NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

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TUESDAY
DECEMBER 15, 2015

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Carol Raphael and Debra Saliba, Co-Chairs, presiding.

PRESENT:

CAROL RAPHAEL, MPA, Co-Chair
DEBRA SALIBA, MD, MPH, Co-Chair
JOSEPH AGOSTINI, MD, Aetna
ROBYN GRANT, MSW, The National Consumer Voice for Quality Long-Term Care
E. LIZA GREENBERG, RN, MPH, Visiting Nurses Association of America
ROGER HERR, PT, MPA, COS-C, American Physical Therapy Association
BRUCE LEFF, MD, Johns Hopkins University School of Medicine
JAMES LETT II, MD, CMD, National Transitions of Care Coalition
CARI R. LEVY, MD, PhD, CMD, AMDA -- The Society for Post-Acute and Long-Term Care Medicine
SANDY MARKWOOD, MA, National Association of Area Agencies on Aging
SEAN MULDOON, MD, Kindred Healthcare
PAMELA ROBERTS, PhD, OTR/L, SCFES, CPHQ, FAOTA, American Occupational Therapy Association

SUZANNE SNYDER KAUSERUD, PT, American Medical Rehabilitation Providers Association
CAROL SPENCE, PhD, National Hospice and Palliative Care Organization
ARTHUR STONE, MD, National Pressure Ulcer Advisory Panel
JENNIFER THOMAS, PharmD, American Society of Consultant Pharmacists
LISA WINSTEL, Caregiver Action Network

SUBJECT MATTER EXPERTS (Voting):

KIM ELLIOTT, PhD, CPH
GERRI LAMB, PhD
PAUL MULHAUSEN, MD, MHS
EUGENE NUCCIO, PhD

FEDERAL GOVERNMENT LIAISONS (Non-voting):

ALAN LEVITT, MD, Centers for Medicare & Medicaid Services (CMS)
ELIZABETH PALENA HALL, MIS, MBA, RN, Office of the National Coordinator for Health Information Technology (ONC)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON:

CLARKE ROSS, DPA

NQF STAFF:

ELISA MUNTHALI, Vice President, Quality Measurement
MARCIA WILSON, Senior Vice President, Quality Measurement
TAROON AMIN, Senior Advisor
LAURA IBRAGIMOVA, Project Analyst
ERIN O'ROURKE, Senior Project Manager
KATHRYN STREETER, Senior Project Manager
MARGARET TERRY, PhD, RN, Senior Director
SARAH SAMPSEL, NQF Consultant

ALSO PRESENT:

ANDREW BAIRD, HealthSouth

MICHELLE BRAZIL, Centers for Medicare & Medicaid Services (CMS)

LAURIE FEINBERG, MD, Acumen

TROY HILLMAN, Uniform Data System for Medical Rehabilitation

TERESA LEE, MPH, JD, Alliance for Home Health Quality and Innovation

TARA McMULLEN, MD, PhD, Centers for Medicare & Medicaid Services (CMS)

KIM SPALDING-BUSH, Centers for Medicare & Medicaid Services (CMS)

C O N T E N T S

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

9:02 a.m.

CO-CHAIR RAPHAEL: Before we begin this morning's work, which involves several measures related to the IMPACT Act and several measures related to the Hospice QRP, a few people have approached Deb and me with some questions about the process that we are engaged in.

And I think everyone needs to recognize that two things have occurred. First of all, we're doing our work at a much earlier stage in the development of measures than we traditionally have.

And secondly, the National Quality Forum has really tried to step back and constantly assess how the process can be improved. And to make adjustments.

So, as we're in this period of evolution, I thought it would be valuable to have Taroon, who is the staff to the MAP Coordinating Committee, and I thought I -- there he is.

Taroon, I am calling on you to kind of

just speak a little bit about the process. And then we can turn to CMS and kind of hear their perspective on the process as well.

So, Taroon, take it away.

MR. AMIN: Thank you, very much Carol. Good morning everyone. My name's Taroon Amin. I am an NQF consultant supporting the MAP Coordinating Committee, along with some of my other colleagues here, in particular Erin, and some other colleagues in the back.

So, we wanted to just raise a few topics of conversation that seemed to emerge during the discussion yesterday. It seems there's additional conversation over dinner with the Committee yesterday -- or with the workgroup yesterday around the measure under development pathway.

And then also, the voting procedure. And to see if there's any conversation among the workgroup, or any concerns, outstanding concerns. Just to make sure that we're all feeling comfortable about the decisions and the decision

making process.

And also, that I can provide you as much context as possible in terms of how these decisions are made. And where these decisions are made.

So, in particular, I'd like to sort of articulate that the MAP in general, and the Coordinating Committee, has really been undertaking a significant amount of process improvement activities over the last two to three years, to really try to enhance the ability for the Coordinating -- for the various workgroups and the Coordinating Committee itself, to focus on the major issues that emerge in conversation.

And less -- reduce the over processing if you will, given the number of measures that are put in front of the various workgroups and the Coordinating Committee during the time for evaluation.

And make sure that there's conversation around some of the key issues. And so, with that said, one of the key enhancements

last year was the introduction of the consent calendars.

The purpose of introducing the consent calendar was not to limit discussion, by any means. Which is the intent of why any member of the workgroup is welcome to pull any of the measures for additional discussion.

And really focus and create sort of a cohesive group of measures so that we're discussing them in an efficient way. One of the key elements, and also, I would just sort of point out, that we are trying to continue to -- we continue to try to ensure that there's a reduction of unneeded variation between the different workgroups.

Granted, we're looking at different settings, where the different programs are, in various different stages. So, with all that being said, we're trying to make sure that the process is relatively consistent.

One of the key pieces of input that we heard at the end of last year's pre-rulemaking,

from the various different workgroups, and particularly the hospital workgroup and the clinician workgroup that are -- the hospital workgroup in the sense of how many programs that they're evaluating, a significant number of programs.

And last year with the clinician workgroup, the number of measures was significant. That the -- there were a number of individual workgroup members that sort of counted up the number of times that we asked them to vote.

And given, you know, how much we respect and value the time that you're spending here with us, and providing this input to CMS, we realized that that was not necessarily the best use of time.

When there is general agreement, or unanimous agreements on certain decisions, to focus the discussion really more on the conversation and less the voting procedure and, you know, putting Laura through the pain of

finding the extra two votes that happen to be around the table.

And you know, going through that. The extra minutes that we take to do these votes end up actually taking a significant amount of time.

So, with that, one of the questions that had emerged, was whether there was a need for a final vote on the consent calendars after the discussion. And one of the policy changes that occurred was really, you know, asking the Chairs to look to the Committee to see if there was unanimous agreements on accepting the workgroup -- or I mean, the preliminary analysis recommendation from Staff.

And then, if any workgroup member wanted to change that recommendation, open to having that conversation. But, otherwise, there was not a need to go through the formal clicking process.

So, that was one issue I just wanted to clarify where that came from. That might not be as much of an issue for this workgroup, given,

you know, the type of measures and the programs and whatnot.

But, clearly we had a robust conversation around all these topics yesterday. But, that sort of explains why the Coordinating Committee and the workgroups, the other workgroups had a little bit of a concern and recommendation around improvements for this year, around removing that element of the deliberation.

So, before I move on, I just wanted to clarify that component. Ask the Chairs if that's a sufficient response to that discussion.

And then I'll move onto the measure under development pathway. Which is a little bit more complicated.

CO-CHAIR RAPHAEL: Okay. Are there any questions on that? Robyn?

MEMBER GRANT: I muted myself again. Okay, I just wanted to make sure that we're on solid ground legally.

That this, you know, holds. That it's not something that could come back to bite us

later or be, you know, maybe a loophole could be exploited down the road because we didn't technically vote.

So, I just wanted to --

MR. AMIN: That's fair. And again, any --

MEMBER GRANT: Get some assurance there.

MR. AMIN: Any concerns that the workgroup has, I mean, we're in an environment of continuous improvement. I mean, the goal would be not to try to change some of these processes while we're in this rulemaking cycle.

But if there are concerns like, this is why we what to have a conversation about it. And you know, we can address them if they're needed.

So, thank you for that. And you know, from what I understand again, this particular element of the decision making was broad. And we had a conversation with the Coordinating Committee, it's generally accepted with the

Chairs I should say, the Coordinating Committee.

And it was generally accepted. So, you know, I'll just put that aside.

I think the second issue requires a little bit more conversation and an acknowledgment that there's a reasonable -- there are reasonable concerns that have been raised by commenters around the question of, and I would welcome comments and reflections from our CMS colleagues, around the measure under development pathway.

So, for some historical context, you know, when we started with MAP a number of -- five years ago, you know, there was sort of a viewpoint that a lot of what MAP would be doing was looking at endorsed measures and making a decision around selection of these measures for programs.

As the MAP has evolved and these programs evolved, and the statutory requirements have evolved, MAP has found itself in a position of actually commenting much more on measures much

further upstream.

And basically what this translates to, and this is what created the measure under development pathway last year, which is why there's this decision around continue further development or do not continue further development, was that there was a clear goal that CMS asked for the MAP to provide early input on measure concepts, given potentially a short turnaround time for potential implementation.

Or that they wanted early input before the significant investment was taken to continue on measure testing. And so, the -- a large number of measures sort of fell into this measure under development pathway.

And we wanted to make it clear in the MAP decision making that it wasn't just using the same decision categories as fully developed measures. Which is why we created this -- different decision making categories for measures under development.

Which is continue further development.

Or do not continue further development.

I think one of the concerns that have been raised during the comment session last -- yesterday, and is something that the Coordinating Committee will be taking up during their January meeting.

Which, this will be an issue that's going to be spanning all of the workgroups. Is that this has created a potential concern in the view and from the perspective of many stakeholders.

Which is that some of these measures that are very early in development, get a decision from the MAP, which is go ahead and continue development. And that may be perceived as, you know, go ahead, this is approved with no conditions, given that these measures may not have even gone through the endorsement process.

And you know, again, one of the challenge here, one of the challenges here is that clearly the MAP is making recommendations to CMS. And these recommendations are about

measures, you know, these are about measures that are still under development.

And so this is a reasonable concern that has been raised. I would just sort of characterize that what the intent of the measure under development pathway was to clarify that these are not measures that have enough information, meaning the testing information in the setting that they're intended to be used, for the MAP to really make an up or down decision fully.

And so, this was intended to create a separate pathway. So, maybe I'll just stop there. And sort of -- in terms of what the context is.

I would welcome sort of comments or reflections from our CMS colleagues or any other MAP Staff. Or the Chairs if there's any place else I can sort of expand.

CO-CHAIR RAPHAEL: Okay. Let me turn to our CMS representatives. And ask if you have any comments as we're shaping this new process?

MEMBER LEVITT: Well, first of all, thank you. Thank you for the explanation. And really, thank you for the workgroup.

I thought that we had a very, very constructive meeting, and talking about very important measures yesterday. Some of the measures which have statutory time lines on them. And other measures that don't.

And you know, at CMS we, you know, we really try, and I think we're successful at being as transparent as we can, possibly can, in terms of, you know, discussing these measures and getting feedback from you.

I think many of you came to me yesterday and mentioned that you appreciated the openness that we have in terms of some of the, you know, issues going on. And the opinion that we wanted from the MAP.

As we move forward with these measures, if the measures are opposed for any of the programs, certainly what's gone on here today will be discussed and will be explained. And you

know, will not be ignored at all.

And as to, you know, what any sort of future time line might be with the measures, that really depends on, you know, our policy decisions and decisions, you know, in terms of the importance of, you know, moving forward the measures. But we always take the MAP's opinion and the importance of the NQF into account in terms of these things.

CO-CHAIR RAPHAEL: Bruce?

MEMBER LEFF: Yes. Just a clarification. I really appreciated that explanation. And I too thought yesterday's conversation was terrific.

So, tell me if I'm still not completely understanding this. But, it feels that even within the measures under development category, those that have statutory, you know, statutes standing behind them, seem to be in even a different category.

Like that train is going to move forward. Our role here is truly advisory input.

Is that fair?

And if that's so, it may mean you need a slightly different designation for those. Because I think it would help. I think that's where I was really very confused yesterday.

And also, if you could clarify for me, I think I have it, but I'm not 100 percent sure. How the measure under development framework and the endorsement framework ultimately come together.

MR. AMIN: Okay. I will try to start with the -- I'll start with the second. And then I would actually ask some of my colleagues, maybe Erin, or even the Chairs to reflect on the first.

Which is around the role of the MAP sort of being advisory. And what the decisions of the MAP sort of represent in terms of the process that CMS uses.

I mean, inherently it is an advisory -- in an advisory role. But, again, I'll take a step back from that and ask others to sort of reflect on that.

You know, this is another topic that the Coordinating Committee is going to spend some time on in January. Because the relationship between MAP and the consensus development process, the endorsement process, is an evolving discussion.

So, with that being said, you know, when measures under development sort of come into the MAP process, you know, the MAP is making a decision on whatever information is available at that time.

It may be because the measures are still early in development. That's generally the reason. And the definition, one of the main reasons why measures go into the measure under development pathway is because there's not testing.

And that testing, not even the quality of the testing, it's just whether it's fully been tested for that setting and the data source. Which is information we get from our colleagues at CMS.

So, with that being said, that's why NQF feels relatively strongly that it's difficult to really make a full -- a recommendation from the MAP. Given the type of information that's available at the current state.

So, you know, that's the measure under development pathway. That's the definition. That's how you get into it. There's just not full testing.

And that's what the Staff uses to sort of bifurcate the measures that go into this pathway. It's the measures under development pathway versus fully developed measures.

Now, how does that interact with the endorsement process? The NQF endorsement process really looks at measures that are fully developed, fully tested, and fall into an endorsement project cycle.

So, a measure that's sort of developed in let's just say neurology, just using that as an example, that's, you know, still a concept. It can be looked at by the MAP.

That information is then translated to the Neurology Standing Committee that looks at all of the new fully developed measures and tested measures. And they make a decision, a scientific evaluation of the quality, of the reliability, validity of the measure, and the evidence supporting the measure in summary.

And that endorsement information ideally is then translated back to the MAP if they are looking at measures that are fully developed. And that information in turn is provided back to you in terms of the preliminary analysis.

Which is what Staff pulls from to make, you know, for fully developed measures. If you're considering fully developed measures.

So, they're relatively independent. I mean, just because the MAP recommends continued development, doesn't mean that the measure's going to be endorsed. In fact, I mean it -- I mean, it's sort of interesting information.

But, the endorsement process is

looking at a much more robust set of information. And it's looking at it much more, you know, looking at all the scientific testing information and all the evidence to support the measure.

Which obviously, given the volume of what you're looking at, would not be possible. And, you know, the way that the Committees are seated is slightly different as well.

So, I don't know if that answers your question. I don't want to just continue to sort of --

MEMBER LEFF: No. No, it does. And just a quick follow up, if we have a moment. So, if you're a measure developer, is there an advantage to first going through measure under development as a lead to endorsement?

Or are they just independent that it doesn't matter?

MR. AMIN: I mean, currently there's really no, you don't have any insider path.

CO-CHAIR RAPHAEL: Clarke?

MR. ROSS: I wanted to speak about how

pleased I was that the National Quality Forum developed this measure development process. I was a member, and am a member, for the last three years, with a workgroup on persons dually eligible for Medicare and Medicaid.

And we continually were frustrated because we do have very limited measures that are performed in isolated communities and States. That address very important concepts that the full duals workgroup supports.

And so, when the National Quality leadership came up with this second process, we're delighted that there's this opportunity to elevate something that's not ready for full stage implementation. But, is not ignored because it's not ready for full time implementation.

So, I know there are some stakeholders with financial interests who don't like that status. But, from a consumer point of view, and the majority of the duals workgroup, this is a wonderful opportunity.

And we're excited. And we're

proposing different kinds of isolated measures that we'd like to see brought to scale.

CO-CHAIR RAPHAEL: All right. Thank you. I don't know if anyone else from NQF Staff wants to weigh in.

Oh, Bruce, you were asking --

MEMBER LEFF: Was there an answer to the question about the statutory issue on some measures?

MS. O'ROURKE: So, I can try to take that. And may look to Tara and Alan for some help.

I think for a number of the programs that were created by legislation that has some fairly strict requirements about what's to go into that program, and what measures are to be used, MAP does have a more limited ability on what input you could really provide.

I think the idea of perhaps an alternate designation for those where you're more looking at the -- how a certain measure might be implemented, may be more useful than how we're

currently putting it to you, since for some there's not a lot of choice.

There's some, you know, some of these statutes as Joel was presenting yesterday, you know, for the SNF EDP program, basically only one measure can go in there.

So, I think that would probably be another good item for the Coordinating Committee to take up on how we can most handle -- effectively handle those programs where MAP has a limited box to play in if you will.

That there's some fairly strict requirements put on things by Congress. And how you can weigh in, in the most effective manner.

Taroon, would you add anything? Tara? Alan?

MEMBER LEVITT: I think, I mean, every measure is different in terms of, you know, where a particular measure might be in terms of its development. Some measures may already be being used in other programs and be NQF endorsed.

And you know, they may be brought

because they want to be considered for a different program. So they're already endorsed measures, but yet they're under consideration for a different or a new program.

So, they can be going there. Some measures that are -- have statutory mandates may already have been, you know, fully developed.

For example, you know, Joel's -- one of the measures for the Value-Based Purchasing Program yesterday was already in. You know, a measure that had gone through the endorsement process.

So, it's a hard question to answer. I mean, like I said originally, we value this input. And we want to use it as best as we possibly can, you know, within the -- within the limits as to what the schedule can be here and what schedule we, you know, need to go by as well.

And I think that we've noticed, thankfully that, you know, in continuing to try to make this better and better that we need to

relook at this and say well, considering how things are, and the schedules that are, you know, everyone's under, what is best to move forward?

So, I mean, I think it is a constructive time to do it.

CO-CHAIR RAPHAEL: Let me just check and make sure that we accommodate any public comment. So, let me ask the operator to see if there are anyone on the line who wants to make a comment on this issue around the process we're engaged in.

OPERATOR: Okay. At this time if you would like to make a comment, please press star then the number one.

(No response.)

OPERATOR: There are no public comments at this time.

CO-CHAIR RAPHAEL: Okay. Let me turn to our audience. And see if there's anyone in the audience who wants to weigh in on this.

DR. GIFFORD: Hello. So, I think that the whole NQF MAP process is an incredibly

important process in this review process.

And actually in the IMPACT Act, we advocated really strongly that in the original language there was nothing in there about NQF review of IMPACT Act measures. And we advocated that that be inserted into the measure process.

And so we see this as a vital thing. I think you've heard a lot today from CMS about statutory requirements and time lines. And they are in a real bind.

If I was in their shoes developing the measures that they're developing, I would do exactly what they're doing. And I'd have the exact process they're doing.

They are under staffed and under resourced. And they have unrealistic time frames.

However, NQF also has a statutory requirement. And this body has a statutory requirement to review the measures and provide feedback.

And so while CMS is moving forward on

a fast time frame, the requirement, they do not -- this is a body and NQF is an advisory process. Their requirement is that what comes out of the MAP process, they have to address in rules.

And they have to explain when they use measures that are not NQF endorsed measures that have gone through the process. And so they just have to explain that. And they have to give the rationale.

And so if there's concerns here, my concern on the new process, of creating this loophole of measure under endorsement, it allows them to then just sort of say yes, let's go forward.

And it diminishes the feedback and concern that many of you have raised around that to not having to necessarily be addressed in the rulemaking as they go forward on these fast measures.

So what Congress said, do these measures and do quickly. Congress also said, we want a balancing entity, a consensus by the

entity to review and give feedback to the Secretary on these rules.

So, I would strongly urge you to think about as you go through and vote on these measures, to make sure it's clear what feedback you want to address.

Because in the past, I think a lot of these measures were used for quality improvement purposes. And were just thrown up as reporting.

They are now being used fundamentally differently. They are now being used in payment models.

They're being used to create post-acute care networks. They're being used to provide information by providers to consumers on making post-acute care decisions.

And so, some of these issues and feedback for these measures, the denominator definitions that are not fully specified, the risk adjustment can really have profound impact, unintended impacts that many people brought up.

So, I would strongly encourage you as

you go forward, to think about that. And the current process of measure and develop -- or not pursue, does not allow that sort of robust more feedback that the Secretary then has to address as it goes forward.

And so, I think as you think about the voting and reviewing process that you consider that more carefully. I also would, not being a lawyer, slept at a Holiday Inn last night, I would -- haven't been on a lot of boards.

I would recommend that, and I would agree with Robin's point, I would bundle at the end. And I agree that their intent was to decrease all the measures. And I support the consent calendar.

But usually a process is that consent calendars get a vote. And there's a process with Staff with consensus. There's not even a verbal vote going on here.

This is a small thing. And I don't want to take up extra time. Maybe you bundle it all at the end. Because, if not, it's

technically there is not a vote on it. And technically it's not clear.

Now there doesn't have to necessarily -- there's been a laid out vote process by the MAP. But in the statute there is no voting process.

So, I'm not sure where the legal issue is, but I think -- I'll just give you some concern and pause about that. Then there is the workgroup's or maybe it's the MAP's. It doesn't matter.

And so I don't know. I defer to legal counsel at NQF. But, I give you some pause to think about how you go through and consent to it.

CO-CHAIR RAPHAEL: Thank you. Tara, did you want to say anything? Or was it Alan?

MEMBER LEVITT: No. Thank you. And thank you for the comment.

I do want to -- I do want to make a couple of comments. First, we are developing these measures based on certainly looking at Congress' recommendations and Congress' vision.

And Congress' time lines that they've set up based on feedback that they've received from people in the room, in terms of some of the needs that are here. We certainly do not consider ourselves under-staffed or under-funded to meet these needs of the consumers as well as our stakeholders.

We are proposing these measures for the programs that we are proposing them in. As I said the other -- said yesterday, these are quality reporting programs.

These are programs that will be reporting the measures that you gave us advice on yesterday if they, you know, when it got proposed in those programs. For the -- our consumers to be able to look at and for you to be able to use in your quality activities.

If any type of Value-Based Purchasing Programs were to be statutorily mandated, those programs would use measures that I would assume, I don't write the statutes, but I would assume be similar, would require a similar process too.

Which would include coming back to a body -- a consensus body such as the MAP. So that when you are viewing the measures, view them to the program that the measures are being looked at for.

Don't -- please don't assume anything else. Because if other programs do come along in the future, those programs would have their own statutory requirements as to, you know, how measures could be proposed or, you know, be part of that program.

CO-CHAIR RAPHAEL: Thank you. And we're going to hear from Paul. And then we're going to close up this discussion and move onto other business we need to conduct today.

So, Paul?

MEMBER MULHAUSEN: Yes, just in terms of procedure. It's my understanding that we have taken a vote on each of these consent calendar deliberations.

We've essentially approved them through affirmation. And if we wanted, any

individual one of us should have had the -- have the opportunity to have asked for a formal vote.

But, from my point of view, we have voted on the consent calendar. And that each of those action items were approved through affirmation.

So, I don't think it's a fair characterization to say we have not used this opportunity to vote on the consent calendar.

CO-CHAIR RAPHAEL: And in line with that, we just checked with the NQF Staff this morning to affirm that everything we did was consistent. Reflecting the processes that had been put in place and legal.

So, just to give everyone a sense of confidence in the process thus far.

MR. AMIN: Carol, can I just ask one question? Sorry.

CO-CHAIR RAPHAEL: Sure.

MR. AMIN: I think Paul characterized exactly the intent of the voting procedure. I just wanted to clarify or ask if any of the

workgroups felt that, you know, the final recommendations, which was essentially unanimous across the different consent calendars for accepting this, you know, Staff recommendations.

There was a number of measures that were pulled off and voted separately. But, if anyone doesn't feel that we sort of reflected Paul's vision or Paul's discussion here of, you know, I would ask you to raise those concerns.

We certainly don't want this to be a, you know, process that doesn't reflect your input. And we can do a separate vote on those measures if it's required again.

But that is the -- that was the intent if, you know, if the measures aren't being pulled, you're accepting the Staff recommendations. And that is your formal vote.

So, I just wanted to be clear about that. And I would really like to thank the public commenters on these issues.

They're certainly ones that need to be considered more thoughtfully and across all the

workgroups. So, it's certainly something we will bring back to the Coordinating Committee for further discussion as well.

CO-CHAIR RAPHAEL: All right. I think we are going to move onto the next part of our agenda, which has to do with measures on the consideration for the IMPACT Act.

This is one I'm particularly interested in. Because when we did our core measure set, I would have to say one of the areas we grappled with was how to deal with costs.

And we had one of our core measures had to do with cost and access. And so, let me first ask the Operator to open the lines to see if we have any public comments on this particular set of measures.

Operator?

OPERATOR: To ask a question, please press star then the number one.

(No response.)

OPERATOR: There are no comments at this time.

CO-CHAIR RAPHAEL: Thank you so much. Let me again turn to Members of the audience to see if anyone wants to make a comment on this. Okay.

MR. BAIRD: Thank you. Good morning. My name is Andrew Baird from HealthSouth. Thanks for your discussion yesterday on some of these measures.

We are a post-acute care provider. I think I've introduced myself as of yesterday. I'll just note that as an avid observer of this process, there is very little for us to provide a comment on in way of this measure.

And since that the specifications are relatively opaque, especially about when particular accounting for a cost for different types of post-acute care. Post-acute care providers would begin what portions of different post-acute episodes would be attributed across the entirety of a post-acute episode.

AKA, when a patient's entire post-acute experience, and how that would be divided.

Or if that would be divided at all.

So, I'd just like to reiterate for this group that the amount of specifications that are currently published, are very opaque. And it's been hard for anyone at least on the stakeholder side, to get an idea of what exactly this measure looks like.

We've heard from several people that discussions at the TEP were also somewhat ambiguous in terms of whether or not they settle on the measure framework.

But again, I just wanted to underscore the fact that the amount of information that is out there to say this is a good or a bad measure, seems to be relatively low compared to the measures that we discussed yesterday. Thank you.

CO-CHAIR RAPHAEL: Okay. Thank you.

DR. GIFFORD: I would amplify that in that the measure specifications are not provided for this. And I would encourage you to vote insufficient information at this time.

This one can piece together what the

measure may look like from different pieces of information out there. But, even the TEP itself has not received a measure -- a set of measure specifications to work on on this measure.

So, I think this is an important measure. I think it's an important issue to go forward.

It's specified in the IMPACT Act and statute as a time frame. But there currently is insufficient information at this time. I would encourage you to vote on that level.

CO-CHAIR RAPHAEL: Okay. Okay, can you please introduce yourself. We know David Gifford.

But we want to just be sure that each person introduces herself or himself.

MS. LEE: Sure.

CO-CHAIR RAPHAEL: Okay.

MS. LEE: Teresa Lee with the Alliance for Home Health Quality and Innovation. And thank you again to this body, NQF and CMS for the opportunity to comment.

I agree with the former commenters. We greatly look forward to seeing the specific measure specifications for this measure.

We have in the past looked at the MSPB measure for hospitals. And so, you know, my comments are based on, you know, the assumption that this might look somewhat like the MSPB measure for hospitals.

And vis-a-vis that measure, I think that our concerns are somewhat similar from a home health perspective to the concerns about the hospital MSPB measure. First and foremost, that we continue to be concerned about just looking at costs alone.

And that that might be confusing for consumers. Because cost alone does not necessarily mean anything vis-a-vis quality.

Low Medicare spending per beneficiary might mean efficient care. But it might not. It might just mean low spending. And that might actually mean poor quality of care.

So, that continues to be an issue. If

that track is pursued, we strongly urge consideration of a measure that relates to access to care.

I definitely think that MSPB is a significant consideration for payers, for the Government. Probably increasingly for accountable care organizations and those running bundled payment arrangements.

But likewise, I would think that for consumers and patients, it's very much of interest to have some kind of a measure that relates to access to care.

So, those are probably my primary considerations. And just as with any measure, we believe very strongly in the need for adequate testing and validation of the measure.

And would urge sufficient time and reporting to providers before making any measure like this public. Thank you.

CO-CHAIR RAPHAEL: What do you mean by that?

MS. LEE: You know, I think that what

we mean by access isn't, you know, we'd be very interested in working with CMS on a measure that relates to access. Because I think that we haven't given enough thought to it.

But, I remember at the inception of the Medicare Shared Savings Program, I want to say that RAND did an analysis of what kind of measures should be developed in -- for the Medicare Shared Savings Program.

And one recommendation and, you know, identification of a gap, was that there needed to be some kind of measurement that relates to ensuring that patients have adequate access to care.

Simply because in any kind of shared savings arrangement or bundled payment paradigm, there might be a concern about inadequate, I'll just say, you know, under use as opposed to over use.

So, that's a question that I think I and many might have with these types of arrangements. And when you're looking at

Medicare spending for beneficiary, you know, there's clearly going to be an opportunity to use this measure as a way to select providers who are spending lower over the course of an episode.

CO-CHAIR RAPHAEL: Okay. Let me see if Laura has anything in the chat box?

MS. IBRAGIMOVA: No, there is nothing.

CO-CHAIR RAPHAEL: Okay. So now, this is I guess something where we really do want to understand this measure.

Sarah, I'm going to turn to you to start us off given that we have heard that the measure spec is not very, very illuminating.

MS. SAMPSEL: Okay. So, this is very much a -- all four of these are similar measures. The Medicare spending per beneficiary post-acute care and being on the MUC List for use in home health QRP, inpatient rehab QRP, long term care, as well as skilled nursing facility.

These are all -- the preliminary analysis are all very much similar in that we had the information, you know, that we had when we

received the MUC List this year.

And so it was very preliminary information. So, the information in your discussion guide would be the descriptions that were available to us.

And through that information and knowing that these measures all support and are being offered forward as components of the IMPACT Act and the statutory requirements as well as overall and knowing there are other similar measures specifically for hospital, made us come down to the side of recommending these measures and encourage continued development as you've seen previously.

I think I would also say, you know, in light of our conversation this morning, this would be -- these would be a great example of where CMS is really early in the process of fully specifying the measures, taking in information, meeting this advisory input so that as they move forward with testing and using the data they have available to them, that they do come up with the

best measure.

But, the staff recommendation for all four of these measures, is encourage continued development.

CO-CHAIR RAPHAEL: Okay. Let me turn now to CMS.

MEMBER LEVITT: Okay. Well, thank you. I'll just -- I'll start off. First of all, thank you again for the review and all the comments.

I wanted to introduce Kim Spalding-Bush. Kim and her team have developed this measure as well as the other Medicare spending per beneficiary measures throughout the various programs that we have.

I need to apologize I guess a little bit to the workgroup and to Kim. Because you know, historically we haven't given presentations of measures prior to the measure being done.

We responded very much in the way that we responded yesterday. In terms of, you know, responding back to the comments.

And I apologize for the confusion that that may have undertaken. Because there is more to the measure than meets the eye.

And I'll turn to Kim now if she can maybe give some of that. So, thank you.

MS. SPALDING-BUSH: Thanks Alan. I'm Kim Spalding-Bush from CMS. And I apologize. I don't have a placard either.

So, I do understand the importance of providing more detail around the measure in order to get more meaningful comment. And I think at this point, the measure has been through a Technical Expert Panel.

And we've gotten some really good and meaningful feedback from the TEP members with regard to exclusions and that type of thing. So, one of the commenters mentioned the Medicare spending per beneficiary on the hospital side, which is the name of the measure, as Congress gave us in the IMPACT Act.

So, these measures do look a lot like the hospital level Medicare spending per

beneficiary. I think there's an important distinction that we've begun to explore with the TEP, which is what types of services will we want to actually exclude from this measure?

So, for the hospital level measure, it's all Part A and B. Everything's in. For this measure, we are taking a look at things like congenital, you know, treatment for congenital issues that the beneficiary may have that could be wholly outside of the scope, or the influence of the post-acute care provider that we might want to exclude.

The TEP also suggested issues that may arise on the first day of a post-acute care stay. Where they may actually reflect more or something that could have happened in the hospital and then a UTI maybe appears and they need treatment for that in the post-acute care setting.

So, those types of things that we received from the TEP, we are exploring. And we will be providing the detailed measure specifications after, you know, we receive your

input and we do the public -- and get more stakeholder and public comment on these measures.

So, I also wanted to speak to the concern that this is a resource use measure. And I understand that as well.

And that it was sort of delineated as such in the law. But that CMS, you know, historically has used resource use measures when they do become a part of any sort of a Value-Based Payment Program used alongside with quality measures so that you do take the total picture as more of a value.

We understand that a resource use measure just inherently is looking at costs. The things that we could expect to recognize that, you know, may reflect better quality within a resource use measure are limited.

So, things like improved care coordination that reduces unnecessary services, prevents readmissions, those types of things, will show up as better performance in a resource use measure.

But, we don't present the measure as sort of an inclusive quality and cost measure. It is really a resource measure. And I think with regard to the access of care issue that's also an important one.

While the measure itself isn't, as you know, set up to consider that, it is something that we have done analysis on in a hospital level. And we intend to continue that type of monitoring analysis as we move forward with these measures.

And we were able to look at things like, was there a spike in resource use after the end of this post-discharge window. Were providers delaying needed care to try to avoid, you know, those services being captured in the measure.

And we have found in our analysis at the hospital level, that that did not occur. But it's something that certainly with post-acute care setting, we will continue to monitor for.

And I think that's about all I have in

response to the comments that we've heard so far. Alan, is there anything else that you might want to add about the measures?

I'll put you on the spot.

MEMBER LEVITT: No, I mean I guess maybe we'll turn to the workgroup and see how the workgroup -- questions the workgroup may have.

And maybe you can help. You and your team can help in terms of clarifying the questions.

CO-CHAIR RAPHAEL: Gene, you're our lead discussant on this. So, before we turn to the entire workgroup, do you want to weigh in?

MEMBER NUCCIO: Thank you. Again, I'm not representing any particular provider. I am one of the technical representatives.

Certainly, we support the idea of measurement of cost across providers. And that's clear that that's one of the charges that we all have in terms of -- in addition to giving quality.

I do have three concerns or concerns

in three parts. First, the concern of inherent differences among the four different post-acute care health group providers.

They clearly serve very different patient populations in terms of the medical needs and resources and interventions that need to be given. Why else would we have four different kinds of groups if we did not have at least four different kinds of patients.

The patients are served in quite different physical environments. Quite notably, home health is not in a bricks and mortar kind of environment.

The three -- three of the groups have a payment, the SNF, IRF, and LTC -- LTCH, excuse me, LTCH. Have primarily a fee-for-service kind of payment model.

Whereas home health has a perspective payment model where people who have the same diagnosis are -- the agency receives the same payment. And so, there will be inherent differences in terms of variation found within

these four different groups.

The second concern is the comparison format. While the methodology is quite clear, I mean, it's very standardized of a 60-day period with a provider and a 30-day post provider period.

The -- there's a -- some inherent differences in terms of the settings. And we discussed this yesterday when we talked about both readmission and discharge.

What does it mean to be discharged? Or what's the likelihood of being discharged from an IRF to a -- to the home setting?

And so, the payers that are likely to occur in this 60-day period, and then the added 30-day period, will look quite different amongst these four different groups.

There is something that we also discussed yesterday, and excuse me, and also parenthetically with that, there are also quite clear empirical differences in region in terms of what these care patterns are.

So, the regional differences are -- could be within State, or it could it be across the ten CMS regions. So, those regional differences would be of concern.

Yesterday, we discussed the role of risk adjustment in these models and the previous models. And again, perhaps because it's such an early development phase, that -- the whole risk adjustment process, and how the clinical case mix is going to be addressed, is not quite clear in these and needs to be much more explicit.

The third area is sort of psychometric issues. And the language of the average of the ratio of standardized episodes spending level, and the expected episode spending for each provider, is somewhat technical.

And maybe not exactly as accurate as some of the technical people would like. What do you mean by standardized? Not very clear. And how would that differ from setting to setting?

You use the term expected episode spending, which suggests some sort of a risk

model. Again, not clear in how this needs to be developed.

The exclusions, I was curious whether or not dual eligibles would be included or excluded in the setting. There is some language about whether or not, you have to be fee-for-service for the entire period of time.

But, if you're -- and then there's also language about your primary payer source. And so, if you move from a Medicare to Medicaid kind of model in that, you have a -- there might be an issue.

In terms of the denominator, there is a -- the description of a weighted median. And while Alan certainly knows, I have no objection to using the median in computations, I need to know what the weighted is.

Also, with regard -- the third -- this third part, is the issue of unintended consequences. And I think we've already heard some of that.

And in fact it's called out in some of

the descriptions that you provided. Notably, the cherry picking issue for -- in some care settings. But, I thought also there might be a positive.

That is, if we have this -- if a SNF has a -- is on the hook if you will, for 60 days in the SNF, and then 30 days elsewhere, they might begin to partner with the most effective home health agencies around. And so, there might be some inherent positive in this 60 day/30 day idea.

But again, -- again an unintended consequence, we do have four measures. I am concerned that there might ultimately be a comparison of costs across each of these four -- post-acute care settings that again, going back to my first comment, we serve inherently different patients.

And so I would, you know, be aware that, you know, that this comparison across groups as opposed to within groups, is an issue.

And one last comment just to

summarize. You know, again I do support the idea of measuring costs, costs of care.

But I want to ensure that the -- that what we're really all about here is measuring the value and the quality of care given to patients first.

And understanding that that cost of care involves both the integration of both outcomes and processes that are delivered to them.

So, sorry for it being so long.

CO-CHAIR RAPHAEL: Okay. So, I'm going to turn now to workgroup members. And I think the first thing we have to decide is if we want to pull these from the consent calendar.

And I -- Gene, I'm going to ask you your thoughts. You know, you said that you're in favor of beginning to really measure costs.

But, you gave us a lot of caveats. So?

MEMBER NUCCIO: Can I say that there's a lot of work to do? I worry that if we use the

insufficient --

CO-CHAIR RAPHAEL: Information.

MEMBER NUCCIO: Information, which there probably is. Okay, in reality there is insufficient information.

I don't want to discourage the amount of work that needs to be done in order to bring this measure perhaps back to the MUC in a more detailed and mature form.

CO-CHAIR RAPHAEL: I mean, I would say that's something that I'm grappling with here in the sense that I haven't found the house that I would like to inhabit.

Because the house, you know, if insufficient information doesn't feel like the appropriate house because I think we as a workgroup, have really tried to foster some work on cost and access.

And so, this is the first time we have seen some work in that area. And we want to kind of continue that.

On the other hand, if we say encourage

continued development, to what extent are we endorsing, in quotation marks, the road that we're traveling?

So, that's just something that I'm kind of trying to deal with here. So, if you have anything that's enlightening, that would help.

MS. O'ROURKE: Sure. So, I don't think I can really answer the question about what to pull or how to vote.

But, I did want to clarify that we capture all of your discussions. And we do pass that along in the Statement of Rationale that goes along with whatever decision the workgroup ultimately comes to about each measure.

So, your recommendations are not going to CMS in a vacuum. There is a detailed Statement of Rationale that captures all sides of the workgroup discussion, and sends that along with it.

So, if that helps you for your decision making.

CO-CHAIR RAPHAEL: Okay. Yes. Lisa?

MEMBER WINSTEL: I know that this has been addressed, so forgive me for asking it again. But, I really would like just a really direct, simple answer as possible on this.

If this measure or any of these measures are voted for continued development, after they have been developed more, will those measures come back to this Committee? That's a yes or a no question.

MEMBER LEVITT: I apologize. Can you say it again?

MEMBER WINSTEL: Oh, if there -- if any of these measures were to be voted for continued development, will that measure come back to this Committee for review before implementation?

MS. SPALDING-BUSH: So, that may be more of an NQF process question.

MEMBER LEVITT: No. Yes, again, I was hoping before we kind of looked procedurally as to how to vote, whether or not Kim could give the

workgroup some more answers to Gene's very thorough analysis.

I think you're seeing right now why it was great to have Gene as a member of the Committee. Because he really does a great job of looking at things.

And give Kim a chance to talk about it.

CO-CHAIR RAPHAEL: Okay. So, what I'm going to do, Kim, I'm going to hold off. Because I think we want to make sure we get the whole range of issues.

And then I'm going to turn to you. So, that's asking a lot of you. But, I think you're up to it.

All right. Suzanne, you were first.

MEMBER KAUSERUD: I think you had asked if we wanted to take it off of the consent calendar for the discussion. And I would like to move to do that.

I think it needs some more in-depth conversation. And I feel like there's going to

be some contention around this one. So, I think it would be important to get those details.

And then from the measure, from the information, you know, as stated it's very limited. It's hard to, you know, give a lot of input just because there's not a lot that we have at this point in time.

But I think looking to the inpatient, or the acute care Medicare spent per beneficiary, some of the things we would want is to make sure that any of the risk adjustment done on severity would be done off of the case mix groups instead of DRGs.

Because the case mix groups in inpatient rehab in particular, -- and I would assume it's the same for skilled nursing, you know, as well as home health.

And well, LTAC would be off the inpatient. But, because the severity is captured through those payment systems a little bit better.

Also, risk adjustment on socioeconomic

status as well as other characteristics such as availability of care giver and community supports would be important. Because that's a huge variation at least in patient rehab, of whether a patient is going to be able to return to the community with a lifelong disability.

Also, just some concerns, and this might be a little selfish because I am in a facility that takes a lot of unfunded and underfunded patients. And so, our low income provider adjustment is quite sizeable.

We're also a teaching facility. And so, we have been told by our Medicare Administrative Contractor before that per case, we are the highest paid inpatient rehab facility in their area.

And it's because of our facility characteristics. So, I think that it would feel wrong to me.

And it's just my opinion, but it would feel wrong to be penalized as a provider who takes low income patients and is a teaching

facility, to be penalized for those characteristics of our facility.

So, I think those would be important. As well as any other, maybe a rural adjuster. We're not rural.

But I think a rural facility gets an increased payment as well because of their setting. So, I think normalizing that would be important if you're going to compare between facilities.

And then the numerator description, there's several terms. And this is why I'm kind of thinking -- personally I'm thinking about insufficient information.

Because a lot of the terms could go -- there's terms that I'm not familiar with that standardize episode spending, expected episode spending, average standardized episode spending, information about the weighting methodology.

And then the terms about planned and -- planned care and routine screening. I think we would need to know what planned care is.

And what routine -- what falls into those categories to make intelligent decisions about the measure. So, I'll stop at that point.

CO-CHAIR RAPHAEL: Liza?

MEMBER GREENBERG: Thank you, Suzanne. I would like to amplify Suzanne's remarks.

I think we do need a lot of the definition. And I agree that we should vote on it individually.

I think it's a statutory measure. It's an important measure. But, I feel like we don't really have enough information to really get into the weeds about what it's -- what's going to happen with it.

I know I'm concerned about possible double counting. And wonder if there's like some way that we could, you know, have a couple of models of patient pathways through post-acute care.

Where we could, you know, look at a patient that goes from a hospital to SNF and then to home health. Or a patient that goes, you

know, different models like LTAC to SNF to home health.

So that we can kind of standardize what is happening to the patients. Because although I know that CMS will have every intention of looking at costs paired with quality that Congress might not.

And that might affect sort of how different path providers are viewed in future payment increases. So, the cost and quality pairing I think is really critical.

I'm concerned about the safety net providers and what this might do to safety net, I think is also a very valid concern. And mainly also just more detail on how to interpret and understand the specs.

CO-CHAIR RAPHAEL: Roger?

MEMBER HERR: My first is a process question. If one person requests a poll, are we then polling?

CO-CHAIR RAPHAEL: Yes.

MEMBER HERR: Okay. So then, I'm just

making sure that was clear to everybody. And my second part is, I think we're having a really rich discussion.

So, I hope if that's how we're doing it, wonderful. I think all I'm hearing from the group are very important details that are needed.

But overall, these are measures that we were encouraging from the beginning. And we're finally getting some direction. I understand Gene's issues of comparing settings.

But, if we're able to capture all of our feedback here and give that as future development in this area, I think we're going in the right direction.

CO-CHAIR RAPHAEL: Okay. All right, Jim?

MEMBER LETT: Oh, thank you. These measures feel profoundly different to me than anything I've ever discussed in this forum before.

I mean, we are the National Quality Forum. I feel very comfortable in hashing

through measures of quality. I am far less comfortable in considering this the National Cost Forum instead.

I think I support not only the ability and right of CMS to understand what it costs to render care. As a taxpayer, I think they should be obligated to do that.

And I think it's an excellent thing. I am having a hard time finding a bright line between costs and quality in this discussion.

And I am concerned that cost may at some point become more relevant. I'm reminded of the famous and probably apocryphal story about Gus Grissom, one of our first astronauts.

That they supposedly interviewed him before he was blasted off into space. And they said so, how do you feel, Astronaut Grissom, about this? Are you nervous?

He said, how would you feel if every part in your rocket was the lowest bidder. So, I'm -- I want us to be clear what we're measuring and why we're measuring it.

I again, firmly support the need to have cost as part of the discussion. I'm worried about the blurring line with quality.

And I think there's insufficient evidence both from the technical standpoint and from the moral standpoint as to where we're headed with these measures. Thank you.

CO-CHAIR RAPHAEL: Robyn?

MEMBER GRANT: I have a couple of things. And one of them is a process question.

And that's what does happen if we go with insufficient information? Does it just disappear off the books?

Or does CMS continue to work on it and then bring it back? And we need to look at it again.

MS. SAMPSEL: I'll start. And does it fall off the books? No.

I mean, we feed back to NQF the full list of all the measures discussed and your final disposition, based on your votes and your recommendations. Along with, as Erin has already

commented, all of the rationale behind them.

Past that, it's then up to CMS internally to figure out, you know, what kind of -- where that measure goes. The direction for development as well as where it comes back. And if it comes back to NQF.

CO-CHAIR RAPHAEL: Erin, do you want to add anything?

MS. O'ROURKE: I would just echo that Sarah's point, it would be up to CMS at that point. They don't have an obligation to bring things back to us, no matter what the disposition is.

So, in an ideal world, yes, they would bring it back the next year with the measure more fully tested. And allow the group another chance to weigh in.

And hopefully, that is what would happen. But, from a process wise, we don't have any guarantee.

CO-CHAIR RAPHAEL: Okay. So it goes back to you Robyn.

MEMBER GRANT: Okay, thank you. So just a couple of comments. One, is just from a consumer perspective, I think what matters is that you get the care you need when you need it. And that it's good care.

And that quality -- that the cost of it is not what the consumer is really thinking about and making a decision. And those other factors are, I think, the real key ones.

I want to amplify or build on what Gene said in terms of unintended consequences. In addition to the cherry picking, I'm concerned that, as he's mentioned, might result in individuals getting less care then they need in order to keep the cost down. Or look at premature discharge.

Because again, that's the way the provider to keep his cost down. So, I really worry about that across the measures.

CO-CHAIR RAPHAEL: Cari?

MEMBER LEVY: Thank you. I just wanted to ask a question about is there -- are

there any thoughts about characterizing provider markets?

And the reason I ask is I know we have a number of rural communities where there's really a substitution of home health for SNFs, where SNFs don't exist.

And so, if we're really doing a lot more home health for example in an area that doesn't have a SNF, will they be penalized because they've ramped up those services to substitute for no SNF?

I don't know if there will be. I know there's a rural/urban adjustment. But that may not account for this rural substitution.

CO-CHAIR RAPHAEL: We'll hold off on that one. Paul?

MEMBER MULHAUSEN: So, thank you. This has been a really excellent discussion.

I guess I'm a little concerned that we're contemplating the vote of insufficient information. And I guess I want to speak to that personally.

So, from my world, any time we consider value in the delivery of services, we worry about the unintended consequences. Of the cost side of that equation.

So, I think it's an inherent concern whenever any of us try to raise the issue of value. But, I think anybody who contemplates the cost of care to our community, recognizes that we simply have got to try to grapple with this particular issue.

I think these are worthy measures. I don't know if they fall into the framework of quality as Jim has pointed out.

And I do think they are certain -- there is certainly insufficient evidence here to endorse them as an NQF endorsed measure. Which in my world of trying to develop programs, picking NQF measures means something.

But I'm also uncomfortable giving the message to our colleagues at CMS and say to them, you know, there's not enough information here. We can't even advise you to move forward on this.

I'm pretty comfortable that I want to give them the message. Yes, you grapple with this. Find the risk models.

Develop the details that Gene says are missing. Because we can't endorse them as unique measures without that information.

But, I would be loath to vote that there's insufficient information to endorse moving forward on this. That's my comment.

CO-CHAIR RAPHAEL: Thank you. Bruce?

MEMBER LEFF: Yes, thanks. So, just another potential unintended consequence that comes by having each of these measures on a separate ledger as it were.

So, I wonder whether accounting for these different venues each separately, could actually lead to discouraging imaginative partnerships within health systems?

So, if you think about at least in theory perhaps, a lot of the fat in care delivery being in the hospital, it could be that a good home health agency would partner with a hospital

that's not particularly efficient.

Take some of those people out of the hospital earlier. Help the hospital keep their costs down. Maybe raise the costs on the home health side.

And if they're engaging in some sort of shared savings arrangements, that's something that by keeping separate ledgers might be discouraged in this kind of system.

The other question I have is, are costs that are not covered by Medicare captured in this equation?

So, I don't know if anyone saw the front page of the New York Times today, looking at, you know, basically prices.

Price is God, right? People are finally coming to the realization that you really have to think about price of things.

So, it seems like there was actually very little relationship between Medicare costs in the market and private insurer costs in the market. And those needs depends a lot more on

the characteristics of the providers in the market.

So, I'm just wondering whether in any way that was being captured. Is there price shifting going on, you know, in the secondary -- on the secondary side? Secondary insurer side.

Just some things to think about. And I agree. I would just endorse Paul's comments as well.

CO-CHAIR RAPHAEL: Okay. Sean?

MEMBER MULDOON: Clarify for me -- and it matters more on this one because it is costs where cost shifting is probably desirable under a lot of these arrangements.

This only applies to fee-for-service traditional Medicare. And therefore, creative arrangements done under ACOs, bundles, and risk sharing arrangements would be systematically excluded from this.

Is that true?

CO-CHAIR RAPHAEL: I only know that Medicare Advantage is excluded. And I don't want

to say that ACOs and bundled payments.

My assumption had been that they were excluded. But I would want to have that confirmed.

MEMBER MULDOON: That was -- well, that would be the caveat to your concern. Because we really do want post-acute care in the next five years to be saying, this use to be good for me.

But not good for the whole episode. And let's move those dollars around, so again.

And second question, I think is a comment. And being that these are statutorily required, these -- development is going to continue regardless of what this Committee votes. Correct?

So, if that's the case, then, you know, we either just punt the thing and say too messy, we don't want to mess with it. Or we get on this slow moving train and say we'll figure it out as part of the process.

So, that would -- if that is true, it

would lean towards a vote to -- with a lot of reservations, to continue development.

CO-CHAIR RAPHAEL: I think that's an important point. Because to be realistic, if, you know, we're not -- none of the votes that we would in fact engage in, would pull the train off the track.

The train is going to continue on the track. So, we need to be aware of that.

This is tied to the IMPACT Act. It has time frames dependent on it. So, just so that we are doing this wide-eyed, if not bushy-tailed.

Okay. Deb?

CO-CHAIR SALIBA: So, this follows up on some comments that folks have made. And Ms. Lee made this comment as well.

I do want to -- I understand that the MSPB is moving forward. And that's a good thing.

But, I want to make sure that in parallel, there is consideration given to how this translates into value measures. Because I

think that ultimately is where we want to head.

And it may be important as you're developing these measures to bear in mind that you want them to be part of a value-based measure. It may influence some of the ways that you set this up ultimately.

Because I do think we don't want to just be going to the lowest bidder. I thought Jim's -- I smiled because Jim always has great stories to tell. So, thank you for another one.

Because we really don't want to be in a position where it's just about cost. It's got to be the combination of, you know, bang for the buck kind of approach.

CO-CHAIR RAPHAEL: Cari and Suzanne, do you want to add anything at this point? And then we're going to turn it over to Kim.

MEMBER LEVY: In following on what Deb said. And I know this will be accounted for, and I guess I can't understand and I probably should be able to.

But, will this be something that's

reported in real time? I mean, will this potentially be a hot potato patient?

Because we've had this happen where we know that there's people who are spending a lot in our system. And they suddenly become this hot potato where we didn't want them.

We didn't want to touch them anymore because they were spending so much. And we had some who spent $3 million over the span of a year.

And they became a hot potato and no service wanted them. Because they were causing all these troubles.

And so, if it's going to be obvious to anyone that this is one human being who's costing them a lot, that is probably not a great situation.

MEMBER MARKWOOD: My question was primarily a process question too. I mean, it sounds like because statutorily this will move forward that the best value that we can have in this discussion, and we've had a lot of

discussion about concerns raised about elements of this moving forward.

Is, if we did vote to keep it under consideration, would there be other opportunities for this Committee to have to dig deeper into some of these issues that we've raised as major concerns?

CO-CHAIR RAPHAEL: Lisa?

MEMBER WINSTEL: I just wanted to raise one more unintended consequence. Because as people are discharged, whether it's from home health or from an IRF or whatever, if they are discharged sooner, if there is a goal of reducing costs, the burden of care is going to fall on the family care giver.

And that family care giver is going to ultimately, and we know this from comprehensive research, then be forced with a choice of whether or not they have to leave the workforce themself.

They're going to be forced to either pay for care that is not covered. That is home helpers and aids. Hence, bringing on more out of

pocket costs.

And then ultimately, and again, we know this from research, that family care giver, who could also be a Medicare beneficiary, will then have their own health issues.

Because it is well documented that the family care givers because of stress and the fact that they're taking care of somebody else and ignoring their own issues, then becomes a patient.

So, as we transfer the burden of care out of the system and into the home, we might ultimately be driving costs up.

CO-CHAIR RAPHAEL: Suzanne, back to you.

MEMBER KAUSERUD: Thank you. I just want to amplify Deb's comments about value. The value conversation here.

And I know that we try to look at the measures kind of in a vacuum. But, it's important to also put them in context.

The -- I think there's general support

for Medicare spend for beneficiary measure. I think it's a really important measure.

But, I think it becomes pretty weighty if -- in the inpatient rehab setting because our one proposed measure for value-based purchasing, we have only one measure listed in the proposal. And it is Medicare spent for beneficiary.

So, for that setting, it's really important that the measure be -- not be -- that it be done well.

Because I would anticipate that if the measure gets passed through as one of the quality IMPACT Act measures, it would be the same one that would be used in the Value-Based Purchasing Program.

So, I do definitely, I don't want to say that we're not supportive of them, the measure. I think just the details are very important.

CO-CHAIR RAPHAEL: Okay. Kim?

MS. SPALDING-BUSH: Okay. Thanks everyone for all of your feedback.

So, I think first I just want to speak to something that I understand, I wasn't present yesterday. That Alan addressed yesterday about whether or not we would be able to bring the measures back with further information.

Which is something we can't guarantee we that we would do. But even if our statutory time lines don't permit us to do that, I just want to assure the panel that we are held accountable for your comments.

So, when these measure, you know, go forward for further stakeholder feedback, we do have to respond to the things that you have raised. We do address all of those.

So, I don't want you to feel like even if they don't come back that they won't be considered. That they won't be taken into account.

I mean, that we won't be responsive to them. Either in adjusting the measure to address them. Or explaining clearly why we weren't able to, you know, given our construct here.

So, just to start with that. And then I think the other big point I want to make, is that we are actually looking at setting specific measures here.

So, I think a lot of the concerns that were just raised, aside from that maybe a one measure across all settings would actually potentially in a sense some increased care coordination.

But, I think there are some issues with doing that. And at this point, we're actually looking at setting specific measures.

So, there are things like that the patients are inherently different in these settings. That we may not be able to recognize those differences in our claims.

So, therefore we wouldn't be able to appropriately risk adjust for them. That's an issue that we don't have to deal with because we're doing setting specific measures here.

So, LTAC patients are compared to LTAC patients. The risk adjustment is being done at

this case mix level because it allows us to better predict what the spending would be for a patient within that setting that falls into a certain case mix type group.

And then the rationale for not using the DRGs for the RUG codes, is that those are, at least to some extent, under the influence of the providers. When they do their assessments.

When they classify those patients. When they predict what level of therapy they're going to need in the SNF. They've set them into a RUG group.

And so if we risk adjust based on those, I mean, it's a less objective, I think measurement. Whereas the, you know, the group that they fall in based on their diagnosis is a more objective way for us to estimate what we expect the spending to be.

So I want to also apologize that we didn't provide a little bit more background information for you. I think it would have made it a little easier to digest some of this.

I think we made an assumption about what's out there around the hospital level measure. And some of the information that we provided to the panel, didn't get into those technical terms that we used in that measure.

But, so just to sort of explain, I think some of the questions that I heard around expected spending, et cetera. So the numerator of the measure is the observed spending divided by the expected spending.

So, what that observed spending is, is what we see within the treatment window. Which is 30 days for most of the settings. It's 60 days for home health.

And we look at what we observed during the window and the post-discharge set time frame. We adjust for things like geographic wage index differences.

So, we take out those urban/rural payment differences that the Medicare program imposes through our payment systems. We also adjust for add on payments for teaching

hospitals.

So, the IME payment comes out. You're not looking more expensive because you're a teaching hospital. Disproportionate share payments come out.

So, the standardization kind of levels the playing field so to speak. So, we take out wage index, geographic practice cost index, and some of those incentive payments that are in there to support broader Medicare program goals.

So that the facilities and providers who receive those aren't looking more expensive just by virtue of providing those services that CMS has decided are important.

It also takes out any other value-based incentive payments that people may have. So, if they're receiving a penalty for example, under some program, they're not going to look less expensive.

It sort of neutralizes all of that. So, the numerator of the measure is that observed spending, standardized payments divided by the

expected spending. Which is the risk adjusted amount.

So, that's how we get our risk adjusted spending. We take a look at the patient's diagnosis prior to the start of the episode, as well as some other factors.

You know, and we'll provided detailed specifications of course, you know, as the measures move forward with what exactly is in the risk adjustment methodology for each setting. And then that's divided by the national weighted median.

And what we mean by that is that it's case weighted. So a larger facility that has more cases for a given price, is going to weigh more into the denominator then a smaller facility that has fewer cases.

So, I hope that makes sense. It's sort of the facility or the agency's own spending amount divided by the national average. Where their own spending amount has been adjusted for the patient's severity of illness and their age

and some other factors.

So we don't do socioeconomic status adjustment as the measure is currently constructed. We do hear the concern with that.

It's something that we're continuing to explore. But we're cognizant of the work that's going on in parallel in that space.

So that NQF has undertaken is in the middle of this two year, you know, trial of looking at socioeconomic status adjustment. The Assistant Secretary for Planning and Education, ASPE has also been required by the IMPACT Act to take a look at socioeconomic status adjustments.

So, at this point as the measure is currently constructed, it doesn't include an adjuster for that. The idea being that we're just looking at the patient's clinical status and their clinical picture to describe how we expect their Medicare costs to look.

And so, it becomes more incumbent on the provider to manage some of those other issues. But, we are willing and open to taking

into consideration any of the results that come out of the work that's going on concurrently in the socioeconomic adjustment space.

So, I think -- what are some of the other questions that I heard? We don't exclude the dual eligibles. They're in there because we have a full Medicare claims picture for them since Medicare would be their primary payer.

They don't appear to be less expensive. Unlike a Medicare Advantage patient, where we wouldn't have the Medicare Advantage claims in our claim system.

And so for ease of implementing the measure, you know, reducing the burden on the providers, this is a claims-based measure. So, we do exclude patients who become enrolled in Medicare Advantage for part of this -- the episode window.

Because they would look less expensive just because Medicare Advantage was paying for some of the services. Which isn't the case with the duals.

CO-CHAIR RAPHAEL: So, before we move to a vote here, let me just check. Pam, did you want to make a comment?

MEMBER ROBERTS: I just had a little bit of clarification. You just mentioned, so the start of the episode is -- the diagnose for the start of the episode is from their acute care start diagnosis. Not from where they're going?

MS. SPALDING-BUSH: Can I -- and I'll invite the Acumen Team on the phone to correct me if I misspeak. Because they're the technical experts.

But it's from prior to the start of the episode, we take a look at claims submitted for 90 days prior to the admission to the setting. And then Acumen, is the diagnosis billed at the actual post-acute care setting also included in the risk adjustment model? Or if Lori's here.

DR. FEINBERG: Yes, I'm -- hi, I'm Laurie Feinberg. I'm a physician from Acumen.

And the 90-day look back is for the

risk adjustment. The post-acute care episode starts with admission to the specific post-acute setting.

It's in that way unlike the hospital measure, which does three days before. We thought that in this setting, our -- that it would -- and the TEP agreed with this. That the look back of three days is different.

So it starts with the admission. It goes through the end of the admission. Or, in the case of the home health agency, a 60-day period, which would be the episode of care even though the patient might have had less than 60 days.

And then it continues for 30 days beyond that time of discharge, or the 60-day episode.

CO-CHAIR RAPHAEL: All right, that --

MEMBER ROBERTS: Wait, I have one more question.

CO-CHAIR RAPHAEL: Oh, I'm sorry.

MEMBER ROBERTS: So, the other

question is, for States that have nursing staff ratios, is that included? Because that would increase their costs.

DR. FEINBERG: I'm sorry, could you repeat that?

MEMBER ROBERTS: Yes. For States that have nursing staff ratios that have for different levels of care that will increase their costs. Has that been adjusted for?

DR. FEINBERG: Remember we're looking at Medicare expenditures. So the expenditures are not their costs.

In other words, it's what Medicare pays the facility.

MEMBER ROBERTS: Okay. Thank you for the clarification.

CO-CHAIR RAPHAEL: Deb?

CO-CHAIR SALIBA: Thank you. I understand that it's claims-based. And about expenditures.

And I certainly understand the issues with the RUGs being, you know, often based on

utilization as opposed to just the characteristics of the individual.

With that said, I think it's really important to think about functional status as an adjuster. I mean, you've got those data sets available to you. I know they're not in the claims.

But, it -- study after -- work after work after work, these forward have shown that that's a huge predictor of cost. So, I would encourage you to think about it.

You're nodding, so.

MS. SPALDING-BUSH: Yes. Thank you for that. And we are interested in learning a little bit more about how the functional status indicators impact cost.

As the measure is currently constructed, we don't intend to use the functional status indicators. It has a lot to do with the way that the statute was written for us.

Which says that we can use claims elements as well as standardized assessment

items. Which are currently in the works of CMS.

So, it's certainly something that we'd be open to future refinements for the measure when those become standardized. And then the law would clearly allow us to use them to adjust our predicted cost for the measure.

So, yes.

CO-CHAIR RAPHAEL: And I have three concluding comments. And then we're going to move to a vote. Liza?

MEMBER GREENBERG: This sounds granular. But it will help me conceptualize the measure a little bit more.

So, if a patient is admitted to a hospital from home health, does it matter how expensive that hospital is? Or is there like a standardized, we're dinging you this much for your admission.

It doesn't matter if you went to an expensive university hospital or one that's not going to do many interventions. And so, your total cost for that would be lower.

MS. SPALDING-BUSH: We would include that -- unless it was an excluded admission, which we have some exclusions for planned admissions that are consistent with the readmission measure. That was the Yale RTI Methodology.

So, if it was not a planned admission that got excluded, or a treatment for a congenital issue, but if the hospitalization is included, we include all of the Part A and B Medicare payments that occurred during that stay.

And we do take out the teaching hospital adjustment, those kinds of things when we standardized the cost. But, if they do go to a hospital that provides them with more treatment, more complex care, more expensive care, it would be captured in the measure.

It's important to note too, though that this measure also exists in the hospital space, which is nice. I mean, we are now working at aligning our incentives across our programs.

So, in the hospital Value-Based

Purchasing Program, the measure does exist. So there is that incentive there as well.

But that hospital most likely would generate an episode around this admission also. So, we've got an incentive there for them to try to provide efficient and effective care that would reduce their own downstream costs.

So, they're sending the patient back to that SNF, you know, with the hope that that patient's healthy, isn't going to get readmitted. And I guess healthy that's not a good choice of words.

But, you know, the patient is stable. You know, unlikely to be readmitted. You know, and that they've managed the care well within a hospital setting.

CO-CHAIR RAPHAEL: Bruce?

MEMBER LEFF: Yes. Another -- I'm just trying to think of this here, and it's fuzzy.

But is it possible another unintended consequence since it's per beneficiary cost,

could this scheme provoke say unsavory actors, not so much from cherry picking, but taking more easy cases to extend their denominator reduce per beneficiary cost?

I'm just wondering about that. So, you take people into home health or a SNF who, you know, were kind of on the border.

But now, you know, now that's actually good for me. Because I'm going to reduce my per-bene cost. I might look bad in the claims. Or I might just kind of sneak by in the claims.

So, could this actually one unintended consequence be to actually increase unnecessary utilization?

CO-CHAIR RAPHAEL: And Gene, the last comment?

MEMBER NUCCIO: Just two quick comments. One, I'd like to support Deb's comment about conceptualizing this in terms of how it might be used in a value-based model. Which we are clearly all going to.

And the second part is, again is a --

I was a member of the NQF TEP on sociodemographic risk adjustment. And you need to think broadly beyond socioeconomic to more demographic issues. Which includes health literacy and those kinds of matters.

And clearly that -- we were talking about patient compliance, which we did yesterday, in terms of these things. And you need to think very broadly about that.

CO-CHAIR RAPHAEL: You know, as I've listened, this is clearly more complicated than trying to measure Medicare spending in a hospital. I must say.

You know, I think we started with different populations in the different settings. You have patients who go to multiple settings that you have to capture.

And that's expected. That's good. We want them to go to multiple settings.

And I think the whole issue of what's excluded to me is complicated. Because you bring someone in who's had a hip replacement and

they're depressed.

Their diabetes goes out of control. And they land back in the hospital. And how you ferret through what's attributable, what's not attributable, I think becomes very complicated for certain patient populations.

And I think functional status really does become an important factor as well. That being said, I think for us the question is, given that this train is on the track, given that we would like to influence the station that it ends up in, what is the message that we want to send to CMS?

We have three options here in our voting. To support continue, encourage continued development, not encourage continued development, or insufficient information.

I mean, two messages that I heard, but I don't know that we can put this into our categories, is this really needs to be connected to value. Because it can't just be cost alone.

And the other thing is, there's just

a whole variety of unintended consequences that we have identified. I think the panoply is pretty broad.

So, we can -- I don't know if we have the prerogative to recommend that CMS bring this back to us. There's no way we can ensure they're going to follow our recommendation.

But, we can make a wholehearted recommendation that they do bring it back to us. So, those are just some thoughts that I have.

And I don't know if NQF Staff want to say anything. But, I would like to see if we can add a recommendation to whatever vote we take. Right?

MS. O'ROURKE: Absolutely. And we've been capturing all of the caveats and the lists of unintended consequences that the group has been discussing.

And we will summarize those and put them in the rationale. And we can also include that these measures are a particularly unique case.

And make a strong request for CMS to bring them back for MAP review in the future. With the caveat that that is CMS's decision. That we can't guarantee anything.

CO-CHAIR RAPHAEL: Right. Okay. So now, can you please all take your device. And we are going to vote.

And can you just review the three categories, Laura, so everyone is aware? One, category one is --

MS. IBRAGIMOVA: So, right now we'll be voting on the recommendation for IMPACT Act Medicare Spending Per Beneficiary, MUC15-1134.

Your choices are encourage continued development, 1. Do not encourage continued development, 2. Or insufficient information, 3.

(Voting.)

MS. IBRAGIMOVA: So today we only have 20 voters. So the results are 65 percent encourage continued development. Five percent do not encourage continued development. And 30 percent insufficient information.

CO-CHAIR RAPHAEL: So, given our rules of 60 percent, then it's number one. Is that correct?

MS. IBRAGIMOVA: Yes. So, combining -- yes, so it's 65 percent.

CO-CHAIR RAPHAEL: Okay. So it's go onto the next one.

Okay. Laura, this is the second one.

MS. IBRAGIMOVA: So now you'll be voting on MUC15-287. Your choices are 1 encourage continued development, 2 do not encourage continued development, and 3 insufficient information.

(Voting.)

MS. IBRAGIMOVA: So the results are 70 percent encourage continued development. Zero percent do not encourage continued development. And 30 percent insufficient information.

CO-CHAIR RAPHAEL: Okay. So it's number one, right? Onto our third one, 289.

MS. IBRAGIMOVA: So now you'll be voting on MUC15-289. And your choices are 1

encourage continued development, 2 do not encourage continued development, and 3 insufficient information.

(Voting.)

MS. IBRAGIMOVA: So the results are 71 percent encourage continued development. Zero percent do not encourage continued development. And 29 percent insufficient information.

CO-CHAIR RAPHAEL: Okay. And now we're at number four, the last one, 291.

All right, this is our last vote.

MS. IBRAGIMOVA: So now -- you are now voting on MUC15-291. Your choices are 1 encourage continued development, 2 do not encourage continued development, and 3 insufficient information.

(Voting.)

MS. IBRAGIMOVA: The results are 71 percent encourage continued development. Zero percent do not encourage continued development. And 29 percent insufficient information.

CO-CHAIR RAPHAEL: Okay. So let me

thank everyone. And we're going to break for ten minutes.

Forgive the shortened break. But we are a little behind schedule.

Before we break, I just want to be sure I welcome Carol Spence, who was on the phone yesterday. And I'm glad she can join us today in person.

So, see you back at 11:50 -- 10:55.

(Whereupon, the above-entitled matter went off the record at 10:45 a.m. and resumed at 11:03 a.m.)

MEMBER LEVITT: Okay. I'd like to thank everybody for coming back from the break on time. And we're going to ask the back of the room to resume their seats, please. So I thank everyone for coming back on time. And let's get started. We're moving on to looking at the Hospice Quality Reporting Program. Is the Operator with us? Are we back online?

OPERATOR: Yes, you are.

CO-CHAIR SALIBA: Thank you. Can you

open the lines for public comment.

OPERATOR: If you wish to make a comment, please press star one.

There are no comments at this time.

CO-CHAIR SALIBA: Okay, thank you. The measures on the consent calendar are Hospice Visits when Death is Imminent, and Hospice and Palliative Care Composite Process Measure. I'd like to invite members of the audience to come to the mic and make comments. Is there anyone? Okay.

(No response.)

So hearing no one's at the mike, so we'll move on. Laura, is there anyone on the chat box?

MS. IBRAGIMOVA: There are no chats.

CO-CHAIR SALIBA: Okay, great. So I'd like to move on to ask Peg to give a brief overview of the QRP and the measures that we're talking about.

DR. TERRY: Can you hear me? So great. So I'm going to start with the Hospice and

Palliative Care Composite Process Care Measure, and many people here may know about this measure. It is a composite of seven NQF-endorsed measures. And I'm going to just mention them, so you hear what they are. People in the world of hospice understand these measures quite well.

The first is treatment preferences, the least values addressed, pain screening, pain assessment, dyspnea screening, dyspnea treatment, and patients treated with an opioid who are given a bowel regime. This is, as both measures are, encouraged to continue development.

The second measure is Hospice Visits when Death is Imminent. And the death which is imminent is one week prior to death. This is a measure that measures basically -- let me scroll down and find this real quickly -- it's a measure that measures the visits by certain individuals, certain professionals, as well as individuals who are volunteers.

And included in the visits in the last week before death are visits by nurses, licensed

professional nurses, nurse practitioners, hospice aides, physicians, physician assistants if acting as the attending physician, chaplains, spiritual counselors, therapists, which includes physical, occupational or speech therapy, medical social workers and volunteers. So it's a broad array of professionals and volunteers that are included in visits in the last week prior to death. As I said, these are both measures that are encouraged to continue development.

CO-CHAIR SALIBA: Thank you. CMS.

MEMBER LEVITT: Thank you. Thank you very much. I guess the first comment is the second measure that was mentioned, actually there's been a change in the measure. I think we sent the updated specs to NQF based on the changes. I apologize, Peg, if you didn't get the changed specs. But is it okay if I just explain --

DR. TERRY: Sure.

MEMBER LEVITT: So the second measure, same concept that we are all -- I think that's

been a noted concern of the care giver community, stakeholder community as well to ensure that, you know, visits are done prior to death being present. And this has gone through care giver workgroups. It's gone through TEPs as well, and even pilot testing of what would be some new items that would be added to the hospice item set to account for and be able to look at these sorts of visits.

And what came out of the testing and the TEP was that we need to have more than just what was kind of listed initially as this one single measure. And we've actually broken it up now into two different measures. I'll have to look a little bit at my notes. But the first measure is a measure that's really looking more at clinical care and care coordination. And that's look at, specifically at a 3-day window. And the visits on those would be from what you would think they'd be from: physician, nurse, nurse practitioner or physician's assistant that we'd want to have a visit from one of those

within the last three days prior to death.

And then we've also got then a second component to the measure. And the second component is again this concept of the last week. And that this would be more towards the individualized type of care that a person or a family would want to have during that final week prior to death. And that would be for social workers, chaplains, spiritual counselors, licensed practical nurses and hospice aides. And the requirement would be to have at least two visits in the last week.

The volunteers was actually, was actually taken out of the measure because during the testing there were concerns of excess burden for volunteers. So that was actually removed from the measure. But it's absolutely the same concept that was brought in the initial specifications but just want it to be more, more clear about it.

To us it's a very important measure. It's a measure, like I said, that's really been

asked of us multiple different ways. It was pilot tested, like I said, in the summer at nine different hospices. It will require more testing now that we, you know, changed to have these two different measure specifications. But and the TEP has been very favorable to everything that we've done. In fact, we followed the TEP's recommendations on this.

The first measure is, as Peg said, is a composite measure of the existing measures that are on the hospice item set. They would -- again those, that, there would be no excess burden associated with that.

One thing just to note about that is that in the midst of us developing this composite, we are requesting, because we don't -- we normally seem to own a lot of these measures, but we don't own these measures in terms of being the measure steward on these measures. And as of now, there's a length of stay restriction on these measures in terms of 7-day exclusion that we really think should be brought down to one

day. And so we're going to try to work with the steward while we're also having this composite, to work at changing what we think is an exclusion that needs to be changed. That's it.

CO-CHAIR SALIBA: Okay, thank you. And Carol and Art were our reviewers on this.

MEMBER STONE: I would, I would defer to my eminent member of the panel, Carol, who is the expert on this part of it.

MEMBER SPENCE: Thank you. So I'm not sure which one to start with. Let's go with the imminently dying one. This is a really, really important area. And we're very happy to see that CMS has focused on, on this, you know, care of the dying patient, imminently dying patient. Not only is it a critical time for symptom management to the patient but, don't forget, the majority of hospice happens in the patient's home or in their residence, which could be a nursing home.

And that means the family is providing the day-to-day hands-on care. So support for the family is also a very critical piece.

Patient/family is unit of care. You've heard me say that in here before, but I can't, I can't emphasize it enough for hospice. So this is why a broad look at everyone who is going in there is really important, because the entire hospice interdisciplinary team is providing the care. Each one has a role to play, especially at this time. And so to be able to take this broad look at everyone who's going in really does round out the picture, not only of the care being provided, but of the holistic approach to hospice care.

So having said that, there are a couple of issues. However, I also didn't understand the official update on the measure. So that does address one of our concerns with the length, you know, length of stay issue.

The other complication on this, and you all may not all be that familiar with hospice payment, but payment reform for hospice was part of the ACA, and that has been implemented in the last final rule and will start January 1. And part of this is an increased payment for RN and

social work visits in these last seven days. And so having a, you know, a look at most of this, -- let's put it this way: that will have some influence in this too because there, you know, there may be an increase in RN and social work visits just because of the payment structure.

So there needs to be a focus on quality of care from this measure, measure standpoint, with just the idea that payment piece is in the background. So the other piece of this is -- and this is what makes hospice care rather difficult to create quality measures for -- hospice is not one size fits all, it is individualized care. The patient and family have a lot of say. They are partners in determining their care; it is not prescriptive.

And so there is a possible unintended consequence, we've heard lots of those, for every single measure, of hospices wanting to look like they're providing -- they want to be outstanding when public reporting in the STAR system comes for Hospice Compare. We need to be careful that

the care provided is suited and matches the needs and the wishes of the patient and family. And while this may sound a little silly, we don't want care being provided or we don't want people going in that the patient and family don't want.

And we want those visits to be meaningful, thoughtful, directed visits and not somebody just stopping by so they can get the check box that they, you know, had a visit by each of these disciplines as it's being measures. Should I go on and talk about the composite one since you were talking about it earlier?

CO-CHAIR SALIBA: Yes, Carol, that would be good. Thank you.

MEMBER SPENCE: Okay. So the composite, as Peg pointed out, what it does is take seven measures that are already in place. Data collection is ongoing for those, creates a composite. And there has been no public release of data on performance on those measures. However, we have reason to believe that these are basic process measures, that performance on those

measures is probably pretty, pretty high. And, therefore, having a composite for those measures does make sense.

One of the problems here, length of stay, though, comes into play. And in hospice there are -- there's a 48-hour window to have a comprehensive nursing assessment. There's a 5-day window to have the rest of the comprehensive assessment by the rest of the team. And so for a third of the patients in hospice, you know, die within, you know, within seven days.

So those length of stay restrictions on the original measures could eliminate a third, you know, of the patient population. On the other hand, hospices that have even a more significant proportion of their patient population with a short length of stay, three days, you know, less than three days -- three days is not, you know, I can't give you the proportion but it's also very high -- may not be able to get all of those seven measures accomplished.

And again, we don't want unintended consequences. We don't want the check box being predominant because of the quality measure. When you go into a home and that patient, on day of admission is actively dying -- and I've had that as an admission nurse. It is not an unusual occurrence. In that situation, you are going to think about what parts of that assessment are relevant to that patient and you are going to want to be providing the care and addressing the family's concerns and needs based on your assessment of those needs, not the check box of the quality measures that are supposed to be covered. So, you know, that is a concern.

And then the other piece for public reporting -- again these are process measures -- the public is not familiar with hospice processes. And then when you create a composite measure, that complicates that even more. So there's going to need to be a lot of succinct but thoughtful and very explicit explanation of what these measures mean and the significance of them

when it comes to public reporting. Thank you.

CO-CHAIR SALIBA: Thank you very much. Art, did you have anything to add? Art, did you have anything to add?

MEMBER STONE: No.

CO-CHAIR SALIBA: Okay, thank you. So these two items are on the consent calendar. Did anyone want to request that they be removed from the consent calendar for individualized voting?

(No response.)

Okay. So we'll proceed with discussion of these two items. And the floor is open, so anyone that would like to comment? Jim, your tent is up.

MEMBER LETT: Thank you. Just a couple of things. One is only it may be hard to fulfill this because only in retrospect do you know the last seven days of life. So I presume there is some -- and if you know what those markers are, let me know, because I'm going to be intensely interested, personally --

MEMBER SPENCE: It's a crystal ball

that each hospice nurse gets, you know, when she's --

(Laughter.)

MEMBER LETT: The second thing is, putting on my SNF hat, skilled nursing facility hat, we in long-term care in the post-acute arena see a fair number of hospice patients, both for respite and even for post-acute care.

So I would just ask as you all go ahead with this measure -- part of it is what personnel see them in the last seven days in life. Well, in the nursing home you're going to have all the same players that you do in hospice. So which, does the SNF nurse count, does the SNF chaplain count, does the SNF attending physician count because we often take care of the instead of the hospice medical director when they're in long-term care?

So that was one. The other thing is under the exclusions was asking what is meant by general in-patient care? Does that include a skilled nursing facility, as an in-patient care,

or is it only hospitals? So some clarification I think would help.

And the other thing is maybe an exclusion around if death occurs within a predetermined amount of time from the hospice referral, that is, if the hospice gets the referral and the patient dies that day, which sadly is not all that rare, or within a few days, is that really an adequate period of time to fulfill this multi-headed other measure? Thanks.

CO-CHAIR SALIBA: Sean?

MEMBER MULDOON: Looking at the numerator of the number of people who received, essentially, any touch from a hospice person in the last week of life, implies that a lot of people are in hospice and aren't seen at least once a week. Is that true? Because if it's not true then the -- it is true?

CO-CHAIR SALIBA: So for folks on the phone there was a head nod from some of the content experts on that. So, Paul, did you want to?

MEMBER MULHAUSEN: So I'm a former hospice medical director and attending physician. And we, you know, especially in the sphere of dementia care and staged dementia care it would be not unusual for a person to go a week and not be seen by one of the formal hospice providers until nearing death.

CO-CHAIR SALIBA: Lisa.

MEMBER WINSTEL: Thank you. Thank you for the clarification, Alan, because I think that some of the changes that you described addressed many of my concerns. Because while all of the different and varied hospice providers are important, since some families prefer to not have some, but medical care is different and the visits, separating out the visits by a clinician, by the doctor or the nurses as one group, and the other hospice workers as another, I think is a step in the right direction.

Because too often we hear that it was really great that the volunteer came by, but there was still a pain medication that was not

being delivered. So capturing those both I think is very important. I also want to continue -- encourage you to continue looking at that period of time, that window, because it's limiting to seven days you are actually not only just excluding a third of the population, but some of the families and the patients who are in the most distress.

CO-CHAIR SALIBA: So we've heard seven's probably not what people want. Any, any comments about what the alternative might be?

MS. BRAZIL: Hi. My name is Michelle Brazil. I'm a lead for the Hospice Quality Reporting Program. For the hospice visits when death is imminent, we do not have a length of stay exclusion.

CO-CHAIR SALIBA: Liza?

MEMBER GREENBERG: I just wanted to indicate support for both measures. I think they're really important and will be important in the sense of providing quality. I think there are a few technical things to be addressed in

terms of, you know, requirements about when visits occur, when assessments occur, figuring out which touches count towards it.

And also, maybe, some finesse about how exactly we want to impose accountability for those very urgent referrals that occur within 24 hours of death, or three days of death, when we really need to focus on making sure the patient gets what they need, not necessarily hitting certain metric and milestones. But I think it's overall incredibly important measures, so thanks.

CO-CHAIR SALIBA: Tara?

DR. McMULLEN: Lisa, so the second part of the death when imminent assesses patients receiving at least two visits from the social workers, chaplains, spiritual counselors within the last seven days of life, where the exclusion it seems to me to be the overall aim of that intent, of that measure. I saw your face of confusion, so I just wanted to clarify that for you.

CO-CHAIR SALIBA: Alan?

MEMBER LEVITT: I guess further clarification, but also to answer a question. The measure, the measure that has the two measures in it, it does exclude patients with one day length of stay because the feeling is that the two visits that would be necessary for that second component to the measure would not be able to occur in that. But otherwise there is no length of stay exclusion.

As Tara just mentioned, there are different time windows for both measures. And that was the choice of the technical expert panel that felt that if the care coordination and clinical care one, which is actually three days, you know, one visit within the last three days, if that was extended out to seven days, we would see, very quickly, a topped-out measure.

The technical expert panel felt that we needed to have a shorter window on that first component to the measure, whereas the second component was the two visits within seven days. So it really is two different time windows, two

different purposes almost. The general in-patient care, I'm going to need to look at Michelle Brazil for a nod on this, but that did also include nursing homes; right? Nursing home and in-patient hospice? Waiting for a nod. Okay.

CO-CHAIR SALIBA: She's checking on that.

MEMBER LEVITT: Yes, yes. It also excludes, if you didn't notice in your measure, if you have continuous home care it would exclude it as well, so. Michelle, you need to turn it on.

MS. BRAZIL: For residential nursing home visits it would be included. So if the patient is receiving that residential level of care that would, the nursing visits and the hospice interdisciplinary team visits would be included.

MEMBER LEVITT: And the other levels?

MS. BRAZIL: So if a hospice has a contract to offer in-patient care, whether it's a

hospital, a nursing home or their own facility, then it would be excluded from that piece. So patients that are continuous home care, patients that are receiving respite, and patients that are receiving in-patient care, because that care is being provided around-the-clock for that patient.

MEMBER LEVITT: Does that answer your question, Jim?

MEMBER LETT: It does.

MEMBER LEVITT: Okay.

CO-CHAIR SALIBA: Carol?

MEMBER SPENCE: I was just going to back up a little bit from what Michelle said in that I'm not sure everybody here even understands the four levels of hospice care. These are designated levels. It's not setting specific. The level of care is an intensity, you know, so to speak, designation. So that GIP, that general in-patient care, there's a separate, there's additional regulations that go with that. There are additional requirements.

I can be provided in a nursing home.

You know, the setting is not the critical piece. It can be a, you know, a free-standing in-patient unit that the hospice owns. It can be a hospital that contracted that. It can be a nursing home contracted, but the main thing is that the hospice is responsible for this more intense level of care.

It's for acute management of symptoms and then you move back to a less intense, you know, level of care. So and the same things for continuous care. It's one of those designations, expressed as one of those designations. Though, Alan, you just said respite. And how does this measure fit or not fit? Is respite also not part of this?

MEMBER LEVITT: That is correct. That's an exclusion for the first measure.

CO-CHAIR SALIBA: Other comments? Questions? Thoughts? Any comments or thoughts about this exclusion window? Carol, did you -- and there's different exclusion windows for the different items. Any comments that you wanted to

bring up about that?

MEMBER SPENCE: No, again I just because I haven't seen the second or the newest, the latest version of this, the one-day exclusion applies to both measures, or just the imminently dying one?

MEMBER LEVITT: It's to the measure itself. If you have a length of stay of one day, because you can't complete both measures, so.

MEMBER SPENCE: But it doesn't apply to the composite?

MEMBER LEVITT: No. The composite measure is not. The only exclusion for the composite measure would be any exclusion from the component measures.

MEMBER SPENCE: Okay, so you're including those? Because that wasn't clear under the exclusions. Again, the list said, you know, 18 years was the only exclusion, but it also said that you had to be in the numerator from the other measures. And those other measures -- six of those other measures have a 7-day exclusion.

MEMBER LEVITT: Right. And again, that was one of the other discussion was that we'll be working with the measure developer to change that.

MEMBER SPENCE: To change that.

MEMBER LEVITT: Yes. Yes.

MEMBER SPENCE: Yes, okay. All right.

CO-CHAIR SALIBA: That's why I was inviting comment, because since that is under development and being considered, if there were other comments about what that should be if it's not set out.

MEMBER SPENCE: You know, it cuts both ways because, again, you don't want to take out a third of that patient population but you want to be fair to hospices who, as the example I gave, where you're walking in and that patient is dying that day, you know, your bowel program opioid measure is not relevant. It wouldn't even begin to address it. So some, some way to understand that you still need to put the patient and family first and not measure box check-off first.

CO-CHAIR SALIBA: Thank you. Cari?

MEMBER LEVY: Just a quick clarification. This might be in the updated material. But it does say on this specification that respite is not an exclusion. And I'm assuming that the reason for having general, in-patient and continuous is because they're in, the staff are in there so frequently it wouldn't make sense. But respite wouldn't necessarily be that way. Would that be correct?

MEMBER SPENCE: That was why I was double-checking on respite. Respites done in a nursing home?

MEMBER LEVITT: Right. Correct me, but my exclusions were patients receiving continuous home care, in-patient respite care, and then the general in-patient care.

MS. BRAZIL: That's correct. I'm sorry, yes, it was in-patient respite care. My mistake.

MEMBER SPENCE: Okay.

CO-CHAIR SALIBA: So, Carol, you --

MEMBER SPENCE: So I'm still confused about where a nursing home comes in in this because in-patient respite is not the same as GIP. Respite is done -- has to be in a facility.

MEMBER LEVITT: Right. And that's true. It's in-patient respite

MEMBER SPENCE: That's what you're calling it?

MEMBER LEVITT: Right.

MEMBER SPENCE: Okay. So respite is off the table then.

MEMBER LEVITT: In-patient.

DR. McMULLEN: And, Carol, I think there's a deep knowledge that a lot of these measures, the population of case mix, will tie into that nursing home setting. And so, since we have the Nursing Home Quality Initiative and the SNF Quality Reporting Program, we're looking at those trends, and the confluence of data, what those mean when you have that one patient who is maybe in that nursing home setting whose using that health benefit. We call it the hospice

benefit on the MDS, so we are looking into that. And those are discussions we have at CMS a lot.

CO-CHAIR SALIBA: Yes. Okay, any other questions, comments?

(No response.)

Okay. So, we have agreed that this was by assent, that it would stay on the consent calendar, and so there is not voting at this point. So we'll move on to the next agenda item. The next agenda item is looking at the, let's see, we're looking at the -- oh, this is Erin. Erin.

MS. O'ROURKE: Yes.

CO-CHAIR SALIBA: We wanted to have you talk about the MAP and long-term care core concepts discussion.

MS. O'ROURKE: Great. Thank you, Deb. So, given how much has changed in the post-acute care/long-term care world and the number of new faces that we have around the table, I wanted to give you a little bit of the history of the core concepts, and then open it up for discussion to

see if these are something that we need to re-look at, do they need to be refreshed? Does the group still agree with our core concepts, since they've really been a framework that the PAC/LTC Workgroup had used to guide their decisions about measures under consideration.

So to give you a little bit of the history, the PAC/LTC core concepts were a key element of the coordination strategy that the PAC/LTC Workgroup developed back in 2012. The group realized at the time it was not possible to align around a particular measure across settings due to issues such as differing populations, services provided, and data sources.

However, the group realized that a person-centered approach that assessed care across an episode could allow measurement to move beyond the current silo of -- or the site-specific approaches and better integrate PAC/LTC measurement with hospital and clinician measurement.

So the group identified six highest

leverage opportunities for measurement for post-acute care and long-term care providers. And within these areas the group identified a set of 13 core measure concepts. And the group has used these measure concepts to unify their work across the various settings where they review measures, recognizing that while aligning at the measure level might not be possible, progress can be made by assessing the same concepts across types of care.

So if you take a look at this slide it shows you the high-leverage areas and the associated core concepts. It's a little bit small, so I will read them out for everyone. You'll see the core concepts are functional and cognitive status assessment, mental health, establishment of patient/family care giver goals, advanced care planning and treatment, experience of care, shared decision making, transition planning, falls, pressure ulcers, adverse drug events, inappropriate medicine use, infection rates and avoidable admissions.

So on this slide you will see where each of these core concepts are currently addressed in the Quality Reporting Program for each setting. If the box is gray, there is at least one measure addressing the concepts for that program. So there are still some fairly significant gaps in the programs around the PAC/LTC core concepts, particularly around some of these more challenging to measure issues.

Next slide. So with that, I'm happy to take any questions or welcome any reflections from some of the longstanding workgroup members who were around when we developed these, if anyone wanted to jump in. If not, we can turn back to Deb for discussion.

CO-CHAIR SALIBA: Don't worry about showing your age by commenting. Can we go back to the slide that shows the core concepts? Back one more. That shows that. I think that will help if people can reference that as we're, as we're talking. Jim, you have your tent up.

MEMBER LETT: Yes. I'd be remiss as a

representative of the National Transitions of Care Coalition not to point out that we do not have care transitions called out. We talk about transition planning, which is not the same as actually by gum doing it. So I think either effective, or quality, or whatever other adjectives we want to put with it, but I think that's a big gap and a big hole, personally. Thanks.

MEMBER LAMB: I think when we started this -- and I'm not afraid to say I was here in the beginning -- was that care transitions really was a huge priority, and that we needed to get a handle on that before we looked more broadly at the concept of care coordination.

Since that time there has been a measurement gaps group that has re-looked at the whole framework for care coordination. And I think it might be a good time for this group to re-look at the care coordination framework and think beyond just transitional care, and to look more broadly at the whole framework. Because I

think a lot of the discussion that we've been having over the last day-and-a-half really is it has a transitional care and a lot of the unintended consequences were related to that, but I think we could have a bigger frame that is much more consistent with the current thinking that came out last summer.

CO-CHAIR SALIBA: Gene.

MEMBER NUCCIO: Perhaps because I'm part of the new group, can you go to the next slide that shows the coverage area? There is experience with care, there is the CAHPs measures that are out there. Have they not come through NQF for endorsement?

MS. O'ROURKE: So they've come through NQF for endorsement. This slide shows where they're being currently used in each of the quality reporting programs, so a little different from their endorsement status or what MAP has reviewed. So this is actually used in a program.

MEMBER NUCCIO: Thank you for the clarification.

CO-CHAIR SALIBA: Other -- yes, go back to the other slide. There you go. Thank you. So, were there any other comments or questions? So let's start with just asking, from these high-leverage areas, are we good on those? Robyn.

MEMBER GRANT: So under goal attainment it talks about establishing the goals and advanced care planning and treatment, but there's not necessarily anything there about attaining the goals. So you could establish them, but not necessarily achieve them.

CO-CHAIR SALIBA: Okay, thank you. I noticed that too. Okay, other thoughts about the high-leverage? Yes, Gerri.

MEMBER LAMB: Along the same lines that Robyn was just talking about, one of the areas that's being looked at in care coordination as a meaningful outcome is not related to goal attainment, and if you look at the new framework it's not framed that way. But the other one is unmet need, and that seems really very appropriate to our discussions here, so we may

want to look at kind of the shifts in concepts and focus.

CO-CHAIR SALIBA: And for unmet need, are you thinking of that as a high-leverage area or as a concept that would go within one of those high-leverage areas?

MEMBER LAMB: You know, it's not clear to me because goal attainment is an outcome. But that one in the care coordination framework is -- there was huge discussion about whether that was the relevant way to frame it. And so it could go under an outcome for the leverage area of care coordination, but it may be also worthwhile to look at goal attainment and whether it is high leverage, or whether that needs to be re-looked at.

CO-CHAIR SALIBA: Liz.

MS. PALENA HALL: So under the category again of care coordination I just wanted to point out that one of the IMPACT areas that is required is also around the area called accurately communicating health information and care

preferences when a patient is transferred. I just wanted to point out to you that, you know, in terms of IMPACT -- and another key point of IMPACT is around interoperability.

So we, I think there are a number of -- this is also an area under 1.C and I think also through other HHS programs where we're certainly looking at transitions of care and how health IT can support that. So there's a lot of work that's going on through our -- our work, at least 12 states that are looking at post-acute care settings and those transitions and how -- and the information that's needed to be exchanged, as well as the work flow and processes.

So I think as measures such as this come forth there will be some information to share. I just wanted to point out, though, that that is an area that is an area that is taught out by IMPACT.

CO-CHAIR SALIBA: Thank you. Jim.

MEMBER LETT: One area that I think

might be worth expanding is education. That is, as -- of the family/patient unit. As we move further into establishment of their goals, advanced care planning, experience of care, shared decision making as we move more and more towards a patient engagement empowerment role, we have to give them the tools to make those good decisions.

I don't want them flipping the coin as to whether or not they should put in a feeding tube. We have to at some point educate them on what is good and what is not good about that, and then engage them in, okay, help me with your goals, help me with your decision and we'll follow it. So I'm not seeing education anywhere there.

CO-CHAIR SALIBA: And are you thinking of that as a core measure concept that would go under one of the high-leverage areas? Safety?

MEMBER LETT: I'm not sure. I don't see a high level -- high-leverage area that it fits under well. Maybe goal attainment, or

patient engagement. Oh, thank you.

CO-CHAIR SALIBA: Great, thank you, Jim. Paul.

MEMBER MULHAUSEN: I had a couple of thoughts. I don't know how helpful they'll be, but I thought rather than not share them I would share them, as my error. So the first one would be symptom management, and I think about what I do as a physician in long-term care settings besides helping achieve these goals. Symptom management to me is a very important area in which I think it would be helpful to get feedback on how we're doing. Although I think you could potentially put that under goal attainment, the two core measure concepts here in my mind don't quite capture that.

And then the other one is a reflection on what I think is happening in long-term care which is intensification of the medical side of care in the spirit of improved efficiency, and I worry that it might lead to some degradation of quality of life. And I know that's a nebulous

kind of concept, but -- and you could even wrap all those into, well, if you achieve those things, the quality of life is better.

But are we capturing the quality of just living out one's life in these settings that we're discussing as we feel the pressure to make it part of a more efficient care flow?

CO-CHAIR SALIBA: Thank you. Joe, Joseph.

MEMBER AGOSTINI: Yes, it strikes me in looking at these that even though inherently a team-based care is required to achieve a lot of these performance areas, you don't explicitly mention interdisciplinary expertise, whether it's physical therapy, behavioral health, nursing, you know, all experts working together to achieve some of these performance areas and goals.

CO-CHAIR SALIBA: Thank you. Tara.

DR. McMULLEN: Yes. I was going to note that these type of conversations really, really -- it's productive, it's important to CMS. We like to hear what's important to NQF and our

stakeholders. And I was wondering if after the conversation today and receiving feedback in the summary report, if panel members had any recommendations for measures, primarily goal attainment. That's something that definitely stands out to me as something that's a very important concept.

So are there measures that are being developed or are currently used as your gold standard in your setting or your practice or whatnot that, you know, would be a good concept to assess? I think that would be most helpful. I don't know if that's what this is about, but.

CO-CHAIR SALIBA: Bruce.

MEMBER LEFF: Yes, just to -- I would amplify Paul's comments regarding, you know, potentially quality of life as a high-leverage area might be something to add to that list.

CO-CHAIR SALIBA: Carol.

CO-CHAIR RAPHAEL: I just wanted to also affirm what Paul said. One of the things that I often think about is how to not over-

medicalize goal attainment, because as we try to work on metrics, I think we often move toward things that are quantifiable.

So that if someone's goal is to get to their grandson's graduation, or to be able to meet for coffee with his or her buddies in the morning, that's what they want to do, you know, and mobility is kind of on the road, and functional status is on the road to doing it. To me it's how do you capture those things that really matter to people that's part of the fabric of their quality of life that we never think about as we think about what are the goals that we can count and really weigh?

So that's just something that I want to be sure we don't lose sight of as we move along on that path to goal attainment. And that is what motivates people. That's what's going to help them to recover. That's what's going to lower the cost of care and produce a better quality of life and patient experience.

CO-CHAIR SALIBA: Thank you. Other

thoughts, comments? Oh, I'm sorry. I hemianopsia here.

(Laughter.)

MEMBER MARKWOOD: That's okay. We're sitting over here in the corner. I just wanted to echo those thoughts as well. And just to ensure that the social determinants of health get incorporated into, directly into the work. Because I think that, you know, to echo Carol's comment, I mean oftentimes the goal attainment is to be able to walk my dog rather than it is to be chronically free of pain. So I think the thing is is just to have that as an overlay into the work that we do.

MEMBER WINSTEL: Well, Carol and Sandy have been very, rather, eloquent about this but I want to add to it the other issue of perhaps we need to, as facility-focused as we are, look at that perhaps a patient and family's choice is that the patient wants to stay at home, for example, as long as possible. And that if the goal is to age in place, the goal is to not go

into a facility, then measuring the days in in-patient rehab, for example, starts to take on a different measure. Of if a patient declines an in-patient setting and prefers more home health, and taking that and sort of translating that into the facility outcome.

CO-CHAIR SALIBA: Liza.

MEMBER GREENBERG: I think in looking at this list it's extremely important, and very patient centered, and I really like the direction it's going. If we could develop our measurement approach around these, I think we would move the system towards more patient-centeredness. I wanted to amplify two suggestions from the room. One was around symptom management, which I think is also palliative care, and I think that's a very important component to many patients.

And unmet need was called, but which is also access. And I think not having access drives patients to higher levels of intensity, which can potentially be around higher cost levels as well.

So I think putting those in there, plugging them in, could be an important element. And I think once that list is in place, you know, if CMS can look at it in terms of alignment of benefit coverage as well, I think that would be real important. Because a lot of times we drive things to really perverse directions because we don't have the right benefit coverage, and so patients have to seek, you know, meeting their needs in other places. So that's another element.

And I just wanted to return to the first slide which said the LTC Workgroup said it was not possible to development an alignment strategy due to differing populations, services provided and data sources, and point out that the IMPACT Act has really transformed that equation. And with 75 million bucks and some legislation you can go there.

So I think that's pretty awesome. And maybe the care coordination might be the next thing that we could tackle with one of those

incredibly complicated statistical measures that does capture a lot of elements, so.

CO-CHAIR SALIBA: Thank you, Liza. Kim.

MEMBER ELLIOTT: I think one thing that we just really need to specifically state in there is family involvement, family engagement.

MEMBER LAMB: I wanted to go back to what Sandra was saying. You know, when I look at the high leverage areas I don't know that it quite fits, but I think it's really critical that we -- particularly for this group, that the social determinants be called out in some way.

I was at a meeting last week where I was hearing about new measures of social complexity. And for the first time they were beginning to really pull out the stuff that we deal with in the community really that makes it difficult or easier to achieve outcomes. And while it's not sort of the pillar, it's a cross-cutting. And I'd hate to lose what Sandra was talking about. And I thought that whole construct

of social complexity that folks are beginning to deal with is really a critical one for us to consider.

CO-CHAIR SALIBA: And we might could see it as something that's a concept under cost and access. It's certainly an access issue, so.

Other -- Liza, did you have more thoughts? Okay.

Anyone else that had thoughts or comments? This has been really, really helpful, and great ideas. Is there anything? And as Tara said -- Clarke.

MR. ROSS: I just wanted to share with the group two measurement systems used in the world of intellectual disability that might be helpful in making some of these concepts come to life. And one is the National Core Indicators and the other one is the Personal Outcome Measures. Both of these systems are 20 years in operation.

And the National Core Indicators just in the last two-and-a-half years has been

expanded through the National Association of States United for Aging and Disability to apply to persons with physical disabilities and people who are aging. And I just will read the three major domains in both of these areas to give you how important some of these concepts are and how less important some other concepts are.

So in the National Core Indicators we have a whole bunch of measures around individual outcomes, how the individual beneficiary sees their world and how the world responds to them.

We have family outcomes, how the family who supports the individual beneficiary sees the world and how they can be helpful and supportive to the individual.

And then we have the more traditional health and wellness and systems kinds of measures that most of you are very comfortable with.

In the area of personal outcome measures, similar -- slightly different concepts but similar three domains.

Myself. And so these are a series of

person interview questions around the individual about how the person views themself in the daily world.

My world. My world is more where I live and how the structure of who I live with and the rules of where I live and what rights and freedoms I have to get a beer at four o'clock in the afternoon or have a guest spend the night or something like that. So my world domain questions.

And then personal outcome measures have my dreams. Given where you're at today and then these are measures for all adults who have intellectual disabilities, so we're talking about young adults, you know, 20, 21 through 80 and 90-year-old folks. But my dreams are you have a reality of where you live and how that's structured today, but where do you want to live in the coming five years? And how do you want to get there? And can we help you get there?

So I just wanted to report that there is 20 years of operational experience in the

intellectual disability world with two different measurement systems. And we are experimenting and piloting them with the Administration on Community Support Financing in the area of physical disability and aging.

CO-CHAIR SALIBA: Thank you.

Robyn.

MEMBER GRANT: I wanted to thank Clarke for raising those points because I think that's very helpful. And as you were saying that, that made me think of a core concept that comes up in our work with consumers all the time, and that's autonomy and control. And I guess, you know, you could work that into some of these. But it seems to me that it's so important that it might rise into a highest level or a organizational concept.

CO-CHAIR SALIBA: Thank you, Robyn.

MR. ROSS: Can I respond to that?

CO-CHAIR SALIBA: Yes.

MR. ROSS: So I was going to wait till we discussed the next topic, measure gaps, that the Duals Workgroup has developed seven measure

gaps that we developed in 2013 that were reaffirmed in '14 and reaffirmed in 2015. But three of them are exactly -- three of the seven are exactly what Robyn has identified.

The first is goal-directed person-centered planning and implementation.

The second is shared decision making.

And the third is beneficiary sense of control, autonomy and self-determination.

And, again, we do have, through the National Core Indicators and the Personal Outcome Experience, questions and measures on how to get to these. But we don't have it for the broader population. That's why it's a measure gap.

And that's why this morning I spoke about how important measure development is because we have these little -- I mean there are hundreds of thousands of people that are affected, but we have these population-targeted measures. And we need to pilot them and adapt them for the larger population.

But three of the seven measure gaps in

the Duals Group are the points Robyn raised.

CO-CHAIR SALIBA: Thank you.

So to recap, and we have a lot of great ideas. I took two pages of notes while everyone was talking. So thank you. And to echo what Tara said, if you have other ideas, please let the MAP work team know and/or Tara. Thank you.

So that was a great transition to the next item on the agenda which is identifying gaps or discussing gaps. So, Sarah, would you like to pick up?

MS. SAMPSEL: Sure. And I feel like we've already crossed over this -- into this quite well. But I think what we wanted to do in this portion is kind of review not only the measures that had previously gone through rulemaking and the gaps and the core concepts that have been filled previously in multiple areas, but also these tables don't reflect anything that's in this current rulemaking cycle. So it doesn't reflect anything that has not yet

gone through the Coordinating Committee and out for public comment, et cetera.

So in some cases you are going to have to shade in your head in where we filled in some holes. But we wanted to use these, too, to continue to draw out those gaps and those measurement ideas. And I think we really heard in the discussion about the core concepts some of those areas. But we wanted to open the floor, too, to exactly what Tara asked is where are there measures in development that we may not know about, that CMS may not know about, that we could really start doing some outreach and some follow-up?

Because you also heard Chris talk about, you know, NQF really working on getting the measure incubator up and going. And so this is an ideal opportunity for us to look for additional partners on filling those gaps and what might be the NQF/CMS role, et cetera.

So, Erin just showed you this slide. This slide identifies across the four QRP

programs where the core concepts have been identified previously and where we'll obviously do some morphing of this based on our most recent conversation. But, you know, is anybody aware right now of any measures that we're missing in these areas that could give a leg up to the next step towards measure development and testing?

Clarke.

MR. ROSS: Well, one, most everybody around the table probably is aware it's happening, that's the CMS Home and Community-Based Service Experience Survey which is an adaptation of the CAHPS measures. So sitting on the Duals Workgroup we have learned for three years how the survey is designed but we haven't seen any results. And so we're getting antsy because this holds tremendous potential.

And they've interviewed thousands of people in 13 states or something, and experimented with how to frame the questions and which questions work in what environments. So we just want results as quickly as possible.

And the other area, the National Institute of Disability funds a university-affiliated program at Westchester Institute in New York. And the Westchester Institute people have taken the CAHPS survey for clinicians and adapted it for people with severe intellectual disability. So the assumption that certain people can't answer their own questions, there's a lot of work being done to demonstrate they can. But this is three years and we still have -- we have findings of how adaptations have been made but not any recommended CAHPS changes.

But those are two very important things that are happening that we're hoping we can translate into delivery one of these days.

CO-CHAIR SALIBA: Thank you.

Lisa.

MEMBER WINSTEL: I am sure that many of you around the table are familiar with the current PCORI-funded project, Project ACHIEVE, which is looking extensively at transitions of care, at patient-reported outcomes, at caregiver

experience. It's a multi-year project. We're not going to have outcomes from the project for a while. But I do believe that since they are going to be looking at many of the things that we're looking at here, that it's going to be able to either recommend or inform some very substantive and well-informed measures around this.

CO-CHAIR SALIBA: Will you spell out that acronym, please?

MEMBER WINSTEL: Oh, P-C-O-R-I.

CO-CHAIR SALIBA: No, not PCORI.

MEMBER WINSTEL: Oh, sorry. Oh, Project ACHIEVE. Oh, the acronym for ACHIEVE.

Oh, I pulled this up here. It is Achieving Patient-Centered Care and Optimized Health in Care Transitions by Evaluating the Value of Evidence.

CO-CHAIR SALIBA: The brainpower that went into that. Thank you. I just wanted to make sure I heard you correctly.

MEMBER WINSTEL: Yeah. ACHIEVE.

CO-CHAIR SALIBA: Okay. All right, thank you. Kim.

MEMBER ELLIOTT: Along with what Clarke was talking about, there is also a functional assessment that's being tested in the home and community-based setting by many states. So that might also be beneficial.

CO-CHAIR SALIBA: Thank you.

And I think I jumped the gun. Apparently Sarah has more slides. Sorry, Sarah.

MS. SAMPSEL: It's totally fine. Why don't we just go ahead and go through the slide -- the next slide.

So, you know, just as another exhibit. And, of course, this is the great example of where there are some more holes that we could be filling in this slide in the near future. And as -- certainly as CMS is taking into consideration the feedback that you've all provided them in the additional development of their measures but, you know, we felt it was important to bring up the IMPACT Act domains.

And as you've rightly identified earlier, you know, the core concepts came out before the IMPACT Act. So now we're kind of seeing everything come together. And one of the things I think we'll have to consider as a workgroup and with staff and with CMS, is do we need both the core concepts and the IMPACT Act?

We certainly have heard from Tara and Stacy in our fall webinar that while these are the main IMPACT Act domains right now, we're not limited to those domains, and CMS is not limited to those domains. So they really do want to think broadly.

So we just -- we wanted to bring this up as an additional exhibit of, you know, where work is being done, where some focus is being made. And, obviously, we've talked about many of these areas so far today.

Next slide.

And then with the Hospice QRP which is a little bit different since it's not falling under the IMPACT Act, these again are areas that

have been identified as high priority areas for measurement, and then where we can map across where there are existing measures in the Hospice QRP. You know, this is an example of a program that does have the CAHPS survey in it already with the Hospice Experience of Care survey. And that recently came through as an endorsed measure as well through the person- and family-centered care work.

But there continues to be holes here. And you see at the bottom there's not only what we've talked about is the unmet need, but then there's the unwanted treatments. And so how do you change that dynamic when we're talking about the hospice patients? And I really do think that's a different discussion to have.

And I think Karen is still here. Karen Johnson in the back, who will be leading NQF's palliative care work for consensus development coming up in the spring and in next year, so that we will be seeing more measures coming out there.

Next slide.

So before we go to public comment, just again this is our last call -- well, not last call, you are welcome to email us at any time. But really want to know did this generate any additional ideas for measures, measure concepts that should be prioritized that we can make sure get into our final report to CMS?

CO-CHAIR SALIBA: So now discussion. Jim.

MEMBER LETT: Well, I'm going to be the one-trick pony around care transitions again. Thirty-day re-admissions is not a particularly good quality measure. Hasn't been. Won't be, according to the experts that I've talked to and read from.

So I'd like to see us go more to measuring did your transition actively give the correct information in a timely fashion, in the proper way to the next site of care? And does that site of care then respond to the sending entity that says, hey, I got it, I have a few

questions. Or, I didn't get it. Or, Ms. Jones got here and things are fine.

We have a very passive, I think, posture in terms of measures around transitions. Did Site A send all the information they should to Site B? Not did Site A ensure Site B got that information, ask for feedback and be responsive to questions? And then did Site B take that information and act on it?

So it's a difference between hearing and listening. That is, just sending a package of information to Site B from Site A doesn't ensure any action, doesn't improve quality, doesn't even mean anybody read it. So I would like to see us create measures that reach across those divides. And God forbid practitioners actually talk to each other about patients as they move through sites of care, and of course involving the patient and family with it.

The other piece of that is if there is some way NQF -- I know that we are not a measurement development organization -- is there

some way you can connect organizations who want to develop measures? I have the part of two of them that would love to. But it is just prohibitive in terms of resources and time in volunteer organizations to try and pony up cash and get the statistical work done behind them.

So if you can find an organization that will fund or assist, hook it up, put it out there so that other organizations with great ideas can put them into action. I think it would help a lot with the gaps.

CO-CHAIR SALIBA: Thank you.

Alan.

MEMBER LEVITT: I may be hastening my departure from CMS, but I just wanted to make sure, I know it just came up about should we still be doing our work here because the IMPACT Act is out there. And does measurement gaps, core concepts, does any of that matter?

I mean I just want to reinforce that the answer is yes. That, you know, I think Congress did get it right in terms of the IMPACT

Act and the domains it has chosen. And we can argue about the time lines. But, again, I think that's all important.

But what this represents is what we all in the post-acute care community -- now I'll put on my post-acute care hat -- feel is really important as well and that, you know, we need to continue to promote what we think our core concepts are, what the gaps are. Because we shouldn't just cede the entire quality of the programs that are so important to us to Congress. This is our job and it's an important job. And, you know, in both my hats I find that this sort of dialogue is really important, so.

CO-CHAIR SALIBA: Thank you. And the long-term care piece as well, I think -- I'll have to think about.

Gene.

MEMBER NUCCIO: I'd just like to ask that NQF look at or encourage measure developers to think more integratively, if you will, joining process and outcome. Much like we talked about

yesterday with the falls measure where what the provider does and the outcome of that.

If I can coin a term or semi-officially, I would call that an efficacy class of measures which joins process, outcome and perhaps even cost, and when they begin developing these measures within the domains that you've already provided.

So just as we've seen our process measures come to NQF historically as, did you assess? Did you put it in a plan to make a difference? And did you do something? And have each of those individual ones endorsed by NQF, we've now seen today -- in these last two days, composite measures where you take the entire set of steps and put them into a position.

I encourage that the measure developers think to integrate both process and outcome, okay, in the future set of measures that we begin to consider.

CO-CHAIR SALIBA: Thank you.

Liza.

MEMBER GREENBERG: Whenever I hear anyone ask for what more measures do we need, it sort of strikes fear in my heart from the provider's side because being new in my job I've had to learn about the 26 Home Health Compare measures and all the value-based purchasing measures and the, you know, coordinated care for joint replacement measures. And there's a lot of measures out there.

So I would just also urge us to maybe consider as part of the MAP role, you know, working towards NQF submission of parsimony, and trying to think about what needs to come off the table or what can be clustered in a composite measure.

Because, again, not only is it burdensome to agencies to -- it's not that the reporting is as burdensome as it used to be, but thinking about them all and improving them all, especially when they've topped out. But it's confusing to consumers. You know, to a consumer when you try to go through Home Health Compare

and you're like, you know, expanding and contracting the little buttons to figure out what's what. I think that the stars are a huge step forward. But you know, then really looking at what we can retire.

CO-CHAIR SALIBA: Thank you.

Gerri.

MEMBER LAMB: Two things. Wanted to just reinforce what Liza and Jim were saying in terms of working on more composite measures that really close the loop. That's been a real issue for the care coordination domain of getting these one-part check-listing things coming forward, plus not getting anything coming forward in the last year.

So I really would just support what Liza was saying is maybe this can be a focus area as we look at more complex measures in the future.

The other was to go back to what Joseph was talking about with teamwork and interprofessional care. And the National Center

for Interprofessional Practice and Education is really looking at kind of best in class measures. And there is a new measure of teamness that folks at the University of Oregon, Virginia Tilden, has been developing, and the psychometrics are quite good. And so we may be on the verge of looking at better measures for how teams perform as a process measure for linking to outcomes. And that may be really important as we get to attribution.

CO-CHAIR SALIBA: So, Gerri, National Center for Interprofessional --

MEMBER LAMB: -- Practice and Education.

CO-CHAIR SALIBA: -- Practice and Education. Okay.

Sean.

MEMBER MULDOON: I'll take some risk at piling on with the providers' viewpoint. But I would like to reiterate that providing people with data is just the first step of a long process of interpreting the data, troubleshooting

the data, developing plans, and then starting your own PDCA cycle.

And it reminds that when balanced score cards are discussed, one of the -- one of the key components is the fact that if you've got 30 elements on your balanced score card, you don't have anything that people will ever respond to.

So if ultimately we're trying to help consumers make better decisions, and providers do some QI and ultimately use some of that for VBP. Just recognize that at some point the pendulum goes the other way, and the more you know, the less you actually can act on.

CO-CHAIR SALIBA: Thank you.

Cari.

MEMBER LEVY: Yeah, and following on that, I'm just thinking of I review a lot of post-acute care charts, and 98 percent of what I look at has nothing to do with the human being, it has everything to do with meeting requirements. Right? And it's checking a box

and it's generating paper. And there's so little about the human in a chart.

And so to the extent that what we're doing here can increase the amount of attention we pay to the person that's there, I think that would be a wonderful thing to be able to do with what we're trying to accomplish.

CO-CHAIR SALIBA: Thank you.

Carol.

CO-CHAIR RAPHAEL: I just wanted to kind of follow up on what Sean said, because I always try to think about what can we do that's actionable and that sort of really moves the bar for quality upwards.

And, you know, AARP, the SCAN Foundation and the Commonwealth Fund have done this score card on long-term care. And it takes the states and it scores them. And I think it's five domains: access, affordability, something on quality, there was caregiver support. And I can't remember the fifth.

And they first did it in 2011. And I

have to tell you I got calls from four different governors' offices like, how could this be? What does this mean? You know, how could we be 41 on, you know, the list of states here? Because Americans, I've discovered, love rankings. And then they just re-did it this past year in 2015, and almost every state improved.

So, you know, I do think there is something to be said for kind of keeping it in a manageable group that you can really digest and act on. Doesn't mean, you know, that we don't have many roads to travel here, but I think the core should be really what is consequential.

CO-CHAIR SALIBA: Clarke.

MR. ROSS: I wanted to report on one other measure gap identified by the Duals Workgroup. And this will make Sandy's day too.

One of the measure gaps is the absolute importance of non-medical, frequently non-profit community-based organizations for both people with disabilities and elders. And they get neglected by both CMS and the National

Quality Forum because the funding are hospitals and the four IMPACT groups and, fortunately, home- and community-based services. But they're all siloed. And they're siloed at the National Quality Forum.

And so one recognized the absolute importance of these non-profit community organizations, thousands and thousands of them across the country. That's the daily interface that most people who are outside an institutional setting have who are disabled and elderly are with those organizations, not with the ones that we're focused on.

And then related to that concept, I don't know how many of you know that ONC and ACL have a long-term care electronic record discussion group that has been going on every week for almost a year. And it's one little domain, the domain of electronic health records, and how do we make this link between medical facilities and the non-profit community-based organizations?

So there's this little network that has no official standing, it's just whoever wants to join. But there are a lot of state disability and elderly -- aging folks on the calls who just brainstorm about this linkage issue through the vehicle of the electronic health record.

CO-CHAIR SALIBA: Liz.

MS. PALENA HALL: I'll elaborate a little bit more on that because I am one of the federal leads for that effort. And so behind that is actually some CMS Medicaid work. And so there's a grant called TEFT as we affectionately know, and part of that -- so there's four components of TEFT, some of which is the CAHPS -- the CAHPS tool that was discussed, the care assessment and modifications to that, and also the standards work.

So in partnership with CMS we have a weekly group. It's through the ONC Standards and Interoperability Framework. And so there are seven states that participate in that work, they're grantees. And so they are required to,

as part of their grant work, to pilot standards that are being identified.

And so we also coordinate quite a bit with the NQF HCBS Workgroup. And so right now the standards work is in a phase where we are starting pilots. So it's not only states but also non-private sector entities that are beginning to pilot some of this work.

So I think we certainly would have -- I think there was some discussion about potentially presenting to one of the other workgroups on where those pilot organizations are at. And so we can share some of that, inform, you know, some of the NQF workgroups.

So but there is -- and I would say that in terms of the standards work, it will go through a number of phases of piloting. So it will not only -- they'll not only be piloting this year but also through 2017.

CO-CHAIR SALIBA: Thank you. And the other part of your comment, we -- our center at the VA just got a large grant from the VA to do a

better job of integrating at the point of discharge from the hospital, integrating our veterans with community-based organizations and services. So I think that's also an area that is coming along but, correct, it's still a gap.

So any other? So I think there was one -- there were three topics that Sarah brought up that she wanted us to think about. And I think we've covered some of them: measure gaps and domain, domain sufficiency from the IMPACT Act. But we didn't talk about Hospice QRP. Did anyone have any comments that they wanted to talk about in terms of the Hospice QRP?

Lisa.

MEMBER WINSTEL: Just to really encourage development around the timeliness and responsiveness of care.

CO-CHAIR SALIBA: Anyone else?

Clarke.

MR. ROSS: My brother-in-law died in May and was the recipient of hospice. But the thing I want to share is that the professional --

the professions were great, the nurses and social workers. The support personnel, the people who were supposed to come and help with bathing and toileting, were absolutely horrible and not dependable.

So when we think about quality measures we tend to focus what should the nurse do and that's great. But the day-to-day grunt work that makes quality of life is frequently the non-professional aide kind of person. And so please remember that.

CO-CHAIR SALIBA: And I was assuming, Lisa, that your interprofessional group included that type of --

MEMBER WINSTEL: Well actually, most specifically I was referring to medical assistants, talking about end of life when there's an absolute need for pain relief and the next time you see somebody is 36 hours later. That's not acceptable.

CO-CHAIR SALIBA: Earlier when you mentioned the National Center for

Interprofessional Practice and Education, was that you? Maybe that was Gerri.

All right, any other comments, thoughts about Hospice QRP?

(No response.)

Okay, thank you, guys.

So we'd like to open the floor now for public comment. Can we check -- have the operator check on the line and see if there's anyone that would like to contribute online, on the phone?

OPERATOR: Okay, and at this time if you would like to make a comment please press star then the number one.

There are no comments at this time.

CO-CHAIR SALIBA: Thank you.

And in the audience here today, is there anyone that would like to make a comment, please?

MS. LEE: Teresa Lee with the Alliance for Home Health Quality and Innovation.

I want to thank this group again. You're clearly just a really thoughtful group.

And I appreciate the candor and openness from CMS as to where things are today.

And, you know, the one thing that occurs to me in this conversation about measurement gaps is that there's just been a lot of ground covered today. I've just heard so many different comments, all really meaningful, all really constructive. And we've sort of focused in today mostly on the IMPACT Act domains that are enumerated. But it is contemplated in the IMPACT Act that there might be future domains identified and pursued.

And I think that this body could be a good one to sort of think comprehensively and in a streamlined, meaningful fashion about what further domains CMS might wish to take up once they get past the enumerated domains that have specific statutory deadlines.

So it's just something to think about for the future. Certainly something that I would want this group to be very careful about. I, like Liza, you know, worry about just more measures.

You know, there -- home health, we're the poster child for lots of measures. We've got lots and lots of measures. And it's, you know, there's not -- I think that a lot of them are meaningful, but now we worry that, you know, how do we focus our quality improvement activities when there are so many measures?

So if there's a way to think about it comprehensively to give CMS some recommendations about, you know, what's the way forward, I think that all of us would be very interested in helping to support those activities. Thank you.

MR. HILLMAN: Thank you to the committee again.

This is Troy Hillman from the Uniform Data System for Medical Rehab. We represent roughly 900 subscribers, both in the in-patient rehab skilled nursing facility and long-term facility that are collecting data utilizing the FIM instrument as well as all of these quality initiatives and measurements that are being examined by the NQF and created by CMS and other

measure developers.

A lot has been stated today about the IMPACT Act and about the specific deadlines. And one of the things I really question is, at what point do we require that these measurements that we're all being held up to and that we need to consult, educate, train, and have each of these providers the ability to collect the data and examine their -- when do we require that these go through a fully developed and tested process?

A number of you on the panel today asked whether these measures would come back through the NQF process for endorsement. Now, while we know that there are specific deadlines stated within the IMPACT Act, there's also provisions that the Secretary can remove and/or suspend any of these measures at any time through justification in the Federal Register. Do we, as part of this NQF process request, as part of our recommendations forward, that the Secretary examine the potential for removing or suspending these requirements until such a time as they can

answer your questions that you've asked today?

We truly appreciate all of the consideration given by this committee and by this panel, and especially for CMS and their measure developers in the process. But, again, we come back to the question of we have measures that look to be implemented this coming October or the next October or, depending on which program you're in, being implemented where you begin collecting the data.

At this stage we're becoming the data collectors for the validation of measures that have not met these requirements yet. And at what point do we, as a committee, or you, as a committee, and we, as an industry, begin to ask that these measures go through these fully developed and tested measurement endorsement processes?

Again, thank you so much for your time. I hate being the last one, as I was yesterday as well. But again, thank you so much for your time, for your consideration and for

your thoughtfulness. Thank you.

CO-CHAIR SALIBA: Are there any other comments from the audience so that Troy's not the last one?

(No response.)

Okay, thank you so much. So I think we're now going to talk -- just summarize the meeting for the day. Carol, do you want to?

CO-CHAIR RAPHAEL: Well, let me just very briefly -- first of all I want to thank CMS and Alan and Tara. Really, you know, you do not need to go through a multi-stakeholder process. You are not required to. You chose to. And I think you have exhibited the fact that you really value the guidance and input that this group has provided.

So I really want to thank you. And, you know, you have -- we have seen a real evolution in that partnership over the time that we have all been involved in this. So thank you for that.

Secondly, we are involved in a new

process that, you know, I don't know if I would call it its infancy, but maybe it's even before giving birth. Who knows what stage we're in, but we're in an early stage in developing a process that really works, when measures are kind of not yet crystallized and not at the scientific level that we have historically been accustomed to.

So we have used something that we've been doing in other workgroups with the consent process. I'm assuming, unless someone raises a hand at this juncture, that everyone understands the process, that you have assented in all instances to the actions that we've discussed and agreed upon. And that we still continue to wish, and particularly in certain areas, that we will have more involvement and ability to shape the final measures that emerge and that will be worked out.

I wanted to just ask Erin to review next steps. Where do we go from here?

CO-CHAIR SALIBA: One person has their tent up. So, Jim.

MEMBER LETT: Tell me if this is the appropriate time. Just a suggestion for process for next time.

I really backed into liking the Lead Discussant concept. When I got the agenda and I saw I was the Lead Discussant for a number of those, I first panicked. And it -- but it made me really in depth read the measures, look at the exceptions, even do some research, background research about them, which I think helped me understand these measures a great deal more.

There are, frankly, I think too many for any one person, who also has a job, to be able to go through them in significant depth. I would probably suggest that next time that we meet, when you assign Lead Discussants, as you obviously have topic based on the organization or the person involved, to make them responsible basically for knowing that core set of measures they're going to comment on so that they can really make some terrific refinements, suggestions to this panel, as well as to CMS and

our other partners.

CO-CHAIR SALIBA: Thank you.

Erin, I'll hand it back.

MS. O'ROURKE: Thanks, Deb.

So just to briefly run through the upcoming steps.

We'll be releasing the draft recommendations for public comment on December 23rd. And that will run I believe through January 12th. January 12th. So please be on the lookout for that if you'd like to make any formal written comments on the draft deliverables. I will be putting out the workgroup recommendations as well as the draft programmatic guidance. So we'd appreciate any feedback and input from the public or from members of the workgroups.

The MAP Coordinating Committee will be meeting on January 26th and 27th to review and finalize the MAP pre-rulemaking input. So we'd welcome anyone who is interested in following that meeting to attend as a member of the public or dial in. You can see the MAP webpage for more

information.

And then, finally, February 1 we'll be releasing the spreadsheet of every measure, with the recommendation and rationale. And on February 15th, we'll be releasing the programmatic guidance, or the written deliverable that goes a little bit more into the workgroups' guidance and more cross-cutting issues.

CO-CHAIR RAPHAEL: Are there any questions about the process moving ahead here?

CO-CHAIR SALIBA: I just want to thank everybody for their input today and yesterday. I think we heard a wide range of input and very constructive and extremely helpful. So I just wanted to thank you all. It was a pleasure working with you.

Alan.

MEMBER LEVITT: I really wanted to thank everybody again. I can't thank you enough for the support you give us, for the input you give us. We have differences sometimes, but we actually really -- we have the same goal in

heart, so to speak, at hand here.

We need to think back, as Carol was saying, you know, where we were and where we are now, and how much progress we've really made, and how good the future looks too. I know we talked all about the IMPACT Act measures. But as I was mentioning to Teresa and Liza I guess a week ago, the IMPACT Act also has all standardized interoperable data that's going to be able to be used and useful for our patients longitudinally across settings. And that's such a remarkable feat to see that beginning.

And that is a beginning for us. And it's going to be so important to implement that and, hopefully, implement it not beyond this workgroup into other settings as well.

But, again, we hope to continue the dialogue, to be back, to continue, you know, discussing future measures with you. And thank you again.

CO-CHAIR RAPHAEL: To everyone a happy, happy holiday. And thank you so much for going

above and beyond the call of duty.

MS. SAMPSEL: And just real quick. Lunch will be here. It's on its way.

And on behalf of NQF, obviously we want to thank everybody as well. And we are open, Jim and everybody, to suggestions. You know, right, MAP has been around for a while, but year to year we are trying to improve and we'd like to hear what thoughts that you have as we prepare.

And we'd just like to recognize not only the staff on this team, but there's a lot of behind-the-network folks working on MAP for NQF that pulled this all together. Amber and Wunmi specifically in the back, who try to bring all the staff together and promote consistency.

So thank you all. And we'll look forward to talking to you in the future.

(Whereupon, the above-entitled matter went off the record at 12:38 p.m.)

J

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Post-Acute Care/Long-Term Care

Before: NQF

Date: 12-15-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter