or remove to get a better measure that's going to get us where we need to be.

Co-Chair Lamb: Nicole, my thinking on that -- this is Gerri -- is kind of the combo of what we heard from the measure developers and the fact that we would make a recommendation that this needs to be looked at.

That part of the reason that it was not, you know, brought back for endorsement was because of that lack of variability.

And so this becomes a hypothesis that if we measure it better, that we will have that variability, but I don't know that we can know that for sure.

I think what we're seeing is this is an important measure, we need to make changes in it, but we don't want to lose it.

So I think that's, you know, I don't think we have any guarantee that it's going to do that, but given why the measure developers pulled it, you know, we can hope.

Member Fallon: So can I just ask one follow-up then from a process standpoint, because I agree.

I think we have to get this piece cleared up so that we're getting more consistent responses and then we're comparing apples to apples.

I think, if I remember way back when we talked about these measures under consideration for removal, there was a discussion that there's a three-year cycle, I think. So we wouldn't circle back to home health QRP measures to reconsider for

removal for another three years.

Is that right, Jenna, or others?

Ms. Williams-Bader: I believe so, but CMS can correct me if I'm wrong there.

Member Fallon: And I guess I'm just trying to evaluate if we get this cleaned up, if we get the valid referral piece cleaned up, how much time do we have to assess and then can we revisit this issue?

And obviously, technically doesn't harm anybody by having the measure in place, but --

Member Schreiber: So, Gerri, I'm sorry, what's the exact question to CMS?

Member Fallon: Michelle, I was asking what -- I think you said, when we met months ago, that because of the magnitude of measures we would only look at certain programs -- I think it's every three years; is that right?

Member Schreiber: That is correct.

Member Fallon: Okay. So we'd have a chance to get the measure right, get this clarity, have some evaluation and then revisit this particular one if we wanted to.

Member Schreiber: That is correct.

Member Fallon: Thank you.

Co-Chair Lamb: Jenna, any more hands or are we ready to --

Ms. Williams-Bader: Yes, I'm sorry. No, I was just getting myself off mute.

Pam has her hand raised.

Member Roberts: I have a question or maybe clarification. So -- and I do believe that timely

initiation of home health is important.

But if a home health agency doesn't accept a patient, then where would they fall on this measure?

And would this become an access issue if they can't meet it because of staffing needs or something else, and so then where does that make it fall?

So that, to me, makes it more important to have the measure so that we get the continuity of care from the acute care hospital or post-acute care when they go to home health.

Co-Chair Lamb: Can the measure developer answer that? I know that, Morris, you put in chat what the metrics are.

Can you specify what happens in terms of start date if a home health agency gets the referral and refuses it?

Did I get that right, Pam?

Member Roberts: Yes. Correct.

Mr. Hamilton: So, Nicole, you might need to support me on this one, but --

Ms. Keane: Yes, I will.

Mr. Hamilton: Yeah. I believe the OASIS is completed by the accepting home health agency.

Ms. Keane: It gets a little tricky because certain -- today, certain insurances, you know, Medicare you fill out the OASIS assessment.

At what point do you decide not to take that patient? Have they already been referred? Have you already accepted the patient?

But in a traditional sort of scenario, the physician refers the patient. If you've accepted the patient as a referral and you don't see that patient in a timely

manner, for whatever reason, you get dinged.

Member Roberts: So just can I ask a clarification?

So that means if you decide not to accept it because you don't have the staffing to accept it, then you would not be dinged for that.

Ms. Keane: You have to fill out the OASIS assessment. So in that scenario -- and, again, remember we could have multiple scenarios here, but if you have not accepted the patient, you wouldn't have filled out the OASIS items to create this measure. It's an OASIS-based measure right now.

Member Roberts: Thank you.

Member Saliba: So I think what you're pointing to is sort of the need to look at both as a national quality metric, not a home health agency by home health agency quality measure, let's say, in the AHRQ report or something.

The delay between hospital discharge and initiation of -- or between hospital physician requesting home health referral and the actual initiation of home health as a national, but not attributable to a particular home health agency.

And this other -- the timely initiation once you've accepted the case, you know, are you getting out there and starting care within a timely period, you know.

So just in terms of feedback not that we're voting on that first thing that I just talked about, we're not voting on the national metric, but that might be a way to balance the issues.

Co-Chair Lamb: Deb, that's really helpful.

In terms of also addressing ways to look at the access issues that a lot of people are talking about, is to kind of break the process down and if it's

someplace that the system is falling down, that there is a need for short-term metrics to really shore that up. So I think that's a really helpful comment.

Are we ready to vote?

Ms. Williams-Bader: Yes.

I would like to move to a vote, if we can. If anyone has a critical comment to make, please raise your hand, but otherwise let's move to a vote.

Co-Chair Lamb: Okay. So the vote is a vote for conditional support to retain.

Mr. Zimmerman: All right. Voting is now open for Measure 00196-C-HHQR: Timely Initiation of Care.

Do you vote conditional support for retaining? We currently have 13 votes. We will need 14 to meet quorum.

Ms. Williams-Bader: And we should have the 14 we need unless someone stepped away. So as a reminder, please use the link that NQF sent at 12:11 Eastern Time via email. Do not use the link from yesterday.

Okay. Looks like we have 14.

Mr. Zimmerman: All right. I will close the poll. Voting is now closed for Measure 00196-C-HHQR: Timely Initiation of Care.

Results are 14 for yes and 0 for no. The measure is voted to be conditional support for retaining at 100 percent.

Ms. Williams-Bader: Thank you, Gus.

And since we have quorum right now, if we could go back and vote on the previous measure as well, which I believe was a conditional support for retaining.

Mr. Zimmerman: All right. Give me one moment to pull it up.

Voting is now open for Measure 00187-C-HHQR: Improvement in Dyspnea. Do you vote conditional support for retaining?

And I see we are at quorum, so I'll give everyone about 10 or 15 more seconds to get any additional votes or change votes.

All right. Voting is now closed for Measure 00187-C-HHQR: Improvement in Dyspnea. The votes are 12 for yes and 2 for no. The percentage is 85 percent and the measure is conditionally supported for retaining.

I will turn it back over to presentation.

Dr. Amin: Thank you, Gus.

Okay. So we will go to the next sets of measures on the improvements. I do want to note, Cody, I know we're going to lose you at one o'clock. So I might go slightly out of order and ask for the rural health perspective on this measure.

And the other two on the Improvement of Management of Oral Medications and Bed Transferring seemed more supported from the rural group, but I'll just do a quick introduction of the next measure and then I'll turn it to Cody, and then I'll go back to CMS just to make sure we get your input, if that's okay, Cody.

Mr. Mullen: Works for me.

00185-C-HHQR: Improvement in Bathing

Dr. Amin: Thank you. All right. So we have 00185-C-HH -- the Home Health Quality Reporting Program: Improvement in Bathing, the percentage of home health quality episodes of care during which a patient got better at bathing self. Measure is endorsed. It was selected by five MAP members

for discussion.

We'll go to the next slide in terms of the criteria, which I'll leave in front of you. And then I'll turn to Cody first to just discuss the main topics here.

And then if you have any further clarification items that you want to share with the group on Improvement of Management of Oral Medications or Improvement in Bed Transferring, we'll take those as well.

Mr. Mullen: Yeah. So I would be happy to discuss all three real quick.

So in Bathing, we had a 25 percent vote in favor of advancing that measure, and 63 percent no, 13 percent unsure.

The main concern here in our discussion was if this is an adequate measure that would show improvement over time.

These would be patients who come home, especially in the rural setting, and either have the skill at discharge from the hospital or it would not be anticipated that they would never have the skill upon discharge and that would not be a goal and, thus, disproportionately affect the rural home health providers. So that was our main concern on that measure.

The other two measures, 75 percent were in favor of the Management of Oral Medication at 00189-C. And on Measure 01000-C, the Improvement in Bed Transfers, we were at 67 percent in favor of that.

I have two half-hour calls. So if I get a break between them, I'll hop back on and then I'll be back at 2:00. So I apologize for that.

Dr. Amin: No problem, Cody. Thank you for that input.

Okay. So let's go back to Improvement in Bathing.

Summary statement is the other two measures that are later on in discussion were generally supported by the Rural group.

We'll start with the CMS program lead, Joan, for a one-minute introduction on this measure, Improvement -- contextual comments on this measure, Improvement in Bathing.

Ms. Proctor: Hi. Thank you.

Yeah, Improvement in Bathing is an endorsed measure, which is also part of our payment in the home health value-based purchasing model.

The measure is also reported on Care Compare and is a part of the Home Health Quality Reporting Program Five Star Rating. As such, we believe aligns with the Home Health Quality Reporting Program goals.

Performance scores have increased over time. In 2019, the overall performance for this measure was 83 percent, and in 2021 the score increased to 85 percent. The scores are low enough to still have room for improvement.

In terms of addressing comments on this measure, one of them was whether or not we had any exclusions.

There are no exclusions based on functional goals for this QM or for terminal illness. This is true for both this measure and other HHQRP improvement quality measures.

Functional quality measures that address maintenance are of interest to CMS, but it's not the focus of the improvement in function QMs.

So we also want to note there is some strong correlations between the functional improvement QMs and other quality measures such as home health discharge community. And this has consistently been true over the years of analysis.

We also want to note that we are currently developing a strong cross-setting outcome measure to address functional status in post-acute care settings with a discharge score measure which would be appropriate for maintenance population, thus getting at those comments that others had about maintenance patients. Thank you.

Dr. Amin: Thank you, Joan.

I'll turn it to our lead discussants, National Partnership for Healthcare and Hospice Innovation.

Larry?

Member Atkins: Yeah. I haven't -- I was not aware that I was going to be a discussant on this today.

Dr. Amin: Oh, not a problem, Larry. Thank you.

And then I'll turn it to Elissa. Any comments on this measure as a lead discussant?

Ms. Williams-Bader: She might have stepped away for a minute and I don't know if she's returned yet.

Dr. Amin: Okay. And, Jill Cox, I know you might have needed to step away for a moment as well, but, Jill, are you online?

Member Cox: Yeah. I'm here. I'm actually going to step away at two o'clock.

Dr. Amin: Okay.

Member Cox: So, yes, like Larry, I was not aware that I'm a lead discussant, but I did have a question for the measure developer.

When you state 83 to 85 percent compliance to the measure, is that compliance to the documentation of the measure?

So we really don't know what's happening, it's just did they document in the OASIS that bathing was occurring at one of those levels?

I guess just clarification, what does that mean? What does --

Dr. Amin: That's correct. That point is correct, Jill.

Member Cox: It means they documented that.

Dr. Amin: Yes.

Member Cox: So it seems like bathing, to me, is just one particular act that's part of a whole functional status assessment and that this particular measure could have many exclusions, you know, someone who has poor mobility, poor cognition, stroke, things that are never going to change.

So I'm not actually -- it's sort of, to me, a difficult measure to sort of isolate and I apologize I don't know what the literature shows in terms of if bathing is linked.

I would assume independence in bathing is linked to other improved functional status outcomes. So just my observation.

Dr. Amin: Thanks, Jill.

And we will be -- we heard from Cody. Beth from the health equity perspective.

Ms. Godsey: Yeah. This is Beth.

Just to reiterate what we've already discussed related to access and referrals for home health, I think there was the bigger challenge as mentioned with the other measures and we'll continue to make that comment for the remaining measures.

I do think that it's important to stratify these measures by race, by the individual components or characteristics of the patient that are really -- historically have been marginalized.

And so we would want to make sure that that is evaluated prior to any removal of this measure, but

feel it's an important component to consider with respect to equity.

Dr. Amin: Thank you, Beth.

Jenna, I'll turn it over to you. I'll ask the Committee to raise hands in order for any clarifying questions and discussions. And I'll turn it over to Jenna to facilitate and to Gerri.

Ms. Williams-Bader: Thank you very much, Taroon.

Okay. I'm not seeing any hands right now, but I will wait a minute to see if anyone raises their hand.

Okay. Jolie?

Member Harris: Yes. I just wanted to clarify the question in regards to the 80 percent.

Is it the understanding that that 80 percent show improvement in bathing from admission to discharge?

Mr. Hamilton: Jolie, that's right. I'm not sure if the question that Alrick answered was necessarily the question that was being asked.

So for OASIS 100 percent of episodes are completed. And so 100 percent of the item M1830 (phonetic) would be completed.

So you would get a valid response 0 through 6 and we'd evaluate that at start of care, resumption of care, or at end of care, and then we'd compare those two values.

Member Harris: All right. Thank you.

Mr. Hamilton: The 83 percent, I believe, is an episode level number. I'd have to check, but you can see that that roughly corresponds to the home health agency level scores that I had posted in chat.

Member Harris: And thank you for that.

And so I think I just echo the comment I believe Jill had made in regards to those with advanced cognitive disease or even terminal illness in regards to the expectation that we would expect an improvement in bathing independence from admission to discharge in a home health episode. So thank you.

Ms. Williams-Bader: Thank you.

Okay. Any other questions either for the developer or comments?

Nicole?

Member Fallon: Yeah, just -- I know I keep harping on this, but, in general, this improvement versus maintenance piece, and I think a few others now have mentioned this, too, I'm just concerned that somebody comes in and even before hospitalization wasn't able to bathe themselves. How are you going to get to an improvement point with them? And so then is that a realistic expectation of the home health agency?

I'm not up close to the measure. I'm just saying I think maybe we need to think about the exclusions a little bit more.

Co-Chair Lamb: Nicole, good question.

I'd like to go back to Joan for a minute. Joan, I thought you had mentioned that there was work in progress that was looking at cross-setting use of this measure as well as a maintenance function to answer that question; is that correct?

Ms. Proctor: What we're looking at is not necessarily in correlation to this measure. It's in relation to functional measures that evaluate and would be appropriate across settings for our maintenance population.

Co-Chair Lamb: Okay. How does that address the question, Nicole, the Committee just raised about

people who might not be expected to improve?

Ms. Proctor: I don't think -- I think what I was pointing to was an acknowledgment because we've heard it not just in this improvement measure, but in other improvement measures that, you know, CMS has focused on the improvement aspect.

And I wanted to simply note for everyone that that aspect and that concern has been taken seriously by CMS and that we're working in refining some of our current functional cross-setting measures to address this concern that we've heard not just from one, but from multiple organizations.

And I'm going to look to Alrick or Morris if they have anything additional they want to add.

Member Fallon: And I just want to say thank you, Joan, for that. You cut out a couple of times for me previously. So I may have missed that comment.

Ms. Proctor: Okay. Sorry about that.

Mr. Hamilton: Joan, this is Morris from Abt.

I think that statement is largely on point. The cross-setting measure that we're working on does try to do a good job of capturing maintenance patients.

The specifications are a comparison of your function using a composite measure at discharge relative to your predicted value where the predicted values is -- currently uses -- we're still working on the specification, but it uses clinical information at start of care as well as possibly some other items for social risk factors which we're evaluating on whether or not that makes sense.

Ms. Williams-Bader: All right. So, Alice, I see your hand is raised.

Member Bell: Thank you. So just kind of a follow-up to that. I want to make sure I understand.

So it sounds like there's an acknowledgment that for the cross-setting measure this issue has to be addressed, but this is going to come up with other measures today as well.

So is there some effort to address it in the context of these measures as well in a similar way?

Ms. Proctor: I think if you look back to when this was developed as a payment item, I think you'll see that there has been an interest.

I can't speak to this particular aspect of it with a degree of expertise as much as I'm aware of the fact that the M items (phonetic) at some point may replace payment items that are currently the improvement items.

It has always been an interest for CM and it was noted when the improvement -- I mean, when we brought on the cross-setting ones that although they were using the M -- going to continue to use the M items, it will be evaluating.

So I hope that that in responding to you and providing that insight and being responsive from the perspective that if they are no longer -- and we've always heard this concern that there's a duplication of function being evaluated by having within our program right now an M item, but also having these function items that we currently use that are improvement.

And so I would think where we'd be addressing this concern by evaluating the replacement of the items that are currently used, the improvement in bathing, et cetera, I -- the hope is that the payment policy folks would be able to use our cross-setting functional where, at that point, we would be collecting information that is focused on not just improvement, but also focused on those maintenance patients.

Does that help?

Member Bell: Absolutely. Thank you very much. I appreciate that.

Ms. Proctor: You're welcome.

Mr. Edwards: Just as one minor point of clarification, I think Joan might have misspoken.

Joan, did you mean to say that GG (phonetic) may replace the M or --

Ms. Proctor: Yes. I kept saying M items, and I meant to say the GG items. Thank you, Alrick. This mind isn't what it used to be. Thank you.

Dr. Amin: So, I mean, this conversation is extremely helpful and I'll ask Gerri to see kind of where this takes us.

I might just encourage the Committee to focus on the measure that's in front of us and understand the context of perhaps other measures and what they may be bringing contextually.

But if there are recommendations on maintenance that you have, which it sounds like there seems to be a theme, we should make those recommendations in the context of this measure.

Again, future plans with CMS is obviously contextually relevant, but as this relates to this measure specifically, you know, let's take that into account both in the voting, but also in terms of your feedback from CMS, which I'm sure they're interested in hearing.

Gerri and then Jenna also just in terms of where we are with others, but, Gerri, give us a sense of kind of where you see --

Co-Chair Lamb: So thanks, Taroon.

So again we're looking at 00185-C-HHQR and the discussion has been that this is an important measure. It's one of a functional measurement set.

There is variability and room for improvement. So that's additional data for us. It is risk adjusted.

There was some discussion about whether there were certain populations that you're just not going to see improvement in that might be part of that -- kind of that new specification.

So with that and given what Taroon just said, given this measure and this place, is that I'm hearing that the maintenance and addressing that is important.

And that also the populations that may not improve and actually what we would want to see is a slower decline in loss, that this would be -- and I'm going to be interested in comments -- conditional support to retain with, you know, with the understanding that CMS is doing respecification work and that that respecification would be looked at in terms of the concerns about the current measure.

Is that a fair summary, because the alternative would be to say to support to retain, but what I'm hearing is more consistent with conditional support to retain.

Ms. Williams-Bader: So, Gerri, a couple -- there were -- there are -- there were a couple of hands raised. So we should get to those.

I guess the respecification work is on a different measure. So I don't know if that would change the impact on the vote here, but just to -- I don't know if those changes would get applied to --

Co-Chair Lamb: Okay. So that actually, even in my view given this discussion, moves us more towards conditional support to retain, that this measure needs to look at maintenance as well as populations that may not see improvement.

Okay. So, Jenna, if you could go with the hands then?

Ms. Williams-Bader: Yeah. Pam? Pam, did you still

have a comment?

Member Roberts: Sorry, I'm talking with mute on. I apologize.

I said I think this is an important measure and to look at maintenance and especially the exclusions, but I think it's very important in the home health environment especially to help decrease the dependence on caregivers and making it as safe as possible for the patient to do as much as possible moving forward.

So in support of the conditional support.

Ms. Williams-Bader: And then Elissa?

Member Charbonneau: Yeah, and I apologize. I have a family emergency going on today.

So I have some -- I'm going to step out for a minute, but can someone explain to me is there an expectation that this is related to the GG functional measures that we're using for across sectional assessment in ADLs or is this something totally different?

Mr. Edwards: This measure is still based on the M items on the OASIS tool. There is also the GG items, which the intention, as Joan mentioned, was that the cross-setting measures would be based on GG since the -- those are the --

Member Charbonneau: Right.

Mr. Edwards: -- cross-setting data elements.

Member Charbonneau: So is it redundant to have these two different -- do we need this one if we're also using the GG?

Mr. Edwards: Great question.

Mr. Hamilton: I think there is somewhat of a timing issue here. The cross-setting function measure has

not been finalized and has not been submitted for NQF endorsement yet, whereas this measure does exist as being publicly reported.

So say this measure were to remove -- be removed today, there would not be a measure evaluating this aspect to function, whether in a composite or by itself currently.

Member Charbonneau: Okay. Thank you.

Ms. Williams-Bader: Okay. I'm not seeing any other hands raised; however, I believe we no -- we do not have quorum at the moment. Just double-checking.

Member Fallon: Jenna, while you're checking, just on that last point, do we want to add that as one of the kind of conditions of support?

So making a note to CMS that once that -- should that cross-setting measure be approved, that they would reexamine this measure for redundancy or something to that effect?

I mean, who knows? Maybe that will fall into our three-year review window.

Co-Chair Lamb: Nicole, I would expect that that would be the case. I think, though, to call it out is a good thing and important.

And I do know that the NQF team really listens to the dialog here and I imagine that would be in the summary.

Dr. Amin: It will.

Ms. Williams-Bader: Okay. Has anyone from the workgroup joined this afternoon who was not on previously for roll call?

Okay. So I think we should circle back to the vote on this later and we'll see if we can get quorum later.

I think we had some people who listened to part of the -- we had someone who was able to listen to part of the conversation.

So when we pick this back up, we -- Gerri, you wanted to vote -- do you know where you want the vote to start?

Co-Chair Lamb: Yeah. This was conditional support to retain.

Ms. Williams-Bader: Okay. So we'll pick that up when we have quorum.

Dr. Amin: Right. And the conditions are focused around exclusions and of populations we don't expect to improve and maintenance along with the context -- in the context of future measures that may be better positioned to do that.

Okay. So, Jenna, can we move on?

Ms. Williams-Bader: Yes.

Dr. Amin: Okay. Thanks, everyone. I know with busy schedules we have some people coming and going and that's -- we're right on the cusp of quorum for voting.

So appreciate everyone's flexibility and for staying on the meeting as your schedule allows. It really helps to move the conversation along.

00189-C-HHQR: Improvement in Management of Oral Medications

Okay. Our next measure for discussion is 00189-C-Home Health -- I also wanted to acknowledge the developer. I appreciate all the clarifications that are happening through the chat.

That is really moving the conversation along and, quite frankly, adding a lot of clarification as we go. So, again, just want to acknowledge your contributions there.

00189-C-Home Health Quality Reporting: Improvement in Management of Oral Medications. The percentage of home health episodes of care during which the patient improved the ability to take their medications correctly. This measure is endorsed and four MAP members selected this measure for discussion.

You'll see the criteria on the slide along with additional survey feedback that was received on this measure.

We will go to CMS to provide some contextual comments. And of the lead discussants, I believe, Aparna, you will be first on deck.

I don't believe we have Paul or Kindred Healthcare. So just so you know, you'll be next on deck.

So CMS, I'll turn it to you for -- yes, maybe Paul will join at 1:30 and, CMS, I'll give you a minute to provide contextual comments on this measure.

Ms. Proctor: Sure. For the Improvement in Management of Oral Medications it is currently endorsed.

It's also reported on our Care Compare site, a part of the Home Health Quality Reporting Star Ratings, and the Home Health Value-Based Purchasing Model.

CMS seeks to keep this measure since a patient's ability to independently manage oral medications reliably and safely is critical to patient safety.

And this is especially important for underserved and rural populations to prevent hospitalizations in acute care.

The measure does not meet the criteria of being topped out and aligns with our HHQRP goals. Thank you.

Dr. Amin: Thank you, Joan.

Aparna, any lead discussant comments that you have on the criteria rationale or any of the additional survey feedback comments?

Member Gupta: Yeah. Thank you, Taroon.

I, you know, first of all I'm going to comment I really like this measure because it really speaks to a couple of things across the quality safety spectrum, right, medication adherence, safety and ADLs, and that's where my question comes for the measure developers.

What was the thought process? Was this measure initially intended to speak to medication adherence leading to better management of -- better self-management of chronic disease or was it more leaning towards speaking to ADLs and managing your daily activities better?

Dr. Amin: Thank you, Aparna.

On rural, I think the only additional item that I would add to what Cody described prior to stepping away was that, again, some of the questions related to patients who may not be expected to perform this function for whom overall management -- or for whom management of oral medication may not be part of their goals of care was a concern raised, but there was overall support from the rural group.

Beth, anything to add from health equity?

Ms. Godsey: Nothing to add compared to what was already stated. Just again commenting on the fact that, from a home health perspective, the lack of referrals.

And then once the lack of referrals, you'll likely see some absence of historically marginalized populations in these measures.

So when Improvement in Management of Oral Medications is available and is made from a referral perspective to populations, we recommend that it

be stratified and take a look more to see around what those unintended consequences from a health and equity's perspective in support of looking at this measure in the future.

Dr. Amin: Great. Thanks, Beth. Important points. Appreciate it.

Co-Chair Lamb: Taroon, can we get a response to Aparna's question related to what the concept is here?

Is it -- correct me if I'm wrong, either is it intended as an adherence measure or a functional status measure?

Dr. Amin: I'll turn to the developer or CMS.

Ms. Keane: It's Nicole. I'll take it.

It's funny I just don't think of it that way. As a clinician, I'm going out there and I am assessing how they're managing their medication.

So it's part of patient care. I don't know that I would necessarily bucket into one or the other, but I do see it as a patient safety issue.

Member Gupta: Thanks, Nicole.

That's sort of where my mind was going as well, you know. My background being an MP, so when we're looking at medication administration and ensuring medication safety, we're thinking safety, but I also see that when we look at the list of similar measures, there are some measures that have been deemed similar that are in the ADL sort of a bucket, if you will. So that's where the question was.

How does this eventually connect with the value-based purchasing program? What kind of outcomes are we thinking here?

Member Gupta: Thanks, Nicole.

Ms. Keane: So I represent the Home Health QRP Program. I can't really respond for the HHVBP Program. I'm not sure if others on can.

Ms. Proctor: No. Unfortunately, we're unable to speak on the VBP aspect of this. I'm not well-versed enough to (audio interference).

Member Gupta: Thank you.

Dr. Amin: Okay. With that, Jenna, I'll turn it to you on the raised hands. I see Jill's comment, but I think it may be being addressed by the developer on the chat, but I'll leave it to, Jenna, for you on the raised hands and Gerri obviously to facilitate.

Ms. Williams-Bader: Yeah, I'm not seeing any at the moment. So I guess I would just ask, yeah, Jill, if once you've seen the response from the measure developer, if you want to make any comments related to your question. And obviously others can raise their hands.

Co-Chair Lamb: Okay. So, Jenna, in the meantime I'm going to summarize. And if you have questions, please raise them.

Okay. So we're talking about 00189-C: Improvement in Management of Oral Meds. And this is an endorsed measure. It was endorsed in 2018.

And I think we've addressed, you know, through the reviews that it is an important measure. It has the potential for disparities and the -- I think the burden issue has been addressed in the chat related that this comes directly out of OASIS. And I also note there were no public comments.

So given all of this, I think the recommendation on the table is support to retain. And I do see a hand up there.

Ms. Williams-Bader: Yes. So, Jill?

Member Cox: Yes. Hi. So thank you.

I think I actually just saw my response from Morris regarding how is this objective defined in terms of the level for the caregiver on the OASIS form.

So it's really just their ability to take the medication. Do they need assistance taking it? It has nothing to do with their knowledge of the medications or access via -- because of insurance, noninsurance, you know, pharmacy, et cetera.

So I'm assuming that's the correct interpretation. It's just physically taking the med.

Mr. Hamilton: Hi, Jill. This is Morris Hamilton from Apt.

Yes, that is the correct interpretation.

Member Cox: Okay. Are those other aspects of medication administration in home care addressed in other measures, because, to me, those seem very important.

Not necessarily who physically gives you the pill, but what's all those other ramifications surrounding medication.

And that's completely my ignorance and I apologize if others on this committee are probably much more well-versed in that.

So are there other measures? That was my question.

Mr. Hamilton: For home health there are not other measures that are measuring these items.

I do personally view them as important speaking for myself, but I do think to incorporate them in the OASIS we'd probably need to consider provider burden, things like that.

Co-Chair Lamb: Jill, if you would, keep that one in mind for our gaps discussion so that we get that one on the table in terms of other aspects of

medications that CMS might want to consider.

Member Cox: Okay.

Co-Chair Lamb: Thanks.

Any other hands up?

Ms. Williams-Bader: No other hands, but, Jolie, I see you've made a comment. Is this -- do you want to make that statement verbally?

Will it impact the vote or does it contribute to how you're thinking about the vote?

Member Harris: I just think this is a similar -- along the similar lines of the discussion we had with Bathing in regards to those with advancing cognitive limitations and/or terminal illness. The expectation of improvement from admission to discharge in self-administration of medication is not likely.

So could we possibly consider any exclusions in this area? Thank you.

Co-Chair Lamb: Okay. Jenna, let me ask you on that, then, because I think what Jolie was just suggesting raises a consistency question related to what category we put things in.

So does that, in your view, move us from support to retain to conditional support to be consistent across the board, because this is going to come up in all the -- I'm assuming in all of the functional measures.

Ms. Williams-Bader: Yeah. I would say that if the workgroup feels there should be changes to the measure, that to be consistent it would be conditional support for retaining.

Co-Chair Lamb: Okay. Thank you.

Mr. Hamilton: I will partially comment on Jolie's comment about the exclusion for terminal illness

and advancing cognitive decline.

We do include not as an exclusion, however, as a risk factor, items related to cognitive function, confusion, anxiety and depression.

For additional details I can post the specifications. It's, frankly, where I'm pulling all this information in to the chat. I'll post a link to the specifications if you want more information.

Co-Chair Lamb: Thanks, Morris.

You know, I think, you know, this is going to be a consistent issue in terms of exclusions and risk adjusters.

And I'm just posing the question to NQF, then, is if we are moving to support -- conditional support because we don't have complete information about risk adjusters and exclusions, I'm assuming, that can go into the report, what would you recommend there?

Ms. Williams-Bader: That's a good question.

I guess it -- this might not be as helpful an answer as it could be. I would say I guess it depends on how strongly you feel about those elements that you don't have complete information about or feel like you don't have in front of you today.

If those would really strongly sway you in one way or another, then, to me, I think that would be conditional support.

It would help to be able to say how you're thinking would change depending on what the results would be or what the details are.

Again, I think the comments for CMS are what's most important. So I don't want to split hairs here, but that's what I'm thinking.

Does that help?

Dr. Amin: Jenna, I might add just to, again, for clarification, perhaps, maybe, is that one way to interpret it just even in terms of the MUC process is we have conditional support -- here we have conditional support for retaining.

On this particular issue, what I'm hearing from the workgroup is that there's conditional support and taking into account patient populations that we don't expect improvement.

That could be handled through exclusions or through adequate risk adjustments. That's sort of the statement of the Committee.

If the developer or if CMS interprets that and reviews their measure and believes that the risk adjustment does address it more specific, then the condition is met and just -- that's sort of the same way we can think about endorsement in the future is that if the measure does get endorsed, then the conditions for support have been met and I think that's probably a reasonable standard.

Given the amount of moving parts that we have with these measures and how they're constantly being updated, we can think about it as a point in time with the information we have.

Co-Chair Lamb: I think, you know, that's, you know, that allows us to kind of have our ability to say this is important.

And also to say, you know, once you go back and review, we, you know, we think it's important -- an important measure and we want to make sure that this is taken care of.

Is everybody okay with that? Because if you are, then we're going to move to conditional support to retain.

Dr. Amin: I would ask CMS in particular too just to confirm that our interpretation of how we are

putting forth votes are reflected in how you're receiving them, how you're understanding we're receiving them.

Member Schreiber: Yes, Taroon, that we are.

Dr. Amin: Okay. Thanks, Michelle.

Ms. Williams-Bader: I do see that Alice has her hand raised.

Member Bell: Thank you, and I apologize if this is extraneous. But I think the concept that we're continuously struggling with is that the issue of sustainability as a goal of care.

For many patients, when you're looking at risk mitigation and what you're trying to do is keep the patient at a level that their risk doesn't rise. I'm not sure that risk adjustment addresses that question or issue.

I just wonder, and this is maybe something we put in the larger comments, if we start to think that the goals of care for many patients are either improvement or sustainability. And so how do we kind of acknowledge that separate population for which the goals of care are sustainability when we have so many measures that use the term improvement. Just a general comment.

Dr. Amin: Alice, we hear that comment loud and clear across -- that's across all the improvement ones related to maintenance and ultimately we're hearing that the MAP Workgroup is recommending that this concept be considered, how it is considered ultimately. Even endorsement committees can make a scientific judgment on that, but the main emphasis I think has been captured. Thank you for reinforcing.

Co-Chair Lamb: I think the concept that you have specified is an important one. What you're describing is not stabilization, and you framed it as

risk mitigation, which is reducing the decline.

I think we got that on the table, and I agree with Taroon. I don't think we need to repeat it for all the functional measures. I think we can agree that it goes across all of them.

Dr. Amin: Mm-hmm.

Co-Chair Lamb: Okay, so are we ready to vote?

Ms. Williams-Bader: We still don't have quorum, but it sounds like if 00 we do still want to note what the vote is, if we have quorum at some point we'll circle back. If not, we will be doing a survey. So knowing the category we want to vote on is important. It sounds like this one is also conditional support to retain.

Co-Chair Lamb: Correct.

Dr. Amin: Okay, so in the interest of time -- actually, let's do a quick time check.

We have one more measure in this improvement category, and then we are getting to the group of measures that we were intending to start at 1:20. Perhaps we're about 40 minutes behind, but I think we'll get there. Good discussion, though. Excellent discussion.

01000-C-HHQR: Improvement in Bed Transferring

Let's move onto the next measure on 01000-C-Home Quality QR, improvement in bed transferring.

The percentage of home health quality episodes of care during which patient improve the ability to get in and out of bed. The measure is endorsed. Five MAP members selected this member for discussion with the criteria and rationale listed on the slide in front of you.

Additionally, some additional survey feedback was also provided on this measure. For our lead

discussants on this measure, we have Pam, Jill and Aparna.

Pam, why don't we start with you?

Member Roberts: Sure. A similar discussion that happened earlier on this measure that talked about, I just want to bring it up, some of the upcoming changes with the cost-cutting measures of the GG probably applies here. I just want to make that note.

Overall, this one is currently endorsed. It looks like there is no issues with variability of data. There is differences in their overall outcome.

There may be some issues with disparities that was noted with non-white, younger, and lower income patients as well as those living in the Western United States. There is still the ability for improvement. I'll stop there.

Dr. Amin: My apologies. Now, I'm the one speaking on mute. My apologies. Let's go back to CMS. Again, I apologize for moving the agenda quickly.

Joan, can we go back to you for a one-minute introduction, and then we'll go to the other lead discussants with Jill.

Ms. Proctor: Sure. Similar to the improvement in the management of oral medication, in improvement in bed transferring it is currently endorsed. It is reported on Care Compare. It's a part of the home health quality reporting star rating, and the home health value-based purchasing model.

The measure does not exist anywhere in the HHQRP. The measure of performance has improved over time. Twenty nineteen, we were looking at 81.2 percent. In 2020, it went to 82.5. In 2021, it's 84 percent. The measure still has demonstrated room for improvement by HHAs. That's it.

Dr. Amin: Great.

Jill?

Member Cox: Yes, just a couple of observations.

Not to reiterate again, the exclusion criteria that we have discussed I think holds true for these as well in terms of functional impairment, cognitive impairment.

Other things actually would might potentially be access to physical therapy or rehab medicine in a home as a contributor to either non-improvement in this particular measure and the inability to get equipment in order to assist with transfer, just a couple of my observations, more so from my clinician side. That's basically what I'll add to this.

Dr. Amin: Thanks, Jill.

Member Cox: Okay.

Dr. Amin: Aparna?

Member Gupta: Thanks, Taroon.

Similar to what's been stated around the exclusion, a comment/question sort of the thought process behind developing this measure. I'm looking at what Martha shared in terms of scoring. Thinking about what was the thought process in improvement in bed transferring as it relates to outcomes.

It was their thought process and maybe having the threshold of what's the goal for bed transferring. For example, Score 4. I'm sort of thinking I have a patient and I'm setting a goal, care plan for this patient. So Score 4 and Score 5, they're still bedfast.

So from 5 to 4, it may look like there's improvement. And even if they go to 3, it may look like improvement, but depending on what the goal is for this patient, it actually might not be

improvement. So what your thought process in the future having the threshold, or how would this measure connect to outcomes in patient care?

Dr. Amin: Does the developer want to respond to that or CMS?

Ms. Proctor: I think to be kind of transparent here because if this were to contain this program and it were to be opt out per se, we'd probably be looking at some types of assessments. And you understand why I'm doing all of the ifs, because we're not there yet. Also, the interest of bringing on the GG items, but I wanted to be transparent as to what my current thinking is. I'm curious as to your feedback on that.

Dr. Amin: Thanks, Joan.

Aparna? Anything else to add there, or is that sufficient?

Member Gupta: I appreciate it, thank you.

Dr. Amin: Okay.

Cody, we reviewed this -- Gerald, I welcome you to the committee. And also welcome any feedback that you may have from the Health Equity Advisory Group.

Mr. Mullen: Thank you for that. I'm glad to be here. I don't have any feedback at this time.

Dr. Amin: Great, thank you.

I just note the same items here that we've heard around improvement being the correct standard for someone with a disability was one of the main topics also brought up at the advisory group.

Okay, I think those are the main introductory comments here. I'll turn it over to you, Jenna, to collect the raised hands and to Gerri to facilitate.

Ms. Williams-Bader: Thank you, Taroon.

Since it's already come up, I think we can assume the condition around looking at considering how to address the certain populations where improvement might not be possible. That's a condition. Let's focus on other comments on the measure.

Jill, I see you've got your hand raised.

Member Cox: Yes, just a question, actually. It came up when Aparna pointed out that 4 and 5 are both bedfast. Since I represent the National Pressure Injury Advisory Panel, when we look at patients who are bedfast those are the patients at risk for worse outcomes, meaning pressure injuries.

So in the OASIS, are pressure injuries tracked? Again, my clinical area is acute care, so I am not familiar with the pressure injury measure within OASIS or if there is one. And this measure is sort of like a circuitous way to almost get to pressure injury risk, if you will. I know they're probably doing pressure injury risk doing Braden or something.

I don't know if the measure developer -- yes, so pressure injuries are tracked within there. That is sort of a secondary benefit of this particular bed transfer sort of looking at that --

(Simultaneous speaking.)

Member Cox: Just a comment.

Ms. Williams-Bader: Thank you, Jill.

Gerri?

Co-Chair Lamb: This is for the measure developer or CMS. Is in the criteria, it was indicated that this is duplicative. Are there any other measures like this in the program?

Ms. Proctor: This is Joan Proctor. No, there isn't. There is not. This --

(Simultaneous speaking.)

Ms. Proctor: -- sort of like looking a measure -- an older measure set, because at one point we were tracking multiple improvement activities, and some of those improvement activities are no longer in our program.

Co-Chair Lamb: Okay. Thanks, Joan.

Ms. Williams-Bader: I don't see any other hands.

But, Julie, you made a comment. Did you want to say anything additional about that?

Ms. Malloy: No, I just wanted to be sure the importance of being able to improve function in bed mobility and other ADLs, right, can just be important for our clients. Of course understanding that we need to address the maintenance issue as well.

Ms. Williams-Bader: Thank you.

I'm not seeing any other hands at this time.

Co-Chair Lamb: Jenna, how are we doing on quorum?

Ms. Williams-Bader: I think we still do not have quorum.

Co-Chair Lamb: Okay, so let me summarize. We're hearing similar things for the functional assessment important potential for disparities. This is an endorsed measure. There is room for improvement. It is not duplicative.

We still have the same questions about populations, as Jenna said, as well as issues related to mitigation and maintenance. We would be in the same court of conditional support to retain.

Dr. Amin: Thanks, Gerri. I just note, again, just know your own voting support for that voting

category, and we'll convene --

Ms. Williams-Bader: Can I just -- sorry. I don't mean to interrupt. I know we're behind on time.

I guess, Jill, you did bring up a specific point for this measure about access to physical therapy or rehab medicine. That will be captured in the notes, but is that something that's rising to a level of a condition for you? There wasn't much discussion about that.

Member Cox: I think that is a concern if there is no -- depending on the goal for the patient. Is the goal to improve functional status and mobility, then having access to a home physical therapist and they actually facilitate that.

And if there is none available, that can be deleterious to that rehab goal, quote-unquote, rehab goal. When you say is it conditional, meaning that should the vote be changed to conditional?

Ms. Williams-Bader: I think the vote is conditional support to retain, but the only condition we have attached to it right now I believe is that the measure developer and CMS looks at those populations where you would not expect to see improvement or they would maintaining instead. Again, just wanted to make sure we didn't go too fast over that point to see if it rises to the level of a condition or not.

Member Cox: Not having a pulse on what happens in home care in the country and knowing if physical therapy is the norm. I know in my area of the country it would be the norm for Medicare patients to get physical therapy in the home.

If that's not the norm across the country, then it wouldn't be conditional if that's not the usual standard of care. I don't know if there's other experts from functional area, Physical Therapy Society, right? And occupational therapy.

Ms. Williams-Bader: Alice, you have your hand raised?

Member Bell: Yes. I was just going to say and put in the chat that both OT -- the home health agency is required to ensure access to necessary PT and OT services. That's kind of a condition of participation. In the case of PT, PT can actually open the case. So, yes, I think that would be the -- that is just kind of a standard of care nationwide.

Dr. Amin: I'm hearing we can add it into the commentary around the measure but may not necessarily be a condition.

I see Gerri's head nodding.

I think an important point that we'll capture in the discussion rationale.

Co-Chair Lamb: It's also something, Taroon, we've heard it a lot from the Equity Group is access to services.

Dr. Amin: Right.

Co-Chair Lamb: Like Alice is saying, this is a condition of providing services. It's what do you do when the services are understaffed or not available. It's a different issue.

Dr. Amin: Mm-hmm. Right. Especially when we're measuring improvement. Good points all around.

Any other comments on this? I don't mean to move us too quickly. So certainly if there's any other comments here, take them, Gerri, I'll look to you. Can we move on?

Co-Chair Lamb: I think so.

Dr. Amin: Okay, let's go onto the next measure.

00212-C-HHQR: Influenza Immunization Received for Current Flu Season

00212, influenza immunization received for the current flu season. The percentage of home health quality episodes of care during which patients received the influenza immunization for the current flu season.

I think this comment in the chat -- Michelle, do you need air time for this comment, or do you think that stands on its own?

Member Cox: I think it stands on its own, and I was putting it in chat so people had to read it. There had been questions on home health VBP, which most people know is a CMMI model in nine states. And so I think the question was what are the measures that are going into it. I was just listing it out for everybody.

Dr. Amin: Okay. All right, thank you. Thank you very much.

Back to influenza. The endorsement was removed. Four MAP members selected it for discussion. The criteria and rationale are listed here.

CMS, I will ask you for one minute of introduction or contextual comments. Joan.

Ms. Proctor: Sure. The influenza immunization received for current flu season as reported on Care Compare is also a part of the Home Health Quality Reporting Program star rating and home health payment program. The measure does not exist anywhere else within the Home Health QRP program.

This measure has important public health implications, especially in light of a current COVID-19 public health emergency, and the HHQRP's goal to offer immunization to patients who are not already immunized during a home health episode.

The QM was due for -- the quality measure was due for NQF endorsement but was not put forward due to NQF recommendation CMS's decision to harmonize this measure with minor changes in the specification to the flu measures used by other PAC settings.

This policy approach was bumped in priorities by the IMPACT Act-based cross-setting measures and respecifications to align with other PAC settings has yet to be realized.

The home health quality program would like to retain this measure and intends to update the specifications to match that of other PAC setting specifications, specifically what is employed currently by the SNF quality reporting program.

Ms. Williams-Bader: Thank you.

Dr. Amin: Thank you very much. Raj, I know you're on. I'll turn it to you in terms of lead discussants, but do we have any other representatives from the ATW. I don't believe we did at the beginning of the meeting, but I'll just ask here again just to confirm.

Doesn't sound like it. Raj?

Member Mahajan: Yes. Thank you, Taroon.

Mainly wanted to put forward for some of the mature programs, and again probably not for home health, but this is one of the measures that has either topped out or has been retired. Other than that, no additional comment from my end. It definitely, you know, home health QRP is one of the youngest programs. So we'll support that and agree with current, at least proposal, to keep it in the program.

Dr. Amin: Thanks, Raj.

So from the rural perspective, Cody, it looks like we have you back online. Any feedback from you and then I'll turn it to Gerald from the Health Equity

perspective.

Mr. Mullen: Our recommendation during our meeting was 63 percent of a yes to continue -- sorry, yes, 63 percent. Twenty-five percent no, and 13 percent unsure.

There was a lot of discussion around this measure being specifically influenza and the potential for including other vaccines that may be needed annually.

Discussions surrounding the COVID-19 shot and lack of access in the rural and incorporating that into home health bundles. And there was also some concern about it not being endorsed but did recognize the need for consistent influenza vaccination through home health.

Dr. Amin: Thanks, Cody.

Gerald, anything from the Health Equity perspective to bring here?

Mr. Nebeker: None other than what's already been brought up with the issues of consent and such. I have nothing else to add. Thank you.

Dr. Amin: Okay, great.

All right, Jenna, I'll turn it to you to collect the raised hands.

And, Gerry, to facilitate on the conversation.

Ms. Williams-Bader: Okay, thank you.

All right, any questions or comments? I'm not seeing any hands raised.

All right, Nicole --

(Simultaneous speaking.)

Ms. Fallon: Hi, Jenna. Sorry, not a lot here, but vaccine is very important. I wonder if this is the

right measure at this point? I mean, should it be a matter of that Home Health has confirmed vaccination status and has offered.

To me, this always go back to this is a post-acute setting, so to speak, and shouldn't this have been addressed at the hospital. Not that it's not important, but I'm hoping the hospitals, and I'll admit I don't know their quality measures, but I'm hoping they're being held accountable for these standards as well.

Ms. Keane: Nicole, it's Nicole, the measure developer.

I might offer -- I think you can think of this as a backstop measure. So pre-COVID what the intent was is, I'm a clinician, I have a patient, I've asked this at admission. They are not -- it's during the flu season. I think what is that? Like, September through March. They are not immunized. I get flu vaccine to my agency, and I can bring that out and vaccinate the patient.

Again, if the hospital hasn't done it and agreed that would be ideal, we have the ability to do that as a clinician in their home.

Ms. Fallon: One follow-up question. What happens if they say no? Are you dinged because of that? That would be my only other concern.

Ms. Keane: Morris, Alrick?

I don't think so. I think they can ask and refuse.

Mr. Edwards: Under the current configuration -- yes, under current configuration, you wouldn't be dinged. I think that's the other point worth noting is also we have a fair amount and growing population of folks getting home healthcare that are not coming directly from acute care. I know we're considered --

(Simultaneous speaking.)

Ms. Keane: That's true. That's true here.

Mr. Edwards: But I just wanted to note --

(Simultaneous speaking.)

Ms. Keane: Thank you for clarifying that.

Ms. Proctor: I think it's 60 percent of our patient population is coming (audio interference).

Ms. Williams-Bader: Okay, Gerri?

Co-Chair Lamb: Just a question about topping out.

I think, Raj, you were saying something about topped out. When I was looking at the material, it looked like there was still room for improvement. It was still in the 70-some odd percentile. I just wanted to check that.

Member Mahajan: No, I mentioned not for home health, but there are programs where either -- I don't remember off the top of my head, but there are some mature quality reporting of value-based programs where this particular measure has been retired or topped out.

Co-Chair Lamb: Okay, but not in home care?

Member Mahajan: Not --

(Simultaneous speaking.)

Co-Chair Lamb: Okay, thank you. Thank you. Okay, that was my question.

Ms. Williams-Bader: Okay, I'm not seeing anything in the chat, and I don't see any hands raised.

Co-Chair Lamb: All right, so summarize. We are looking at 00212, influenza immunization. I'm assuming are we at quorum or not quorum? We just keep moving?

Not, okay.

Ms. Williams-Bader: We are not at quorum.

Co-Chair Lamb: Okay. So we have -- this is not an endorsed measure. We have talked about it being important with public health implications, potential disparities, rural disparities. In the process of being harmonized with other cross-setting measures, but it's not been done yet. I think we're in the ballpark of -- yes. What is it now?

There we go. Conditional support to retain.

Ms. Williams-Bader: Sorry, Gerri. What would be the conditions for this one?

Co-Chair Lamb: This one is that it's not endorsed and that -- actually until it's harmonized, that's not a condition. If it is in fact harmonized and changed, that would take precedence.

The fact that it's not endorsed would be one condition. But the other is sort of a let's wait and see, and if there is a new measure and it's stronger, then that would take its place.

Mr. Edwards: Let me make just one clarification. This is Alrick, measure developer team.

We do want to note that refusal is counted as a negative outcome. It's not excluded. It's a part of one of the considerations in harmonization is to deal with the issues of the nos. I think Morris posted in the chat Indicators 4 through 8 and how those are addressed.

Co-Chair Lamb: Okay. So, Alrick, just to clarify in response to the earlier question. If somebody refuses, it's still is a negative outcome currently?

Mr. Edwards: Yes.

Co-Chair Lamb: That is being looked at. Is that correct?

Mr. Edwards: That's correct. Yes.

Co-Chair Lamb: Okay. Do we want that in our conditions is that handling of refusals?

That's a question to Committee.

Dr. Amin: They may need a second just to review the chat.

Gerri, I heard that the question around the condition being around the harmonization, it sounds like from the developer Items 4 through 7, which are the No categories, are the elements that are being considered under the harmonization. So we can specifically point out that the No category should be evaluated specifically to reinforce the point.

Co-Chair Lamb: Thanks, Taroon.

Dr. Amin: It seems like Jolie and Nicole are supportive of that.

Co-Chair Lamb: Okay. I think we're seeing that that should be part of the condition is to look at how refusals are handled.

Dr. Amin: Okay, Gerri. It sounds like conditional support for retaining with those two items around endorsement and the harmonization as a specific callout on the refusals and 4 through 7 in the chat.

Again, thank you to the developer for providing the specific information in the chat before it's needed. It's helpful to move the conversation along.

Okay, just in terms of time track, we were scheduled to take a break at 2:00. I'm going to ask if we can take this next measure, which would bring us to the break and see if we can move that one forward and then take our break after that.

Gerri, is that agreeable?

Co-Chair Lamb: As long as it's comfortable for everybody else.

Okay, let's do it.

Taroon, you might mention here that we are now entering -- the last four are all mandated ones, and CMS is still very interested in our comments.

Dr. Amin: Right. Yes, absolutely. I'll reinforce those points, and CMS can obviously re-emphasize those in their contextual comments.

02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary (MSPB) - Post-Acute Care (PAC) HHQRP

The next measure for discussion, 2943, total estimated Medicare spending per beneficiary, MSPB, post-acute care.

This is assessment of Medicare spending of home health agencies, MSPB-PAC Home Health episodes, relative to Medicare spending of the national median home health agencies. MSPB-PAC Home Health episodes across the same performance period. Note -- I'll let you read the note.

This measure is not endorsed. Seven MAP members selected this for discussion today. The criteria is included on the screen in front of you additionally with some survey feedback. Just note specifically that the MSS, the Measure Summary Sheets, were not available at the time the survey was taken, which is why there's some need for some further data, especially on a measure such as this.

If we do have another measure developer for this measure, again I would just note for speed of discussion or just efficiency of discussion, if there are clarification on the measure specifications that would be helpful from the measure developer's perspective or CMS, feel free to throw them in the chat.

With that, I'll turn it over to our CMS program lead, Joan, for a one-minute introduction on any

contextual comments of the measure. Again, I'll just re-emphasize Gerri's point that this measure is required by statute.

However, CMS would still welcome feedback on the specifications of the measure to see if there are any opportunities to enhance. Again, I'll turn it over to CMS to provide any contextual comments of the measure.

Joan?

Ms. Proctor: Sure. The total estimated Medicare spending per beneficiary, of course you were just going over how it's statutorily required. While the spring 2020 NQF Cost and Efficiency Standing Committee did not recommend the measure for endorsement, we believe this measure adds value to the HHQRP.

The home health Medicare per beneficiary quality measure receives strong support from NQF's Scientific Acceptability Panel review on very rigorous criteria for validity, reliability, reportability and usability.

Using Spearman's rank correlation is positively correlated with the functional improvement quality measures of a 0.6 to a 0.16, suggesting that more spending may lead to functional improvement. All correlation efficients are statistically significant at the 0.001 level.

MSP is also positively correlated with ACH with 0.28 and emergency department with a 0.05, indicating more spending means more hospital interactions. The correlation with discharge community is negative 0.09, indicating more spending means more hospital interactions.

But it's also negatively correlated with PPR of a negative 0.03, indicating more spending means fewer preventable readmissions. The correlations with ACH, emergency department and discharge

community all make sense because MSPB includes associated care-based spending in its numerator.

Thank you.

Dr. Amin: Thank you very much, Joan.

For our lead discussants, we have the American Geriatrics Society, Dan Andersen, and then the American Academy of Physical Medicine and Rehab.

Deb, do you want to take from the American Geriatrics Society first and then we'll turn it to Dan.

Member Saliba: Okay, thank you.

Our quality committee looked at this, and they were unanimous in supporting removal because they raised concerns about adverse selection premature discharge. It's notable, as was noted just now, when the NQF Cost and Efficiency Standing Committee voted on this measure, they voted that it did not meet scientific acceptability criteria.

Their vote on validity was nine moderate, seven low. It was really noting that given that the assumption of the measure is that you should be spending less not more, the fact that home health agencies that were spending more, their patient population had more functional improvement.

And also found that the spending was very heavily driven by rehospitalization and that it wasn't really avoidable hospitalizations that were driving it. That was consistent with the concerns raised by our committee when they looked at it.

There was also some discussion that was a little interesting in the notes about the exclusion of social risk factors. Interestingly, it went the opposite of what you might hypothesize in that dual eligibles actually had less spending than not dual eligible.

That was a little odd and also pointed out by the Cost and Efficiency Committee. There were a lot of

concerns with the current measure despite the fact that it is a statutory requirement.

Dr. Amin: Thanks, Debra.

The last item related to spending less on certain populations did come up in the Health Equity Advisory Workgroup as well.

Dan?

Member Andersen: Thanks. I'm not sure I have a ton left to add following Deb. I do concur with her assessment, especially looking at some of the respondent comments and questions. I think it does get to some challenges here that they're pointing or asking for more clarity on. I think the information provided might answer some of the things.

They're about more data, but there's a concern about the only including Medicare fee-for-service costs and in fact looking at -- the report seems like 20 percent of episodes are being excluded.

I'm wondering if that -- just that surprising finding about less spending on duals might be attributable not to on-the-ground reality but more so just some of the spending is actually being excluded because we're not including Medicaid cost and things like that.

I think the biggest challenge would probably be around the Criteria 10, which is the negative unintended consequences. There are some. It could have adverse selection or holding back on care to reduce costs as well as maybe consumers and the beneficiary not really understanding what it means.

They might be looking at this measure as more spending might be good. I'm going to get the care I need, right, when a lot of them face challenges with fighting for benefits and things like that.

Dr. Amin: Right. Thanks, Dan. I know the developer and CMS may have a number of comments and

feedback to this. Let's just get through some of the lead discussant introductions.

American Academy of Physical Medicine and Rehab, is there a representative from that group that would like to add any additional comments on the criteria or rationale?

Okay. Cody from Rural?

Mr. Mullen: Yes, we discussed this when we were pretty split on this. We had five yes at 56 percent, three unsure at 33 percent, and one at 11 percent. There was concerns about the validity of the measure and small sample size in rural and how it'd be thought through and applied but also recommended as a statutory requirement for the measure already.

Dr. Amin: Mm-hmm. Thanks, Cody.

Gerald, anything to add from the Equity perspective?

Mr. Nebeker: Nothing to add, thank you.

Dr. Amin: Thank you.

Okay, Jenna, I'll turn it to you in terms of addressing hand raises from the committee, and I will turn it to Gerri to facilitate.

Ms. Williams-Bader: Thank you, Taroon.

I don't see any hands raised -- okay, I take it back. Nicole, go ahead.

Ms. Keane: Sorry. I'm just a thorn in your side today. The challenge with this one I think is a couple of things.

As it was noted, hospitalizations are the primary driver of cost when you think about (audio interference) that quality measures and that outcome or the performance of an agency on that

particular measure, it needs to be something they can affect.

They can affect hospitalizations, that is true, but I say that's probably the main and almost only thing that they can impact that's going to affect the number.

Others have already talked about the fact that sometimes spending more is actually a better quality outcome, yet I'm not sure that that works in our favor. I think this one's problematic.

I also think that it's redundant in one sense. If hospitalizations is the main thing that we can affect, we're already capturing rehospitalizations and other emergency use on other measures. I get that this was Congress's wisdom on something that should be tracked, but it might be time to have a gut check with them.

Ms. Williams-Bader: Thank you very much, Nicole.

Okay, I'm not seeing any other hands raised at this time, but Dan has asked a question if there are any other measures in the works to get at cost?

Dr. Amin: Jenna, maybe we can open it also back up to CMS on some of the clarifying points that came up already from the lead discussants if they have any reactions as well.

Ms. Williams-Bader: Thank you, Taroon. Good idea.

Ms. Proctor: This is Joan. I'm not sure I really have anything to provide in terms of feedback. I can say that I've not heard of a conversation surrounding the development of a different type of cost or spending measure, per se. But I look to others here that may have something else, but I don't think I really have a whole, whole lot of feedback.

The comments that you provide are similar to things that we've heard in the past relative to this measure, but I'm not sure -- because this would be

something that we'd have to work across all of our programs to modify cost measure. I'm not sure if anyone else from CMS has something they want to provide here in terms of future direction.

Member Schreiber: Joan, it's Michelle. I completely agree with what you said.

Ms. Williams-Bader: Okay, I see Jim has his hand raised.

Member Lett: Thank you. I think we all share an inherent discomfort when start talking about finances with kind of a -- I'm not trying to accuse CMS or anyone else in trying to do bargain-based medicine, but it's the kind of an uncomfortable feel that I think clinicians, caregivers get when you start starting about how much does it cost to take care of a specific patient.

Now, if we can make this a meaningful measure, I think we all need to know what things cost. I think if we are able to connect it with outcomes, return to the hospital versus how much things cost, perhaps the more you spend the less likely people are to come back to the hospital or come back to the emergency department or develop mortality as a result.

I think it'd be very helpful just as -- and it's just me, not the organization that I'm representing. If we can link cost to doing a better job with outcomes for patients, it will go a lot further and perhaps have that kind of discomfort that a lot of people experienced dissipate to some degree.

Mr. Hamilton: Hi, this is Morris Hamilton at Abt. I think that's an excellent point. I do want to clarify however that the MSPB measure is not just the more you spend. It is the more spend relative to the national median. There is that distinction in the way that it specify. I don't want to say anything more to that, but I just want to clarify the specification.

Dr. Amin: Thanks, Morris.

And, Jim, Thank you.

Are there any more hands raised, Jenna?

Ms. Williams-Bader: There are. I see Gerri.

Co-Chair Lamb: Yes, thank you.

I would like just to hear Deb talk a little bit more what about what she in chat would be ideal. Can you elaborate?

Member Saliba: Yes. Basically, it's sort of what Joan was just saying. I probably put it in before Joan started talking.

Maybe one possible direction to think about is to think about this in terms of efficiency are identifying particular goals or outcomes and then it's the cost per outcome achieved.

And then we could, again, risk adjust it and thinking about expected versus observed. But thinking about it really in terms of the outcomes achieved.

That's, I think, what Congress wants us to get at. Although, that's not the language they used. They just used per penny cost. I appreciate that that puts CMS in a difficult position.

Co-Chair Lamb: Deb, what I'm hearing is kind of moving towards a more value-based metric.

Member Saliba: Exactly.

Co-Chair Lamb: Which is getting to the outcome at reasonable or lowest cost.

Member Saliba: Yes, exactly.

Ms. Williams-Bader: Dan has his hand raised.

Member Andersen: Yes, I was going to confer with the last two commenters.

I think, Gerri, you're exactly right. We're talking about a definition of value here so moving away from cost, which I again can be challenging, especially for a consumer to kind of interpret what does that mean. If a good outcome and how much does that cost. I think people can reasonably understand that.

I think we mentioned that as kind of a gap area across these programs where we'd want to head in the future. So maybe this is the, you know, maybe this is the impetus to look at it. Because I think we all agree we have to have an eye on the costs for the programs, but we might need to be a little bit more holistic.

Mr. Pyatigorsky: This is Mikhail Pyatigorsky at Acumen, one of the developers. Just to respond to that quickly, you can think of the MSPB measure as an efficiency measure. The outcome here is essentially an episode of care.

In other settings, there are many cost measures that are specific to an episode of care triggered by a particular event like a knee replacement surgery, for example. Here, it's just an episode of care.

So given the risk adjustments and the fact that as part of the risk adjustment, it is compared to the national population over a period of time. The goal of the measure is to say that an efficient provision of care during an episode during which a patient is being cared for by a home health agency is viewed as a positive outcome.

And the correlation with some of the other outcomes are what gives us some confidence that this is actually correlated with other events that we want to see.

Ms. Williams-Bader: Okay, I'm not seeing any other hands raised.

Unless, Dan, you had another comment?

Member Andersen: No.

Ms. Williams-Bader: Okay. Nicole asked a question in the chat, does the measure account for variation and geographic cost?

Dr. Amin: I think the developer can answer that, but it is a risk standardized measure adjusted to Medicare paid amounts.

Correct, Developer?

Mr. Pyatigorsky: Yes, that is correct. And also the cost themselves are adjusted for the geographic payment variation.

Co-Chair Lamb: Okay, so we are ready for me to summarize then, Joan?

Ms. Williams-Bader: Yes, go ahead.

Co-Chair Lamb: Go ahead, all right.

02943-C, the comments have identified several concerns about this measure. Many of which are consistent with previous reviews and is not an endorsed measure.

Some of the concerns were related to scientific acceptability, the exclusion of social risk factors, the unintended consequences related to lower costs and that Rural has identified that small sample may be problematic.

We also have talked about that this is one that's harder for home health to impact and may be redundant with higher cost services like hospitalizations and ER.

So what I'm hearing in terms of our discussion is that this is a support to remove.

Anybody want to respond to that? And I don't know whether we have quorum.

Dr. Amin: That sounds consistent with our lead

discussants, Gerri.

Member Mulhausen: This is Paul. I'm actually not in support of removing it. I think if you look at this in isolation, it's problematic. If you look at it programmatically, I think it's a reasonable way to meet the statute and try to get at this issue of value and efficiency.

If this is the only thing we measured people on, all of those issues that have brought up make this toxic. I think in light of a program -- I think it's a very reasonable thing to be measuring people on.

I agree consumers may not do as well, understanding what it means. I probably would. I do consume healthcare services and have a dependent family member who uses home health services. I think there are some sophisticated consumers who would use it. I agree most might not fully understand it.

I think it has problems. It's required by statute. In my mind it becomes just sort of a principled stand. I think programmatically, it has utility to get at some of the things that Deb and Jim has talked about. I think it could be improved, but I don't think as part of a program measure.

It's something that I would support removal for. Those are just my thoughts and responding to what you said, Gerri.

Co-Chair Lamb: Thanks, Paul.

Question to NQF, I think the -- and Paul's points needs to be put in the record. What I heard thematically from the other comments was more consistent with a removal, not a conditional support for removal. I'm thinking that should just stand. And then of course the comments like Paul had said would go down in the report.

Dr. Amin: We certainly would reflect any minority

opinions in the discussion, obviously.

Co-Chair Lamb: Okay. Thanks, Taroon. I just wanted clarification because I didn't want Paul's comments to be lost.

Dr. Amin: Absolutely.

Ms. Williams-Bader: We're actually just doing a quick check. There's a number of hands. While we work through those hands, we will also check to see if we have quorum.

Larry, I see your hand's raised?

Member Atkins: Yes. I just want to make kind of a basic point. While I think this is a good thing to try at efficiency and value in what we're using. I think it's the two things, efficiency and quality, are not the same thing. They're really quite opposite in some ways.

The whole point of the quality metric is to be able to serve as a way to make sure that as we strive to reduce healthcare cost, we're not compromising the outcomes for patients and shorting them on services.

I think to put them in a quality metric in a quality environment is really the wrong place for it. You have value-based purchasing, and I think that's where in that context you're looking at value, the cost side of value. I agree with the idea that it should be removed from quality metrics.

Dr. Amin: Thanks, Larry.

Jenna, any other hands?

Ms. Williams-Bader: No, there were a couple, but they've been lowered.

Dr. Amin: So, Gerri, it seems like we again are still in the same place with some additional contextual comments that certainly can be added.

Gerri, are we good with that discussion? Then, Jenna --

Co-Chair Lamb: Yes.

I'm just wondering where are we at with quorum, Jenna. I had gotten the impression we might be at quorum.

Ms. Williams-Bader: Yes, sorry. I think we are not. We could attempt to do a vote to see where we are. I know we're tight on time. We'll do a count during the next discussion and see where we are. Let's go ahead and move. I think we're actually going to take a break right now. That might be a good time for us to check.

We have, by my count, three measures left. And then we have the discussion of gaps and feedback on the process, which we definitely want to leave time for. Our break was supposed to at 2:00, and we're at 2:30. Let's go ahead and take the ten-minute break. Let's come back at 2:40. That will give us eight minutes.

(Whereupon, the above-entitled matter went off the record at 2:32 p.m. and resumed at 2:42 p.m.)

Ms. Williams-Bader: Okay. Welcome back, everyone. Thank you so much. We do not have quorum, so we'll just keep talking through the last three measures. I think if we can get through the remaining three no later than 3:40, then we'll have enough time for discussion of the last two agenda items and have the opportunity for final public comments. Obviously, if we end earlier, that's great. If not, that's what we're aiming for.

Taroon, I'll hand it over to you.

Dr. Amin: Great. Thanks, Jenna.

02944-C-HHQR: Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

All right, we have our marching orders. We'll move onto the next measure. So 02944, discharge to the community, PAC Home Health Quality Reporting Program.

This measure assesses successful discharge to community from home health agencies with successful discharge to the community including no unplanned hospitalization, no death within 31 days following discharge.

The measure is endorsed, and four members selected this measure for discussion today. We'll put the rationale and criteria up for everyone's review, and additionally the survey feedback. We will first start with the CMS one-minute contextual feedback on the measure.

Joan? Can I turn it to you?

Ms. Proctor: Sure.

This is a claims-based measure, so I wanted to start our presentation off with that. We agree that when the measure data review by the committee was compiled, information from a separate discharge committee was used instead of the claims-based measure as part of our HHQRP.

The measure is relevant to Home Health QRP as it assesses an important outcome for HHAs, the successful discharge of Medicare beneficiaries to the community. This is a priority outcome for the Home Health Quality Reporting Program since its instruction to the Home Health Quality Reporting Program has been a strong measure used to differentiate at HHAs.

Thank you.

Dr. Amin: Before we move on, I just want to

reiterate this measure is required by statute. We have the SNF Alliance, AMDA, and then the National Transitions of Care Coalition. So we'll go Jolie, Raj and then Jim.

Jolie?

Member Harris: In regards to this measure, I thought it was helpful the number of exclusions that it had to really clarify this measure more succinctly. It was consistent across other levels of care, other post-acute care, and looking at the similar measure. I saw a comment that it was a burden to reporting, but I think the prior comment noted that they were looking at a different measure, and since this comes from claims, that shouldn't be a burden for reporting.

It also had a note of lack of risk adjustment as a comment, but I saw in the denominator it did have risk adjustment. Again, that may have been the other measure they were referring to.

But an interesting point I thought they made in the comments from the committee was the area of the dual eligibles. Although it is risk-adjusted, that may be a really interesting factor that we could consider as a recommendation to look at whether this data could be split up by duals and non-duals as a measure as this is also a way MA plans are looking for greater stratification in their measures along that line of duals and non-duals.

And then there was a comment about hospice and didn't want that to be discouraging, and I guess considering that you'd be transferring to a different level of care and a different primary provider under a hospice that maybe that could be considered also as an exclusion criteria.

That's all.

Dr. Amin: Thanks, Jolie.

Raj?

Member Mahajan: I'm sorry, I don't have the access to the Society's feedback, but no additional comment from me at this time.

Dr. Amin: No problem, Raj.

Jim, any additional feedback on this measure?

Member Mahajan: Again, as a Society representative, I know nothing additional.

Dr. Amin: Okay, great. Thanks, Raj.

Jim from National Transitions of Care Coalition. Anything from your perspective?

Member Lett: Just a few things. Is this claims-based as well?

Dr. Amin: Yes. I think the developer clarified that, yes.

Member Lett: That kind of addresses the high-level of reporting burden point, which is helpful. Certainly, NTOC is interested in trying to do the best we can with our handoffs and our transitions from one side of care to another.

Certainly, measuring -- well, we all assume we do a good job, right, I mean anybody on the call that thinks that they don't good a job, raise your hand because I'd like to know.

We all work as hard as we can, but it is difficult to know if that hard work is translating to better outcomes for the people who serve without having some data to look at to get an idea of where we stand.

I think in the spirit of harmonization, I think that NTOC would that it is good to see where we all stand in terms of readmission data. It doesn't say here, but I assume that this is also a 30-day

readmission metric, is that correct?

Dr. Amin: Can the developer clarify?

Member Lett: Well, my point would be that 30 days has been the magic number for other venues of care, hospitals, et cetera. There is no magic about 30 days. I think that more thought needs to be given on what period of time -- I'm sorry, yes. Thank you for the note, Doctor.

I think it is useful to see how many people do get back to what they call home. And home may be a nursing home, it may be a senior apartment, it might be all kinds of sites different than a house in the suburbs. So I think it's good to have standard or I should say a measurable as to how you're doing.

I'm sorry, I rambled a little bit, but I think in general it is good to have a yardstick to see how you're doing, and it is consistent to look at discharges and where they go across the continuum.

Ms. Williams-Bader: Thank you, Jim.

Cody, any perspectives from the Rural perspective?

Mr. Mullen: From the Rural perspective, this measure we didn't spend as much time discussing. Sixty-seven percent were in favor of it, 33 percent were not in favor it. We recognize that it's a needed measure, and important especially when there's a long distance transfer for patients for home health to maybe an urban center for treatment.

Dr. Amin: Thank you, Cody.

Gerald from the Health Equity perspective?

Mr. Nebeker: Again, nothing to add on this one, but thank you.

Dr. Amin: Excellent. That rounds our lead discussants for the measure.

Jenna, I'll turn it to you to review the queued hands and to Gerri for facilitation and discussion.

Ms. Williams-Bader: All right. Let's start with Elissa.

Member Charbonneau: Thank you. I just wanted to point out that there was value in having this measure across post-acute care settings and that this measure also exists in in-patient rehab facilities and long-stay acute care hospitals, LTCHs, which is in line with the IMPACT Act intent to create a standard measure that's interoperable across post-acute settings.

Ms. Williams-Bader: Thank you for that comment. I'm not seeing any other hands at this time. Let me check the chat. We just have a clarification from the measure developer. Thank you for providing that.

A question from Nicole, is the measure the same across all post-acute care settings? I think that's a question perhaps for CMS.

Ms. Proctor: Yes, this is standardized.

Ms. Williams-Bader: Okay, any other --

Ms. Keane: Can I just follow up, Jenna, on that? I'm sorry.

Ms. Williams-Bader: Yes.

Ms. Keane: My sense is it's not exactly the same because if you're in a SNF, discharge to community is slightly different. But this appears to be more for the purposes of home health more of a readmission measure --

(Simultaneous speaking.)

Mr. Edwards: -- standardizing principle, I think your point is valid.

(Simultaneous speaking.)

Mr. Edwards: Are you going to a higher acuity of

care after you're discharged, or --

Ms. Keane: There you go.

Mr. Edwards: Yes, thank you.

Ms. Keane: Thank you.

Mr. Edwards: This is an issue we have to note with standardization across measures. There's some exclusions that will not apply for home health that would apply for a SNF. We obviously keep that in mind. I think the principle of having the measures as consistent as possible is what we try to apply.

Ms. Keane: Exactly, and this is an overarching statement of the challenge of applying these measures across these settings because you have residential care settings versus in somebody's home care settings.

Ms. Williams-Bader: Okay, I'm not seeing any other hands or -- oh, okay.

Jolie, isn't the discharge community for SKN only for short-stay patients?

Does the Measure Developer want to clarify that? Skilled nursing facilities.

Mr. Edwards: That's correct. Yes.

Dr. Amin: Gerri, you want to --

Co-Chair Lamb: Okay, yes. I'm ready. 02944, discharge to community. This is an endorsed measure. It was reviewed in 2018 and it's claims-based, that it's an important measure, it's important to have it across settings. It is risk-adjusted. The number of exclusion criteria was identified as a strength. It's not a burden; it's claims-based.

Jolie, I had a question for you kind to make the decision between support to retain and conditional support. You raised the fact of looking at dually

eligibles. You framed it as interesting, not essential. Is that a conditional in your view, or are we doing support in terms of your recommendation?

Member Harris: As far as my recommendation, I think I'd do it as support. But an area of note from the comments that were given as a recommendation to consider because I do think this information and discharge to community splitting it out by the duals as we're doing in the MA Plan with much of our future quality measures is, yes, you can get an overall positive score on a measure.

But when you really begin to drill down and how do you measure duals and how do you measure non-duals, that it really reflects that maybe those duals needed more focus. I wouldn't say that I wouldn't support the measure because of that, but I think something to consider for the future.

Co-Chair Lamb: Okay, Jolie, what I was trying to clarify is we have two choices. Either a clear support or a conditional support. In the discussion, the only thing that's come up as a condition is to look at duals. So are you recommending conditional support?

Member Harris: No, I just recommend support.

Co-Chair Lamb: Support, okay. So I think the vote on this one is support to retain.

Dr. Amin: Thanks, Gerri.

03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Unless there is any other comments, we can continue to move on. The next measure is 03493, application of percent of residents experiencing one or more falls with major injury, long stay.

The percentage of quality episodes in which patients experience one or more falls with major injury

defined as bone fractures, joint dislocations, closed-head injuries with altered consciousness or hematoma during the home health episode. This measure is not endorsed, and five MAP members elected this measure for discussion today.

We'll go to the next slide.

These were criteria which were selected and the additional survey feedback that was mentioned. This measure is required by statute, as a reminder. We'll start with Joan from CMS with a one-minute contextual comment on the measure, and then we'll go to American Physical Therapy Association with Alice, Leading Edge with Nicole, and Encompass Health with Elissa.

Joan?

Ms. Proctor: I really don't have any comments or feedback or --

(Simultaneous speaking.)

Dr. Amin: Okay, thank you. We'll go straight to the lead discussants, then.

American Physical Association, Alice.

Member Bell: Okay, thanks so much.

I think this measure, similar in terms of the challenges of taking a measure from one setting and applying it across another. So some of the concerns -- well, first already identified that the measure is not endorsed, but the challenge of looking at reporting on something that one may not be aware of or have witnessed.

And then the question is if the goal is really to identify individuals who sought medical care as a result of a fall based on the serious injury, is this duplicated already with ED visit measure.

And the other concern being in a situation where we

have a measure that was developed based on individuals being in a setting where the care team had influence over them for 24 hours a day and could in fact control the environment using that same measure in an environment where that level of control and supervision does not exist could present serious challenges in terms of getting accurate data and also in terms of holding the provider accountable for risks that could not be managed based on patient choice, if you will.

I'll speak to this as an association. The challenge I think we have here is that falls are such a significant risk factor that often are based on modifiable risk factors that we should be intervening on in terms of the plan of care. We know that the impact is huge.

Depending on the statistics you look, anywhere from 33 percent to 50 percent of community-dwelling older adults face a fall within a given year and many of those falls come with extreme dollar and human cost.

I think the challenge is is this the right measure. I think we agree that we need to somehow be able to look at fall risk identification and fall risk management as part of the home health plan of care. But this measure coming from a different setting, is this the right measure?

Dr. Amin: Okay. Thanks, Alice.

Nicole?

Ms. Keane: I'm going to echo most of what Alice has said. Just a couple of observations as well.

So it's my understanding a couple of things. One that home health agencies are doing risk assessment of falls. That's one of their required things that they do at an initial visit. There's a plan of care to prevent falls that's put together after. No one contests that falls are critical important for us

to understand.

I think the challenge that I don't -- I remember see with this are the fact that that hospitalization or that major injury aspect of it is a self-report situation.

I think you can see when you look at the data, too, unless I'm misreading it. You don't see a lot of change in performance over time, and the percentage of folks where this is being reported is in the 1 percent category.

To Alice's point, are we measuring the right thing? And again, the struggle of applying something that is in a residential care setting that then that's applied to an in-home setting.

I think somebody is off mute.

One other thought, I was trying to figure out, too, also to Alice's point. It seems like a place for potential improvement. Could we get at this a different way?

Part of that is the home health agency should have responsibility for what happens within the visit. So if there's a fall with a major injury during a visit, that's something they know of, they can report.

It's a more tangible thing than something that happens in the scope of 24 hours, seven days a week, where they may or may not be in the home. Obviously, we can't control everything that our patients do even with the best of plans. Just some initial thoughts.

Dr. Amin: Thank you, Nicole.

Again, some of those same items related to a component being self-report did come up in the health equity workgroup as well.

Elissa from Encompass Health.

Member Charbonneau: Yes, thank you.

I just want to just emphasize that this is a fall with a major injury. So obviously if someone has a subdural hematoma or a fracture, they're going to wind up in the hospital.

Our comment on this was that it is required for post-acute care providers according to the IMPACT Act of 2014 to have a fall rate measure. However, this measure is not really a fall rate; it's a rate of patients that fall.

It's not the same as how we have to report it in the in-patient rehab setting, which is reported as falls per 1,000 patient days. That kind of makes it not interoperable among different post-acute settings.

Dr. Amin: Thank you, Elissa.

Okay. Cody, I would ask is there anything from the Rural perspective that you'd like to add here?

Mr. Mullen: When we discussed this measure, it was 33 percent in favor, 44 percent no, and 22 percent unsure. A lot of the discussion that we had has already been discussed here with Alice and the other discussants, so I won't repeat.

Dr. Amin: Mm-hmm, yes. So mixed review from the Rural group and from Health Equity.

I think the main points here, just two bullets to add is that the Health Equity Workgroup did note that individuals living at home alone may not -- some from historically disadvantaged groups may not have social systems to support. And then also there may be equity concerns since the measure does also include a self-report component, which had been discussed already.

Okay. Jenna, I'll turn it to you in terms of addressing the raised hands and to Gerri to facilitate the conversation.

Ms. Williams-Bader: Thank you, Taroon. There was a hand raised, but it's been put down. So just give it

a second here to see if anyone else raises their hand, and I'll check the chat. I don't see any questions or comments in the chat. The measure developer has put some details of the measure in the chat.

I still see no hands raised. So, Gerri, maybe if you'd like to summarize.

Co-Chair Lamb: Sure.

Ms. Williams-Bader: Maybe that'll stimulate conversation.

Co-Chair Lamb: Perfect. So 03493, an application of percent of residents experiencing one or more falls with major injury.

As we said, this is not an endorsed measure. I would add that MAP PAC reviewed this measure in 2016 and gave it conditional support for many of the same reasons that were discussed here.

We described that it was an important risk factor in this discussion that there are preventable risk factors. The concern is the application to home care and that home care does not have the same control over the environment that other settings do.

There's also, as was mentioned, interoperability in having consistent measurement across settings. Some of the issues related to self-report, and it was noted that there is a low rate of reporting overall.

I think our discussants raised the key question of it's important, but is this the right measure and should we be looking at a more meaningful measure of falls.

What I'm hearing from this, and again put your hand up to discuss, is that without this measure there is not anything exactly the same is that it would leave a gap so that it would be conditional support to remove.

Ms. Williams-Bader: Okay, thanks for summarizing that, Gerri. I'm just waiting here to see if any raises their hand.

Mr. Edwards: This is Alrick Edwards, one of the measure developers. I just wanted to add a couple of notes. This measure has not been brought forth for endorsement yet, partly because of the COVID public health emergency. So the measure, even reporting was delayed until very recently this year. That's one important note I would want to bring to the committee.

Also, we do see the relationship between this measure and readmissions in the way that you would expect. I know there's some concerns about whether this measure is valid and an appropriate way of looking at this indicator.

I would like to emphasize as well that the goal of creating measures that are standardized in cross post-acute care settings I think fundamentally one aspect to consider is that we want to make sure we are comparing providers to providers.

So in the sense of you would not expect to be comparing a home health agency to a SNF provider that has 24/7 care and can implement a certain set of mitigation strategies that may not be the same for home health where their actions that is feasible is more of education.

I just wanted to note even these are cross-setting measures, the falls measure, the discharge to committee measure, we wouldn't expect you to look at the discharge to community measure for SNF and then compare to that a home health agency and make some conclusion there, but to look at it within care setting, understanding that you're trying to establish a baseline against your peers.

Co-Chair Lamb: Thanks, Alrick.

Can I just clarify what you had said about not

bringing it back to review. What I saw in the notes, and I'm just checking this out, is that this was reviewed by MAP in 2016 --

Mr. Edwards: Yes.

Co-Chair Lamb: in 2016.

Mr. Edwards: Right.

Co-Chair Lamb: And that the recommendations were looked at. They had not been -- what we saw was not acted upon and they haven't been implemented. Is that what you were referring to is COVID kind of got in the middle of that?

Mr. Edwards: What we generally like to do is implement the measure, collect the data, assess whether or not the issues that were raised are borne out. But we have just begun because of the nature of the public health emergency to even move to the stage of having that data nationally available. That was a limitation in the process, if you will.

Co-Chair Lamb: Thank you.

Mr. Edwards: Mm-hmm.

Ms. Williams-Bader: We have two hands raised.

Alice, we'll go to you first.

Member Bell: I just wanted to add as a kind of food for thought. A fall with major injury is kind of the ultimate fail. It's so far down the scale of having gotten to a place of mitigating fall risk and looking at fall risk management.

I would just put out if there's thought around or any way we could look at a measure that would really look at moving fall risk rating. So look at changing those modifiable risk factors based on some sort of objective measure versus looking at measuring the quality based on the ultimate fail, in my terms.

Ms. Proctor: This is Joan Proctor. I can say for CMS, I can say we do monitor our data, but we're kind of early in the process at this point to be able -- we'll need some performance data to be able to determine whether or not there's anything there in terms of the validity of the concerns that you're expressing.

I'm a little hesitant to say anything specific will change as much as we will evaluate as one of our ongoing measure monitoring activities. Does that help?

Member Bell: Yes, thank you. I understand.

Co-Chair Lamb: Joan, the other thing that I was hearing, this is Gerri, that Alice was saying was that as we look at the right measures, bringing it down from too far down the pike to what can actually be prevented and modified so that, as Alice said, we don't measure the ultimate fail. We bring it back to where we can do prevention. And I think that that's an important comment for our notes to CMS.

Ms. Proctor: One of the things that I will point to is being a home-based benefit, we want them to be home, yes, we want them to not have to seek outside care because they are homebound, but we also want them to be safe. And because it's legislatively mandated, it's kind of hard for me to fathom a situation where we wouldn't be having to look at it from the perspective that it's sort of an event that must be tracked in terms of patient safety. Thank you.

Ms. Williams-Bader: All right, Jim has his hand raised.

Member Lett: Oh, thank you. I would posit that maybe we're measuring the wrong thing here. Measuring only major falls, and I know we would like to harmonize across sites of care, but I think the indicator is a fall. The number one initial assessment and address the risk factors.

Then if they do have a fall where they reassessed and with those risk factors and addressed in the environment, the best indicator of a fall is a prior fall. So any time somebody falls in the home health, since they cannot control the environment, is they need to assess when they are entered into home health.

And then if they do have a fall, whether it's moderate, major, then they need to be reassessed and the risk addressed rather than a major fall. Because as, I guess it was Alice that said, that's a postmortem. That's an after the injury. That's an after something terrible has happened, then do something about it. The best time to do it is before the first fall and then certainly after the first fall.

Ms. Williams-Bader: Apologies, that took me a second to get off mute. Two more hands raised. Elissa?

Member Charbonneau: Yes, I appreciate everyone's comments, but I still think that from a programmatic macro perspective, it would be very helpful to have, and it's mandated anyway, we have to have fall rates across these different post-acute care settings so that we can improve the safety of patients at home.

I'm speaking from personal experience, my family emergency today is that my 102-year-old mother fell last night and broke her hip in the home setting with 24-hour home care. So I'm very passionate about this topic. I think that we do need to do better. We need to start somewhere.

Ms. Williams-Bader: Okay, Nicole?

Ms. Keane: Just a couple more thoughts as we're talking this through. One little concern, it's not risk-adjusted. I realize falls are always a problem, and I too with Elissa, my dad fell when we weren't with him. He was living home by himself. But bad consequences come from that.

So couple of thoughts and a couple of questions about how we might move forward. One, I'm trying to figure out since fall risk assessment and care plan is already required and that has to be adjusted if there's an event as well.

Are we concerned that those things aren't happening? Should we be tracking that process as part of getting at the quality outcome that we want? And another thought is since this is OASIS -- I guess OASIS-based right now, would it be better and would we get better data if it were claims-based?

Where there's a hospitalization -- if it's a major fall, somebody is going to the hospital, right? Would it be better if it was a hospitalization and it was -- I don't know if that gets reported as there was a fall that caused the hospitalization.

But because the self-report is part of the problem, I'm trying to get at consistent data. Because when I look at the data right now of what's being reported, I'm not sure we're getting anything anyway.

And then my last comment is if we were looking at it as a rate per 1,000 elsewhere as opposed as to just a pure number, maybe it's better to have some consistency like that across the post-acute settings.

Because I think at the end of the day, and I'm respectfully disagreeing, I thought the point of IMPACT was to kind of look at the care that folks get, similar individuals, might get in the various settings. I think there is -- whether or not we want people to compare, I think there's little bit of comparison going on there.

Ms. Proctor: I am aware of claims-based measures -- this Joan Proctor. We have begun to have some conversations across our programs, specifically with nursing homes that do utilize the claims-based measure.

I am also aware of some recent evaluations of whether or not the data is more reliable when coming from -- claims-based or not. I just wanted to kind of flag that CMS is also not ready to discuss a lot of it right now, we are looking into it further. Thank you.

Ms. Williams-Bader: So any other reactions from the workgroup to what our recent commenters Nicole and others have brought up?

Pam, I see your hand is raised.

Member Roberts: I put it in the chat. If the patient had a major fall with injury and they had end up in the hospital, wouldn't that be captured in every admission home health measure?

Maybe CMS can answer that?

Mr. Edwards: I think the complication is whether or not they only received the visit where they were admitted. It's something we're assessing currently, actually.

Ms. Williams-Bader: Okay, I'm not seeing any other hands raised. I know, Gerri, we've heard comments both for and concern about the measure. Would you like to try to summarize?

Gerri, I think you're on mute, sorry.

Co-Chair Lamb: Okay. I think there's a consistent theme here. Measuring falls is important and that the encouragement to CMS is to look at is this the right measure?

This particular measure has a lot of issues in terms of application to home care. It's with self-reporting, with low rate of reporting and the importance of looking at risk and risk modification.

I guess I didn't hear anything that changed the reviews of the original discussants in terms of conditional support to remove. That there will be a

gap without this measure. It needs to be looked at, but when a better measure comes along, let's use the better measure.

Ms. Williams-Bader: Gerri, I have good news. I believe we're at quorum, so we'll be actually take a vote on this. Unless anyone has anything to say in reaction to what Gerri just said, we will go ahead and take a vote on conditional support to remove.

Mr. Zimmerman: All right. Voting is now open for Measure 03493-C-HHQR, application of percent of residents experiencing one or more falls with major injury, long stay. Do you vote conditional support for removal?

Now that we've reached quorum, I will give everyone about 10 to 15 more seconds to enter any additional votes or change any votes.

All right, I will close the poll. Voting is now closed for Measure 03493-C-HHQR, application of percent of residents experiencing one or more falls with major injury, long stay. The results are 13 for yes and one for no for a percent of 93 percent. The Workgroup does vote conditional support for removal. I'll turn it back to the team for the next measure.

05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

Dr. Amin: Okay. Our last measure for discussion, perhaps maybe not for voting but for discussion. 05853, application of percent of long-term care hospital, LTCH, patients with admission and discharge functional assessment and a care plan that addresses function.

The percentage of home health quality episodes for which patient's mobility and self-care functional status was documented and at least one discharge

goal was recorded. The measure is not endorsed. Four MAP members elected this measure for discussion today. And on the next slide, we have the criteria and rationale selected. Just note again, this measure is required by statute.

Joan, I'll turn it to you for one minute for contextual comments on this measure.

Ms. Proctor: The measure is statutorily required and unique to the Home Health Quality Reporting Program. This measure is not duplicative within the program.

While the measure has never been submitted for endorsement, we acknowledge addressing patient function is best done through an outcome measure rather than the process measures.

We do want to note that we are currently developing a strong cross-setting outcome measure to address functional status in post-acute care settings with a discharge score measure, which would be appropriate for a maintenance population. Thank you.

Dr. Amin: Thank you, Joan. For the lead discussants, we have the American Occupational Therapy Association. So, Pam, we'll start with you.

Do we have a representative for the American Academy of Physical Medicine and Rehab on the line?

I don't believe so. And then for National Transitions of Care Coalition, Jim. We'll start with Pam, and then we'll go to you, Jim.

Member Roberts: Okay, thank you.

Some of the comments on this is that the scores were very high and there's question that it might have topped out and that some performance is uniformly high and there lacks variation. Although, there is a little bit of change on this. There was a

couple other comments that it lacks variation.

It's important to assess function, but as noted they are looking at a cross-setting measure. I guess part of this is going to be timing of when that happens and do we have a gap in the interim.

Thank you.

Dr. Amin: Thanks, Pam.

Jim, anything in addition to add?

Member Lett: Just it is duplicative, and it is pretty much topped out, so I would favor removal.

Dr. Amin: Thank you, Jim.

Cody, I'll turn it to you again. Thank you, Cody, for attending providing the Rural perspective throughout the meeting today.

Mr. Mullen: Absolutely. It's been my pleasure.

In our discussion of this measure, we're 89 percent no and 1 percent unsure, zero said yes as discussed as discussed concerns that this is a duplicative measure. It's been topped out, and the lack of endorsement were all key points in our discussion.

Dr. Amin: And from the Equity perspective, I would just add similar concerns around the measures around the measure's reliance some level of self-report and some populations maybe missing from the measure's data, highlighting difficulties and accessing for disparities.

Jenna, I will turn it to you in terms of addressing the raised hands and for Gerri for facilitating us through the discussion on this last measure.

Ms. Williams-Bader: Okay, I'm not seeing any hands raised at this time.

Okay, Gerri, go ahead.

Co-Chair Lamb: Thanks, Jenna. Joan, I think in your intro remarks you had commented that this was not duplicative, and I heard from our discussants that it was. Could you speak to the duplicative nature of this measure?

Ms. Proctor: Yes, the application of a percentage -- discharge functional assessment and care plan that addresses function, we uniquely adopted this measure, and it is mandated under the IMPACT Act. I believe when we got that comment about it being duplicative within the same program was that there was some material that the committee was reacting to. I'm trying to jog my memory, and I'm going to look to Alrick or to Morris to remind me.

Mr. Edwards: I think the issue is more so that this measure -- there's not another measure that really assesses overall functional goals. So within home health, it's a unique measure in that nature. The same kind of measure is in other post-acute settings, the same measure that's assessing functional goals. Hopefully that clarifies it.

Ms. Proctor: And it is something that we are required under the IMPACT Act to, I've said a couple times to you (audio interference) belabor the point.

Ms. Williams-Bader: Okay, I'll give it another few seconds here. I'm not seeing any other hands raised.

I'm not seeing any other questions in the chat either. Gerri, let me turn it over to you.

Co-Chair Lamb: Okay, and I'm going to unmute myself.

05833 and its application of percent of long-term care hospital patients with an admission and discharge functional assessment and care plan that addresses function.

So this is not an endorsed measure. I will note from

the materials we got that this was reviewed by MAP in 2016 and '17. It was given conditional support due to its importance to care coordination, improving transitions and having standardized assessments across setting.

Today, the comments were that, yes, this is important; however, it is duplicative and it has topped out and lacks variability. The recommendation was put forward, and I want to check to see if anybody would conclude differently that we are supporting for removal.

Ms. Proctor: Also keep in mind that -- I think we mentioned it. This is the measure where we're looking to potentially move into an outcome measure that would allow for capturing (audio interference). So I think in doing such a thing, we would be addressing some of the topped out. Just wanted to mention. I wasn't sure whether or not I said it earlier. I'm sorry, it's getting late in the day and my brain's kind of --

Mr. Hamilton: You did, Joan. I'll add, this is Morris Hamilton from Abt, that this was the same measure that was discussed, I think, when we previously talked about improvement in bathing and improvement in bed transferring in case people needed those context clues.

Co-Chair Lamb: Any comments?

Okay. Jenna, I'm not hearing that there are any hands up, so do we have quorum?

Ms. Williams-Bader: I believe so.

Co-Chair Lamb: So shall we go to vote?

Ms. Williams-Bader: Yes, let's do that. I'm sorry, but this was conditional support for removal?

Co-Chair Lamb: No, support for removal.

Ms. Williams-Bader: Support for removal, okay.

Mr. Zimmerman: Voting is now open for Measure 0585-C-HHQR, application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function. Do you vote support for removal?

Now that we've reached quorum, I'll give everyone about ten more seconds to either add or change a vote.

All right, I'm going to close the poll. Voting is now closed for Measure 05853-C-HHQR, application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function. Results are 13 for yes and one for no. The results are 93 percent, and the workgroup does vote support for removal.

I'll turn it back to you, Committee.

Ms. Williams-Bader: Okay. Thank you all very much. That does take us through the measures, but what we would like to do now that we have quorum is we would like to circle back to the measures we didn't have quorum.

We will briefly summarize the voting category and any conditions or rationale for those measures. We'll take a vote and see if we reach quorum on those. We'll attempt to do that.

The first measure was improvement in bathing. The category was conditional support to retain. I welcome Taroon and Gerri to help summarize the conditions.

Dr. Amin: Gerri, the main items here, again, I would just point out with all the improvement measures were concern about maintenance was -- there are certain populations in which you'd expect to just maintain rather than improve.

Co-Chair Lamb: That's also what I've have, Taroon,

is the priority is the whole issue of maintaining and also capturing a population that might not be as likely to have improvement.

Dr. Amin: Right, and we might bucket that in terms of -- perhaps one could handle that methodologically with exclusions. So, right. We can roughly describe them as exclusions and then maintenance in the way the measure is constructed. Those were the two main conditions, Jenna.

Ms. Williams-Bader: Thank you, both. Team effort at the end of the day here.

I think we'll try to take a vote, then. And that's conditional support to retain.

Mr. Zimmerman: Voting is now open for Measure 00185-C-HHQR, improvement in bathing. Do you vote conditional support for retaining?

I see we've already reached quorum, so I'll give everyone about ten more seconds to either add or change a vote.

All right, I'm going to close the vote. Voting is now closed for Measure 00185-C-HHQR, improvement in bathing. Results are 14 for yes and zero for no. The results are 100 percent in support of conditional support for retaining.

Ms. Williams-Bader: Great, thank you very much, Gus. Okay, so moving to improvement and management of oral medications. This was also conditional support to retain. We had the same condition around looking at those who you might be expecting to maintain rather than to see improvement.

Dr. Amin: Yes --

Ms. Williams-Bader: Just looking to see if there are any other conditions here.

Dr. Amin: Yes, the subpopulations piece as well that

we do not expect to improve. There was a thematic item that's not a condition but was raised around other parameters that we wanted to capture that CMS should consider around medication management dosing, access to medication management as well. But again, those were not necessarily conditions, but we'll include those as contextual comments.

Gerri, you might have others.

Co-Chair Lamb: No, that's what I have as well.

Dr. Amin: Okay.

Ms. Williams-Bader: Okay, so conditional support to retain.

Mr. Zimmerman: Voting is now open for Measure 00189-C-HHQR, improvement in management of oral medications. Do you vote conditional support for retaining?

I see we're already at quorum, so I'll give everyone ten more seconds to either add or change a vote.

All right, I'm going to close the vote. Voting is now closed for Measure 00189-C-HHQR, improvement in management of oral medications. Results are 13 for yes and one for no. And I'm just waiting for a moment for the percentage calculation.

That's 93 percent. The workgroup has voted to conditionally support to retain the measure with conditions. I'll turn it back over.

Ms. Williams-Bader: Great, thank you. Moving on to improvement in bed transferring. This was also conditional support to retain. Condition around, again, the maintaining or the subpopulations where you would not expect to see improvement. I think we had some discussion around some access to services, but I don't believe that rose to the level of a condition.

Team, is there anything else?

Co-Chair Lamb: That's what I have, Jenna.

Dr. Amin: Same.

Ms. Williams-Bader: Before we move to vote, we'll pause really quickly to see if there are any questions.

Okay, let's move to a vote.

Mr. Zimmerman: Voting is now open for Measure 0-000-C-HHQR (sic), improvement in bed transferring. Do you vote conditional support for retaining?

I see we're already at quorum, so I'll give everyone ten more seconds to either add or change a vote.

All right, I'm going to close the vote. Voting is now closed for Measure 01000-C-HHQR, improvement in bed transferring. The results are 14 yes, zero no, representing 100 percent. The workgroup has supported for retained with conditions. I'll turn it back over.

Ms. Williams-Bader: Thank you very much. Next measure, influenza immunization received for current flu season. This was also conditional support for retaining with the conditions being endorsement and harmonization. And specifically as part of the harmonization, looking at patients who do not receive or the No category. Those who do not receive the immunization, sorry. Pause here. Any questions?

Co-Chair Lamb: Jenna, I thought it wasn't a question of not receiving. It was refusal that it needed to handle, but let me check on that with Taroon, too.

Dr. Amin: Yes, refusals. It was --

Ms. Williams-Bader: I --

Dr. Amin: Go ahead.

Ms. Williams-Bader: So, yes, the Committee should definitely speak up. There was some talk in the chat specifically around Items 4 through 8, and I don't know that all of those were just refusal. I thought they were all reasons for the patient not receiving.

So, yes, this actually might be a good point of clarification. Is it about refusals specifically or just patients not receiving the immunization?

Mr. Hamilton: This is Morris Hamilton as the developer. I just want to say the only item, or the Response 4, is about refusal. Just like Jenna said, Items 5 through 8 are just variations of no.

Dr. Amin: Okay. So then it should be 4 -- it was all 4 to 7 was the Committee's area for looking at harmonization numbers, Gerri. We should clarify this now.

Ms. Williams-Bader: I think it's 4 to 8. 8 is also sort of a didn't receive but not in another category, I think. Is that right?

Mr. Hamilton: Yes. It is a no, but I think the comment only pertained to 4 to 7. I don't know if that was intentional or unintentional. You'd probably want clarification.

Member Harris: This is Jolie. I had put that comment in about the exclusion about 4 to 7 because I read 8 as the patient did not receive due to other reasons but not because they had refused or had been offered or there were medical contraindications or their condition or guidelines. But possibly we didn't have the vaccine available or some other reason. So I felt that 4 through 7 was clearly an indicator for no.

Dr. Amin: Mm-hmm.

Mr. Hamilton: And then we'll add -- I think my comment got cut off when I pasted it into the chat,

but Item 6, the Response 6, is a denominator exclusion. But 4, 5, 7 as well as 8, are not denominator exclusions.

Co-Chair Lamb: So I'm hearing, given what Morris was just suggesting -- Jolie, are you good with 4, 5, 7 -- is it 4, 5, 7 and 8 being re-looked at as part of the condition?

Member Harris: Yes. I'm sorry, which one did he say was already an exclusion?

Mr. Hamilton: It's okay. That one, I'll read it out to you verbatim. It is a no, not indicated, patient does not meet age, condition, guidelines for influenza vaccine. That is a denominator exclusion.

Member Harris: Number 6?

Mr. Hamilton: Number 6.

Member Harris: Okay. So 4, 5, 7, I guess I was torn on Number 8 whether that was a reason we wanted to exclude or not due to reasons other than those listed. I don't know if other than those listed would have been under a condition that could have been controlled by the agency. So therefore, we did not want to include Number 8. That was my initial thought, but certainly open to other interpretation.

Co-Chair Lamb: So I'm hearing Jolie is -- there may be other factors that are not within control. Jolie, you are suggesting the condition is 4, 5 and 7?

Member Harris: Correct.

Co-Chair Lamb: Does anybody have anything to add to that?

Any hands up? Jenna?

Ms. Williams-Bader: Yes, Nicole?

Ms. Keane: Just a clarifying question. Not knowing what 8 would capture, my question would be,

shouldn't 8 be examined? Should we ask for 8 to be examined as well for either further clarification where it could be an 8 that says other reasons beyond the agencies control and have a 9, but it's just other reasons beyond all of that. I just don't know what ends up falling into that bucket.

Mr. Edwards: I think if you put it as a condition that we review the noes with the exception of 6 that probably makes sense ---

(Simultaneous speaking.)

Co-Chair Lamb: Makes sense.

Dr. Amin: Yes.

Ms. Williams-Bader: Thank you.

Co-Chair Lamb: I think that's a good solution, Alrick.

Dr. Amin: Let's add 8, yes.

Co-Chair Lamb: So all the noes except 6. Okay, are people ready to vote, then?

Participant: Yes.

Co-Chair Lamb: Okay, let's go for it.

Ms. Williams-Bader: As a reminder, we're doing conditional support for retaining.

Mr. Zimmerman: Voting is now open for Measure 00212-C-HHQR, influenza immunization received for current flu season. Do you vote conditional support for retaining?

We are already at quorum, so I'll give everyone ten more seconds to either add or change a vote.

I'm going to close the vote. Voting is now closed for Measure 00212-C-HHQR, influenza immunization received for current flu season. Results are 14 for yes and zero for no for a result of 100 percent. The

workgroup has voted to retain the measure conditionally.

I'll turn it back over.

Ms. Williams-Bader: Thank you, Gus.

Okay, the next measure is total estimated Medicare spending per beneficiary, post-acute care, HHQRP.

This one, the vote category was support for removal. There were some concerns the measure is not endorsed. Some also concerns about the scientific acceptability back at the exclusion of social risk factors, the unintended consequences to attempts to lower costs. There may be a small sample problem in rural settings. May be harder for home health agencies to impact and may be redundant with others.

Gerri, do you think I've captured that correctly? Am I missing anything, or did I misstate anything?

Co-Chair Lamb: No, you got the full list there, Jenna.

Ms. Williams-Bader: I guess to be fair, I will acknowledge there was at least one member who was not supportive removing and made a suggestion that if you look at this in isolation, it's problematic. But if you look at it in the program, it's a reasonable way to address the statute.

Let me pause and see are there any questions.

Okay, I'm not seeing anything. Let's do a vote for support for removal.

Mr. Zimmerman: All right, voting is now open for Measure 02943-C-HHQR, total estimated Medicare spending per beneficiary, post-acute care, HHQRP. Do you vote support for removal?

We need two additional votes to meet quorum.

All right, we are at quorum, so I'll give everyone ten more seconds to add or change a vote.

All right, I'm going to close the vote. Voting is now closed for Measure 02943-C-HHQR, total estimated Medicare spending per beneficiary, post-acute care, HHQRP. Results are 12 for yes and two for no. That is a percentage of 86 percent. The workgroup does vote for removal. I'll turn it back over.

Ms. Williams-Bader: Okay. I think we have one more. We'll get to the next slide, maybe two more.

Okay, discharge to community, post-acute care, home health quality reporting program. This was support to retain. As far as summarizing the rationale there -- my notes are a bit scant here, but I think it's seen as an important measure.

It is aligned. There's value in having this measure across post-acute care settings. There was one comment that it would be useful to look into stratifying by dual eligibility, but that did not rise to a level of a condition.

Am I missing anything --

Co-Chair Lamb: It's also claims-based, so it's not a burden. This was the one we may have reviewed a different one. This is claims, and that the exclusion criteria, and then there are many for this one, were seen as a strength.

Ms. Williams-Bader: Thank you, Gerri.

Any questions?

Okay, let's go ahead and vote --

Member Atkins: Can I -- yes. I just wanted to re-raise the question of whether or not it was -- it was a suggestion that hospice be excluded from the -- and be one of the exclusions criteria, discharge to hospice.

Member Harris: This is Jolie. That is true. I had mentioned that and forgot to bring that back up at the end of the discussion. That was a comment that had been made in the document and you could consider hospice as an exclusion for it. (Audio interference) maybe transitioning to another primary provider.

Mr. Hamilton: This is Morris Hamilton. I believe, I'm not an expert in this measure, but I believe that hospice is an exclusion in this claims-based measure. I'm going to check and see if I can find it super-fast for you guys, but I think that's the case. I don't want to say that definitively until I have proof.

Ms. Williams-Bader: Thank you, Morris. While you're looking that up, is there anyone from CMS who can speak to whether hospice is an exclusion in this measure?

Okay, we'll wait one second here, then. A few seconds here.

Mr. Hamilton: So I'll list off the exclusions for this measure. Age under 18, discharge to a psychiatric hospital, discharge against medical advice, discharge to disaster alternative care sites for federal hospitals, discharge for court or law enforcement, patients discharged to hospice or enrolled in hospice during the post-discharge observation window. There are others, but that one specifically addresses your concern.

Mr. Edwards: Yes, this was originally not there. I think we added it after some further input. Thanks, Morris, for confirming.

Ms. Williams-Bader: Gerri, I'll turn it to you, but I think that means we do not change the vote? Would it be support for --

(Simultaneous speaking.)

Co-Chair Lamb: I think so, yes, because it addressed the concern that hospice be an exclusion, and it is in fact an exclusion. I think it keeps it support to retain.

Ms. Williams-Bader: Okay, we'll move it to a vote, then.

Mr. Zimmerman: Voting is now open for Measure 02944-C-HHQR, discharge to community, post-acute care, Home Health Quality Reporting Program. Do you vote support for retain?

We are at quorum, so I will give everyone ten more seconds to add or change a vote.

All right, we're going to close the vote. Voting is now closed on Measure 02944-C-HHQR, discharge to community, post-acute care, Home Health Quality Reporting Program. The results are 14 for yes and zero for no for a percentage of 100 percent. The committee has voted to retain the measure.

I'll turn it back over.

Ms. Williams-Bader: Wow, thank you all so much. We really appreciate you being flexible with us as we went back through those.

Gerri, I believe we're now moving to our last public comment, so I will turn it over to you.

Opportunity for Public Comment

Co-Chair Lamb: Okay. Jenna, did we vote on 3493? Just checking.

Ms. Williams-Bader: Is that falls with major injury?

(Simultaneous speaking.)

Ms. Williams-Bader: -- the number is next to my notes. 3493, yes. Yes.

Co-Chair Lamb: Okay, we voted it on it, then we're good.

Ms. Williams-Bader: We did, yes.

Co-Chair Lamb: Okay.

Ms. Williams-Bader: The vote's here, yes.

Co-Chair Lamb: All right, so this is the opportunity for public comment. Like before, if you have public comments, we welcome them. Please do keep your comments to less than two minutes and keep them focused on the measures under review.

Ms. Williams-Bader: I'm not seeing any hands raised at the moment. We'll give folks a minute or two to come off mute, though. Not seeing anything in chat, although I do see a question from Nicole. We'll try to get you the answer to that question. Is there anyone on the phone line?

I still don't see any hands raised. Last call for hands.

Anyone on the line? Okay, I think we can go ahead and close it. Are you comfortable with that, Gerri?

Co-Chair Lamb: Yes.

Discussion of Gaps in PAC/LTC MSR Programs

Ms. Williams-Bader: Great. Okay, we will go ahead and close public comment now, and then we'll move onto a discussion of gaps in the programs. We're going to aim for about ten minutes for this discussion so that we do have time to get your feedback on the process. So if we could wrap this up around 4:15, that would be fantastic.

Gerri, I'll turn it over to you.

Co-Chair Lamb: Sure. Let me just do a quick lead-in and leave most of the time for your comments.

First off, thank you for such a thoughtful discussion. I think we raised a lot of important issues for CMS to think about, so thank you for hanging in there

and for really staying focused on what's important here.

So gaps, as member of MAP PAC long-term care, we have an opportunity to look at the whole measure set and to comment on gaps and make recommendations about where important gaps lie. And I'd like to just bring to you some of the things that I jotted down during our discussion today that I think addressed gaps and then open it up for things all of you would like to add.

This is not just kind of a throwaway discussion. These are seriously considered, and it's part of our ability to make recommendations for the whole measure set.

So the discussions related to gaps are to look at the alignment across measures for PAC long-term care. And we had that discussion related to function, to symptoms as with dyspnea to the whole system issues related to care initiation, prevention as with flu immunization and looking at the relevance across all PAC long-term care.

We also asked which functional measure have the strongest relationships to outcomes and to really fill on those areas across settings as well as in home health, which is what we were focused on today.

There's a whole issue that we raised related to stabilization of measures in contrast to improvement, not to disregard improvement, but that there are some populations that the goal is either stabilizing or risk mitigation. And we did address the whole topic concept-wise of risk mitigation to reduce the rate of decline.

Related to symptoms, we did review dyspnea and raised the questions about which symptoms are most problematic. As CMS seeks to have a meaningful measure set for PAC long-term care, what are the most important measures for home care or home health to identify and then across

settings.

We addressed risk adjustment and looking at when is social determinants of health important here as risk adjustors, which measures captures disparities. There is the broader issue that we raised of system issue of access to home health is that we cannot measure impact if people can't get into the service. That may be also true across PAC long-term care as well as with disparities of access to care.

Related to specific measures, we talked about looking at other aspects of medication and people's ability to self-care with meds. And then we also talked about that some of the measures speak to longer processes of care such as initiation of care. And as you recall with the measure of initiating care, when does it start? And that if only starts when a home care agency accepts the referral, what happens before that?

There was a comment about new cost measures linking to outcomes and trying to capture value more specifically. That's what I had in my notes. There are a lot of gaps there, and I think we had a robust discussion about a lot of them.

So that's where we've been. Comments, other things that you would like to get out there on the report related to discussion of gaps in our area of PAC long-term care?

Ms. Williams-Bader: Nicole has her hand raised.

Ms. Keane: Of course I do, Jenna. Sorry.

Gerri, thank you for keeping track of that, such a comprehensive list, because we have had a really robust wonderful conversation today. One item I know came up on one particular measure that it is relevant, not only to home health, but the post-acute space in general is that dwindling of fee-for-service data.

I don't think we can underscore enough. And I underscore it on two fronts. One, not having enough data to really have a good reflection of what quality.

And Number 2, I think if we're really going to measure quality being delivered, it think it should be measured in these post-acute spaces both in the fee-for-service realm as well as Medicare Advantage.

Because honestly, I think that almost provides a little bit of a validation of how well the MA plans are doing as well. I think there's a broader issue there that we need to look at it, and we're on the precipice of it being 50 percent managed care and 50 percent fee-for-service.

That's nationally. In local markets, we're talking 80 percent in some places. So it's problematic.

Ms. Williams-Bader: I'm not seeing any -- oh, Michelle. Michelle Schreiber, I think. Yes.

Member Schreiber: Thanks. I have a question for the group, Gerri, if you don't mind. In most of the other programs, the clinician programs, the hospital programs, we have measures for promoting interoperability.

We recognize full well that meaningful use kind of didn't really -- the dollars didn't hit post-acute care, but the world is clearly moving in this direction of electronic clinical quality measures, interoperability.

I noticed that nobody has promoted as a gap any measures around interoperability. At what point is that reasonable, or is it never reasonable?

Co-Chair Lamb: I'll start, and then people please jump in.

Michelle, you're aware that we've had a lot of discussion in terms of using the EHR for more consistent measures. And we talked a lot about the U.S. core data set for interoperability.

I think that that train is out of the station, and we do need to look at it, but we have not discussed it in this particular group. It's to talk about what would this look like, where are the priorities, and if people are not familiar with USCDI now is the time to get familiar and to weigh in.

Member Schreiber: Because I will just say that I personally see that as a gap area in post-acute care.

Ms. Williams-Bader: Pam has her raised.

Member Roberts: I would agree that this is a gap area within post-acute care on multiple different levels, especially for prevention of errors and really trying to keep people out in the community and home, especially if they're rural.

Ms. Williams-Bader: There's also a comment from Jolie in the chat. Agreeing with they need to build greater interoperability between the levels of care.

And Jim has his hand raised, and then Aparna.

Member Lett: Oh, thank you, Michelle. I think you have just really scored a huge bull's-eye with your comments.

I think all of us are so used to the fact that we can't communicate with any other side of care that we don't even think about it. As much as I hate to say this, I see that this will not happen voluntarily.

And I think it's going to happen if somebody drops the hammer and says, everybody has to use the same software, everyone has to use the same hardware, and all computers should be able to talk with each other.

And in post-acute and long-term care, I can tell you that we are a lot of times dealing with three different information systems within the same nursing home. As a consultant pharmacist, they'll have their own system. The facility will have their

own system, and often nowadays the attending clinicians, nurse practitioners, VAs and physicians have their own.

So even the microcosm of a single nursing is a Tower of Babel in terms of getting information to and fro. I will tell you when I was the medical director for a quality improvement organization in California, we were visited by a group from Colombia that wanted to learn about the American healthcare system.

And one of our tasks, and I can't remember which one of the -- sorry, I lost what it's called, but scope of work. I'm sorry, I'm trying to remember the scope of work. One of our tasks was to go out to small physician offices and consult with them about what system they should use, both hardware and software.

And they'd say, great, which one should we use? We know what you told us we need, here are our requirements, which ones should we get?

What we had to tell them was, we can't tell you that. We can give you a list of five different systems, and then you have to choose.

And then when I told the Colombian government officials what we were doing, what we were required to do, a lovely gentleman but they basically said, well, that's stupid.

(Laughter.)

Member Lett: In Colombia, we went around and told everybody here's the system we got to use. Here's a grant that I can't remember the dollar figure. Now, go do it. And if you don't do it, you're kicked out of the system. You don't get paid.

So I'm sorry, a long anecdote to say that sadly it will probably take someone a lot smarter and powerful than me in order to make it work, but it's

going to have an external influence and not one within the healthcare system we now have.

Member Schreiber: Thanks. By the way, we had a delegation from Singapore and had a very similar conversation.

(Laughter.)

Ms. Williams-Bader: So there are comments in the chat.

Aparna, I think I'm going to take your comment as the last one.

Alice, perhaps you can put your comment in the chat. Again, we just want to make sure that we have time to get feedback.

So anyone else, if you have comments as well, please do put them in the chat. They do get captured in our official summary. Apologies that we are having to cut this discussion short. It's a very rich discussion.

MAP PAC/LTC Workgroup Feedback on MSR Process

Member Gupta: Thanks, Jenna. I'll make this very quick. Sort of spotlighting what Gerri had mentioned, interoperability and then the state of EHRs in home health. We definitely need a tiered approach.

Going back to my in-patient journey meaningful use approach sort of in a tiered manner did help the hospitals and the health systems get onboard EHR and then do it well.

Now, there's one big difference between the hospital health systems and the status of home health, and by extension hospice, and that is that they may or may not be able to afford the expensive Epics and Cerners of the world.

Thinking about that as well as also understanding

the need for interoperability, first step in just home health across what we're seeing in the chat, PT/OT pharmacy different system that exist. Getting to that first level of just in the home health space, but then extending it to really across the continuum of care.

So suggestions, sort of an opinion, what we see may be helpful would be definitely a mandate but also a tiered approach maybe with some funding. Incentives are always sort of that little push that gets things along the road. Thank you.

Ms. Williams-Bader: Thank you all so much for that. And again, yes, please do continue to add your comments to the chat.

Let's move on then to our last agenda item for the day for us to get feedback on the process. We have three poll questions. We'll do those quickly, and then we'll have an opportunity for discussion. So let's move over to the poll.

All right, the first question is thinking back to April with the survey. The measure set review survey to nominate measures for discussion worked well. We have one strongly disagree to five strongly agree.

I'll wait a few more seconds. I know one or two members have dropped. Luckily, we don't need quorum for this. All right, let's go ahead and close.

So we have a lot of agreement here that the survey worked well. A few who were neutral and one disagree. Okay, thank you for that feedback. Let's move onto the next question.

I had what I needed to respond to the MSR survey. So thinking to the materials we provided along with the survey. One, again, strongly disagree to five strongly agree.

Waiting just a few more seconds.

Okay, let's go ahead and close. Here again, we see

several agree and strongly agree, but then a few more here for disagree and neutral. Definitely want to dive in to this. Let's move to the last question.

The workgroup review of the measures under review worked well, so thinking more specifically to today's meeting and the materials we provided and the process leading up to the meeting today and the past week. Again, one strongly disagree to five strongly agree.

A few more seconds.

Okay, let's go ahead and close. All right. And see a lot of agreement and strong agreement with this statement, one neutral. Okay, thank you all so much for that. I think that's a good starting point.

As we hop over to the discussion questions, I'd like to explore a bit more about the survey. What worked well there? And we saw in the results that maybe we didn't provide everything that would have been useful during the survey.

So what could we have provided that would have been useful at the time you were doing the survey?

What, for example, might have been useful to have that you did not have?

Co-Chair Lamb: Jenna, I'll start.

The point of the survey was to narrow down the universe of items, which to me is a critical step. If we're going to do that in a meaningful way, then it seems to me that we needed to have a bit more of the material that people were asking about today.

And maybe the summary that we got which is not only the metrics, but the exclusions and everything else so that people can anticipate that. Because otherwise, it feels like a random draw and just kind of choose what you think. It's a critical juncture of narrowing down the universe.

Ms. Williams-Bader: Okay. I heard you mention a summary, Gerri. I see Nicole mentioned summary tables, so are people talking about the full measure summary sheets that we provided? Or were there particular parts of that that you thought were really useful or that would have been good at the time of the survey?

Nicole is saying all of it. The follow-up question, then. I don't know how many measures we had on each survey, but there were about 200 to 250 across all three settings. So let's say there are about 70 per setting.

I completely agree how that information would be useful. Is it realistic that the workgroup would look through that information for 70-ish measures when completing the survey?

Co-Chair Lamb: It doesn't seem reasonable, however given the importance of this, perhaps we could split it up. Which is if we had the materials, divvied them up and then had a two-hour meeting so that we could agree these are the important ones to review rather than basing it on incomplete information.

Ms. Williams-Bader: When you say divvy up materials, Gerri, could you say a bit more about that?

Co-Chair Lamb: I don't know if we have that many in MAP PAC, but the other groups might like Hospital. But say we have 30, okay, that's a lot for one person to review. So maybe what we do across our 20 members is we each take two or three, and then we talk about them, and then we propose a set based on more complete information.

Ms. Williams-Bader: Yes, okay. Thank you for that, Gerri.

I think one of the other ideas that's been percolating as we've been moving through this

process is what if -- because it is a lot of information to provide and to collect also because we have to go through a lot of different sources. I know CMS has helped us in pulling together that information, but they're also working -- they've been working on rulemaking while we've been doing this. So I know that's been a challenge for them.

What if CMS or NQF provided a more narrowed list based on a set of criteria that we established and then applied to the measures and then we provide more detailed information on the measures that make it onto that list? What do folks think about that?

I do see a couple hands raised too, so I will get to those.

Any thoughts and reaction to that question?

In the meantime, I'll go to the hands, Jim. I'll go to you. Oh, sorry, I see --

Member Lett: I was actually going to suggest exactly what you said, Jenna.

I think in all honesty, it's kind of like drinking from a fire hose when we get all those handouts and all those graphs and long explanations.

I think we might be better off with a few bullet points that are consistently -- we do with each one of the measures the same. And whether it's a charge or whatever it is, but it is a consistent format for each one so we really get used to how the information is going to be given to us in what order, and then have the links where you can go in and look for more information when we want.

So you give us great information, it's just too darn much that -- so many people are so busy. It's pretty hard to read through it all.

Ms. Williams-Bader: Thank you so much. That's helpful.

I also see there are comments in the chat, so thank you for adding those. Michelle?

Member Schreiber: We recognize that the group needs information to make best decisions, but I just want to be a little -- I want everyone to be a little cognizant of the work that NQF and CMS do to put those together. Information comes from multiple sources, and I will be honest with you, there were 200 measures that we discussed this year. We could not have completed that kind of analysis on 200 measures.

So somehow we need to narrow it down and then have a smaller list that we can compile that kind of detailed information on. Having measure specifications is easy. All the measures have specifications that we can send out. But having kind of the detailed analysis, to be honest with you, that's a lot of work from both CMS and NQF, and we can't do it for 200.

Ms. Williams-Bader: Thank you, Michelle.

I'm trying to be really good about time. So, please, does anyone have any last comments that you'd really like to make. And again, please put them in the chat if you have suggestions

Member Schreiber: Jenna, do you mind if I ask a question to the group?

What do you think of the timing of the meetings and let me just give out another hypothesis. Do you like meeting in the summer that is entirely separate from the MAP meetings, or would you prefer combining this with the MAP meetings of recommendations and having two-day meetings where one day you did removal and one day you did recommendations for measures into the programs? I'm just curious what people think of the timing.

Ms. Williams-Bader: I see a few comments in the chat that are -- they're saying separate.

Michelle, thank you for asking that question. I do think that there might be ways that the team can also try to bring these two things together more, even though they're separate meetings at separate times, but try to really make this a rolling process.

So that might be something that we can consider as well. Looks like several folks in the chat are saying separate because it's a lot to take in at once. Okay, thank you for asking, Michelle.

Next Steps

Again, please feel free to share your feedback with us after the meeting as well. Again, really appreciate your flexibility and how you've stayed engaged with the meeting today, and let me just turn it over. I know we have some next steps that we wanted to cover and want to give Gerri the opportunity to say thank you at the end as well. So let's do that really quickly.

I can run us through this quickly if we can go to the next slide. This is our last workgroup meeting. We will be getting ready to post the draft recommendations from July 22nd to August 5th. We'll have our coordinating committee meeting in late August, and then we'll be producing the final recommendations and report in September.

The next slide, I think, says a similar thing. And here's contact information if you need it. Just onto the very last slide. Before I turn it over to Gerri. Gerri, thank you very much. This was quite a last meeting to go out on as co-chair.

We really put you through your paces today, and you were fantastic keeping up with everything, especially having to circle back and summarize all the measures from earlier in the day. Let me turn it to you to see if you have any closing comments.

Co-Chair Lamb: I do.

Thank you everyone for such a fabulous discussion, for your thoughtfulness, for all the work that went into this. Thank you to NQF team, amazing. Thank you to CMS. Thank you to the measure developers. You work so wonderfully with us throughout this whole meeting. I would just like to say it's been an honor and a pleasure to serve you as co-chair and I will stay with you as a content expert, so I get to play with you for another year.

Ms. Williams-Bader: We are looking forward to that, Gerri.

All right, any last questions, comments from the group?

Member Schreiber: Jenna, I would just like to echo on behalf of CMS. Gerri, thank you. This was a tour de force today. Thank you to the NQF group, our staff from CMS and measure developers.

It's really the conversation, actually, that is most meaningful for us. We recognize that there weren't formal votes on many of the measures today. But honestly, it's the comments and the conversation and people had such insightful thoughts. So thank you.

Ms. Williams-Bader: Thank you, everyone. And have a great rest of your Thursday and a wonderful holiday weekend as well coming up. Thank you.

Adjourn

(Whereupon, the above-entitled matter concluded at 4:34 p.m.)