National Quality Forum
Measure Applications Partnership (MAP) Clinician Workgroup 2022 Measure Set Review (MSR) Meeting
Monday, June 27, 2022

The Workgroup met via Video Teleconference, at 10:00 a.m. EDT, Rob Fields and Diane Padden, Co-Chairs, presiding.

Present:

Rob Fields, MD, National Association of ACOs, Co-Chair
Diane Padden, PhD, CRNP, FAANP, American Association of Nurse Practitioners, Co-Chair
Dan Albright, MD, HealthPartners
Nishant Anand, MD, FACEP, Individual Subject Matter Expert
Rachel Brodie, Purchaser Business Group on Health
Helen Burstin, MD, MPH, FACP, Council of Medical Specialty Societies
Mary Jo Condon, MPPA, St. Louis Area Business Health Coalition
William Fleischman, MD, MHS, Individual Subject Matter Expert
Stephanie Fry, MHS, Individual Subject Matter Expert
Wendolyn Gozansky, MD, MPH, Kaiser Permanente
Lisa Hines, PharmD, Pharmacy Quality Alliance
Amy Nguyen Howell, MD, MBA, FAAFP, Individual Subject Matter Expert
Donald Nichols, PhD, Genentech, Inc.

Louis Parrott, MD, PhD, Magellan Health, Inc.
Geoffrey Rose, MS, MPH, American College of Cardiology
David J. Seidenwurm, MD, FACR, American College of Radiology
Timothy Switaj, MD, American Academy of Family Physicians
Wei Ying, MD, MS, MBA, Blue Cross Blue Shield of Massachusetts
Yanling Yu, PhD, Patient Safety Action Network

Non-voting Federal Liaisons:

Girma Alemu, MD, MPH, Health Resources and Services Administration
Peter Briss, Centers for Disease Control and Prevention
Michelle Schreiber, MD, Centers for Medicare and Medicaid Services

NQF Staff:

Dana Gelb Safran, President and CEO
Tricia Elliott, DHA, MBA, CPHQ, FNAHQ, Senior Managing Director
Ivory Hardin, MS, Manager
Joelencia LeFlore, Associate
Jenna Williams-Bader, MPH, Senior Director

Also Present:

Faseeha Altaf, Yale CORE

Taroon Amin, Consultant to NQF
Greg Bocsi, University of Colorado
Colleen Cole, Minnesota Community Measurement
Jennifer Gasperini, National Association of ACOs
Beth Godsey, on behalf of the NQF Health Equity Advisory Group
Lisa Marie Gomez, Centers for Medicare and Medicaid Services
Jackie Grady, Yale CORE
Dan Green, Centers for Medicare and Medicaid Services
Colleen Jeffrey, Centers for Medicare and Medicaid Services
Brandy Keys, American Academy of Ophthalmology
Kasia Lipska, Yale CORE
Jessica Peterson, MarsdenAdvisors
John Pilotte, Centers for Medicare and Medicaid Services
Anita Somplasky, Mathematica

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(10:04 a.m.)

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Ms. Williams-Bader: Good morning, everyone, thank you so much for joining us today on a Monday morning. My name is Jenna Williams Bader and I am a Senior Director here at the National Quality Forum.

A few quick reminders before we get started, you can mute and unmute yourself, you're welcome to use your video throughout the event. We do ask if you can, if you're on the web platform, to raise your hand if you have questions or comments and lower your hand when you're done.

If you're a call-in user, please state your first and last name when speaking and feel free to use the chat feature to communicate with NQF Staff during the meeting.

Next slide, please. We also have a few ground rules and these are mostly we were asking you to please respect others, respect all the voices here, remain engaged and actively participate.

Please try to keep your comments concise and focused, be respectful of others, and we do really want to hear from all of our MAP Members here, your experiences are important to this discussion.

Just please also keep that mindset of learning from others. Next slide, please.

I'm sure many of you are familiar with the WebEx platform but I have a couple of quick reminders. On the lower left-hand side or lower left center is the mute button and again, if you could unmute yourself when speaking and unmute yourself when not.

Along the bottom again is where you can find the participant list and the chat features. And lastly, if you want to raise your hand, you'll either see a reactions tab or you'll see a little hand raised so you can click on that to raise your hand.

Next slide, please.

Welcome everyone to our measure applications partnership clinician Work Group 2022, measure set review meeting. Thank you all so much for joining us today for this full-day meeting.

We really appreciate the work you've put into this leading up to today's meeting and we look forward to the discussion. I'd also like to thank CMS for funding this work. Next slide, please.

Quick review of the agenda, we'll start with some welcomes and introductions. We'll do disclosures of interest and then a quick review of the meeting objectives. We'll then turn to CMS for opening remarks.

We'll do a review of the measure-set review process and then the measure review criteria that we'll be using as the basis for today's discussion.

We'll then spend the majority of the meeting running through measures from two programs, the Medicare shared savings program and the merit-based incentive payment system.

There will be an opportunity for public comment at the beginning of each program and then one towards the end of the day.

We'll then at the end of the meeting talk about gaps in clinician measure set review programs, as well as we really want to get your feedback on this process.

This is the first time we're rolling out to all of the MAP. Last year we just worked with the Coordinating Committee on a pilot. So, we welcome your feedback on the process and we'll close with

next steps and closing comments.

Next slide, please. I'd like to turn it over Dana Gelb Safran, our President and CEO for some opening remarks.

Dr. Gelb Safran: Thanks, Jenna, good morning, everybody. It's my absolute pleasure to welcome you to today's MAP measure set review meeting of the clinician Work Group.

NQF is honored to continue our partnership with CMS in convening MAP.

As all of you know, MAP brings together multiple stakeholder groups with representatives from quality measurement, research, purchasers, public health, and community health agencies, health professionals, health plans, consumers and suppliers.

And last year, the first time, NQF collaborated with CMS and piloted the measure set review process to offer a holistic review of quality measures and a first ever effort to look at considerations around the possibility of removing the measures from the CMS program.

We did that last year in partnerships with the MAP Coordinating Committee on 22 measures drawn from hospital program settings and the output and final recommendations went to CMS as recommendations and rationale for the potential of removing measures from hospital programs.

This here, the measure set review process, has expanded beyond the pilot and brings together all three of the seven specific Work Groups, hospital, clinician, and post-acute and long-term care, as well as our two Advisory Groups, rural and health equity.

As this is the first year that we are involving all the MAP Committee Members in the measure set review, as Jenna said, we're expecting to learn quite

a bit and we're really looking forward to hearing your feedback about the process and how it can be strengthened, also what works about it in its current constitution.

Today's meeting will focus on discussing the measures under review in the clinician setting including those nominated from the Medicare Shared Savings Program, MSSP, and the merit-based incentive payment system, MIPS.

During today's meeting, this Work Group will consider using criteria that the team will outline for you, the potential and rationale for removing certain measures from clinician-based payment programs and public reporting programs that CMS uses.

We'd like to thank all of you, our Work Group members and federal liaisons, for the tremendous amount of time and effort -- pardon me, I'm just recovering from being a little bit sick -- required to participate in this process including we know the preparation that goes into this.

Thank you also to our colleagues at CMS and to the program leads who have joined today's call and been extremely helpful throughout today's process.

I want to thank all of you in advance for the feedback you'll give us on how to further strengthen this program and finally, I really want to give a special thank you to our Co-Chairs, Diane Padden and Rob Fields, for their leadership and dedication to the MAP Clinician Work Group.

I'm looking forward to engaging in this new process with all of you and at this point we'll hand things back to you, Jenna, thank you.

Ms. Williams-Bader: Thank you very much, Dana. Next slide, please. We'll now turn it over to our Work Group Co-Chairs for some opening remarks. Rob Fields, I'll go to you first.

Chair Fields: Thank you, and I'll really just keep this short and echo the thanks to everyone on the Committee over the last couple years that I've been involved and seeing the dedication of this group taking eight hours of our busy schedules to dedicate to this work is really not taken for granted.

And I just appreciate your thoughtfulness and thoroughness and review as we go through this process. I appreciate your help and support in advance of today.

Diane?

Chair Padden: Thanks, Rob, I will join him in welcoming all of you to this meeting and it is a pleasure to see so many familiar faces and I've enjoyed working with all of you throughout the years and look forward to our time together today.

Ms. Williams-Bader: Thank you both very much. If we could go to the next slide, please? Now we're going to do disclosures of interest. As a reminder, NQF is a non-partisan organization.

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

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

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

We'll start with organizational members.

Organizational members represent the interests of a particular organization. We expect you to come to the table representing those interests.

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

We'll go around the tables to begin with organizational members only, please. We will call on anyone in the meeting who is an organizational member.

When we call your organization's name, please unmute your line, state your name, your role at your organization, and anything that you wish to disclose.

If you did not identify any conflict of interests after stating your name and title, you may add I have nothing to disclose.

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

I'll now hand it over to Ivory to run us through the organizational disclosures.

Ms. Harding: Thank you, let's start with the American Academy of Family Physicians.

Member Switaj: Good morning, I'm Dr. Tim Switaj, I am with the American Academy of Family Physicians and I have nothing to disclose.

Ms. Harding: The American College of Cardiology?

Member Rose: Geoff Rose, I'm the Chair of the

Partners in Quality Subcommittee for the American College of Cardiology, I have no disclosures, thank you.

Ms. Harding: The American College of Radiology?

Member Seidenwurm: Hi, I'm David Seidenwurm and I am a radiologist in California and I do have an interest in this other medical group. Otherwise, I have nothing to disclose.

Ms. Harding: Blue Cross Blue Shield of Massachusetts?

Member Ying: Wei Ying, Senior Director of Performance Measurement and Population Health. I have nothing to disclose.

Ms. Harding: Consumer's checkbook? Council of Medical Specialty Societies?

Member Burstin: Good morning, Dr. Helen Burstin, CEO of the Council of Medical Specialty Societies, no disclosures.

Ms. Harding: Genentech?

Member Nichols: This is Donald Nichols, principal health economist and health policy assistance research at Genentech and I have nothing to disclose.

Ms. Harding: Thank you, Health Partners? Kaiser Permanente?

Member Gozansky: Dr. Wendolyn Gozansky, I'm the Chief Quality Officer for the Colorado Permanente Medical Group and a national Permanente quality leader for Kaiser Permanente. I have nothing to disclose.

Member Albright: Dan Albright from Health Partners. I'm Medical Director for Population Health, nothing to disclose.

Ms. Harding: Were you also with Kaiser Permanente?

Member Albright: Health Partners.

Ms. Harding: Louise Batz patient safety foundation? Magellan Health? OCHIN?

Member Parrott: This is Lou Parrott, Medical Director with Magellan Health, nothing to disclose.

Ms. Harding: Thank you. Patient Safety Action Network?

Member Lu: Good morning, this is Yanling Yu, I'm a patient safety advocate with Patient Safety Action Network. We have nothing to disclose, thank you.

Ms. Harding: Pharmacy Quality Alliance?

Ms. Hines: Good morning, this is Lisa Hines from PQA, Pharmacy Quality Alliance. We are a measure developer and steward and I have nothing to disclose.

Ms. Harding: Purchaser Business Group on Health?

Member Brodie: This Rachel Brody and I am Senior Director of Measurement and Accountability for Purchaser Business Group on Health, or PBGH. Nothing to disclose at this time although we are a measure developer and steward.

But no measures at this time that are a conflict.

Ms. Harding: Thank you, and the St. Louis Area Business Health Coalition?

Member Condon: Mary Jo Condon, senior consultant to the St. Louis Area Business Health Coalition, nothing to disclose.

Ms. Harding: Are there any organizations that may have joined through roll call?

Back to you, Jenna.

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

Because subject-matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities.

When you disclose, please do not review your resume. Instead, we are interested in your disclosure of activities that are related to the subject matter of the Work Group's work.

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

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

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

I also want to mention that we are not only interested in your disclosures of activities where you were paid, you may have participated as a volunteer on a Committee where the work is relevant to the measures reviewed by map.

We are looking for you to disclose those types of activities as well. Finally, just because you disclose does not mean you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

Please tell us your name, what organization you're with, and if you have anything to disclose. Ivory will

call your name so that you can disclose.

We'll begin with our Co-Chairs and I'll turn it over to Ivory to run us through the subject-matter expert disclosures.

Chair Fields: Hey there, Rob Fields, and I sit on the Board of the national Association of ACOs. We're an advocacy and policy group, concentrating on federal programs and value-based care, nothing to disclose.

Ms. Harding: Diane Padden?

Chair Padden: Diane Padden, American Association of Nurse Practitioners.

I've sat on several tech panels looking at measurements under review for the cost evidence base, none of which are on the schedule today but I wanted to let you know that I have sat on those tech panels.

Ms. Harding: Nishant Anand?

Member Anand: Hi, everybody, I'm Dr. Nishant Anand, President and CEO of Altais, which is a provider services organization, and I have nothing to disclose.

Ms. Harding: Stephanie Fry?

Member Fry: Good morning. Stephanie Fry from Westat serving as a subject-matter expert in patient experience measurement.

I have worked as a contractor in measure development for CAHPS surveys, one of which comes up this afternoon, though, I don't know we'll be voting on it so I will recuse myself from that discussion. Nothing further to disclose.

Ms. Harding: Amy Nguyen Howell?Member Nguyen Howell: Good morning, Amy Nguyen Howell, I lead the Office for Provider Advancement within Optum Health, nothing to disclose.

Ms. Harding: Thank you. And William Fleischmann?

Member Fleischman: Good morning, I'm a Director of Quality at Hackensack Meridian Health in New Jersey.

I worked for CMS from 2016 to 2018, some of my work involved working on some quality measures but not on any of the measures we're discussing today.

Ms. Harding: Thank you.

Ms. Williams-Bader: At this time we'd like to invite our Federal Government participants to introduce themselves. They are non-voting liaisons of the work group. Ivory, I'll turn it back to you.

Ms. Harding: The Centers for Disease Control and Prevention?

Member Briss: Good morning, my name is Peter, I'm the medical Director in the Chronic Disease Center at CDC.

I have worked on cardiovascular health measures with the Million Hearts Initiative and I have co-chaired NQF's behavioral health and substance use Committee but I've not been a measure developer or steward for any of the measures today.

Ms. Harding: Thank you. Centers for Medicare and Medicaid Services?

Dr. Schreiber: Hi it's Michelle Schreiber, I'm here for CMS. We also have a number of CMS staff on the call today.

Ms. Harding: Thank you. And the Health Resources and Services Administration?

Dr. Alemu: Hi. This is Girma Alemu with the Health Resources and Services Administration. I have nothing to disclose.

Ms. Harding: Thank you. Back to you, Jenna.

Ms. Williams-Bader: Thank you very much, Ivory, and thank you all very much for those disclosures. I'd like to remind you that if you believe that you might have a conflict of interest anytime during the meeting, please speak up.

You may do so in real time by doing that in the meeting. You can message one of the chairs who will go to NQF Staff or you can directly message NQF Staff.

If you believe that a fellow Committee Member may have a conflict of interests or is behaving in a biased manner, you may also point this out during the meeting, approach one of the chairs, or go directly to NQF Staff.

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

In that case, we'll go ahead and keep moving. Now I'd like to introduce the MAP Work Group Staff. We have Tricia Elliot, our Senior Managing Director on the line and as I said, I'm Jenna Williams Bader, Senior Director.

We have Katie Berryman, who's Director of Project Management, Ivory Harding, and Suzanne Young who are managers, Ashlan Ruth, who is our Project Manager, Joelencia LeFlore, who is our associate, and Gus Zimmerman, who is newly an analyst on the team.

Next slide, please. Lastly, we do have a number of CMS Staff on the line, specifically, I'd like to call out Kim Rawlings, who is our task order Contracting Officer's representative or COR, as well as Gequincia Polk, who is the IDIQ COR.

I thank them both for joining us today. Next slide, please.

The objectives for today's meeting, three main objectives, first will be that we are going to review the measure set review process and the measure review criteria.

We will then provide MAP Members with an opportunity to discuss and recommend measures for potential removal. And then as we mentioned at the end, we will seek feedback from the Work Group on the measure set review process.

Next slide, please. I'll now turn it over Michelle Schreiber for some opening remarks.

CMS Opening Remarks

Dr. Schreiber: Jenna, thank you very much and good morning to everybody, thank you so much for participating today.

You've heard the outline already, and as Dana and Jenna have pointed out, today is your opportunity to make recommendations to CMS about measures in the various value-based programs that should be considered for removal.

And these measures came to us because the group as a whole voted on what are the top measures that people would like to consider for removal. So, that's how we got to this list today.

We very much look forward to your thoughtful and insightful comments. We always learn a great deal at the MAP meetings. But as you've heard, this is a new process involving all of the Committees.

Last year, this just involved the Coordinating Committee. This year it's been opened up to all of the Committees and we've really had some good feedback so far.

As you know, the Rural Health Advisory Group has already met and weighed in, the equity Advisory Group has met and weighed in and last week, the Hospital Advisory Committee also weighed in.

So, today obviously is the clinician group and we will have another meeting for the post-acute care group as well as then followed by the Coordinating Committee who will then make final recommendations.

Just so you know, these recommendations will likely be used in next year's rule writing.

A lot of this year's rule writing as you've seen is already out or shortly to be out, so this will be taken into consideration as we start thinking towards next year's rule writing, which happens very early.

We'd like to very much thank NQF, Dana of course, Jenna and all of the Staff who are on the call from NQF. So far, the meetings have gone very well. As I said, we've had a lot of lessons learned.

In particular, though, I want to extend our thanks to all of you as members of this Committee, both our Co-Chairs, Rob and Diane, and all of you as Members of the Committee because you understand these programs for the most part have had fairly significant experience with them over the years and your thoughtful comments are really very appreciated.

I'd also like to thank CMS. We have a number of our colleagues on the phone today and measure stewards. There's a lot of work that goes on in putting these meetings together, as I'm sure you realize.

When we come to the MSSP measures, there were some scheduling conflicts from some of the MSSP Staff.

That program sits actually in another part of CMS but we will try our best from the MIPS program to answer your questions about the MSSP programs and the measures.

And we will certainly carry back the conversation

and feedback to them. With that, again welcome, thank you, it should be a very exciting and interesting day and Jenna, I turn it back to you.

Ms. Williams-Bader: Thank you so much, Michelle. And I agree, I think it will be an exciting today as we look forward to the discussion.

One more thing I wanted to mention before we move on, we do have someone also on the line from NQF who will be helping me to facilitate today's meeting.

That's Taroon Amin. He's been very involved with NQF, has worked for NQF in the past and is now a consultant. So, I'm looking forward to working with him today on the call.

If we could go ahead to the next slide. I'll now turn it over to Ivory Harding for review of the process.

Review of MSR Process and Measure Review Criteria (MRC)

Ms. Harding: The goal of the 2022 MSR process is to prioritize, survey, prepare, and discuss the measures for review with the output of being a set of final recommendations and rationale for measure removal being provided to CMS.

So far, NQF has worked in collaboration with CMS and with Members of MAP to prioritize programs for discussion and narrow down the list of measures for review.

During completion of the survey, Advisory Group and Work Group Members, nominated measures that they would like to discuss for potential removal and they selected the measure review criteria they were using to nominate the measures.

However, they had limited information about the measures at the time they completed the survey so they were selecting criteria based on what they knew about the measures at the time.

Unless they left comments in the free text field, we do not know why they selected certain criteria. These measures have been analyzed by MAP Members against measure review criteria and the results have been posted for public comment.

The rationale for nominations and the notes for survey Respondents in the MSS comes from the survey. Measures adopted into programs before 2011 may not have been repeated by MAP as MAP did not exist before this time.

Today, Work Group members will get to discuss measures for removal and vote on whether to retain the measure within the federal program. Final recommendations will be published in September and these recommendations are one consideration that CMS will use when deciding to remove a measure from a program. Next slide, please.

Work Group Members were provided with 10 measure review criteria to use in their evaluation of the measures for review during the survey process. The finalized criteria included feedback from the Coordinating Committee, and these will continue to evolve.

The review criteria focused on measures that do not contribute to the overall goals of the program or are duplicative, are not CBU-endorsed, or lost endorsement status, focus on patient outcomes, current evidence, performance variations, reporting burden and unintended consequences.

Next slide, please.

For measures that may have negative unintended consequences, the considerations will be different between the Advisory Groups, the Work Groups, and the Coordinating Committee.

Next slide, please.

There are four MSR decision categories, the first is

support for retaining, then conditional support for retaining, then conditional support for removal and support for removal.

Next slide, please. We will now cover the definition, evaluation criteria, and examples for each decision category.

Support for retaining is defined as MAP support for retaining the measure as specified for a particular program.

During the evaluation, MAP determines the measure does not meet review criteria for removal or the measure meets at least one review criterion. MAP thinks the benefits of retaining it in the program outweighs the MAP criterion.

Additionally, MAP has not identified any changes for the measure.

For examples, MAP's support for retaining the measure despite meeting review criterion, the measure is a PRO-PM that is associated with reporting burden, but it is an important measure to patients.

The measure is not reported by some entities at a low volume but it is a meaningful measure for those entities who can report it. Next slide.

Conditional support for retaining is defined as MAP support for retaining the measure for a particular program but has identified certain conditions or modifications that would ideally be addressed.

During evaluation, the measure meets at least one review criterion but MAP thinks the benefits of retaining it in the program outweigh the MAP criterion.

However, MAP support for retaining is based on certain conditions or modifications being addressed.

As an example, the measure receives CV

endorsement and is aligned to evidence. It is re-specified as an electronic clinical quality measure for eCQM or is modified so that it no longer meets review criteria.

Next slide.

Conditional support for removal is defined as MAP supports removal of the measure from a particular program but has identified certain conditions that would ideally be addressed before removal.

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

For example, the measure is integrated into a composite or a process measure is replaced by an outcome measure or PRO-payment. Next slide, please.

Support for removal is defined as MAP supports removal of the measure from a particular program. During evaluation, the measure meets at least two review criteria. MAP does not think that removal of the measure will create a measurement gap.

For example, the work determines that the measure no longer meets program priorities and removing it will not lead to a measurement gap or the measure is capped out.

Next slide, please.

Quorum is defined as 66 percent of the voting members present virtually for live voting to take place. If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.

Consensus from MAP is a threshold greater or equal to 60 percent of voting participants voting positively and a member of 60 percent of the quorum figure

voting positively.

Abstentions do not count in the denominator. Every measure under review will receive a recommendation.

Next slide, please.

In review for the process of today's discussion, each program will be introduced by NQF Staff before the public is given an opportunity to provide comment on each of the measures within the program.

For each measure, the lead discussants will provide their evaluation of the measure before representatives of the Advisory Groups or NQF Staff Members provide an overview of the Advisory Group discussion.

The discussion will then be open to the entire group for clarifying questions. Next slide.

Work group discussions should provide feedback on data collection or reporting challenges, particularly in an office setting, issues calculating measure performance, and positional unintended or negative consequences related to measure removal from the program.

Co-Chairs will put forth a decision category for voting based on potential consensus emerging from the discussion.

If a consensus position cannot be reached by the Co-Chair, the Work Group will take a vote on each decision category beginning with conditional support for retaining, then conditional support for removal, then support for removal, then support for retaining.

Next slide. NQF Staff will tally the votes. If a measure receives greater than 60 percent of the votes, the motion will pass and the measure will receive that decision.

If no decision category achieves greater than 60 percent, the measure will be assigned the decision to support for retaining. Next slide. Does anyone have any questions on the 2022 MSR process?

Member Gomez: This is Lisa Marie Gomez with CMS. I just had one quick question. In the previous slides, you noted that for Step 5 it was the place in which CMS could answer questions.

I just have a clarifying question about Step 5. Is that the place where CMS programmers are able to discuss the measure or is it in the previous step?

Because I know that there was an added step in which CMS was able to provide a one-minute commentary and I just wasn't sure where that step was.

Ms. Harding: Sure, after the lead discussants open the discussion with their review and then followed by the Advisory Group discussion of review, CMS will then provide their comments.

Ms. Williams-Bader: This is Jenna.

Actually, it's earlier than that so if we go back to the previous slide, Step 1 through I don't know if it was 4 or 5 on it, the first if we're able to go back on this slide.

Lisa-Marie, thanks for clarifying.

We will do it in between so it's not actually called out specifically here in the steps but NQF Staff will read the measure title, description, and endorsement status, then we will invite CMS program leads to speak so you'll hear us ask if you've got comments.

And then after that we will go to the lead discussants and Advisory Group feedback.

Member Gomez: Thank you for that clarification.

Ms. Williams-Bader: Sure.

Ms. Harding: Are there any other questions?

Dr. Schreiber: Jenna, this is Michelle.

I just wanted to make sure the group knew we do have representatives from MSSP from CMS on the call, including John Pilotte who leads the program.

So, I know those are the first measures we're talking about.

Ms. Williams-Bader: Thank you very much, Michelle, yes, I see that in the chat.

Ms. Harding: If there are no other questions, next slide, please. We will now take the time to perform a voting test question. You are provided instructions on how to find the link to participate in an email sent to you all on Friday.

That's specifically for MAP Members. If you are unable to locate those instructions, please notify NQF Staff and we will assist you. I will turn it over Joelencia to lead you through this activity.

So far, the test question is do you like tea? We are looking for around 19 total votes. So, if you're having any troubles, please let us know. Okay, Will, I will see if a team member can send you that link.

It looks like we're still short of a few others, in addition to the ones we're seeing in the chat. Is anyone else having any trouble? I see also Donald Nichols because we are working on sending out those links to Rachel, Donald, and Will.

Anyone else? The email was sent I believe on Friday but we will go ahead and resend. Wei Yang, we can send to you as well. It looks like a few systems are sending these emails to quarantine.

That might be somewhere where you find it. It looks like we have reached 19. As you can see with this

test, after the voting is complete, we will show the results and announce the pursuant reach for each decision.

Thank you, Joelencia. I will now hand the program back to Jenna.

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

We will go ahead and get started with the actual discussion and review of the programs and measures but if you do have any questions about the process or any issues with voting throughout, please let us know.

If we could go to the next slide, please? Today we are talking about clinician programs and specifically, if we go to the next slide we're talking about the Medicare shared savings program and the merit-based incentive payment system.

Next slide, please. We'll start with the Medicare shared savings program. This is a shared savings program as mandated by Section 3022 of the Affordable Care Act.

Through this program, CMS assesses shared savings program, accountable care organization performance annually based on quality and financial performance to determine shared savings and losses.

Beginning with performance year 2021, ACOs are required to report their quality data to CMS via the alternative payment model, APM, performance pathway, APP.

Performance categories and weights under the APP used to calculate an ACO's MIPs quality performance category score, 50 percent is for quality, 0 percent at this time is for cost, 20 percent improvement activities, and 30 percent promoting interoperability.

One thing to note is that APMs are already

responsible for cost and all MIPs APM participants report through the APP will receive a full score for the improvement activities category for performance year 2022 and would not need to submit additional improvement activity information.

Program goals are to promote accountability for a patient population, coordinate items and services for the ACO's patient population, Medicare fee for service beneficiaries and encourage investment in high-quality and efficient services.

Next slide, please. So, I will now turn it over to Rob, who's going to lead us through public comment for the measures within the Medicare shared savings program.

Opportunity for Public Comment

Chair Fields: Thank you, Jenna. As a reminder, please use the raised-hand feature if at all possible in the platform and please limit your comments to two minutes or less.

We'll open it up for public comment. Don't be shy.

(Simultaneous speaking.)

Member Gomez: I just want to make sure, is this the time for CMS to provide comments?

Ms. Williams-Bader: No, we will specifically ask for CMS program leads to comment on each measure as we go through them. This is an opportunity for the public to comment and I am not -- I do see one hand raised. So, Jennifer Gasperini?

Ms. Gasperini: Yes, thank you. So, I have a couple of comments. This is the only comment period allowed for the public for MSSP, correct? And then just the one at the end of the day.

A lot of my comments I think I'll hold until after I've heard the discussion on each of these measures. But just a couple more general and thematic

comments, first off, I just think it's really challenging to provide any valuable feedback here.

In absence of knowing what might be proposed to be added to the measure set, when we shared this with ACOs, they just said they really couldn't even provide feedback not knowing what might be replaced or added in place of a lot of these measures that are being removed.

So, I just would suggest maybe trying to change the process in some ways so that information is available at the same time as you're reviewing measures for removal.

The other issue is really timing for comments.

There was only a short amount of time provided for public feedback on this and especially with this being the first year that you are implementing this proceeding, I think the public needs a little additional time to provide feedback.

Finally, I received some of the emails for the Clinician Work Group but did not see any emails on voting on measures for removal.

So, I was just curious who got those emails and what additional context and information was provided to them as them made these decisions to vote for measures for removal.

Chair Fields: Jenna, can you help me out here in terms of the response?

Ms. Williams-Bader: Yes, I'm happy to answer some of those questions. I think Jennifer, when you're saying who got the emails about voting for measures for removal, you are referring to the survey.

That went out to Advisory Group and Work Group members so members of our Rural Health and Health Equity Advisory Groups and Members of the Clinician Pac LTC and Hospital Work Groups.

They were given some fairly basic information about the measures and I think Ivory noted that in her review of the process as well. It was a very large number of measures across the three settings.

In the survey, I think between the three surveys we had between 200 to 250 measures.

So, information that was provided was fairly basic, some basic information about the measure specifications, whether or not the measure was endorsed, the data sources used, whether the measure was required by statute.

I think those were the key data-points that were provided.

So, again, we did want to raise that for the Work Group to keep in mind today, that it's at this point ahead of the Work Group meetings that we've provided more detailed information about the measures, including performance and reporting data.

And so we do want people to keep in mind that at that time of the survey, there was less information provided. Jennifer, I hope that answers your questions but let us know if you have follow-ups.

Chair Fields: Can I ask a clarifying question? Go ahead, Jennifer.

Ms. Gasperini: I was just going to say that is helpful to know and I just think for MSSP in particular, the context of these is very important.

Chair Fields: I was just going to ask a clarifying question because during the time of those surveys, it sounds like the intent is really to cast a fairly broad net with that initial survey, hence the detail was pretty light.

So, these were all the potential field of measures we might consider in this process. I'm not going to get into a whole lot of curation and then initial surveys

to clarify intent.

That is exactly right. Those surveys included all of the measures that are in the programs that are up for review this year with the exception of MIPS because that has two measures in it.

We pulled a third based on meaningful measure areas or domains.

We would do future categories in later years.

But absolutely, the idea was to put in front of the Work Groups and Advisory Groups all the measures in those programs and then let the MAP Members identify measures they want to discuss, with the intent being that through the discussions that we've been having the last week and this week that MAP Members may decide that measures should belong in the program still, now that they have more detailed information.

Ms. Gasperini: Yes, that's helpful but there was a public comment period already and those stakeholders didn't have that knowledge and don't have additional context that's being provided in these discussions.

So, again, just to comment on the process, I know this is a new process this year. That would be helpful in allowing stakeholders to make public comments.

Chair Fields: Any other raised hands? I'm trying to flip through my participant list here.

Ms. Williams-Bader: I'm not seeing any additional raised hands at this time and I don't see anything in the chat.

Chair Fields: Last call? Here's something in the chat here. NQF is going to provide background as to why each measure is being recommend for removal.

At least at a general level, that is included in the

summary documents but I'm actually not sure who gets to see those.

Maybe, Jenna, you can help me out. I know we get to see them on the Committee but do the stakeholders also see those?

Ms. Williams-Bader: They've been posted publicly so when the meeting materials went live, those went live as well.

The measure summary sheets for each measure include information on the number of Advisory Group and Work Group Members who voted for the measure.

And again, I would emphasize that they really were nominating measures for discussion of a potential removal but again, the discussion might lead the Work Group to the conclusion that they support retaining the measure in the program.

We also provided in the measure summary sheets the measure review criteria that survey Respondents used to explain why they were selecting a measure for discussion and also any free text comments that were made in the survey about the measure.

And that information is on the slides so we'll people will be able to see that and it will be part of the discussion today. And now I see that Rachel has her hand raised.

Member Brodie: I'm sorry and I know this is the public time but I see the criteria that we should be considering in the materials here today but I don't feel that we have the background that was released to the public.

But I don't have a link to it so I'm not feeling very informed about how to discuss this when we don't have the background information about each measure and what the Work Groups said.

You said that it's publicly available but it wasn't in our meeting information.

Ms. Williams-Bader: It should be in the meeting materials.

The particular document I'm referring to is called MAP clinician MSS 2021-2022, 508 PDF, and that's the measure summary sheet that has information on the survey results as well as performance and reporting data, history on --

Member Brodie: Thank you.

Ms. Williams-Bader: There's a request in the chat for the link to be resent so we can add that to the chat.

Member Burstin: It's Helen, if I could just add to Rachel's comment?

Having reviewed all of the summary sheets in great detail, yes, the sheets reflect how the Staff reflected on it in terms of the criteria for measure removal, but it doesn't actually say why the measure was recommended for removal by the person who put it forward.

Ms. Williams-Bader: Helen, the actual criteria, NQF Staff has no interpretation as far as the survey results went. The criteria that are listed there are the criteria that were used by the actual survey Respondents.

In order to nominate a measure for discussion, they selected which criteria they thought applied to the measure.

Those are the criteria that Work Group or Advisory Group Members selected and then there are the free text comments as well like I said.

We do recognize that one of the things we don't have is any further information about why a Work Group Member or Advisory Group Member selected

particular criteria and that's something that we've already heard in feedback and something for us to consider for next year.

But those criteria were not supplied by NQF Staff, they were the ones selected by survey Respondents.

Member Burstin: That's helpful, it would still be helpful to have more information about the logic of why they're proposing it for removal. Thank you.

Ms. Williams-Bader: And just so people know, we did put a link to the meeting materials in the chat. There is a comment from Jessica Peterson that says public comment was due May 25th and the document is dated June 6th.

We acknowledge the measure summary sheets just based on the timing for this year's project. We created measure summary sheets during public comment so they were not available at the time of public comment.

We do have an opportunity for the MAP Work Group to provide feedback on the process later today and then there's also the public comment towards the end of the day if people have additional feedback on the process they'd like to provide at that point.

Chair Fields: Last call for any raised hands or comments before we move on? I'm not seeing anything so, Jenna, I'll turn it over to you.

00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Ms. Williams-Bader: Thank you very much, Rob. Now we'll start going through the measures one by one. Next slide, please. We'll start with 00515-C-MSSP, Preventative Care and Screening, Screening for Depression and Follow-up Plan.

This measure assesses the percentage of patients aged 12 years and older screened for depression on

the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool.

And if positive, a follow-up plan is documented. This measure is non-endorsed and it was selected by three survey Respondents. One thing to note is that this is the web interface version of the measure.

The Medicare shared savings program will sunset web interface reporting starting with performance year 2025. At this time, discussion and vote should be limited to the web interface version of the measure.

The next measure up for discussion will be the version of the measure reported as an electronic clinical quality measure or eCQM. With that next measure, we'll take comments on the eCQM and the registry-based or CQM version of the measure.

I'll now see if there's anyone from CMS or the CMS program lead who would like to provide contextual comments about the measure.

Member Gomez: Hi, this is Lisa-Marie Gomez, I'm just going to provide overarching comment relative to the measure. I just want to highlight that we include different measures in our program based on specific priority areas within our program.

I just want to highlight that mental health is a high-priority topic within our program. I also want to highlight that this measure was previously NQF-endorsed.

I don't know if my colleagues from the shared savings program want to add anything for this measure?

Mr. Pilotte: This is John Pilotte, I would just add, and Lisa-Marie correct me, but this measure has been part of the shared savings program and particularly the web interface for I think actually

maybe since program inception.

So, they're close to adopting it, if not, right around there.

Member Gomez: You are correct, John. This measure for the web interface has been part of the web interface for several years and actually since the inception of the transition to the quality payment program.

So, it has been in the program for a long time and I also know that we have other components within our program who actually steward, not steward but oversee the actual structure of the measure.

I don't know if anyone from our ECEP campaign wants to add anything to this also?

Ms. Somplasky: Hi, Lisa-Marie, it's Anita.

Just some background on the measure, this measure was initially intended to be for all eligible clinicians, not specific to treating depression but making sure that there was a screening and referral for follow-up or treatment for follow-up if needed to try and identify new and early cases of depression.

And it actually was the predecessor of the PQRS program. It's been in the program since then and as you mentioned, it was previously NQF-endorsed.

Member Gomez: Thanks, Anita, that's all we have from CMS.

Ms. Williams-Bader: Thank you very much. I'm not going to turn it over to our lead discussants. I have Nishant Anand and the St. Louis Business Health Coalition and Magellan Health.

Nishant, would you like to start?

Member Anand: I'd be happy to start. Can you hear me okay?

Ms. Williams-Bader: Yes.

Member Anand: I'll start and my colleagues can chime in.

I think I always like to start with assumptions that measures are based on. I think the assumption on this measure is that depression is pretty prevalent and it's increasing, at least in my opinion, even more so.

It's under-diagnosed and an early identification can lead to treatment outcomes. I think those are all underlying assumptions. I'll add a couple others in some of these longitudinal cases based on my clinical experience.

I think at a point in time when you have a process measure such as this, it's only as good as what the longitudinal outcomes will be. So, it's a good starting point to have a process measure such as this.

So, if a patient comes in, they are assess with either a two-question survey or nine or some other screening assessment, and then if they're positive it's documented and then there's a treatment plan put in place.

I think the challenge I have with this is this measure has been in place for a while and I'd like to look at longitudinal outcomes in conditions, especially with depression.

And I worry a little bit that this does not actually meet that measure of improving the longitudinal outcome of our patients with depression. And we haven't seen if there has been an increase in the treatment adherence because of that.

The other thing I'd like to just mention on this one underlying assumption is that I think with screening you have to be targeted, otherwise it's an incredible burden on everyone.

So, I think about the patient, they have to be asked questions. With the PHQ-2, have you felt overwhelmed, a lot of people feel that way so you're going to have that a little bit of positive attachment just based on the way the question is worded.

It's very broad, instead of having a targeted focus of people who are actually suffering with symptoms or appear agitated. So, I think one of the challenges I have with this one is that it's not targeted.

It's a very broad measure and a broad screening tool. So, just going back through some of the questions that were asked, I think the census-based entity did remove their support for this I think it was back in 2020.

The measure steward at that point declined resubmitting. The burden on physicians, since we were talking about the web interface, I hear from physicians and clinicians all the time, F and G codes are laborious to remember.

And I know many times I hear from our clinicians this requires a G code and then they have to document a follow-up plan. That follow-up plan is not always available to the next clinician in there.

And then when you look at the statistics around this, there's a natural gravitation towards the outliers, and what's been reported is an average because everyone gets clustered around that average.

And so it doesn't also help. I think just in summary, the intent of the measure was a good one. I think it's been a process measure that's been around for a long time but it hasn't actually been translated into longitudinal outcome improvement.

I think that's where we should be gravitating towards.

These longitudinal outcomes are key in these

conditions that span a period of time. Otherwise, we're just adding overload and work to both the clinicians, the office staff, as well as even the patients in this situation. So, as I hear this, I'm gravitating towards more of a conditional support for removal. I do think we should continue to focus on screening but I think it needs to be an appropriate audience.

I think the labor involved with this needs to be looked at and we have to find an efficient way to identify the right people, screen them, and then get them to the treatment course they need.

And we need to follow them on longitudinal outcomes. So, I would challenge the team and the stewards who have been involved in this area to look at more longitudinal outcomes.

With that, Jenna, I'll turn it back over my other colleagues.

Member Condon: This is Marie-Jo Condon with the St. Louis Area Business Health Coalition. I agree that over time we need to achieve the goals of really moving towards better longitudinal outcomes absolutely.

I will say, though, that this measure is an important measure for many practices that are really at the early stages of integrated behavioral health that see this as a first step that they can accomplish on that journey.

And while I appreciate the screening questions are broad, I think that in my conversations with clinicians, they often find it is really difficult to identify folks that may be suffering from undiagnosed depression.

And that in fact, those broad screening questions may bring in more individuals who are in need of treatment but have not yet been recognized. I would also just highlight some of the public

comments that was received.

Given the increase in mental health conditions during COVID-19, including depression and anxiety, it is essential to keep depression screening measures in measure sets to encourage proper identification and treatment for patients.

And that was from Otsuka Pharmaceutical Development and Commercialization, Inc., which did support retaining the measure in the program.

I think also while we have had some stagnation on this measure, the results that were provided did show continued improvement and I see a lot of instances of states and multi-stakeholder collaboratives, including this measure in new efforts to advance primary care, quality, and care transformation.

Member Parrott: This is Lou Parrott with Magellan.

I would agree a lot with what the first speaker mentioned but again, because of what the second speaker indicated around the symptom and disease burden that's undetected, if this measure was going to be retired, it would be conditional on replacing it with something that helps improve sensitivity, specificity, and so forth so that we're having a little bit better targeting of those who really need it.

And the other thing I would add, I don't know if it's appropriate in this forum, but to point out collaborative care models which can also really help the members and the patients right there in that practice when they do screen positive.

So, there are some other ancillary tools and programs that could kind of help as well. Hopefully, that's making some sense there. And I don't know if that's a common thing with a lot of these decisions that we make.

If we think that something is not doing as good as it

could, it doesn't go away until we replace it with something better.

The other piece as well is that obviously having performance measures, you do want to see differentiation between high and low performers but given the gravity and concern of the burden out there, I might not want that by itself to lead to removal although I know that's something I want to shoot for to be able to see differences between high and low performers.

Hopefully those comments add something to the discussion here.

Ms. Williams-Bader: I do see a couple of hands raised but before we get to that I wanted to summarize what we heard from the Advisory Groups and you'll be hearing this today, either NQF Staff will be summarizing the Advisory Group discussions or we'll actually have a representative from the Advisory Group here to summarize their discussion.

So, for this measure, the Rural Health Advisory Group, we did a poll with them to see if they supported retaining the measure in the program or not. One member or 14 percent said they did support retaining the measure.

57 percent said they did not and 2 were unsure or 29 percent. From the rural health perspective, there was concern that there was a tremendous lack of resources and that if you do screening but don't have the resources for referral, it creates a burden.

And they also noted there's a shortage of behavioral health and mental health workers around the country.

The Health Equity Advisory Group, one member noted that considering the impact of COVID-19 on adolescents, this is a critical measure to continue and noted that adolescents and children often don't

receive treatment. Another MAP member commented that there's a high proportion of patients with access to portals for digital screening and those have a much easier time reporting on this measure with the electronic version. The systems with less affluent patients.

Another MAP member commented that the measure is useful for assessing equity given the under-identification of depression and minority populations and there may also be intersectionality and intersectionality value given the underidentification in women.

Rob, I will go ahead and turn this over to you for discussion and I see that Peter and Rachel have their hands raised.

Chair Fields: Exactly, as there are two different types of questions, I think it's going to be impossible to decipher between the two here but we're asking for both clarifications on the measure or any of the information given, and then also a discussion.

At this point, we'll just combine the two here but we'll start with Peter. You have your hand up first so we'll go with you first.

Member Briss: Good morning, thank you. Very briefly, I just wanted to pile on on some issues that have been said.

This condition is common, treatable, underscreened, undertreated, worsening before the pandemic and further worsening since the pandemic.

And so generally, the issue is really important to address and this is one of those measures that I would like to echo previous comments.

If you were going to replace retire this measure for something better, it would be good to have something better lined up and ready to go when you

did that.

Chair Fields: Rachel?

Member Brodie: That was exactly my point. I wouldn't want to support removal unless there were better measures available and the true outcome measures, the risk mission and response measures if possible included in the program.

Just because we know that mental health is underdiagnosed in our country, patients are getting screened, this is a key component of integrated behavioral health as stated earlier.

So, it's essential to keep this screening and the CMS measure sets. I do agree, though, that I think part of the problem with this measure not performing well is this two components of the screening plus the follow-up plan.

So, if the measure is not performing well, it's hard to tell whether that was because the patient wasn't screened or because the follow-up plan was hard to document for the measure specification.

So, it's not a perfect measure, I think that's a problem but if we don't have something better, I would also discourage CMS to consider ways to provide quality improvement dollars or any dollars to providers to help with the resources.

The public comment about there being a lack of resources to do the screening especially in rural areas and smaller practices, what can we do as a country to support them better so that we have better patient-reported information?

Thank you.

Chair Fields: Next to the Patient Safety Action Network.

Member Lu: Thank you, I echo some comments that were made before that is important that we have

assumptions in place to either transition into an outcome measure or still have some type of a screening to really access the mental health issue.

And particularly giving the COVID-19 impact in the general population. And also, if we transition or improve with this measure, not totally scrap it, just improve it, and whether the CMS would address the issues raised, inequity issues and the area for those populations.

But my question to CMS is I notice that CMS did not submit re-endorsement in 2020. What is the CMS plan on this measure? I just want to gather a view of it.

Dr. Schreiber: In terms of NQF endorsement or in terms of the measure writ large?

Member Lu: In terms of the measure itself, will CMS still continue with this measure or are we going to replace it with something else or improve this or keep this measure in place?

Dr. Schreiber: The current plan at the moment is to transition this to an electronic clinical quality measure, which we think will be more robust and less burdensome.

I'm trying to think if they're in the programs already or not. There are measures that do look at outcomes. Lisa-Marie, you may have to help me, there's one about remission of depression within a year if I'm not mistaken.

Member Gomez: Correct, depression remission at 12 months.

Dr. Schreiber: But we hear feedback that one burdensome too because you need to follow up with the patient. So, there is an outcome measure out there, we didn't have a plan at the moment to transition to that.

And I would just comment to the Committee that I

think as you vote on removal or not removal, it should be on the merit of the measure, not what CMS may or may not frankly be planning to do in the future.

So, I can't remember who made this point but somebody said they wouldn't want to remove this if they weren't a replacement measure sort of in the pipe.

There is not a current replacement measure in the pipeline at this moment, I will say that.

Member Lu: Thank you for the clarification.

Member Gomez: And just to elaborate on what Michelle noted, in our program the measures that we have are measures where there's no duplication.

And if there is a measure they would be more robust in our program, and we would then implement that measure.

But as Michelle noted, the measures that you see now, this particular measure, this is what we have in the program and there isn't anything going to replace that.

I just want to highlight that. What you see here is what our program has.

Chair Fields: I have a comment also but Dan, go ahead and I'll do mine after you.

Member Albright: Real quick, in the same sort of message that others have suggested, without a replacement I think you should retain the measure with the condition that we're moving towards outcomes, a 6-month remission rate or 12-month remission rate.

Chair Fields: In friendly time for others, I'm looking at the chat here to make sure I'm not missing something.

But just a couple comments, the issue in general for the remission measure just to clarify is not necessarily that the follow-up is burdensome but that measure has really specific measures around follow-up that are not evidence-based.

The follow-up has to occur in a very, very specific window approximately a year after that diagnosis.

It's not the follow-up plan or remeasuring the score is an issue, it's just the specs of the measure are exceedingly narrow and have very little to do with actual clinical practice or evidence about when we should be doing follow-up.

So, I think that's the issue with the remission measure.

Michelle, I'm getting the sense from others because this has come up a few times, I think the idea that we would not consider replacements or the impact on the broader measure set seems a little counterintuitive.

Because I think there is some merit to the idea of relative effectiveness of the measure. There's hardly ever a measure that's black and white, super great or super terrible.

People recommend it usually with good intention and there's some value, but there is relative value.

And I think what people are expressing, which frankly, is an opinion I share is that, yes, this measure may not be perfect and I'd like to clarify some of the opinions I've heard about this measure, but it's better than nothing.

And so if there isn't a replacement, then I think there's a relative value to keeping it unless there's something better out there. It sounds like there isn't but I don't know, maybe I'm missing the point here a little bit.

It certainly is appropriate to judge the measure on

the merits of the measure specifically but I do also think there's merit and value to considering the broader set for this program.

I feel like the charge of this Committee is to evaluate measures for a program, not outside of the context of that program.

Dr. Schreiber: Rob and Michelle, I completely agree with your comments.

I guess I meant that as people are deciding what to do with the measure, I think it has to be whether or not this measure is meeting the needs of the program, whether or not it is considered to be a good measure on an important topic.

But not to be looking at it in the context of just that there's a substitute measure that could be introduced tomorrow. But your points are all well taken and I completely understand.

Member Parrott: This is Lou Parrott again with Magellan.

I'm just wondering in anticipation of the voting, support for retaining, conditional support for retaining, conditional support for removal, or support for removal, one of the things I'm hearing is people might like to remove it if there's something to replace it but there's nothing in the pipeline.

People are pointing out there's some problems with it but recognize the relative value.

If there was an idea to modify it and refine it in some way that allows it to try to improve the relative value but minimize some of the burden, I'm just wondering where that might fit in those four categories.

I don't know if that's support for retaining or conditional support for retaining. it sounds like conditional but that's one of the things I'm wondering and hearing.

I just wanted to get clear on which of those four buckets, something like that, if someone's thinking that way, might need to land.

Chair Fields: Lou, can I restate your question to make sure I got it? Your concern is if the real concern about this measure is really about reporting burden, how should that be considered in the four categories?

Is that essentially it?

Member Parrott: Yes, or if there's nothing to replace it and maybe people have themes for revising the measure, I don't know if that's allowed but how did those sentiments fit into the four buckets?

There's not a conditional support for removal. There's not conditional support for revision and we're not voting on revision but that's kind of what I'm hearing anyway in the dialog here so that's why I was trying to get some clarity.

Chair Fields: And the NQF Staff certainly can help me here but I think it would be that second category and unfortunately, I don't have the slide with the four categories right in front of me.

I don't know how easy or hard it might be to pull that up real quick but is that second category not conditional support for retaining or retention?

Ms. Williams-Bader: Right, Rob, that category is really for if MAP thinks the measure could work in the program, could continue to work in the program if there were specific changes made to it, whereas the conditional support for removal is really for measures that MAP know no longer work in the program.

But it's an important enough area where there needs to be a better measure first. But I think in hearing the discussion today, Rob, let me turn it over to you with that background to see if you had

thoughts?

Chair Fields: I actually was hoping to continue the discussion before we pre-suppose where we might start the voting but I totally agree.

I think to answer the question, Lou, I think you would choose either Category 2 or 3 depending on where you're leaning if you think you feel strongly that it should be removed, you would probably do the one on the screen now.

If you're default is probably it should stay but it could use some tweaking, I would use the one which just saw, which is conditional support for retention. I think that's how I would do it.

Member Parrott: Thanks for that clarification.

Chair Fields: Absolutely. Nishant, please?

Member Anand: Thanks, Rob, and Jenna, I think I was going to ask a similar question to Lou.

That's why when I suggested the conditional support for removal, I know we're splitting hairs between 2 and 3 but it does create a measurement gap and so I think that's why I was interpreting this as more of a process question on our voting and the criteria.

But it does create a gap and we've all accepted that this would create a gap.

I also interpreted this category, this third category, conditional support for removal to create an impetus for finding another measure versus number two is more in keeping just because there's any out there.

So, am I interpreting that third criteria correctly, that if it's not meeting what it was intended to do, going back to Michelle's point, the original intention was that it was going to -- the validity that are related to it, that's not there but it's going to create a gap.

Is that more number 3 as I was interpreting? Or am I interpreting it incorrectly?

Chair Fields: I think that's right, I think that's the way I would interpret it as well. One thing I will add, I know we have a couple more hands raised, maybe I'll parentheses now if the CMS team wants to comment.

One concern that I have from a program perspective is that if this measure is removed, it literally leaves the program with one other clinical measure and that's a hypertension one that is also on the list for review later this morning.

So, I have some concerns that removing this measure leaves the program pretty naked if you will in terms of clinical measures. I don't know if the CMS team has a thought about that and how to think about that context.

But in the meantime, while you're thinking about that, I'll go to the Patient Safety Action Network.

Member Lu: Thank you, I just want to have additional comments around why we think this measure should be in place and is important. Besides the urgency that after the pandemic or during the pandemic to address mental health for the population, general population.

Another thing is that since this program is under MSSRP, it is the perfect place to address this type of issue with coordinated care and that required addressing mental health, it required team care so I think there's no measures that are perfect and we shouldn't throw them out just because there's some other things.

We should look at the risk of doing it to the patients.

Chair Fields: Thank you. Dan?

Dr. Green: I'll be brief. I was around when this

measure was with Anita, in fact, and we developed this measure.

And the idea behind the measure was really to encourage not just mental health professionals or primary care physicians for screening for depression but really open it up to all clinicians.

As you know, some people don't see their primary care doctors regularly and sometimes people come in and everything seems fine, and as we all know, depression is underdiagnosed. And sometimes the signs are obvious and sometimes the signs really aren't.

So, that's why we're trying to encourage people to do the screening.

In terms of burden, if the patient screens negative, obviously in the follow-up plan it's indicated but it really is an attempt to try to catch folks who may not have obvious signs of depression.

If they come in catatonic, I think we would all probably hopefully spot that, but most patients don't come in that way.

Chair Fields: I agree, our estimate said at least 50 percent, in some cities even more, have certain subsections of patients go undiagnosed to that point. Michelle, thank you.

Dr. Schreiber: I just wanted to try and answer your comment that you're right, if this one were removed we would have one clinical measure.

On the other hand, if we removed all of the MSSP measures that are up to date for discussion, we might not have any measures in MSSP.

The recommendations of the Committee as we all know are not binding and CMS obviously has to has a program and would have to decide what would be the better measures in the future.

So, I think the best advice, really, is to vote on each measure individually for the value that the Committee sees of the measure, recognizing that we do have to have a program and we would want to have clinical measures.

But thank you for your comment, you are correct. If we were to remove this without replacing it, we would have but one clinical measure left, you are correct.

Chair Fields: Thank you, and I appreciate the comments and the context. I don't see any more hands up and Jenna, maybe if we could figure out what the magic number might be for the 60 percent?

Could we do that real quick?

Ms. Williams-Bader: Yes, we do have quorum for the meeting in order for the meeting to go ahead and we believe we have quorum for voting as well as 15 members I believe.

Is that right, team? I thought I'd heard that before.

Ms. Elliott: Correct, Jenna, we have 19 members on the call, quorum was 15 to conduct a vote, which we'll be able to do. And then I think, Rob, your question was also the 60 percent threshold to accept a vote.

So, currently we still have 19 so we'd have to have 12 people to get us to that 60 percent to reach consensus on a voting category.

Chair Fields: Thank you, and if the process is similar to how it's been in years past, it's the Chair's discretion to figure out where we start.

So, for those that are new in this process, the four categories we reviewed earlier and we start with what seems to be the most likely response and vote on that first to try to be more efficient with our time and not vote individually in each category.

If you don't believe that is the right category, you vote no for that status and then we go to the next category. So, I'm going to pause for a second to make sure that's clear.

So, I will just say that I'm actually going to start with the first category which is support for retention.

Based on my interpretation of the discussion, if you do not agree that is the right category, then vote no and we will go to the next one and vote on that.

If we get 12 votes for that category, then that's what stays and we move to the next measure. Pausing for NQF to make sure I said that correctly. I see some heads nodding so that's good.

Any questions from the Committee before we start the poll, especially for those that might be new?

Ms. Williams-Bader: I see a hand raised from Patient Safety Action Network.

Chair Fields: Go ahead, I'm sorry I didn't see that.

Member Lu: Thank you. Can we vote twice then? If your first vote got rejected do you vote again?

Chair Fields: Absolutely. So, if you vote and we don't get the 12, we go to the next category, yes, each round is a separate voting category. I'm going to suggest that we start with the poll with support for retention and I'll turn it over to the NQF team.

Ms. Williams-Bader: Rob, just real quickly, I think you covered this, I see Michelle's hand raised as well. Like you said, it's up to the Co-Chairs, you can decide to start somewhere else if you think that's where the group is.

But if you want to start with support for retaining then we can, I just wanted to make that point.

Member Brodie: It looks like the poll is locked still.

Ms. Williams-Bader: We will move to that, you'll see it on the screen when we are moving to the poll.

Chair Fields: I think you said there were hands up but I don't see any hands up.

Ms. Williams-Bader: Michelle. There was a hand raised but it's been lowered.

Chair Fields: I think we're ready. I'll turn it over to you guys.

Ms. LeFlore: All right, voting is now open for 00515-C-MSSP preventative care and screening, screening for depression and follow-up plan. Do you vote support for retaining?

Chair Fields: We're looking for 19 votes so we need 2 more.

And folks, if you have to step away can you please send a note in the chat so the team knows not to expect 19 votes if you're away from your desk, that would be lovely.

Ms. LeFlore: I'll give everyone about 30 more seconds. I'll go ahead and close the poll. Voting is now closed, the results are 13 yes and 5 no. That is going to be a percentage of 72 percent for yes.

Chair Fields: Great, thanks everyone, and we'll turn it over Jenna for the next measure.

eCQM ID:CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)

Ms. Williams-Bader: The next measure is eCQM ID: CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM).

This measure assesses the percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the

date of the encounter using an age-appropriate standardized screening tool and a positive follow-up plan is documented.

This measure is not endorsed and as a reminder, this is the eCQM version of the measure we just discussed. So, the discussion and vote will focus on the version of the measure reported as an eCQM.

Additionally, if you have comments about the registry base or CQM version of the measure, we can take those comments during this discussion.

We won't vote separately on the eCQM but if there are comments that are perhaps individual or specific to the eCQM you can raise those and we will include those in documentation.

Let me see, would one of the CMS program leads like to provide any comments about this measure?

Member Gomez: This is Lisa-Marie Gomez. I just want to highlight that as you saw, there is the web interface version and this is the eCQM version.

I just want to highlight that the eCQM version was added to the shared savings program as part of the APP, another way in which ACOs are able to meet reporting requirements under the shared savings program.

And this particular measure is a measure within MIPS that is also generally utilized under MIPS, and I know this is specific to the shared savings program.

So, I just wanted to highlight how this measure is constructed within the program and I don't know if, John, anyone from your program wants to elaborate on the inclusion of this measure?

Dr. Schreiber: This is Michelle, I'll comment for John for just a moment. As the Committee knows, MSSP is working on transitioning measures to eCQM. The measure is being specified in FIRE, which hopefully

will reduce the reporting burden.

And most of our eCQMs are all-payer measures so we get more robust data.

Mr. Pilotte: Thank you, I don't have anything to add.

Ms. Williams-Bader: Then I'll turn it over to the lead discussants and we have the same lead discussants for this measure as we did for the previous measure.

Member Anand: I think just very similar to the last one, I would just encourage us if we keep the measure to work towards more of a collaborative team measure or longitudinal outcome.

But my preference would be the eCQM version obviously that's coming forward because it does reduce the burden, especially if you can get into some of the registries that are out there.

I'm actually more supportive of this, the eCQM version than the prior version. That's the end of my comments.

Member Condon: This is Mary-Jo Condon with the St. Louis Business Health Coalition. Yes, I agree completely, I think the measure merits are pretty much exactly the same as under the previous measure, however, this does have the benefit of hopefully over time less of a reporting burden for providers.

Member Parrott: This is Lou Parrott, I concur.

Ms. Williams-Bader: Thank you all for that. Before I turn it over to Rob, let me share the Advisory Group feedback on this measure. Again, we had the Rural Health Advisory Group poll and 2 or 29 percent were in support of retaining the measure in the program.

3 or 43 percent were not and 2 or 29 percent were

unsure. They were thinking that the eCQM rather than the web interface version has a reduced burden and it does change the balance in terms of thinking about the benefit versus burden of the measure.

The health equity Advisory Group had no additional comments from what they said for the previous measure. Rob, I will turn it over to you.

Chair Fields: I'm looking at the chat here. Let's see. There's a question in the chat about reporting burden. Do folks actually mean the performing burden?

And I think, please others chime in, but no, actually, the intent in those comments is really the reporting burden.

In the current measure there's often a chart review, a fairly manual chart review that has to occur, depending on what form of follow-up plan is engaged with the patient.

So, some of those could be captured electronically but some may not require chart review. And the eCQM just by definition, it would be an electronic measure.

So, I do think the intent of the comments, please others, I don't want to misinterpret what you're saying, it is actually reporting burden not performing burden.

Member Condon: That accurately captures my intent, Rob, is that it's actually reporting burden.

Chair Fields: Just to give folks another minute if they want to comment, I'm not putting any judgment on it but just making commentary, I know we're not here to discuss eCQMs and I know John and Michelle are pretty familiar with my point of view on eCQMs and all-payer data.

So, we'll preserve that for now but I think one of

the things major differences on the eCQM versus the other is the way it actually functions. And the program, it will include all the specialists as well.

So, just know there could be a radically different performance, I would expect, on the eCQM versus the traditional measure, just based on the denominator or potential encounters we could be including.

But that's neither here nor there, it's just the reality of the measure. Are there exclusions to encounters within the denominator? Yes, there are. In the summary document, there are a list of exclusions.

Let me see if I can pull it up real quick, unless somebody has it handy and can get it faster than I can on my iPad here. I know there was one of them, if someone declines screening for instance.

Ms. Somplasky: Existing depression or bipolar depression are the exclusions for this measure because the intent again is to identify new patients with depression.

Chair Fields: Thank you. Another second or so? I'm not seeing anything else so I think based on what we got last time I would like to propose that we start the polling in the same place, so support for retention.

I'm still not seeing any comments or questions so I'll turn it over to the NQF team for polling or voting.

Ms. LeFlore: Voting is now open for eCQM ID: CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM). Do you vote support for retaining?

It looks like we're at 19. I will go ahead and lock the poll. Voting is now closed, the results are 17 yes and 2 no and that is going to be a percentage of 89 percent for yes.

Chair Fields: Then I'll turn it over to you for the next measure.

06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Ms. Williams-Bader: Thank you very much. The next measure is 06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups.

This measure is a respecified version of the measure risk adjusted readmission rate of unplanned readmission within 30 days of hospital discharge for any condition NQF 1789, which was developed for patients 65 years and older using Medicare claims.

This respecified measure attributes outcomes to MIPS participating clinician groups and assesses each group's readmission rate.

The measure comprises a single summary score derived from the results of five models, one for each of the following specialty cohorts:

Groups of discharge condition categories or procedure categories, medicine, surgery, gynecology, cardiorespiratory, cardiovascular, and neurology.

This measure is not endorsed but based on an endorsed measure, five survey Respondents selected this measure for discussion. I'll now if there's anyone from CMS who'd like to make any comments about this measure?

Member Gomez: This is Lisa Marie-Gomez. I just want to note that as specified under the shared savings program, this measure was highlighted under the APP as the measure that ACOs are assess on.

And this particular measure, stakeholders do not need to give the MIPS data, this is just the

characteristics based on the way the measure is structured.

I have folks from our team that developed this measure who they want to add commentary relative to this measure. Anita, does anyone from DAC want to highlight or talk about this measure?

If not, we can head onto discussion.

Ms. Williams-Bader: Thank you very much, Lisa-Marie. If we could go to the next slide and I'll turn it over to our lead discussants.

I have the American Academy of Family Physicians or Amy Nguyen-Howell?

Member Switaj: This is Tim Switaj from AAFP. I don't really have a lot to say on this, it's a pretty common measure, I've seen it for years. I think overall, my support, I'm leaning towards retention of the measure.

There are some challenges obviously in that.

There's many reasons why a patient may get readmitted and it may be for clinical reasons, it may be that there's a high-risk discharge as social determinants or the lack of proper follow-up care because they don't have primary care, et cetera.

So, there's a lot of challenges to it. I do think the way the measure was set up with the exclusion criteria taking out oncology care, taking out psychiatric care is a really good one because those readmission rates are very difficult to forget.

So, I think in the absence of any better measure, I think my leaning is to retain this as it is a pretty commonly accepted and well-known measure that has been in use for a while.

Member Nguyen Howell: This is Amy. I'll add to that. I do think the recommendation is to retain it.

As said before, it really hasn't been reviewed by MAP for the MSSP program. My only question, and I don't know who can answer this, is really the feasibility.

Since it has not been endorsed, there's a similar measure, NQF 1789, that has. Can someone speak to that so that we can get a better understanding of the differences and perhaps the feasibility?

Member Gomez: This measure was a re-specified vision of an NQF-endorsed measure so it is working towards endorsement.

I just want to highlight that reliability thresholds have been established and there are requirements for minimum group and case size.

So, I don't know if that addresses your particular question.

Member Nguyen Howell: The re-specified measure attributes outcomes to MIPS participating clinician groups and the group's readmission rate. And then the measure specs do differ from NQF 1789, correct?

So, we're not looking at duplication?

Member Gomez: Correct.

Mr. Pilotte: This is John. I'm not familiar with 1789 but this measure actually uses the hospital version of the measure which then aligns with the MIPs version of the measure.

We actually did look at this to discuss this in the rural preamble and we finalized this and proposed it as this measure's performance is correlated for ACOs as well.

So, I just wanted to flag that.

Ms. Williams-Bader: Thank you to our lead discussants. Before we turn to discussion, I wanted

to share the Advisory Group feedback. For the Rural Health Advisory Group, 3 or 43 percent supported retaining the measure in the program.

4 or 57 percent did not. There was quite a bit of discussion about this measure with the Rural Health Advisory Group trying to figure out if rural providers would be reported in the measure or not based on exemptions.

So, there was some concern if rural health providers are left out, they had some concerns about that.

One also noted that because the measure is not stratified by condition and because rural facilities have low case volume challenges, there may be validity concerns for rural settings and the measure could be affected by small fluctuations.

However, others commented that the measure does provide a way to monitor performance and to assist in keeping patients out of the hospital past their discharge.

For the Health Equity Advisory Group, they said the challenge from the equity perspective is there still seems to be need for greater specificity and teasing out condition-specific measures rather than global readmission.

They raised concern regarding the need for comprehensive risk adjustment for socioeconomic status and other social determinants of health factors that can impact outcomes and are unrelated to quality of care provided.

Another MAP Member commented that according to their review of the literature, admissions post the seven-day window are really related more to social determinants of health issues or structural determinants of health issues.

And the question they were raising is around 30 days, how much can a hospital system be

responsible for the readmission outside of that seven-day window?

Lastly, another MAP member commented there are many variables to take into consideration with this measure and therefore, accountability should not be placed solely on the shoulders of providers.

Rob, I will turn it over to you for discussion.

Chair Fields: Please use the raised-hand feature or the chat. I have an opening one of that's okay and it goes back to correlation of this version of the measure versus the older ACL measure.

And it sounds like that correlation can seemingly speak to what the modeling was done, or was that looked at even especially with some of the pandemic fluctuations?

Was that looked at for 2021 utilization as well to see time correlation of the measure?

Member Gomez: I am going to defer to ACS team to answer that question if you're able to do so. I don't know if we have anyone to address the specific elements of that.

Colleen, are you able to address this specific question?

Ms. Jeffrey: I would have to defer to our team if Yale CORE is on to answer the specific testing with this measure.

Ms. Williams-Bader: It's really hard to hear you.

Ms. Jeffrey: I'm sorry, I just said I would have to defer to Yale CORE team for specifics on testing of the measure and how the measure was developed.

Ms. Grady: This is Jackie Grady from the Yale CORE team.

The testing I think that was mentioned prior was

really looking at the MIPs version of the measure and that was done with pre-COVID-19 data because that's what we had available for that work.

The hospital version of the measure, which is the 1789 version, has been -- I don't know if it's even relevant, but it's still being reported throughout the last couple of years. I don't know if that helps or not.

Chair Fields: I think Jennifer put her comment in the chat but this is the same question I have.

It sounds like, John, you had just made a comment that the correlation with the two measures and I'm just trying to figure out how that correlation was tested.

The attribution methodology is radically different. Ms. Grady: Yes, the attribution for this particular version of the measure is at the provider level and it's a multiple attribution technique.

So, there is some differences and as I said, because the attribution is different, we can't do a direct correlation of the hospital version of the measure because that's attributed at the hospital level.

Chair Fields: The ACL measure was actually attributed at the attributed physician level within the MSSP program. Was it not?

Ms. Grady: Right, and Yale CORE did not do those calculations in that so I'm not sure.

Chair Fields: Does anyone know if there was any correlation done between the old MSSP measure that attributed at the attributed doctor level versus this measure, which is done at the multiple attribution level?

Mr. Pilotte: Yes, we actually did look at that and those measures are correlated. I believe that was discussed in the 2020 rule on it but we can get you that information.

I'm sorry, I thought between the ACO version and the MIPS version, given this attribution issue and the measure was performance was correlated, even though there are different assignment rules as noted.

Chair Fields: You said 2020 was the last time that correlation study was done?

Mr. Pilotte: Yes, with that and when we brought the measure over to the programs. So, I think it was in the 2020 final rule, we left it at that.

Chair Fields: And I think there's a comment somewhere I believe in the rule that we'd need to continually look at it, right?

The 2020 utilization was obviously super skewed so hopefully that correlation continues but it's worth looking at just giving that differential. But it's worth looking at just given that differential in attribution.

Mr. Pilotte: I think the data we had at the time, I want to say it was 2019 data but don't quote me on that. I don't think it was 2020 data.

Member Parrott: This is Lou Parrott, I just had a question about the measure itself.

Does this only include in the denominator patients that were already on the clinician group panel before they went for the initial hospitalization and then came back to the clinician group and then had a subsequent readmission that goes in the numerator?

Or does it also include I'm a PCP and I get this patient for the first time right out of the hospital and now they're in my denominator as well?

I'm just kind of curious around how the denominator is factored for this, I'm not sure it completely impacts the decision here but I was just kind of curious about that if anybody knows.

Ms. Grady: This is Jackie Grady again, I can try to answer that question.

So, like I said, this is a multiple attribution measure so the index admission would be attributed to three different types of physician groups potentially.

So, there's the discharge in clinician group during the hospitalization and there is the primary inpatient care provider group. That's the group of clinicians responsible for the patients' care who build the most charges during the hospitalization.

And then there's the outpatient primary care physician group and that's the group of physicians who were responsible for the care outside of the hospital. And that is based on 12 months prior to the hospitalization.

So, if you're seeing a patient newly after their hospitalization the first time, you most likely would not be part of the attribution process.

Member Parrott: Thank you for that clarification.

Chair Fields: I know we have a hand raised from the Patient Safety Action Network. Please go ahead.

Member Lu: We just wanted to voice our perspective that it's highly important, this is critically important for patient and for the public accountability.

And clinicians in our perfect physician to help working as a team of coordinated care and ACOs to help reduce the readmission.

And I think this measure perfectly fit the overall goal of MIPs and MSSP. So, I think we think that this measure should be retained.

Chair Fields: Thank you for those comments. I'm not seeing any other hands raised, no new comments in the chat. I am going to once again propose that we start the voting with support for

retention.

I'll turn it over to the team.

Ms. LeFlore: Voting is now open for 06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups.Do you vote support for retaining?

I'll give the Committee about 15 more seconds.

Ms. Elliott: It's Tricia, we did have one person step away so I think we're good with 18.

Ms. LeFlore: Okay, thank you. Voting is now closed, the results are 18, yes, and that would give us 100 percent for yes.

Chair Fields: Jenna, I'll turn it over to you. I believe we're heading up to lunch, is that right?

Ms. Williams-Bader: Yes, that's right, we're doing well for time so we will go ahead and take our 30-minute lunch break right now which means we will return at 12:35 p.m. Eastern Time and we will put that in the chat as well.

We look forward to seeing you in half an hour.

(Whereupon, the above-entitled matter went off the record at 12:05 p.m. and resumed at 12:36 p.m.)

Welcome back, everyone, I hope you had a nice lunch break.

02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

We'll go ahead and get started with our next measure, this is 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic

Conditions.

This measure assesses the annual risk standardized rate of acute unplanned hospital admissions among Medicare fee for service patients aged 65 years and older with multiple chronic conditions.

This measure is not endorsed but is based on an endorsed measure and was selected by three survey Respondents. Let me pause here and see if anyone from CMS would like to make any comments about this measure?

Member Gomez: This is Lisa Marie-Gomez with CMS.

I just want to highlight that as noted for the other measure relating to the hospital-wide 30-day all-cause unplanned readmission measure, similar to that measure, this measure is included in the shared savings program as part of the APP.

And this measure does not place any burden on the ACOs in terms of them having to provide any data as calculated on their behalf. I will note that the reliability threshold has been established.

And there are requirements for minimum group and case size for this measure. I will turn it over to John if he wants to add anything else for the inclusion of this measure in the shared savings program.

Mr. Pilotte: Thanks, this is John. Just a note similar to -- it was actually the 2022 final rule where we discussed the correlation.

This measure was correlated with the ACO version of the measure to keep measures aligned within the MIPS program.

And that was the context, we looked at also the correlation of the hospital-wide readmission measure as well as part of that with the MIPS version of the measure as well.

Member Gomez: Thanks, John, we don't have any further comments.

Ms. Williams-Bader: Thank you very much. I'll turn it over to the lead discussants and I have the American College of Cardiology, Kaiser Permanente, and Health Partners listed as the lead discussants.

So, we can start with the American College of Cardiology?

Member Rose: Good afternoon, Geoff Rose on behalf of the American College of Cardiology.

Our position is to recommend that this measure be removed. This basis for this I think comes back to the premise of the measure that increased care coordination or care management can reduce admission.

So, not readmissions but admissions. And the evidence base that that is so is actually quite weak on studying the information even when looked at in a highly performing healthcare system.

So, the basic premise that this is a quality measure and not really a utilization measure is one that the College brings forth.

In addition to that, there's some methodological issues that I think were raised by others and that is the influence of socioeconomic status and other aspects of access to care, to primary care, that influence this particular measure.

Of note, this was my understanding or the College's understanding in controlling for this, the methodology used in determining this particular metric actually used an SES evaluation that was in contrast to the NQF's own Disparity Standing Committee.

So, there's some issues of concern there as well. Also, the role of dual eligibility are seen as not being factored in.

Also in the measure, one of the defining chronic conditions of 8 in inclusion in the metric is actually an acute condition, acute myocardial infarction, which leads to expected admissions in the first year after myocardial infarction for planned revascularization or device management.

So, again, curious that an acute condition is one of the eight defining criteria for a chronic condition metric. I'll stop there but those are some of the concerns that are relayed on behalf of the American College of Cardiology with respect to this metric.

Member Gozansky: If I can jump in, this is Dr. Wendee Gozansky representing Kaiser Permanente.

I think that the concept of trying to focus on a specific population to reduce admission through improved care coordination in addressing measures is an admirable goal and I think does speak to the MSSP focus on promoting accountability for a patient population.

I also think that the idea is that hopefully it is higher quality to not be in the hospital if unnecessary.

And so I think that's part of what is hard to understand from this measure is whether it's truly unnecessary or inappropriate admission. I do think there's good variability in the rates.

I think the question is what the variability is actually reflecting and does improved care coordination or specific measures really relate to those decreased rates of admission?

Or is it things related to the risk adjustment type of process? So, I think that to me this seems like a potentially good measure that perhaps needs some qualification.

I agree with the concept of why is an acute condition part of the chronic conditions? I also think

this idea of figuring out a little bit more about what is really underlying the question of unintended consequences, the idea of getting better alignment in the risk adjustment would be helpful.

I do think there are over about 500 ACOs reporting on this measure so it seems that should also be taken into account when we think about whether to remove, retire or perhaps amend the measure.

Member Albright: Dan Albright from Health Partners. I would endorse retaining the measure with some conditions.

I think it does meaningfully assess quality of care team integration in its ability to decrease utilization in high-risk populations.

An example of this that many systems are pushing is transitional care management involving care teams within the hospital, the interface transition between hospitalization and follow-up and care coordination, social work, primary care providers.

And I think this adequately supports that work that we are doing, those are condition-based follow-ups typically and risk-based follow-ups.

A limitation is what's been mentioned, it is clinically based for population, a determination and not social determinants of health base. So, that would be have to be considered in future renditions.

Ms. Williams-Bader: Thank you so much. I'll review the Advisory Group feedback and I just wanted to see if we have Beth Godsey on the line from Our Health Equity Advisory Group?

Ms. Godsey: Yes, this is Beth Godsey, I'm here.

Ms. Williams-Bader: Would you like summarize the health equity Advisory Group discussion of this measure?

Chair Fields: Yes, absolutely.

I think there was some good discussion and understanding that there are challenges with chronic conditions, particularly in historically marginalized populations, that this measure from an equity perspective would be helpful from a stratification point of view, to have deeper insight to see if there are areas or parts of the population where this measure is more challenged than others.

There also is the recognition that this measure incorporates components that can be outside of the provider's locus of control and that was an area that needed to be thought about or re-engineered or considered.

But from an equity perspective, there were certainly interest in being able to showcase this, if this measure is moving forward from a stratifications perspective and give insights into unseen health disparities or health inequities.

Ms. Williams-Bader: Thank you very much, Beth. Lastly, I will summarize the Rural Health Advisory Group feedback. 4 or 57 percent of the Advisory Group Members supported retaining the measure in the program. 2 or 29 percent did not and 1 or 14 percent was unsure.

And while they did have some discussion of the measure, they did not raise any specific concerns from the rural health perspective. So, Rob, I will turn it over to you and I'll note we do have a couple comments in the chat and have a hand raised potentially as well.

Chair Fields: If I could start with the comments? Can anyone from CMS comment on the counting of readmissions in this measure or if there's some sort of episode exclusion?

I assume you calculate the two measures independently so, therefore, the readmission is counted as an admission but I wanted to validate?

Member Gomez: Do we have anyone from the Yale CORE team that can address that question?

Dr. Lipska: This is Kasia Lipska from CORE, hi, everyone. This measure counts admissions but it does exclude admissions that occur within 10 days of a recent admission. So, there is a 10-day buffer period.

Chair Fields: Thank you, that's super helpful. Hopefully that addresses that question.

Member Fleischman: It's a little bit of a wrench. So, it counts some readmissions but not others? It counts readmission within 30 days, which I think the prior measure used, right?

So, it's sort of an interesting overlap there but that answers that question, yes.

Chair Fields: It's interesting, how we count readmissions is a little funny, it's not terribly consistent here.

And then I'll just tackle your other one, I don't know if anyone from CMS wants to comment on the intent because I think this is going to come up on having acute MI as one of the conditions.

Can anyone speak to intent here and why an acute condition such as this was included in a chronic condition kind of way?

Member Gomez: Kasia, would you like to elaborate or address that question?

Dr. Lipska: Sure thing. You're right that the qualifying condition starts with an acute event, which is either a STEMI or a non-STEMI but remember that this happened before that performance period.

So, this is a marker of patience with coronary artery disease. As such, this is a chronic condition that is managed to reduce the rate of current events,

which may include cardiovascular events or heart failure.

So, therefore, it is used to denote this chronic population of patients with coronary artery disease.

Chair Fields: That's what was commented on, but I just wanted to clarify. And then Greg, I thought I saw your hand up and now I see it lowered? Any other questions, thoughts, concerns?

Wendee, go ahead.

Member Gozansky: Can I just get clarification? I was not clear on the denominator exclusions for number 6, which is post-hoc patients not at risk for hospitalization during the measurement year.

I just really didn't understand what that was. There are some good upfront exclude hospice and so forth. Can somebody speak to that?

Member Gomez: Kasia, would you address the question?

Dr. Lipska: Yes, I wish our analyst was here on the line because she had a good answer to this. There were some patients who either were admitted to the hospital at the beginning of the performance year and let's say -- I don't want to give this example.

Basically, those are patients who are not in the outpatient setting, not in the nursing home and have no person time at risk during the performance year.

And there were some specific scenarios, which I'm just not remembering right now where this happened, it was really rare but it was one of the exclusion criteria.

Member Gozansky: So, it's basically a rare exclusion that doesn't have a lot of meaning, thank you for that.

Chair Fields: Anyone else?

Member Fleischman: Can I just ask a clarifying question? From the lead discussants from Kaiser, were they in favor of retaining this or favor of removal? I'm just curious.

Member Gozansky: I would say that in favor of retaining with the idea that it does seem like some additional clarity around the risk adjustment and perhaps the concept of whether we actually are double counting with other measures.

It seems like it's a little bit messy but it does seem like a good measure with lots of participation and significant range to performance.

I think the question is what explains the range of performance and the actual declines in performance. I think the most recent decline is clearly a COVID-19 effect but there has been some additional movement as well.

Member Fleischman: In my mind, just listening to the discussion, it almost comes down to a philosophical, not philosophical, but the question is can intensive care coordination and so on prevent provisional hospital admissions for patients with certain chronic conditions?

That's the question. And we heard from one organization that didn't think so and it sounds like maybe other people think it can.

Member Gozansky: I think Kaiser Permanente would think it can.

Chair Fields: As would most ACOs I would suggest, foundational to the mission of most ACOs. Jennifer, were you going to put a comment? I just want to clarify with CMS, is this mandated by statute or by regulation, this measure specifically?

Dr. Schreiber: This is not mandated by statute.

Chair Fields: Okay. I'm a little bit struggling to know how to start here because I think if we say retain with conditions we should be pretty specific on what those conditions are relative to some of the questions we just had a second ago.

And I know when I heard your comments on the risk adjustment there are some risk adjustments in there for those that hadn't seen it on socioeconomic status. And I'm of course blanking on what the other one was.

But I don't know if there was some specific detail that you're looking for in that risk adjustment that you're not seeing, and then we've established the readmission piece.

We are double-counting to the degree that if a readmission occurs on Day 11 through Day 30, they are being double-counted, maybe that's when we -- I don't know if we're saying a condition for this might be just have it match so we're counting readmissions similarly.

I'm looking for a little guidance here before we put it into a vote.

Member Gozansky: I think my suggestion would be that we don't overlap the readmission criteria potentially and I think I would defer to the health equity group if they feel the risk adjustment for health disparities is adequate.

I can go back and look at my notes but I thought there was some question about using a different methodology.

Chair Fields: Go ahead.

Member Fleischman: I'm not sure, they're not double-counting, it's two separate measures and some of the same encounters fall into one measure and will fall into the other measure as well.

My suggestion to make it cleaner actually would be

to include everything and not exclude anything.

So, that way, you have one measure that only looks for readmissions and one measure that looks at all admissions without exclusions based on time for prior admission.

And nominally, obviously this will target -- even though there's already a separate readmissions measure, this measure will target the original admissions.

So, that would be I think a cleaner way to think about it for mitigation potential.

Chair Fields: I'm not sure, there was a comment about if the CORE team might want to comment on the 10-day buffer rationale. It's a great suggestion but this would be helpful context if the team would like to comment.

Dr. Lipska: Let me comment because it does seem confusing at first if you think about 30-day readmission and 10-day buffer period, how do we get there?

And so just to provide a little bit of context, that 10-day buffer period is a period of transition back to community-based care.

So, a patient that's discharged is going back to community-based care and so we don't want to necessarily hold clinicians, it's different than hospitals, accountable for admissions during that short timeframe after the patient is discharged.

And so that buffer period allows time for patients to be seen within that seven days of discharge as is recommended by CMS's transitional care management service guidelines and for the ambulatory care providers care plan to take effect.

So, that's how we arrived at that 10-day buffer period. It's for clinician and clinician groups because that measure is meant to be a clinician-clinician

group measure as well as an ACO measure. Does that make sense?

Chair Fields: Yes, so it's really trying to protect on the MIPs side of things really more so than the ACO side of thought.

Dr. Lipska: It's trying to protect on the MIPs side of things, if you don't want to hold the hospital -- because part of that responsibility for care for those patients in that transitional period is shared by the hospital and shared by ambulatory providers, it's really shared.

Chair Fields: I've got to be honest, this speaks to fundamental issues that I have about putting MIPS measures in the ACO measure set because I think the intent is really different.

The work of an ACO as a group and as an entity is really different than an individual clinician frankly and the level of responsibility is different.

So, it feels somewhat forced frankly to put a MIPs measure, and we've stated this, the ACO team has stated this multiple times, but we're really forcing an individual clinician measure into a context where it really doesn't belong, at least not in the way it's stated.

So, it is what it is, I know that's the intent of the program and where folks are moving but this just highlights a fundamental flaw because I think you would argue from an ACO standpoint that if you were going to put a 10-day buffer to give the time for the primary care, i.e. attributed provider in the case of an ACO to take hold of the care plan and act on it, then that 10-day buffer should apply to both measures using that logic.

It just is a little problematic. But I'm not sure we're going to resolve it by this vote so it's a different question. Geoff, do you mind making your comment verbally? It's kind of a long one in the chat.

Member Rose: Happy to. Coming back to the acute MI, this is a chronic condition and yet we're using an acute event in there that has an expected need for revascularization with a delayed setting after the event and so forth.

There are codes that represent chronic coronary artery disease just as there are for heart failure and other things that are on the list. I'm just curious as to how this metric was developed this particular way.

Also, synthesizing with some of the other comments that we heard, this metric seems to be provide some range but we don't really know why, we don't really know what the impact is of the high-performers and the low-performers with respect to socioeconomic status.

We don't know the impact of this particular measure so it would be really helpful to hear from the measure developers what outcome metrics we have.

Once again, based upon the data published about the lack of demonstrable effect of effectiveness care coordination and reducing hospital admissions.

Chair Fields: If you wouldn't mind responding?

Dr. Lipska: In terms of the AMI issue, again, I agree with you that those patients are high risk and they have revascularization procedures and other planned procedures.

I just want to remind the panel that first, this is a multiple chronic conditions cohort so the patient had an MI and something else to qualify for the cohort.

That MI occurred before the performance year and planned admissions, such as admissions for revascularizations are not counted in the outcome of the measure.

I think that was the first question just going back to

AMI.

In terms of the evidence base for reducing hospital admissions among patients with multiple chronic conditions, the reason, as we stated in the evidence forms and various literature reviews, the recent evidence base about what clinicians and health systems can do to reduce the risk of hospital admissions.

I think this is at the core of managing patients who have multiple chronic conditions, that's what we're trying to do as physicians, we're managing their chronic conditions so they don't become exacerbated and don't become acute where they need to be admitted.

So, I think it's the core of our mission as clinicians in terms of coordinating care.

I'm happy to cheat a little bit and look at my evidence base attachment here but evidence suggests that there are models of care and practices that can reduce the risk of admission including care coordination, continuity of care, various programs that help dispense medications to patients to provide them in a safe fashion.

And then guard against adverse effect of medications, various patient-centered medical home interventions and team-based care that can really help with those.

I'm happy to provide references as well.

Dr. Schreiber: This is Michelle, can I just comment for a second? One of the reasons for including an MI is really, it's an indicator of worsening of the underlying coronary artery disease.

The hope is the clinician or the ACO is taking the steps necessary to prevent an AMI, not that that can always happen but that's the reason I think it was included.

It was included as a hospitalization marker for CAD.

Chair Fields: Right. Wendee, let's go to you and we'll see if we can try to move to a vote.

Member Gozansky: I was just going to quickly comment on the evidence base. The UCLA Alzheimer's care coordination to decrease admissions, the special needs plan, care coordination work too also.

There is plenty out there so I would just second that I think the data are there.

Ms. Williams-Bader: There's one more hand raised.

Chair Fields: Go ahead.

Member Lu: I think we should keep in mind that this measure targeted a group of a very vulnerable patient and with multiple, not just one chronic condition and this is a group of patient population that quite frequently, I think the evidence and article that I read about this is a group of patients that quite often are admitted to the hospital, revisit, are admitted to the hospital.

And that not only impacts the patient themselves but it also drives up the cost. And that's what this MSP program is designed for, to reduce the cost, to improve quality of care so coordinated care, ACOs.

So, I think this is a perfect place to have this program.

Chair Fields: Thank you, I'm sorry, I do have one last clarifying question. The risk adjustment piece, going back to Wendee's comments earlier, has that been tested at the ACO level? Is there a correlation study done on the risk adjustment?

That did not exist in the prior version of this measure in the MSSP.

Dr. Lipska: I'm so sorry, can you repeat the

question?

Chair Fields: The new risk adjustment components to this measure, I assumed that was always in existence in the MIPS version of this measure but certainly was not in existence in the prior ACO version of this measure.

So, has there been any sense of how this performs at the ACO level?

Dr. Lipska: Yes, the measure was tested both at the ACO and separately at the MIPS clinician level.

Ms. Altaf: And Kasia, I just want to add, this measure has undergone the NQF endorsement process and is currently specified.

And so just supporting Kasia at this point about this measure was tested at the ACO level with these specifications, and helping tie together different NQF processes.

Chair Fields: We'll try to take this to a vote here. Maybe I will start with conditional support for retention with the conditions being -- I don't know how you're feeling about this.

I still have many questions about the 10-day buffer corollary and how those are not the same.

If folks disagree you can certainly vote no, we'll start with in this way but if you're looking for specifics on what the conditions might be, I think reevaluating the definitions of readmissions in the two measures and the validity of a ten-day rule of the individual ACO level I think is -- I'm not sure that makes a lot of sense to me.

If the purpose of the measure to promote care coordination, that should be the same across the board.

So, I don't know if others disagree or if, Will, you have other comments but I think one condition to

look at is at least reevaluating the readmission criteria and the definitions there and the buffer.

Anyone disagree with that? Otherwise, we'll start with a vote with conditional support for retention with that condition. We'll start there and turn it over to the NQF team.

Ms. LeFlore: Voting is now open for 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.

Do you vote conditional support for retaining? I'll give everyone 15 more seconds.

Chair Fields: I know we've lost at least one person, perhaps a couple.

Ms. Williams-Bader: Joelencia, I know we have offline votes from one of the Members that we need to include.

Ms. LeFlore: I'll wait for that input and then I'll go ahead and close the vote.

Chair Fields: I'm not seeing any changes. Let's include those offline votes so we can keep moving.

Ms. LeFlore: I believe someone is back and is trying to put that in right now.

Chair Fields: Got it.

Ms. LeFlore: I'll go ahead and close the vote. Voting is now closed. The results are 15 yes and 3 no, and that would give 83 percent for yes.

Chair Fields: Excellent, thank you, everyone. We'll move to the next measure and I'll turn it over to Taroon.

Dr. Schreiber: It's Michelle, I had my hand up. Can I clarify the conditions so that I make sure that we as the CMS team understand it? What I heard you

say is to reevaluate this 10-day hold window for the ACOs.

Is that because you would illuminate that 10-day because ACOs should be doing coordination of care and should be responsible for that time or we should extend it?

I just want to make sure we're clear on the message.

Chair Fields: I guess I feel like they should match.

I could argue the 10-day window should apply to the readmissions measure as well as the admission measure for the same reason, or you could imagine that depending on the CMS stance that care coordination should be occurring at time zero at the point of discharge and therefore eliminate the 10-day measure.

I could argue it either way but I do think they should match.

If the intent of this measure, either at the clinician level or the ACO level is to coordinate care, to manage conditions and avoid unnecessary admissions, and the point of the buffer was to give the ability for care coordination to take place, that should occur in either instance.

I'm not sure just because it's a clinician versus an ACO the responsibilities are different I guess is really what I'm saying.

Dr. Schreiber: Thank you for clarifying, I just wanted to make sure we had the right message as we start these conversations.

Ms. Williams-Bader: And I do see a hand raised from Will.

Member Fleischman: I would add that the ten-day line, it's obviously arbitrary.

The thinking I'm guessing is one week and at least one week, if somebody is discharged on a Friday but again, it's an arbitrary line to decide who has responsibility for the readmission.

I think a cleaner way to approach it is to simply count all admissions and not have a buffer of any kind for this specific measure, which should lead to plenty of variability and should reward those who focus on hand-offs with no gap in care and would penalize those who have poorer hand-out situations without trying to assign how many days of post-hospital stay who was responsible for it.

Chair Fields: I would agree with that and I think eliminating that buffer and this one would essentially make that readmissions measure match because you don't have a buffer in the other one, why do you need it in this one?

That makes sense to me, Will. I think we are now ready to turn it over to Taroon to do the next measure.

Ms. Williams-Bader: Actually, Rob, the next one is mine, we do have one more in here, the CAHPS measure. We'll be doing the CAHPS measure next, take us through that one, that's okay.

Next slide, please. The next measure is consumer assessment of healthcare providers and systems or CAHPS for MIPS survey.

The consumer assessment of healthcare providers and systems clinician and group survey, CG CAHPS, is the standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their Staff in ambulatory care settings over the preceding six months.

CG CAHPS is endorsed and three survey Respondents selected this measure. We do have some points of clarification here.

The shared savings program recently removed from the program the CAHPS for ACOs survey and is now moving to the CAHPS for MIPS survey.

The CAHPS for ACOs survey was last administered on behalf of the shared savings program ACOs for the 2019 performance year. CMS waived the CAHPS for ACOs survey for the 2020 performance year.

Beginning with the 2021 performance year, shared savings program ACOs were required to administer the CAHPS for MIPS survey as part of APM performance pathway reporting.

The surveys are nearly identical however there are some scoring differences and these surveys are also similar to CG CAHPS. But to be clear, what's in the program is the CAHPS for MIPS survey.

Given how new the CAHPS for MIPS survey is to the shared savings program, the information in the measure summary sheet is for the CAHPS for ACOs survey and the CAHPS clinician and group surveys, or CG CAHPS.

We did not discuss this measure with the Advisory Groups, however, since it was nominated for discussion during the survey, we do want to discuss with the clinician Work Group today.

And the survey and I believe during public comment we did have the CMS measures inventory tool number for the CAHPS for ACOs survey but again, what's up for discussion today is the CAHPS for MIPS survey.

There's been just a bit confusion as the transition has happened here. So, I want to see if there's anyone from CMS who'd like to make any comments about this measure.

Member Gomez: I just want to note, I'm not sure if this was mentioned briefly, but this particular measure for ACOs is required for all ACOs to

support this measure whereas under MIPS it's voluntary.

As Jenna noted, this is a measure that is now being utilized by the ACOs whereas previously, it used a different survey and again, it was very, very similar and there was just one question that was different between the CAHPS for ACO survey.

But in general it's the same. I'm going to turn it over to John if he wants to add anything with regards to this measure?

Mr. Pilotte: I do not. Just to re-emphasize Lisa Marie's point about we've had this survey in the program since the beginning.

And we've we worked to not only streamline and reduce the burden and the number of measures that are in the survey but also to keep it closely aligned with both versions of the ACO, the MIPS version.

And as Lisa Marie noted, there is really only one question that I believe was ever different and I'm not even sure it was scored and I thought it had to do with Internet access.

Ms. Williams-Bader: If we could go to the next slide, we did not assign lead discussants for this measure so I'll briefly summarize what we heard in the survey.

The criteria that survey respondents use when nominating the measure was the measure performance does not substantially differentiate between high and low performers such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation.

The measure leads to a high level of reporting burden for reporting entities and the measure has negative unintended consequences including potential negative impacts to the rural population or

possible contributions to health disparities.

The free text feedback that we heard in this survey, one is have received feedback from stakeholders that the questions, feedback, and rates from the CG CAHPS tools are very hard to impact or improve.

Additionally, the vendor requirements around administration were so burdensome we actually had state legislature prohibiting the statewide quality and measurement program including these metrics and we stopped collecting and aggregating this information.

And second was people with intellectual disabilities are unlikely to be able to participate. So, as I mentioned, we did not discuss this with the Advisory Groups.

Rob, I will turn it over to you for discussion now.

Chair Fields: I'm looking at the chat. I wonder as we're waiting any other comments if the CMS team could comment?

Although the survey is different, I believe the scoring methodology is quite different in the new setup versus the prior ACO setup in terms of specifically how the benchmarks are calculated.

Maybe you want to comment on that at all? I think you were about to answer, I was just trying to clarify the flat benchmarks versus a percentile-based approach.

Mr. Pilotte: I was just going to say in the prior version we used to score each SSN individually but under the MIPS rules -- so, in essence, there are six different SSMs or five different summary survey measure components to the survey.

Under the prior scoring mechanism, each one was scored separately. Under MIPS it's scored as a single survey so all of those roll up into a single score.

Chair Fields: It sounds like there was some difference in performance as a result, right? They saw some more variability?

Mr. Pilotte: We didn't actually fail the survey in 2020 because of the PHE. 2021 would be the first year we have results under the revised scoring.

Chair Fields: I'm not seeing any hands or comments.

(Simultaneous speaking.)

Ms. Williams-Bader: There are a couple of hands now.

Chair Fields: Yanling, you want to go first?

Member Lu: Thank you. From a patient's perspective, this is a very important and valuable measure for them.

There are not many patient-reported outcomes and the CAHPS sees the only one that elicits the patient's direct feedback under the healthcare they received.

That's why it's so important and even though the measure is not directionally related to patient outcome, I seek comments from other members, this outcome measure.

But think about how quality of care and safety, how that healthcare setting allows them things like those major metrics, like rule dismissiveness being listened or not and being included and making decisions, et cetera.

All those measures can significantly contribute to bad patient outcomes. So, we think this measure is very important for patients and the healthcare consumers.

So, I would really encourage the Committee to think about retaining and keeping this measure for the

interest of the patients.

Chair Fields: Wei Ying?

Member Ying: Yeah, I would sort of concur with the previous comment. So, this is the only patient experience measure in the MSSP set.

Also, even though here we see a comment that it seems like there is at least the one state seems to believe that the burden, the data collection burden is too high and not going behind sort of promoting this measure, but at least in our state in Massachusetts, CG CAHPS or a very similar version actually is one of the key measures endorsed by the state measure alignment task force.

So, the health plans, including Mass Health, which is a Medicaid program in our state, not necessarily require, but strongly encourage, advise the state agency to include the PS measure in our quality pay for performance program.

And at the same time, as we look into the equity of the healthcare being provided to our population, stratifying the patient experience measure also becomes one of the key components in there, and we have seen different responses from different, for example, racial, ethnicity, populations. So, I would say from our point of view, we strongly support keeping this measure in the federal program.

Chair Fields: Thank you. I think we lost -- oh, no, sorry, M. Condon?

Member Condon: Good afternoon. This is Mary Jo Condon with the St. Louis Area Business Health Coalition. I also want to express support for keeping this measure and to echo previous comments.

It is one of the few measures that we have available that looks at patient experience, and I think looking at the stagnation of the reported scores on this is, in my opinion, only more reason to keep it.

Some of these scores are low, particularly around the stewardship of patient resources, and I would encourage the committee to recommend keeping it on behalf of patients.

Chair Fields: Thank you, and I will point out a comment in the chat from Rachel Brodie as well discussing the potential use of CAHPS to identify issues in disparities in patient experience.

All right, I'm not seeing any other hands. So, remind me, so we are voting on this or we are not voting on this?

Ms. Williams-Bader: We are voting, yes.

Chair Fields: Are voting, okay. All right, so I think based on the comments, then we will start with a recommendation to retain this measure. That sounds reasonable, and so I'll turn it over to the team.

Ms. LeFlore: All right, voting is now open for consumer assessment of healthcare providers and systems, CAHPS, for MIPS survey. Do you vote support for retaining? I'll give everyone about ten seconds. All right, voting is now closed. The results are 17 yes and zero no. That is 100 percent yes.

Chair Fields: Great. All right, so I think now I turn it over to discuss the hypertension measure.

01246-C-MSSP: Controlling High Blood Pressure

Mr. Amin: Thanks, Rob. Okay, so we have, I believe, two more measures until we get to the MIPS public comment at 2:00. So, we have 01246, the MSSP controlling high blood pressure measure.

This measure assesses the patients from 18 to 85 years of age who had a diagnosis of essential hypertension starting before and continuing into and starting during the first six months of the measuring period, and whose most recent blood pressure was adequately controlled during the measurement

period.

The measure is not endorsed and there was six individuals who selected this measure for discussion. I just want to point out here that this is the web interfaced version of the measure.

This shared services program, shared savings program, will sunset the web interface reporting starting in measurement period 2025. At this time, the discussion and vote should be limited to the web interface version of the measure.

The next measure that is up for discussion will be the measure version which will be reported as an electronic clinical measure, the eCQM version. With this measure, we'll take comments on both the -- with the next measure, we'll take comments on both the eCQM and the registry eCQM version of the measure.

I'll invite the CMS program leads to provide any contextual comments and then we'll go to the lead discussants with Will Fleischman, and ACC, and the Patient Safety Action Network if they have any comments. So, CMS, we'll turn it to you.

Member Gomez: Thank you. I just want to highlight that this measure is a high-priority, intermediate outcome measure. This measure has been part of the webinar face measure set since the inception of the quality repayment program and even prior to that, so it's been in the program for many years.

And I just want to highlight that this particular measure, it does differ a little bit from the NQF and endorsed version, so as a result, we do not specify NQF ID any time that there is any, like, wording changes or different dynamics just to ensure that it's clear, you know, what's endorsed by NQF and what's not, so I just wanted to make that particular differentiation as to why we removed the NQF ID for this measure.

Mr. Amin: Thank you.

Member Gomez: I'll also turn it over to John if he wants to add anything to this measure.

Mr. Pilotte: Thanks, Lisa Marie. I don't have anything to add. Thanks.

Mr. Amin: Thank you, both. Will, I'll start with you from the lead discussants.

Member Fleischman: Sure, thanks. So, I'll try to keep it to this measure, but I think the thinking, the clinical thinking for myself and I'm sure others will bleed into the measure that's actually, well, the measure that's actually going to be used going forward at some point soon.

So, looking at some of the rationale for the people who selected it for removal, I'm just thinking through some of the comments that I was reading. I don't think anyone would argue that long-term blood pressure control leads to, does not lead to better patient outcomes.

Maybe correlating the two, performance on the measure and outcomes, is difficult, but overall, this is absolutely a valid and good goal for CMS and for obviously clinicians to focus on their patients for it.

It is notable that the measure has topped out for quite a while, for the past 15 years. Performance on this measure or something similar to this measure has been about 60 to 70 percent. However, having said that, that doesn't mean that it's not a measure to retain to continue to have peoples and systems focused on it.

One major critique I have of it, which is why I would suggest that this measure should be supported, but with conditional support for mitigation, is the use of the most recent blood pressure. I think that's a fatal flaw in this measure.

A more appropriate measure would be either some

sort of average, but more appropriate is a, I'll just quote one of the commenters who wrote that the measure should move to a time and therapeutic range model, which is more consistent with recent literature and what the studies now use.

And that would be very burdensome to do or much more burdensome to do with this measure, but once you have it in an electronic form, it's obviously quite easy to populate that kind of thing.

So, the most recent blood pressure just seems like a random kind of number to use and to be judged on. That doesn't seem fair. It doesn't seem right. It doesn't seem clinically appropriate, but if this converts to some sort of average or time in a therapeutic range, it's an excellent measure.

One other thing that I saw a lot of comments mention and I agree with is the not allowing use of home readings. I think that's a flaw that needs to be corrected.

And finally, I think I didn't see exclusions listed in the measure, so if someone could clarify if there are encounters that are excluded?

For example, I wouldn't want, obviously, an encounter in an ED to count for, a blood pressure that's measured in an emergency department or for, I don't know, another acute type of visit to count for this type of --

I will say that I saw in the comments that talked about, you know, this is nice, but, you know, the levels here, the thresholds are systolic of 140, I forget what the diastolic is, and a lot of commenters were talking about having a lower systolic threshold and subgrouping certain medical conditions such as EKD and others into separate subgroups.

I think that's nice and eventually an eCQM can evolve to that. As a global measure, the threshold here, I think, is appropriate.

Mr. Amin: Thank you, Will. It sounds like there may be some developer questions that will wait for the overall discussion. I'll turn it to ACC for any introductory comments.

Member Rose: Yeah, thank you. I have very little to add to Dr. Fleischman's comments, which I think are spot on. You know, the college supports the retaining of this particular measure, but we welcome the addition of inclusion of home monitoring blood pressures in the data sets and the other modifications as said before, that this isn't a pass/fail based on one specific number, but that there's a more longitudinal approach particularly as that can be developed.

Mr. Amin: Thank you. Any comments from the Patient Safety Action Network?

Member Lu: Yes, thank you. We think that this is a good measure for the consumers and for the patients. It would provide preventive care, you know, by looking at the upstream, by controlling the blood pressure and therefore to reduce down the stream the mortality and major cardiovascular events, and also the high costs.

You know, heart disease is a leading cause of deaths in the U.S., so this is particularly important, we think, to go look upstream, to do the preventive care through the coordinated care, you know, ACOs and team care model. So, we think it's important for improved population health and patient safety.

And I saw that one of the, there was one comment about, that mentioned an article recently published. Was it JAMA? No, it was in a journal. I forgot which one, by Casey, et al., and he recommend --

You know, you talk about the stagnant and why the population, the blood pressure control over a population has not been improved significantly or dramatically, and he recommend eight steps, they called it a conceptual model or whatever he called,

and to help improve control of the patient population's blood pressure.

So, including, you know, the proper funding, resources, and also, you know, the home care monitoring that previous of my co-discussants did mention about it, and also address social determinants of health, and share decision making and including patients into the, bringing them into the equation to control the pressure, you know, and also how to coordinate with the local, or regional, or national level, different agencies, organization to create a coordinated care system.

So, maybe the sponsors who are looking into those recommendations, the recommendations discussing this paper to improve this measure. Thank you.

Mr. Amin: Thank you, Yanling. Okay, so before we move onto group discussion, I just want to review rural input. Collette Cole, I just want to just check in to see if you're on the line and have any input to provide from the rural health perspective?

Ms. Cole: Great, thanks, Taroon. This is Collette Cole. Can you hear me okay?

Mr. Amin: Absolutely, great, thank you.

Ms. Cole: I'm on the MAP rural group and a measure developer from Minnesota Community Measurement, and I just wanted to share. So, the MAP rural group was split on this measure with 43 percent voting in favor, 43 percent saying no, the measure shouldn't go forward, and one unsure.

There was some concern that a version of this measure used by CMS had not been endorsed related to a spec modification that the program would consider it not endorsed.

And after we met, I kind of delved down a little bit into this measure because we use this measure as well in Minnesota. There was some concern about

one version only focused on essential hypertension, but it appears that the HEDIS measure, the MIPS, and the MSSP measure all focus on essential hypertension, so I think that swayed the group's vote thinking that the MSSP version was not endorsed.

I just wanted to clarify. We try to align some of our measures with this controlling high blood pressure measure, and fairly recently, NCQA started accepting home blood pressures. So, if a patient is taking blood pressure in their home during a virtual visit, or whatever actually, that blood pressure can be included for measurement.

And blood pressures that are related to an acute visit, a hospital visit, or an ER visit are actually excluded from use in the measure calculation.

And the only other comment that we had during our group's discussion, oh, two actually, there was also discussion of the measure construct that didn't rely on the most recent single blood pressure and suggested a time and therapeutic range type of measure.

And comments were made that this is more realistic with an eCQM, a future version, and that the Indian Health Service indicated that the use and value both measures, so that's all I have. Thank you.

Mr. Amin: Great, thanks, Collette, and consistent with some of the introductory comments we've heard already.

The only other thing I would point out from the Health Equity Advisory Group was that some of the members further commented that patients suffering from high blood pressure also deal with equity issues.

So, I'll turn it over to Rob to facilitate conversation of the group. I'll just point out that there is one question in the chat, Rob, related to how the

measure is different than the endorsed measure.

There is also the outstanding question on the measure exclusions that we started with and there is one hand raised from Peter. Thank you.

Chair Fields: Great, yeah, thank you. Let's start with the question in the chat. Hopefully, that will be a straightforward one from the measure team, if it differentiates from the NQF endorsed measure, if at all.

Mr. Amin: Is there anyone from the developer or CMS?

Member Gomez: Hi, this is Lisa Marie. Colleen, are you able to address this question, I mean, in general, overarchingly about this measure?

Ms. Jeffrey: I apologize. Can you repeat the question again?

Chair Fields: It's in the chat. So, the question is how this measure might be different from the NQF-0018 endorsed measure?

Ms. Jeffrey: Oh, yeah, so the difference between the two measures is the time frame given in terms of the diagnosis? The MIPS CQM has it during the measurement period or within the last six months, where the NQF-endorsed version, I believe, is over, anytime over a two-year period.

And I believe also the NQF-endorsed version has a requirement of two visits, whereas the MIPS CQM only has a requirement of one visit, but I can pull that up and double-check it and add it to the chat if I find anything out.

Chair Fields: Okay, there's a follow-up question. Sorry, Peter, I'll come back to you in one second, but is -- a couple more questions before you go. So, the question is, is the NQF-endorsed measure the same as the HEDIS measure? Do you know?

Ms. Somplasky: This is Anita. Yes, it is. The NQF-endorsed measure is consistent with the HEDIS measure.

Chair Fields: Okay, thank you. And then, all right, and which one was the -- this one, this particular one is the -- yeah, sorry. Jennifer, are you asking if this is, in fact, the web interface measure? Yes, we haven't discussed the eCQM one yet.

Mr. Amin: Right.

Chair Fields: Okay, Peter, can we go to you next?

Member Briss: Yes, thank you. So, this one reminds me a little of the discussion earlier on the depression measure. So, it's not perfect, but it's a really important clinical issue, hypertension.

I'll preach to the choir for a second. Hypertension is a leading cause of preventable death in the U.S. and the world. There are -- it's hard to call a measure topped out when there are 43 million people, 43 million adults who are not controlled even to 140/90, sort of ignoring the people who said they'd really rather have the target be lower.

Disparities, especially by race and ethnicity, are bad and rising, and it's likely that the pandemic has made things worse. We agree with everybody else that there's been nearly enough progress on this issue, but would consider that an argument for working harder as opposed to throwing in the towel.

No objection to improving the measure in many of the ways that have been discussed, but this is another measure where CDC would prefer to retain this measure until we have a live better alternative.

Chair Fields: Thank you, Peter. Wei Ying, please?

Member Ying: Yeah, so a similar comment, but first, I'm not sure whether CMS has a plan to move it to NQF, the other one, the endorsed one? They are very similar. To have two different versions does

lead to some confusion on the provider side.

But to echo the previous comment, we have looked at, even though the eCQM version, but again, very similar to this measure, stratified by race/ethnicity category. We do see a significant variation among different subpopulations, so we would strongly support keeping this measure in the federal program.

But I do have a question regarding if there is an endorsed measure and it's very similar, can we just move to the endorsed version?

Member Gomez: So, this is Lisa Marie. I just want to highlight that in the event that, say, like with this web interface version of the measure, in the event that there is just a little bit of language that's changed from the NQF endorsement measure, we remove the endorsement.

Because let's say you're looking at the document and you're doing a comparison, and if there's just a few words or anything that's a little bit different, we want to make sure that it's clear that it's not what was endorsed by NQF.

So, in those circumstances, we remove that endorsement. So, it may not be that the changes are a lot or may even change the meaning of the measure, but when there are little differences, we do remove that endorsement.

Chair Fields: All right, I would just comment, which I'm sure others are thinking, the framing of what is a little change versus a lot is an interesting question there, right?

I would argue, for example, in blood pressure, that having two visits, for example, as opposed to one, and over a two-year period as opposed to a six-month period could make pretty radical differences, right?

Member Gomez: Yes, I agree. Colleen, can you just go over the actual differences? I know you were pulling that up, but I don't know if you're able to -- if you've done that already just in the time frame, but if you are, would you be able to provide the differences, or Anita? I don't know if one of you are able to do that for the differences.

Ms. Jeffrey: Yeah.

Chair Fields: Let's see.

Ms. Jeffrey: Yeah, so those differences are what I -- so the denominator for the NQF-endorsed version does require at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement period.

Whereas, the MIPS measure only requires one visit during the measurement period and then it is looking for that diagnosis of hypertension either during the performance period or starting, I'm sorry, I misspoke, either during the, either before the current performance period or starting during the first six months of the performance period.

So, those are the two main differences between those, and then in addition to that, there are some slight differences in the exclusion in terms of the frailty exclusion being parsed out between patients 66 to 80 years of age and then 81 years of age and older. They have different frailty requirements that don't align with what's given on the NQF-endorsed website for that version.

So, given all of those deviations put together, we just removed the NQF number from the MIPS version of this measure.

(Simultaneous speaking.)

Chair Fields: The differences are substantial enough where it's no longer the same measure ultimately.

Member Gomez: Correct, well, that the elements of the measure are different. Maybe it's not exactly a whole new measure, but elements of it are different.

I just want to also clarify that when we remove the NQF endorsement, it may be for even small changes. I didn't mean that it's only for, like, minor changes, but any time that it does not align exactly, we will remove the endorsement.

So, I just wanted to clarify that, but you are correct in terms of this measure and the NQF measure.

Chair Fields: Okay.

Member Gomez: They're different, but the intent's the same.

Chair Fields: Yeah, understood. So, I'm going to offer a suggestion to the group not seeing -- there's an answer to the question on exclusions. It's in the chat. Thank you, Anita.

I don't see any other hands up, so I'm going to make a suggestion for the group and see how this lands before we take it to vote. One is the suggestion is that we put it up for support for retention conditional, retention with conditions, and those conditions are -- I'm actually --

I don't know how this is going to land, but that we actually move to the NQF-endorsed measure just because my sense clinically is that the differences are not only substantial, but make a lot more sense in the NQF version of the measure rather than the one that's being proposed.

Specifically, for example, using a single encounter or a single blood pressure without -- it speaks that there may or may not be continuity with that patient. It could be an acute visit, for example, for someone that isn't a regular patient.

I think there are lots of issues with just using a

single encounter for this, not to mention sort of the time period, et cetera. So, I would say that one condition might be move to an NQF-endorsed version of this.

And the second might be that we include not using the last measure as a standard and move to either an average or a therapeutic window, right, a control window methodology that was discussed earlier.

And then thirdly, because it's not actually clear that the NQF measure does this, although NCQA sounds like it does, is to include ambulatory blood pressures or at-home blood pressures as part of the measure, so those are the three conditions.

Wendy, let me go to you. You have your hand up. Oh, sorry, yeah, Wendy, go ahead. Lisa, I'll go to you next.

Member Gozansky: Yeah, I just wanted to clarify. So, my understanding of the HEDIS NQF-endorsed measure is that it's looking for people who are having multiple linkages, meaning multiple visits, but the determination of the blood pressure control is still related to the last blood pressure.

It doesn't do any averaging. It's not taking the best of the two. That's just how you get into the denominator.

Chair Fields: Right, sorry, my comments were meaning that in the current, the one that's here that's not the NQF measure, you only need the one encounter, which I think is problematic.

So, moving to an NQF-endorsed measure with these changes to that NQF measure that would not allow for the last reading, that it would allow for --

Member Gozansky: Okay.

Chair Fields: -- a modification --

Member Gozansky: Okay.

Chair Fields: -- of the NQF.

Member Gozansky: Got it, okay.

(Simultaneous speaking.)

Chair Fields: Yeah, yeah, sorry, that was poorly phrased. So, we would start with the NQF measure as the base, but alter that to include ambulatory or at-home readings, and change it from last reading to either an average or window of control sort of therapeutic window category. That's my suggestion. Lisa?

Ms. Hines: Yeah, I just wanted to provide some context that it may not be very relevant to focus specifically on aligning with a specific NQF version. Different testing might be needed for different levels of attribution. There may be delays in updating aligning with HEDIS specifications.

So, whatever is posted most recently publicly as the NQF-endorsed measure doesn't mean that there aren't efforts being made to align the specifications as they're implemented in various programs.

And I'm just speaking broadly as a measure steward with NQF-endorsed measures implemented in different programs, and there can be variations, and so we don't want to get too hung up on an NQF-endorsed version as long as there's alignment conceptually and rationale for differences.

Chair Fields: Okay, then to take it away from clarifying the language then, I think the issues are having multiple encounters is important because, again, the issue of having an acute visit where you may or may not have a long-term relationship with the patient, clarifying those is important, and having multiple encounters is at least one reasonable way, not perfect, but better than using a single encounter.

And I think what we've heard is changing the last

reading as the criteria, go to the two options I described, and then having at-home readings count. So, we don't call it an NQF measure as the base, but whatever that means in terms of conditions. Yanling Lu, please?

Member Lu: Yeah, maybe I don't have to comment because you mentioned we will not be voting to align ourselves with the NQF measure, right? Because I have concerns about it. The NQF measure, as far as I read, I didn't see any focus or having components about coordinated care.

Chair Fields: Yeah.

Member Lu: Yeah, which is, I think, you know, controlling the hypertension for our population is critical. It's not the individual clinician that can do it. It may require everyone to work together, coordinated care, you know, like team care, so, yeah, okay.

Chair Fields: Agreed, thank you. Peter?

Member Briss: Maybe just one more comment. You know, the people that have been thinking about these kind of measures for a while have different perspectives on this issue of multiple visits or not, and if this were a high school debating club, I could argue it either way.

The counter argument to the multiple visits that was just enunciated is that in some ways people that have been seen a couple of times in six or 12 months for blood pressure are the people that I'm least worried about, right?

You know, and that those kind of requirements might have the effect of excluding a lot of people from the measure that we ought to be trying to reach and get into care.

And so, you might, instead of trying to micromanage the details of improvements in the

measure today, which isn't really our primary focus, we might ask an endorsement committee to think about what's the best balance of things like number of visits and the other things that you've raised.

Chair Fields: Okay, thank you. Wei Ying?

Member Ying: Yeah, I agree with Peter that, I mean, this is absolutely not -- the NQF-endorsed version is a better version, but it's absolutely not a perfect version for sure, but again, do we want to put out the specific requirement as the condition or we leave it to the scientific committee on the NQF side when time comes for re-endorsement and raise those sort of more clinical and scientific question.

Chair Fields: So, historically, as a matter of process in this committee, and please, Michelle, I'll look to you to, please, either validate or not what I'm about to say, but we ask for some degree of specificity on what the conditions are when we support a decision on conditional support for removal or retention.

Anything that has conditions, we are often asked for some level of specificity that then CMS takes into account in their greater process, and leaving it just with sort of more general conditions, we have been given the feedback that that is less helpful, but I would defer to the CMS team to guide us differently if that's not the intent.

Dr. Schreiber: Hey, Rob, Michelle, I would agree with you. You know, if we understand what the committee is really looking for, it is much more helpful for us as we go back and reconsider these measures, so thank you.

Chair Fields: Thanks, Michelle. M. Condon? I'm sorry, I don't see your first name and I forgot it from before, and I see the hand got lowered. M. Condon, please?

Member Condon: Sorry, I was unmuting. Hi, this is Mary Jo Condon with the St. Louis Area Business

Health Coalition. Yes, I appreciate the need to sort of defer to a more substantial or sort of intensive process to understand what exactly the measure specifications should be.

But, in fact, isn't that what we're doing if we were to refer back to the NQF-endorsed measure? Because that process in and of itself is the process by which these very sort of nuanced clinical considerations are considered, and there's a forum for multi-stakeholder input and I would say sort of more nuanced study.

Chair Fields: My opinion on that is that, yes, that is generally true, although I think for this measure, we're specifically saying not to use that NQF measure as the base since --

And we were offering more general suggestions to make this measure better, some of which may or may not align with the NQF measure, but you're totally right on the NQF process. Okay, Dan Green?

Dr. Green: Thanks, Rob, just one other thing which may have been said already, but, you know, in the program, to make these measures work sometimes, we do end up tweaking the measures a small amount, like sometimes requiring two visits versus requiring one visit, especially --

I mean, you can imagine that two visits makes sense, especially for a healthcare plan level measure, but may make less sense in a non-evaluation of a healthcare system when looking at clinicians specifically, so that's just one example.

I mean, sometimes in some measures, we've deviated a little bit from the exclusion for, not in this case, of course, but for like hospice, again not in this case of the blood pressure, but these are some of the smaller changes that we make for programmatic purposes, so I just wanted to point that out to the committee.

Chair Fields: Yeah, that's helpful. Thank you.

Dr. Green: Thank you.

Chair Fields: Okay, I think, just given the time, I'd like to try to move us to voting, and we'll start with conditional support for retention of this measure with the conditions that I think we've outlined already.

And as a reminder, then CMS will take this back and do, and take that suggestion along with the greater environment of other suggestions. So, all right, I think we are ready for a vote here.

Ms. LeFlore: Voting is now open for 01246-C-MSSP, controlling high blood pressure. Do you vote conditional support for retaining?

All right, I'll give everyone ten more seconds. Voting is now closed, and there were 17 votes for yes and zero for no, and that is 100 percent yes.

Chair Fields: Great, I think we're moving to the next one which is the eCQM version, I believe.

eCQM ID:CMS165v10: Controlling High Blood Pressure (eCQM)

Mr. Amin: Right, so I think many of these conversations may translate directly. So, eCQM, CMS165v12, controlling high blood pressure, the eCQM version.

The percentage of patients 18 to 85 who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled during the measurement period, not endorsed.

I just want to again reiterate that this discussion and vote will focus on the measure reported as an eCQM. In addition, if you have comments about the

registry version, base version of this measure, we'll take those during this discussion.

I'll first start out with the CMS program lead if there's any contextual comments, then we'll turn it to Dr. Fleischman again, ACC, and then the Patient Safety Action Network following. CMS, please take it away.

Member Gomez: Hi, this is Lisa Marie Gomez with CMS. I just want to note, similar to what we've noted for other measures that are under the APP, so this measure is an eCQM, and as we're trying to transition to more eCQMs within the program, this measure was identified as a measure that would be a requirement. If an ACO chose to report an eCQM, this was one of the measures.

And again, under the program, there are only three eCQMs which have been identified which obviously have the same web interface version, but as we transition, these are the three measures that were identified, so this is just one of the eCQMs. John, is there anything else you would like to add from the program?

Mr. Pilotte: Thanks, I don't have anything else to add.

Mr. Amin: Great. Will?

Member Fleischman: Thanks, I would just echo the comments and the discussion that we had on the previous measure. It pretty much applies to everything here, and with the additional background that obviously the things such as time and therapeutic range or averaging is far easier with eCQM, so --

Mr. Amin: Right.

Member Fleischman: -- we'd like to get more here, so.

Mr. Amin: Right, great, thank you. ACC?

Mr. Pilotte: Nothing to add to Dr. Fleischman's points.

Mr. Amin: Thank you. Patient Safety Action Network?

Member Lu: Not much to add. I think we should support. It makes the measurement more easier, so thank you.

Mr. Amin: Great. Collette, anything to add from the rural perspective?

Ms. Cole: I don't have anything to add. Thank you.

Mr. Amin: And just reiterating some of the main points from the equity committee again, that this measure disproportionately affects patients with lower socioeconomic status. I'll leave it there.

Rob, I'll turn it over to you for discussion and clarifying questions of the group.

Chair Fields: All right, great. So, there's a question in the chat from Yanling. What happens if -- oh, sorry, more stuff is getting added -- both of the conditions are not met?

So, the question is, of the conditions that we've put in -- sorry, this is from the last question, I apologize -- that are not met, will the measure be dropped from the program?

And that is up to CMS. So, we make recommendations and CMS is the ultimate decider, I think is the way to answer that question correctly, but I defer to NQF and CMS on that.

Dr. Schreiber: Rob, this is Michelle. We completely agree. This is a committee. Just like the committees that make recommendations for measures to be put in programs, a very similar process. This makes recommendations to CMS about those to remove, but in the end, it is CMS' decision.

Chair Fields: Great, thank you. So, I'm not seeing hands, so are we -- sorry, based on the discussion, are we ready to put this to a vote different from the last one without any conditions or with the same conditions as the last one? Sorry, I must have missed something here.

Mr. Amin: I heard the same conditions from Will.

Chair Fields: Same conditions. Okay, that's what I assumed, but --

Mr. Amin: Yes, and noting that some of the components might be easier to implement --

Chair Fields: Right.

Mr. Amin: -- in the electronic version of the measure.

Chair Fields: Okay, great. All right, I'm not seeing any hands. Going once.

Member Nguyen Howell: Would you mind just repeating the conditions from the last one? I had to step away.

Chair Fields: Oh, sure. Let's see. There was conditions that included not using the last blood pressure as a standard, but using either average blood pressures or sort of a therapeutic window or controlled window measurement. There was a discussion on at least further consideration, something like not full agreement, but at least consideration for expanding from one visit to at least two visits to count as a denominator for the measure.

Mr. Amin: Right.

Chair Fields: Otherwise, there's more discussion scientifically on that to be had on CMSI.

Mr. Amin: Right.

Chair Fields: Oh, and home readings, including home readings as a condition, as a -- sorry, as a data point.

Mr. Amin: Right.

Member Fleischman: I would add that with the eCQM, you have the additional ability to potentially subgroup eventually -- or develop different thresholds for different populations. That's probably -- I think, I wouldn't attach it as a condition for this measure, but it's common for the measure developers to eventually work on.

Chair Fields: That's a good point. Okay. I'm not seeing anything else. So all right, we will move to a vote to support conditional support for retention.

Member Nguyen Howell: Hey, Rob. Could I just add to Will's point just now in terms of like being able to -- for the eCQMs being able to add to different patient populations and categories. If we could note that that is something that was brought up for this eCQM because I just had a concern about the 85 patients, year-to-age patient population versus like a 75, right? And being able to have that luxury or ability to --

Chair Fields: --- to differentiate in segments?

Member Nguyen Howell: Correct, yes. In segments. That was the word I was looking for. Thank you.

Chair Fields: Sure. And I'm sure that will be reflected in the comments for the CMS team to consider. I'm seeing nodding heads so that will be noted. Thank you.

We'll go ahead and open it up for a vote and turn it over to the NQF team.

Ms. LeFlore: Voting is now open for eCQM ID CMS 2V11 controlling high blood pressure.

Do you vote conditional support for retaining?

I'll give the committee members ten more seconds to vote. All right, voting is now closed. And there are 18 votes for yes, zero votes for no, so that is 100 percent for yes.

Chair Fields: Great. I think we're ready to move on to public comment for MIPS. Am I correct?

Mr. Amin: Yes, absolutely, Rob. Yes. Jenna, do you want to take away?

Ms. Williams-Bader: Yes, sorry, just unmuting myself here. So all right. We'll be talking about the Merit Based Incentive Payment System next. So if we could go to the next slide, please?

This is quality payment program. The incentive structure is that it's pay for performance. There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight. The final score, 100 percent, will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians. And cost accounts for 30 percent; improvement activities; 15 percent; promoting interoperability, 25 percent; and quality, 30 percent.

The program goals are to improve quality of patient care and outcomes for Medicare fee for service and reward clinicians for innovative patient care and driving fundamental movement toward value in healthcare.

Next slide, please.

All right, so one more slide. I'll now turn it over to Diane for public comment on the measures in the MIPS program.

Opportunity for Public Comment on Merit-Based Incentive Payment System (MIPS) Measures

Chair Padden: Thank you, Jenna. At this time, we're opening up our public comment period and if you

have a comment, if you could please raise your hand and keep your comments to approximately two minutes.

Brandy.

Ms. Keys: Hello. Thank you. My name is Brandy Keys and I am the Director of Health Policy for the American Academy of Ophthalmology. We have three measures you'll see on the list there. We represent about 93 percent of the active and practicing ophthalmologists in the U.S.

I'm just going to offer a few overarching thoughts now and we can respond accordingly if there's further public comment.

The Academy is in favor of a robust quality measure inventory that covers the breadth and scope of medical care, but there has to be a balance between managing the measure inventory, like we're doing today, and ensuring that there are clinically relevant and valuable measures available to all eligible clinicians. So for example, using today's measures that are up for review, for the retina subspecialty, there are only six benchmarked MIPS quality measures and QCR measures and two of them are on this list here. If those are removed, retina specialists will be forced to find and report on measures that are completely unrelated to their clinical practice rather than using meaningful measures that truly evaluate the care they provide to patients.

These measures are also important to CMS' strategy for health equity. Black and Latinx individuals have significantly higher rates of diabetes-related complications including blindness compared to White individuals in the U.S. Black patients also have higher odds of worse visual outcomes after retinal detachment repairs. So by maintaining these measures we can continue to advance health equity in the U.S.

I'll close by saying I urge the work group to read the thorough public comments that AAO submitted, which we had about a week to put together and we didn't know which criteria were triggering it, so you'll see we've answered all ten of the criteria for each of our three measures. Two minutes isn't long enough to detail the many reasons, so I would hope that you would read those and keep these measures in the MIPS program. Thank you.

Chair Padden: Thank you very much. Greg. Greg Bocsi.

Dr. Bocsi: Hi, sorry, fumbling with the mute button. I'm Greg Bocsi. I'm an anatomic and clinical pathologist and a member of the College of American Pathologists Quality and Clinical Data Registry Affairs Committee. And I wanted to speak about the Barrett's Esophagus measure that appears here.

I mean specifically request that you vote in favor of retaining that measure. We have submitted sets of written public comments which you have access to describing how we feel that it does contribute to the overall goals and objectives of the program, as well as how it can, not directly, but indirectly lead to better patient outcomes inasmuch as notation of dysplasia in the pathology report is absolutely critical for making appropriate patient care decisions.

You know, due to the unique features of the practice of pathology, pathologists have minimum number of performance measures that they can report, so it's very important to the specialty to have this measure.

And I guess the other thing worth mentioning is that the -- in the slide it's noted that it is currently not endorsed that endorsement was removed. And I just want to point out that that was not an active consideration that it didn't merit endorsement on the basis of the structure or form of the measure or

anything like that. It's just a matter of resources at the time that it came up for renewal and not being able to invest in that process.

But looking at the totality of the measure, we still feel that it's incredibly valuable and as I mentioned we strongly request that you vote in favor of retaining the Barrett's Esophagus measure. Thank you.

Chair Fields: Thank you. And I think we have one more from Jessica Peterson.

Dr. Peterson: Yes, thank you. My name is Jessica Peterson. I'm the Vice President of Health Policy at Marsden Advisors. One of the things that we do hear is we help people with MIPS. A lot of the people that we help, a lot of the practices are ophthalmology practices. So we have a lot of hands on, feet on the ground experience with what it takes to successfully report MIPS and to get meaningful results for ophthalmology practices.

So the measures we'd like to comment on are the Adult Primary Rhegmatogenous Retinal Detachment Surgery measure, the Diabetic Retinopathy measure, both manual and eCQM, and closing the referral look.

For the diabetic retinopathy measure, as mentioned before, and the retinal detachment measure, there are only six benchmark MIPS measures, both regular quality and QCDR, only four of which are available at eCQM. So that makes it really burdensome for retinal practices and retina specialists to report MIPS. We see people trying to report on BMI, on immunizations, et cetera, et cetera just to have sufficient measures to report MIPS, so they're not actually getting any meaningful feedback and neither are their patients because of the need to choose not germane measures.

By getting rid of these measures which they actually do find meaningful and do encourage care

coordination, I think that CMS would be doing a disservice and if NQF suggested that removal, I think that would be doing a disservice, not just to the patients which -- who really do need this measured for health equity reasons and also for continued encouragement of care coordination reasons, but also to the practices that will need to find completely irrelevant measures to report on.

For closing the referral list, this measure is -- it's one that hasn't had a lot of reporting on it, but we've been starting to encourage practices to use this measure and when we introduce it, they often realize how important care coordination is and that it's something that they've neglected, both sending and receiving specialists' reports. So often after discussing this measure, this is something the practice decides to use. And since we represent thousands of physicians, that's a lot of reports that will be increasing in the future. So if that's a concern, I just want to let you know reporting is increasing.

And that's it. So please continue to encourage care coordination by keeping these measures -- by not recommending the removal of these measures and also allow retinal specialists particularly to have germane measures on which to report. Thank you very much.

Chair Fields: Thank you, Jessica. At this time, we going to turn it back over to NQF, is that right?

00641-C-MIPS: Functional Outcome Assessment

Ms. Williams-Bader: Yes, that's right. We've got all the public comments. So we can go ahead and move to the first measure then. This measure is 00641-C-MIPS Functional Outcome Assessment. It assesses the percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the data being counted, and documentation of the

care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

Endorsement was removed for this measure and four survey respondents selected it for discussion.

Is there someone from CMS who would like to make comments on this measure?

Member Gomez: Hi, I this is Lisa Marie Gomez with CMS. I would just like to highlight that this measure is a high priority measure. It has broad applicability. Its quality actions can prove patient quality of life and it's this particular measure allowing the cross program within CMS. This measure has been endorsed starting July 23rd, 2015. However, the measure steward made the decision to not seek re-endorsement during resource prioritization.

I also want to highlight that the use of standardized assessment tools based upon clinician preference results reduces reporting burden. Though the measure tag is clinical visits, the measure only needs to be completed at 30-day intervals.

This measure is in its second year of topped out life cycle. However, measures that can be made broadly applicable can help reduce the overall number of measures -- the measures within our program. It also allows for care comparison across multiple clinician types again within our program.

While this measure does look to see that functional assessment was documented which may define it as a checkbox measure, it does require that a plan of care be completed for those patients with positive functional outcome assessment, which supports optional patient -- patient care. And that's all I have for this measure. Thanks.

Ms. Williams-Bader: Thank you very much. Okay, we have two lead discussants for this measure, Genentech, and the Council of Medical Specialty

Societies. I believe we have our representative from the Council for Medical Specialty Societies had to step away, so I think Taroon, you're going to read those comments, and then we can go to Genentech.

Mr. Amin: Sure. Just reviewing the comments from this Council of Medical Specialty Societies, this measure is one of a very small measure of functional outcome measures in MIPS, the combination of the use of a standardized functional assessment tool with documentation of a care plan based on patient identified deficiencies is an important measure with the requirement to act on patient identified deficits through a care plan where an individual disagrees with the commenters that this is a check the box measure.

While we have all pushed for greater use of PROs, their use in clinical practice remains limited and if maintained this measure will continue to encourage clinicians to use standardized tools of patient functioning. The few PRO performance measures that we have that are focused on change in outcomes are for specific measures -- specific procedures. Attempts to build PROs for general medical conditions have been largely unsuccessful given the need for risk adjustment and a recognition that those -- that for many patients maintaining function is the goal.

There are no unintended consequences associated with the use of this measure and my overall recorded performance is high. There are no data regarding results by sub-populations. Given the pandemic, it's also difficult to assess any trends in performance. Without a replacement for this measure MIPS, that supports routine incorporation of functional assessments into clinical care, the lead discussant does not support removal of this measure for functional assessment. Thank you, Jenna.

Ms. Williams-Bader: Taroon, thank you. And do we

have someone from Genentech?

Member Nichols: Yes, I'm here. This is Donald Nichols from Genentech.

In addition to what's been stated by the other reviewer in CMS, the only other thing that we noted is that this is kind of one of those compound metrics, measures again where there's an end statement. So you can -- it's going to be difficult to kind of like separate whether or not it's a low utilization of assessment or is it not -- the plans are being made for certain populations. And so we also noted that there seemed to be little support, public support for continuing with this measure I think for some of the reasons that have been previously stated in terms of check the box and being topped out. So that's pretty much the extent of what we observed.

Ms. Williams-Bader: Great. Thank you. All right, I believe we still have Collette Cole from the Rural Health Advisory Group on the line, is that right?

Ms. Cole: Yes. Great. Thank you. Just wanted to share our MAP Rural Group had a majority vote for removal of this measure with zero votes for support; 4 for remove; and 2 for unsure. And a great measure concept, but the main concern is the denominator of this measure, expecting a functional status at every visit for all patients age 18 and older.

So there could be benefit if the denominator of this measure was more focused on certain conditions and not an expectation for all patients 18 and older. Thank you.

Ms. Williams-Bader: Thank you very much. And from the Health Equity Advisory Group, so they did think there were some equity concerns relating to recovery from strokes and other significant events. However, there was also concern that the measure is too broad. They thought that insight regarding

the absence of functional outcome assessments in certain populations by stratifying the measure would be helpful to fully assess the measure.

And with that, Diane, I'll turn it over to you for discussion.

Chair Padden: Okay, thank you, Jenna. I see Will, you have your hand up.

Member Fleischman: Yes, thanks. It did strike me looking at the measure how broad it is and I agree with him that that seems to be the main concern, I agree with those concerns. Has there -- I don't see it in any of your comments, and I'm wondering if anyone else at CMS or I don't know if any of the measure original supporters or stewards are here. With regards to comments about how to narrow it, what would be -- were there -- are there suggestions or were there suggestions for revising the measure to have it be more narrow?

And one other question is it seems like from some of the comments that this is an abstract, a chart abstracted measure, is during an electronic -- is there a registry or electronic version of this?

Ms. Somplasky: Hi. So this is Anita. In terms of the measure, interestingly, this measure was originally developed as a non-MDDO measure meaning it was intended for some of those non-physician specialties to be able to report. When it was first developed, it was very specific to PT/OT. Over the years, speech language pathology asked that they be added to it and then we additionally had other clinicians ask well, can you expand it and add additional encounter coding for it?

So as opposed to asking for it to be more narrow, folks have been asking for it to be more expanded.

And then you had a second question, this is a CQM registry measure.

Member Fleischman: So I guess a follow-up would be when we're talking about removal, it would be removed entirely for everyone or we're talking about removing it for a specific subset of the clinician?

Ms. Somplasky: If you are suggesting removal, obviously, CMS and I will defer to Lisa Marie or Dr. Green or Dr. Schreiber for that. It would be -- it gets removed from the program.

Member Fleischman: Okay, I guess I was -- the surveyor, the people who answered the survey which it sounds like how it ended up here before us for potential removal, they were talking about removal entirely from the program.

Member Gomez: Hi, this is Lisa Marie. Are you indicating that the comments from the other work groups were indicating that this measure should be completely removed from MIPS? Is that what the commenter is saying? I'm sorry, I'm kind of like following the conversation.

Member Fleischman: I heard, yes, there was a comment that -- I forget, it was four, four votes for removal and two unknown. Those folks that were looking at this for potential removal are looking at this for removal entirely from the program as opposed to narrowing it down to specific clinicians who could use the measure.

Member Gomez: That's correct. So when this measure was removed or assessed for removal, it was assessed holistically from the program. There weren't comments. And also discussion for these measures -- it's not by a group of clinicians because the way our program works is that, especially when we have like broad, applicable measures like this, there may be some specialties that do not have a lot of measures to report and so when like measures like this are more broad, they may have the option to select these measures. In our program, we are required to select at least six

measures and we'd like to have more applicable, broad measures so that different specialties can select to be able to report on.

So I will say that I didn't hear any comments in the other work groups that said there would be removal for specific clinicians. And we also don't remove measures for specific clinicians unless let's take, for example, under a specialty set, but this is not under a specialty set. This is a broad measure.

Member Fleischman: Right. From this perspective, you know the comments, for example, talk about how broadly inclusive it is and that be a major issue. If I'm a physical therapist and all I see is people with functional disabilities, naturally, or some sort of functional issue, then this is not broadly inclusive at all. It's very targeted and specific for that population.

Obviously, using it for a -- if I'm just a primary care physician or a provider seeing patients in the office of all kinds, yes, it would way too broad for me to use or for my organization to use. So I guess that really changes how I look at it. Why would I remove a measure for the PT -- why would I recommend that the program remove a measure that a physical therapist finds useful if I as a -- let's say a primary care provider don't find it useful. Just a thought.

Chair Padden: Thank you. Collette.

Ms. Cole: Yes, thanks. Anita, appreciate that additional context on the history of the measure, the MAP World Group was not aware of that during our review, but I agree with Will, if the measure was applied to PT and OT areas that is kind of a narrowing of patients that are having functional outcome problems, so probably more applicable in those areas.

I just wanted to share our assessment of that was from the broad, general use in physician practices. Thank you.

Chair Padden: Wendee?

Member Gozansky: If I can just clarify and I think this is related to Will's comments. I thought my understanding is that the denominator is when you actually use a standardized assessment tool for functional outcomes. And so -- and then the question of do you have the care plan for the numerator compliance? To me, it's not saying that you should do a functional outcome assessment for everyone. It's saying that anyone 18 or older who clinically you think that outcome should happen, we are doing this. And to me, that seems appropriate, but maybe I'm misunderstanding.

Ms. Williams-Bader: Yes, I'd like to clarify that point about the denominator because my understanding is that it's broader than that. So does CMS want to speak to the denominator before we move on?

Member Gomez: Hi, I'm just going to -- this is Lisa Marie Gomez at CMS. I wanted to direct this question to Colleen.

Colleen, would you be able to address the question?

Ms. Jeffrey: Well, currently, this measure set up with a denominator that looks at all visits for patients age 18 years and older on date of encounter. However, that encounter denominator set has specific CPT codes that can be utilized for a denominator eligible encounter. So it's going to include those PT/OT encounters. It's also going to include an audiology and SOP encounter.

And as Anita said that they did request to be added into this measure and then it's the numerator that's going to be looking at is that functional outcome assessment was completed and if it was found that there were functional outcome deficiencies, if there was a care plan in place.

One thing to point out is that again, though this is an every measure -- or every visit measure tag, it

does state in the numerator notes that this is only be done at minimum every 30 days. So if you are seeing that patient for multiple visits within that 30-day period, it would only be expected to do that functional outcome and assessment at every 30-day interval. So it's not quite as burdensome as all -- as every 30 days. And again, this would just be expected to be completed by those clinicians who this measure would be appropriate and applicable to and who decided to submit that data.

Member Fleischman: Right, so it does -- so to clarify looking at the measure summary, the denominator is all visits except -- unless it's specifically documented that the patient is not eligible for a functional assessment or eligible for a care plan.

So if someone chooses to report this measure, they would either -- they would report all visits unless explicitly documented, again, with that 30-day proviso that was mentioned, but yes, it would be entirely inappropriate, of course, for a regular -- for a non -- for a clinician who is not focused on functional assessments and care to use this measure. But I -- personally, I don't see anything wrong with the measure and it doesn't seem to me more broadly inclusive than it should be when focused specifically for clinicians who are -- who are specialty focused on this.

Chair Padden: Okay. Thank you. Dan.

Member Albright: Yes, I had the same question and need for clarification. So if all of the denominator is, you know, all visits for that provider, it feels like that would sort out those who would use this measure and those who wouldn't. It would be PT/OT, PM&R, Pain Management, and perhaps --- you know, primary care physicians it would not be applicable. So maybe the measure sorts out the right people to be doing this work.

Chair Padden: Thank you. You have Yanling.

Member Lu: Just a clarifying question. Maybe I'm not understanding well. Did someone say or CMS or someone said that if a group or a group of clinicians or a clinician felt this was too broad for them to use this tool, do this measure, they have a choice to not include this measure in their portfolio? Is that -- am I understanding this correctly? So if someone said this is -- in my -- you know, it's right in my field, I need to -- you know, very relevant to my patient population, then they include it in their portfolio. Others just say, too broad, I'm not going to include it? Do they have that choice at all?

Dr. Schreiber: Yanling, this is Michelle Schreiber from CMS. All mixed measures are voluntary, so all mixed measures are submitted by choice basically. So for the provider where this applies, the speech therapist, the physical therapist, they would or might want to submit this measure but others would not have to. So all mixed measures are voluntary.

Member Lu: Okay. Thank you for clarification. So that seems like a -- it seems irrelevant for this too broad comment in my opinion, because you have a choice.

Chair Padden: Okay. I'm looking to see if there are any other questions, clarifying questions.

Ms. Williams-Bader: Fran, I just -- there was a comment in the chat from Rachel Brodie. I don't -- it was -- Rachel, I don't know if you want to say that out loud.

Member Brodie: It was a while ago. I just early on was -- I just agreed with the comments from the initial CMS presenter and also from the Council for Medical Specialty Societies about the broad application across specialties and also CMS programs and the need for advancing use of pros in routine care and it not being a checkbox measure. But -- well, of course, now I'm a little conflicted about the comments of sort of narrowing the denominator to certain like outpatient physical

therapy, and so I'm not sure. I've gotten a little bit confused about the denominator through this discussion.

Chair Padden: Is there any way to help clarify that?

Member Brodie: I think part of the problem is that in the materials, it talks about exceptions. Sorry, I'm looking for it. It talks about denominator exceptions that if a functional outcome assessment is not documented as being performed, so I think that goes back to the conversation that if a provider thinks the patient is not appropriate for this measure, then they just don't report that patient so, therefore, that solves the issue of this being broadly applicable across any specialty, because the provider's making a decision about which patients are appropriate, correct?

Chair Padden: That's the way I understand it.

Member Brodie: Okay.

Member Fleischman: It's actually slightly --

Member Brodie: Yes.

Member Fleischman: -- slight wrinkle to that. So if you read the next sentence, the last part of the sentence, which is and does that -- it doesn't say "and" but I think that's what it implies. So if a functional assessment is not done, and there is documentation that the functional assessment -- the patient was not eligible for it, that patient is excluded from the denominator. So if I'm a provider, if I'm a PT and I report this measure, every one of my visits will count in the denominator unless it is documented that the patient is not eligible for a functional assessment, or it has basically been within the 30 days of the last functional assessment.

Member Brodie: Got it. Okay.

Member Fleischman: Yes. And I'm thinking of it like

if I'm a PT and I see someone, you know, for their usual, let's say, six weeks of therapy, they would essentially get one, maybe two functional assessments depending on when they start and end.

Chair Padden: And vice versa if you were seeing them on a, say, twice a week that you wouldn't be doing a functional assessment every time they came in.

Member Fleischman: Right. You do basically, yes, once every 30 days and you wouldn't actually have to document, although I don't know how that would -- you know, you could easily set it up within the PT's EHR to account for it, but you wouldn't have to document each time that a patient's not eligible. They would -- sounds like by the measure definitions, they would only be eligible once every 30 days.

Chair Padden: Okay. I'm just going to take one more look to see if we have any other hands.

Ms. Williams-Bader: Diane, can I ask CMS? There are - -it's not just PTs and OTs and the other types of clinicians you listed that are -- that have codes in the denominator, is that right, though? Are there also --

Ms. Somplasky: Correct.

Ms. Williams-Bader: -- primary care physicians and are there any other types?

Ms. Somplasky: It has the more broadly-applicable encounter codes, the what they call the 992 series. However, those were added mostly because the chiropractors who wanted to be able to report this, that is what they use for the follow-up. So unfortunately, yes, it's a broadly-applicable code, but it was specifically added because they wanted to be able to have those follow-up codes in there and new patient evaluations.

Ms. Williams-Bader: Thanks, Anita.

Chair Padden: All right. Based on that discussion, I am --

Ms. Williams-Bader: I'm sorry, Diane. Now there's a hand raised.

Chair Padden: I missed that one. Okay. Collette.

Ms. Cole: Sorry. It's Collette again. I just have a question for clarification about numerator and denominator. So if a patient has a functional status assessment and it's negative, do they come out of the denominator so it's only patients that have a positive functional status and then have a documented plan that would be considered for numerator?

Ms. Somplasky: Collette, this particular measure is to make sure any patients being seen who are denominator eligible have an assessment done and a plan of care if it's, you know, based on any deficiencies. But it would have to be documented that there's no deficiencies

Member Fleischman: The denominator is the visit? Denominator is not the assessment being positive or negative?

Ms. Somplasky: Correct. That's the numerator.

Ms. Somplasky: Thank you.

Chair Padden: And there's also discussion in the chat about the denominator exception. The patient is not eligible if one or more of the following. Patient refuses, patient unable to complete the questionnaire, or the patient is an urgent or emergent medical situation where time is of the essence. Okay. Any other questions?

Now, where to land after that robust discussion and clarification? I think -- I'm thinking, and I'm just going to throw this out there, we started that it was

very, very broad and were not sure that it would be -- that it should be retained. However, after multiple discussions and clarification, it appears that it's not necessarily broad, and it was -- the measure was expanded to include those clinicians who would need a measure of such. So I am thinking that what I am hearing is that the vote would be to retain the measure, unless there's other thoughts. I see Dr. Fleischman shook his head. Okay. So I believe that we're ready for the vote then to retain this measure.

Ms. LeFlore: Voting is now open, 400641-C-MIPS Functional Outcome Assessment. Do you vote support for retaining?

And I'll give everyone 15 more seconds.

Okay. Voting is now closed; 14 voted yes, and 3 voted no, and that would give us a percentage of 82 percent for yes.

01101-C-MIPS: Barrett’s Esophagus

Ms. Williams-Bader: Okay. Moving to our next measure then. It's 01101-C-MIPS, Barrett'S Esophagus. This measure assesses the percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also included statement about dysplasia. Endorsement was removed from this measure and four survey respondents selected this measure. Would a CMS program lead like to make comments about this measure?

Member Gomez: Yes. Give me one moment. Sorry. So for this particular measure, I would just like to highlight that the removal of this measure would have an impact on the number of measures developed over the specialty. Measure reflects current clinical guidelines, measures that have been adopted, determined by the existence of the 2020 benchmark and/or the 2018 performance data.

I'd like to say that the pathologies that currently have these measures, the removal of this measure would drop it below the Quality Performance Category Requirement 55. This measure is not affecting the rate at which Barrett's esophagus is being diagnosed. It's affecting whether or not the biopsy reports for patients with Barrett's esophagus include a statement about dysplasia, which is critical first step in clinical assessment that determines future therapies as these patients are at an increased risk for esophageal adenocarcinoma. Therefore, it does not discourage like assessment. Basically, what this assessment is is a pathology report for the patient population.

The measures do or do not seek reimbursement not because the measure was not worthy or could not have met the criteria but due to lack of resources. And currently, this measure is able to produce a historical benchmark and therefore is not considered as having quote unquote low adoption. This measure produces usable performance data. That's all I have. Thank you.

Ms. Williams-Bader: Thank you very much. If we could go to the next slide and just actually as a note, this measure and the previous measures, these -- the slides with the measure criteria were updated to reflect what was in the measure summary sheets. Can you go to the next slide, please? There we go.

And we will post the updated slides, but let me turn it over to the lead discussants. I have Stephanie Fry and Kaiser Permanente. Stephanie, are you on?

Member Fry: I am, yes.

Ms. Williams-Bader: Okay. Would you like to go ahead?

Member Fry: Sure. So a few things stood out about this particular measure. So adoption is not tremendously high. It's a very specialized measure.

That said, adoption sort of has been stagnant over the last couple of years I noticed, and performance on this measure is very high, 99 percent in the last measurement year. And so that, I think, made up a lot of the feedback about this particular measure in terms of its ability to distinguish and it just being a topped out measure.

That said, the public comment is really strongly supportive of this measure because it is specific to this population, and it would be a reportable MIPS measure that is highly relevant.

There wasn't anything in there about sort of a potential downside to this measure and in fact, because it is sort of a leading indicator or a preventative measure, potentially could lead to positive health outcomes and potentially positive health outcomes across different population groups. So those were kind of the high level pieces that stood out to me.

Member Gozansky: The only thing that I would add is I do think that, you know, having performance at 99 percent or in excess, it doesn't seem like there is a role for continuous improvement here. It does seem like this is a basic standard of care and so, you know, looking at some of the other measures around something about -- you know, it seems like there should be something more around accuracy of dysplasia, something that would be more meaningful if you were looking for conformation or looking for something else to improve detection here and prevention. I also think that there are other measures around kind of timeliness or those sorts of things which probably could be other considerations.

And I don't see that this would, in any way, push for excessive endoscopy. And again, I just think really that not having the ability to move the measure more and that this seems like a basic requirement for recording, you know, I would not be supportive

of continuing this measure. It seems like it should probably be retired and a new measure put forth.

Ms. Williams-Bader: Thank you very much. All right. Advisory group representatives, do we have Collette? You're still on?

Ms. Cole: Yes. I am still here. So the MAP rural group was split on this measure, and I think part of that rationale was the recognition that the pathologists needed something to report on. However, as -- or I should say our vote for continuing was 3; no was 4, and unsure was 1, and a recognition that the measure is topped out and represents a standard of care.

Ms. Williams-Bader: Thank you. And do we have Beth Godsey on from the Health Equity Advisory Group?

Ms. Godsey: Yes. I'm here.

Ms. Williams-Bader: Great.

Ms. Godsey: So from a health equity perspective, there wasn't too many concerns expressed from the committee or from the group. They did refer to how this measure was topped out and mentioned although in the same breath that it's an important measure and it is one of the key measures that pathologists can look at and take a view from, the other components related to health inequities were it wasn't stratified in a way that we could provide any insight. So there is generally a caution that the health equity group would put forth to say even though a measure might be topped out, it's important to look at a measure stratified so that organizations and folks can take a look to see is there really any health inequities that are not represented or not showing up because we're viewing it as topped out.

There were some comments that there were -- it would be challenging from an health and inequities

perspective from the pathologist report, although there was some discussions that there might be some opportunities to improve but not a -- not an intense heavy focus form a health equity perspective.

Chair Padden: Okay. At this point, I'm going to open it up for questions and discussion, and there is one comment in the chat box from CMS for Michelle that the MIPS program does have a statutory requirement to have measures for all MIPS eligible specialists and for pathology, as noted, there are few measures to choose from, which some of you have stated.

Now I believe we need to go to our committee members, and I'm just seeing that Greg has his hand up, but that was a public comment and he commented already. So I am going to ask -- I believe we go to our committee, correct?

Ms. Williams-Bader: Yes. I would say if we've got specific questions for the measure developers, then they can answer those specific questions, but I don't know that we've had one raised yet. I do see Will's hand raised though.

Chair Padden: Yes, correct. I see his --

Member Fleischman: Yes. So actually, I do have a question for the measure supporters so if Greg is allowed to comment, I would love to hear. So I'm trying to understand -- and I think Stephanie mentioned this -- isn't -- wouldn't this be -- isn't this similar to asking -- to having a measure, for example, for radiologists to comment on whether there's a brain tumor on a CAT scan of the head or a cardiologist what the ejection fracture is for an echo? Isn't this basic standard of care, what is included in a report, or is the dysplasia, the commentary around dysplasia truly kind of an additional thing that is not necessarily part of a pathologist's report on an esophageal biopsy?

Dr. Bocsi: Am I free to respond to that?

Chair Padden: Yes. Go ahead.

Dr. Bocsi: All right. Yes. I mean so a pathology report, there's no criteria other than what the ordering physician expects from the pathologist, the pathologist's training and potentially expectations of other pathologists who would read that report. And so in fact, most commonly, esophageal biopsies may come in with simply a request to identify whether or not, you know, there's Barrett's esophagus.

The additional information about dysplasia then allows one to decide in the presence of Barrett's esophagus do I follow-up in six months, do I follow up in three years, do I have follow-up in five years, do I immediately intervene in this, you know, intensive intervention for the patient. And so, you know, what you see, what we see when you look at pathology reports is that even the way that the Barrett's esophagus itself is described is variable. And so for that reason, the important additional piece of information is not just that there's a Barrett's esophagus, but the degree of dysplasia, because that's really -- you know, step one, Barrett's esophagus, okay, we're going to have to follow-up. Then beyond that, the nature and duration and frequency of follow-up really requires that dysplasia comment.

And so the performance -- the mean performance is, of course, going to be good for a type of measure like this, because many pathologists are subspecialized. But then the long tail on towards, you know, poor performance is where improvement is really possible by keeping this measure in the program, because it highlights the fact that, you know, in addition to good practice why, in fact, your performance in the quality domain can be measured by reporting this measure. So does that answer your question? I mean it's more than just that you

have Barrett's esophagus. You need to have that dysplasia information in there as well. And, you know, true, a lot of people are able to capture that but like I said, there's -- there remains this tail that we need to catch up on.

Member Fleischman: Can I ask a follow-up? Is -- but the dysplasia comment, is there actually a requirement as part of the measure to have a recommendation for length of follow-up similar to, I'm thinking of, a radiologist will include sometimes a recommendation for follow-up for pulmonary nodules.

Dr. Bocsi: Yes. That's a great question and it's not a requirement of the measure. For a gastroenterologist, to follow their guidelines, they would need to have that dysplasia comment in there quantifying it. And so I would -- it's possible that some pathologists, as part of their practice, could include the guideline statement from the gastroenterology guideline indicating that. But this measure itself doesn't require the pathologist to stipulate what the appropriate follow-up would be.

That's actually, to be honest, why -- well, this is off track, but pathology oftentimes has a difficult time creating outcome measures because our outcome is the precision of the diagnosis and the information that we provide. But then the medical decision-making beyond that point tends to fall outside of our scope.

Member Fleischman: Yes. I'm just thinking with a measure that's 99-plus percent reporting, because I think it is basic standard of care, it would -- the way it sounds like what you're confirming, is there a way to somehow tweak the measure and say that we support retaining it but with some additional requirement, with some additional modification potentially, and could that potentially help? And I get the response that it's not exactly analogous to -- let's say pulmonary nodules, we -- cause they're -

- the ACR, for example, has specific recommendations of when imaging has to be performed again. Here it's more of handing it off to the gastroenterologist to decide if and when to do a biopsy or further follow-up.

Dr. Bocsi: Yes. We -- I mean if -- in some cases, the pathology measures can be tweaked to, I guess, reduce performance if there is a rationale that's acceptable to pathologists, you know, that seems like clinically meaningful change that would suggest -- just not change it alters the performance for the sake of altering the performance. And this measure, there -- the ideas for tweaking it that have been entertained don't, I guess, fit into the work flow of a pathology practice, and for that reason, they aren't feasible to implement.

But, you know, each year we review these as a committee to look for opportunities for improvement. They just released a good new guideline on Barrett's esophagus, so we looked at that to see if there was any opportunity to tweak it. But I guess I can't offer any particular suggestions right at the moment to make a change that would, I guess, reduce the performance.

Member Fleischman: And, you know, I guess the key thing is that in that regard, the performance is quite good, and it's because you really funnel pathologists to a limited number of measures. And, you know, if this measure goes, they actually don't have any alternatives. So if there were, you know, measures that weren't topped out, you know, we could potentially funnel them there but there, at present, aren't any alternatives.

Chair Padden: Thank you. Helen, you have a question?

Member Burstin: Apologies for not being here all afternoon, but I heard most of this conversation before I dialed in. You know, I think one of the complicating factors, as you've heard, is it's just so

difficult to get measures in pathology. And I think it would be difficult to just leave a field with not having measures. So while I understand these measures probably are getting to the point where, you know, you're identifying top performers, there may be opportunities to expand the population of pathologists who may be not participating but may not have the high rates performance of those who participate. But I guess I'd encourage us to not act and lose all measures but maybe to sort of, as you've just done, give direction about potentially where a measurement could go but not kind of throw the baby out with the bath water and lose the ability to have pathologists as part of these programs? Thanks.

Chair Padden: Thanks, Helen. Dan?

Member Albright: Yes. I just want to clarify the category of "remove with condition" may pertain to this. It's the same for this group. We are not saying that pathology should not have a measure but this one is topped out, and we would maintain it until another one is available for them to use. So I think by removing with condition allows that to happen.

Chair Padden: Thank you, Dan. Any other comments? Okay. All right. Let me see. I think you said it nicely, Dan. Perhaps we're -- remove with condition is what I'm hearing, that the measure is about standard of care. We don't want to leave our pathologists with no measure, so we would not remove it unless we had some other alternative for them. Did I get that right? Okay. Can we have a vote?

Ms. LeFlore: Voting is now open for 01101-C-MIPS, Barrett's Esophagus. Do you vote conditional support for removal?

And I'll give everyone 15 more seconds.

Okay. Voting is now closed; 16 members voted yes, 1 member voted no, and that is going to give us a

percentage of 94 percent for yes.

02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

Ms. Williams-Bader: Okay. Thank you very much. We do have a scheduled break at 3:10, but I think we're going to try to get through one more measure before that break. So if we could go to the next measure? Thank you. This is 02381-C-MIPS, Adult Primary Rhegmatogenous Retinal Detachment Surgery, Visual Acuity Improvement Within 90 Days of Surgery. This measure assesses patients age 18 years and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity from their preoperative level within 90 days of surgery in the operative eye. This measure is not endorsed and three survey respondents selected this measure. So would the CMS program lead like to say something about this measure.

Member Gomez: Hi. This is Lisa Marie with CMS. I just want to highlight that this measure is a high priority outcome measure. It reflects current guidelines. There are a limited number of measures for retinal specialists. I just want to note that ophthalmology has 15 measures; for retinal subspecialties, there are only 3 measures. The benchmark was removed from this measure for the 2020 performance year due to a substantive change for reporting of measures within MIPS at the clinician's choice. However, I just want to highlight as we're transitioning to other ways in which our clinicians can participate, MVP, which is MIPS' Value Pathway implementation will reduce the number of measures for subgroup reporting which will, hopefully, boast adoption for these types of measures.

MIPS measures reach a wide variety of specialists and subspecialists, and it's important that there are

measures to drive quality of care for these areas. As such, this quality measure does support a subspecialty of ophthalmology and retinal specialists. That's all I have. Thank you.

Ms. Williams-Bader: Thank you. All right. I'll turn it over to the lead discussants, and I have the Purchaser Business Group on Health and Amy Nguyen Howell. I'll start with Purchaser Business Group on Health.

Okay. Perhaps they've stepped away. Amy?

Member Nguyen Howell: Hi, yes. So as TMS mentioned this is not an approved endorsed measure. It is a new outcomes measure. I agree with the recommendation receiving from the -- sorry -- reviewing from the public comments, especially from the American Academy of Ophthalmology. Given the limited number of measures in the program for specialists, this particular measure for retinal detachment is supported by the AAO, American Academy of Ophthalmology, 27,000 members. And they really supported it and having it as a measure to identify and measure a quality outcome with visual acuity for members, patients post 90-day retinal detachment. So yes, that's what I have. I didn't know if Rachel had anything else from PPGH.

Chair Padden: I'm not seeing her on. Jen, are you seeing her?

Ms. Williams-Bader: Oh, no. I think she did have to step away, so we'll go ahead and keep going. So do we still have Collette on?

Ms. Cole: Hi, yes. So the MAP rural group reviewed this measure. I think it's a great patient-reported outcome measure, but the MAP group voting was split; two for yes and four for no, two for unsure. And their main concern was the potential for low volume. The prevalence of this condition is 5 to 7 percent of the general population, or 1 in 10,000.

So the only hesitation from the MAP rural group was small volume for reporting in the rural areas.

Ms. Williams-Bader: Thank you, Collette. And then from the Health Equity Advisory Group. So a MAP member noted their concern again about -- they also had a concern about low volume and the difficulty to assess equity issues based on various subgroups when there is low volume. They did acknowledge the public comment recognizing outcomes for certain groups are worse following retinal detachment, and this could highlight a health equity concern.

So I will go ahead and turn it over to you, Diane, for discussion.

Chair Padden: Okay. So any questions for our measurement developers or discussion questions to clarify from the committee?

Member Nguyen Howell: Diane, I have a question. So to clarify, how many measures are there available for MIPS for ophthalmology?

Chair Padden: Fifteen, did I hear her say 15?

Member Gomez: Yes. For general ophthalmology, there are 15. When we get to like more subspecialty, that gets to 3 when we think about like retinal therapy.

Member Nguyen Howell: Okay. So there's only three for retinal --

Member Gomez: Yes.

Member Nguyen Howell: -- specialty.

Member Gomez: Three for retinal.

Member Fleischman: One of the comments says six, comments Marsden Advisors, the public comment says that there are six benchmark measures for retinal specialists.

Member Gomez: Colleen, would you be able to confirm that? In my notes, I have retinal subspecialists, there are only three measures.

Ms. Jeffrey: Yes. I will look at that. I'm wondering --

Dr. Green: Or Anita ---

(Simultaneous speaking.)

Ms. Jeffrey: -- collection types.

Dr. Green: Anita, if you know --

Ms. Somplasky: Yes. So let me check. I thought that they had less than that.

Ms. Williams-Bader: There is a comment in the chat from Lisa Hines that I could -- the difference may be benchmarked measures.

Ms. Jeffrey: Yes. So if you're looking at benchmark measures, there are going to be six because the diabetes eye exam has three collection types, and then there are a couple of other measures. So I think that may be where they're getting that higher number, but looking within the measure's list, there are only three measures that look specifically at retina. It's the diabetes eye exam and then this measure as well as the other rhegmatogenous retinal detachment surgery measure looking at return to the operating room within 90 days of surgery.

Chair Padden: I'm sorry. Dan, you have a question?

Member Albright: Yes. I may be missing -- I know it's a small, you know, number of patients, but the retinal, you know, especially is small, too. Do we have numbers on the number of eligible retinal specialists, you know, who are using this measure and the percentage of patients who, you know, are at goal. Or is it yet to be determined?

Member Gomez: So for this particular measure, I

have some stats here and I think you all were also provided with statistics. So I'm just looking through the data here, because there are two measures that are like almost the same, but there's just like wording but in general, are you asking because -- sorry --

Dr. Green: Yes. And just I was wondering ---

(Simultaneous speaking.)

Member Gomez: -- version of the measure. I'm sorry. I just want to make sure I'm reading the right -- is the ECQM, cause for the ECQM version, I don't have --

Dr. Green: It's the CQM.

Member Gomez: Oh, the CQM. So the total number of groups that reported for just the CQM, is -- there were 123 groups, which is .16 percent of like the reporting rate for groups. And then for individual actual clinicians, the number -- and this is for 2020 -- the number of just individual clinicians for 381.

Member Fleischman: Is that part of the 160 or separate of that?

Member Gomez: Right. So the 120 is the number of actual group practices, and then the other number that I indicated, the 381, were just individual actual clinicians who may be like solo practitioners or --

Member Fleischman: Right, right.

Member Gomez: -- maybe part of a group but reported individually. But I want to highlight that for 2020, reporting was optional as a result of the pandemic so, for the health emergency.

Chair Padden: So of those numbers, does that -- how would we -- how do you know who's eligible, whether or not they've decided to? Or are you saying that that is --

Member Gomez: So --

(Simultaneous speaking.)

Chair Padden: -- eligibility versus those who actually reported?

Member Gomez: -- so the numbers that I have are those who actually reported. I don't have the number of all total like eligible clinicians who maybe could have reported. Again, because of the public health emergency, the number may have been higher. But looking at previous years, the numbers were slightly higher. Like 2019, there were 153 groups and then 447 total just individual clinicians. And then in 2018, 147 groups and then 466 total individual clinicians. So when we look at the data -- this is what the data we received. If there was a clinician who didn't report or was part of a group, like I wouldn't be able to know what those numbers are. This is just only data in terms of those who submitted data for this measure.

Dr. Schreiber: So this is Michelle from CMS. To add to Lisa Marie's comments, she's entirely correct. We don't look at the clinician type and whether or not they should have reported x-measure. So for example, we don't have a list of all retinal surgeons to look if all retinal surgeons have reported this measure. I think it's an interesting concept going forward, and there's been some discussion about that, especially when it comes to MIPS Value Pathways; should we be matching, say, DRGs or complaint codes that clinicians are billing for to see if they're actually reporting on something that is related to their specialty, but we have not done that at this point.

Chair Padden: Thank you.

Dr. Green: I think the -- this is Dan. I'm sorry, just real quick. The other thing to bear in mind, to Michelle and Lisa Marie's point, you could have retinal surgeons and general ophthalmologists

embedded in multispecialty groups, and I hate to say it, but riding on the coat tails of the primary care folks. And Michelle knows that all too well from her days in Detroit. And, you know, as MVPs come into play, if any kind of smaller group reporting, you know, should ever become mandatory, obviously, they won't -- they wouldn't be able to do that in the future. So, you know, we are trying to give an opportunity and have all specialties, to the extent we can, represented.

Member Gomez: Yes. And I would also note -- this is Lisa Maria. I would just also note that when we discuss the ECQM version and -- we'll actually see more reporters under that version of the measure, and that's a collection type so the measure's the same but it's just the way in which you collect data and report it to CMS. So under the ECQM version of the measure, there's higher reporting rates for that collection type.

Chair Padden: Okay. Thank you. I have some hands up. First, I have MJ.

Member Condon: Hi. This is Mary Jo Condon with the St. Louis Area Business Health Coalition. You know, I thought it was compelling that the American Academy of Ophthalmology was so supportive of this measure. And looking at some of their comments and particularly versus the comments of the American Society of Retina Specialists, there seemed to be some disagreement as to whether or not the fact that CMS has been not able to calculate benchmarks is because of this low sample size issue, because of few providers reporting. And I was wondering if CMS could comment on whether or not they see that as sort of a problem with the measure or something that should lead us to think that it is difficult for providers to achieve sufficient numbers of patients for this measure.

Member Gomez: Dan or Colleen, would you be able to address that question?

Dr. Green: Yes. It's --

(Simultaneous speaking.)

Dr. Green: -- I mean certainly -- yes, go ahead, Colleen, or --

Ms. Jeffrey: No, go ahead. You start, Dr. Green.

Dr. Green: Yes. I was going to say certainly, you know, because of the, I won't say rarity, but because it's not a super, super common condition, it definitely is going to be more challenging, of course, to establish benchmarks. Certainly, groups, on the other hand, you know, two or three retinal surgeons, you know, would make it easier to reach the volume. I mean as you know, there's a limited number of retinal specialists in the country, and if you look at the incidence and, you know, kind of do the math, I mean somebody's taking care of these patients. As an individual clinician, depending on their practice, however, as you point out, could be challenging.

Dr. Schreiber: So this is Michelle and I'll just comment to a point that both Dan and Lisa Maria made. For large multispecialty groups, ophthalmologists, retinal specialists are frequently embedded in the reporting of primary care, so several things will happen in the future. Number one is this becomes an ECQM. We are much more likely to get data around these procedures, and I think we'll have a larger volume there. And number two, is we transition so that multispecialty groups are reporting by subgroups including ophthalmologists reporting ophthalmology measures. We think that we will see better numbers because of that as well.

So basically, although I think it may be hard right now, we think that the future trajectory will improve.

Chair Padden: Thank you. And I believe we have

Yanling Lu had a comment.

Member Lu: Yes. Thank you. You know, the comments about ECQM implementing, we might see more reporting, I think that's very encouraging. We should give -- be patient and give time to let this evolve to see how -- whether the reporting is, you know, few reporting is indeed an issue, actually improves.

And also, because this is, you know, not many -- it's not very common condition or situation like blood pressure, hypertension, or others, but those are type of surgery that after the surgery, the quality of life, okay, has a great impact on patients', you know, their quality of life, I mean how well they can see, how well they can function, take care of themselves and to enjoy their life. So I would agree, think that we should at least think about the impact on the patients rather than how many report really out there. And even though there are small numbers -- and also, you know, there's not many ophthalmology measures out there, and this would help to really address those specialties in a smaller population, but it greatly impacts patients' quality of life. So I think we should support.

Chair Padden: Thank you. I'm going to look real quick. Any other questions? Any other discussion? One more hand. Helen?

Member Burstin: Hi, everybody. I just put it in the chat just real quickly. Just, you know, I think it's important from a visual acuity is a really important patient-centered outcome. So I think that there are ways the measure could be probably addressed in the future to make it work. But, you know, we don't have very many of those so, you know, as much as we can get patient-centered outcomes, the better we are -- the better off we are.

Chair Padden: Thank you. Will?

Member Fleischman: Yes. It's interesting to see the

disagreement between the side of retinal specialists and the ophthalmologists. The retinal specialists do bring up a few points about how the measure could potentially be improved; for example, lengthening the 90-day timeline, maybe looking at some features of the procedure, although I think that probably muddies the water. They essentially prefer a process measure versus an outcome measure, and I agree with keeping it as an outcome measure.

I'm wondering if -- I don't know if the American Academy of Ophthalmologists, the ophthalmologist who earlier gave the public comment from the AAO-something, AAOS, I think, is still on and could comment on some of the, I guess, proposals, if you will, from these retina specialists to improve the measure, what the AAOS thinks about it, and could we potentially support with -- give conditional support for retention with some improvements of the measure.

Chair Padden: I'm not sure if I see that --

Ms. Keys: This is Brandy Keys and I am representing the American Academy of Ophthalmology here. I am not a doctor. Thank you, though. I'm the Director of Health Policy for the Academy, AAO. You know, we have opened up conversations with a retina specialist group, and we are certainly open to working with them to make this measure the best that it can be. I can't speak to specifics right now. That's probably a better question for our leader of our registry department who is on vacation today, so I am standing in.

Member Fleischman: Thanks. Yes. I do think that there are some reasonable comments that I think could be, as opposed to -- I don't know why they would push for eliminating the measure entirely. I think there's definitely some improvements, minor tweaks that could be made to improve the measure and address some of the concerns that were raised. And as per context, I was looking this up, there are

about -- and Brandy, maybe you have better numbers on this -- but I think there are about 4,000 or so retinal surgeons in the country. And if you look at the numbers, the 116 or 116 to 150 groups that are reporting plus the individual clinicians means a pretty significant chunk of the retinal specialists are -- have been reporting for the previous few years.

Ms. Keys: I don't have any additional details, but I did want to say that, you know, we have -- we spoke to, we worked together with the retinal subspecialist group in writing our comments. I think that if we had had a little more time in the public comment period, we could have presented something that was more in alignment and given more specifics on the steps that can be taken. So just reflecting back on the time that was allowed for public comment for these proposals, we had about six days. Thank you.

Chair Padden: Any additional comments, questions?

Ms. Williams-Bader: There's just -- there's a comment in the chat from Wendy.

Chair Padden: Yes. Agree with the concept of improving the measure and staying focused on visual acuity. So I was just kind of pondering h ere, because it appears that in the last couple questions, discussion, we -- I seem to hear that we may be moving to conditionally retain the measure with some opportunity to improve the measure, which would be focused here. And as Michelle said, we would need some conditions of what we would be asking to improve it, which would be focused on visual acuity. Were there other specific suggestions on how it might be improved?

Member Fleischman: One specific thing would be -- which is one of these the retina specialists comment on, is lengthening -- potentially lengthening the follow-up period to allow for additional correction before you have to submit the visual acuity.

Chair Padden: Okay. Yanling, you had a comment?

Member Lu: Yes. Thank you. I saw that this measure specifically looked at visual acuity improvement, so I'm a little bit confused about this focus on this type of improvement? Isn't that this measure specialty looking at this? I'm just confused --

Member Gozansky: Can I comment --

Chair Padden: Yes.

Member Gozansky: -- on that?

I think the reason -- so the reason I was doing my pun intended on focusing on visual acuity is that there was a recommendation that, you know, it's about anatomy and not acuity. But from a patient-centered perspective, I don't care about my anatomy. I care about my visual acuity. What I do think is important, though, is that it actually seems to me that there could be a potential for additional exclusions, you know, depending on the -- what the starting anatomy is from what they are suggesting in the commentary. So to me, maybe an increase in length of follow-up, maybe some additional exclusions depending on macular involvement, etcetera would be the type of thing that I think improve the measure.

Member Lu: Okay. Thanks for clarification.

Chair Padden: Okay. Any additional comments? I see one more in the chat. Review by CBE may be useful as well. Also, the approach to allow time for AAO and ASRS to work together, I think that's also great. So we have some specific suggestions for improving the measure.

So I believe one more time through for hands. No more hands. Okay. I think we're ready for a vote, and that would be conditional support to retain the measure.

Ms. LeFlore: Voting is now open for 02381-C-MIPS, Adult Primary Rhegmatogenous Retinal Detachment Surgery, Visual Acuity Improvement Within 90 Days of Surgery. Do you vote conditional support for retaining.

And I'll give everyone 15 more seconds.

All right. I'll go ahead and close the vote. Apologies. I'll give my team a couple more seconds to add a vote. We have to add in the background.

Okay. Perfect. I think they added the vote. Voting is now closed; 17 members voted yes, 0 members voted, and that would give us 100 percent for yes.

Chair Padden: Okay. Thank you. I think we're going to have a little bit of a break, is that correct?

Ms. Williams-Bader: Yes, we are, but since we are about 25 minutes behind schedule, we are going to go ahead and do a 10-minute break instead of a 20 minute break. So we will see everyone back here at 3:45 Eastern Time.

(Whereupon, the above-entitled matter went off the record at 3:34 p.m. and resumed at 3:46 p.m.)

Ms. Williams-Bader: Welcome back everyone. Okay, before we get started I wanted to make one quick note about the controlling high blood pressure eCQM.

When we were doing the voting I believe the eCQM ID was perhaps not readout correctly. But so just to have it on the record that measure is CMS165v10. But we will go ahead and get back into it.

00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Yes, next measure is 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care. This assess the

percentage of patients age 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular of fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular of fundus exam at least once within 12 months.

Endorsement was removed for this measure and three survey respondents selected it. This is the version of the measure reported via registers.

The next measure up for discussion will be the version of this measure reported as an eCQM. Let me turn it over to CMS. Would anyone like to make any comments?

Member Gomez: This is Lisa Marie Gomez with CMS. I just want to highlight. Jenna noted the measure we're discussing now is one version of the measure. And what I mean by version is collection type.

It's the same type of, it's the same measure, just a different collection type. So the information I am going to discuss now is also applicable to the eCQM version or slash collection type.

So for this measure it's considered a, or we consider it a high priority measure. There is strong stakeholder support for this measure. Removal of the measure would have an impact to the number of measures available for a specialty.

This measure is not talked out and so due for improvement, or a performance gap. And it's a digital quality measure.

I just want to highlight that this measure, it was proposed for removal in the 2022 PFS, or physician fee schedule, proposed rule. However, we maintain this measure due to significant opposition for removal for this measure. So there was extreme opposition for removing, for moving it.

I just wanted to highlight that an ophthalmologist is needed to inform a primary care physician or an endocrinologist about a particular patient in opathy. If possible, diabetic macular edema or other ocular comorbidities.

When opathy serves as a strong predictor for others whose medical condition, such as heart attack, stroke, kidney failure, amputation and others, that regular reporting from the ophthalmologist on this issue to the primary care clinician lacks viable information key to the overall management of a patient.

This measure is essential and patients need key and complete feedback essential for treating a deadly common disease. Before this measure patients were not being referred for retinal exams until the blinding stage off the disease.

I also want to highlight, this is other feedback we've received. That most ophthalmologist practices only have six measures to report and removing the measure would make it impossible for practices to proceed in MIPS. Also, there are concerns about the impacts of removing this measure on small rural practices.

It's also important to continue offering the eCQM version for reporting since many providers do not want to pay for other reporting services. And removing this measure would make it difficult for retinal specialists to find measures to report.

I just want to highlight that the measures steward did not seek re-endorsing, not because the measure was not worthy, but could not have meet the, or that it could not meet the criteria, but due to the lack of resources. Without regular reporting from the ophthalmology on this issue, primary care clinicians lack viable information key to the overall management of the patient. That's all I have, thank you.

Ms. Williams-Bader: Thank you for that. Okay, so then lead discussants. And if we could move to the next slide as well.

So we have Blue Cross Blue Shield Massachusetts, Pharmacy Quality Alliance and Genentech. So, we can start with Blue Cross Blue Shield Massachusetts.

Member Ying: Sure. So I read through the summary, that one thing that, actually, probably wanted some clarification, I think what the CMS representative just said is that removal of the endorsement was not because of validity of the measure, was just because the lacking of a resource at the time, maybe from the developer.

But maybe what, at least what I could tell from the material summary is that an NQF standing committee expressed actually pretty significant concern with the measure, validity and the reliability. Especially the validity part.

The reliability vote was about half-half. But the validity vote significant more participants in the standing committee actually questioned the validity of this measure.

So, totally understand that for the mix purpose each specialist's area has to have a sufficient number of measures to be measure off. However, with the, I think my question is, is it always good to include the measure that the NQF standing committee has sort of a strong objection in terms of its validity to be part of the program, are we rarely measuring what we want to measure. So that is my takeaway from the summary from the NQF discussion in the past.

And also, there was another issue that was raised about the NQF standing committee with the, I think the clinical value of this communication, granted is that of course we want to encourage all levels of communications among the different physicians taking care of each individual patients. And it's great that ophthalmologists and retinal specialists

are in strong agreement that they want to keep this measure, and believe in the value of this measure.

I think that the question is, since the PCP and/or the chronologists are the ones on the receiving end, have they seen the value in this communication. Whether they have changed their treatment plan for an individual patient based on this type of report. I think that is a question mark.

So these are the two main takeaways that I have from reading the material. But again, with the understanding that the number is limited for this specialty area.

Ms. Williams-Bader: Great, thank you. Do we have someone on from Pharmacy Quality Alliance or Genentech?

Ms. Hines: Hi. This is Lisa Hines from PQA, Pharmacy Quality Alliance.

I agree with the takeaways. It does look like NQF endorsement was sought. The maintenance was sought and then there was no vote because the must past criterion of validity was not met, in addition to not meeting evidence and reliability criteria.

So that, in and of itself, is concerning that the measure doesn't meet standard measure criteria. And in the benchmarking report, this one was noted as being topped out, but I know that that can be questionable when we're looking at averages.

Really appreciated the comments from the American Academy of Ophthalmology and thought that they were thoughtful responses. And agreed with the importance of coordination of care.

And so I would be concerned about removing this, these measures, this measure, without additional measures, but I do think that some things better, more meaningful would be useful in the future.

And I think that those are all the main points that I had thought through. Thank you.

Member Nichols: This is Donald from Genentech. And the two previous reviewers have covered all the thoughts that I had as well.

Ms. Williams-Bader: All right, thank you. Okay. So do we have, check here to see if Beth Godsey is on the line. Yes. Okay, great. Beth, would you like to go ahead.

Ms. Godsey: Yes, absolutely. From a health equity perspective there was quite a bit of discussion and support that there is known challenges with diabetes from historically marginalized populations. That there are inequities that are occurring with, particularly around diabetic population.

And so, from a health equity perspective this is certainly an important measure for stratification and evaluation. And would encourage us to consider this measure moving forward.

Ms. Williams-Bader: Thank you. And then from the Rural Health Advisory Group. So they voted one support retaining in the program, which is 13 percent. Seven or 88 percent did not support retaining the measure in the program. However, they did not raise specific concerns about this from the rural health perspective.

And I believe that's all the comments, so I will turn it over to you, Diane, for discussion.

Chair Padden: Okay. Do we have any members of the Committee that would like to speak, have questions or state their opinions? Helen.

Member Burstin: Yes, hi. I just put it in the chat as well. I just thought it was an interesting comment in one of the comment letters that the ADA is leading an initiative here to address that gap and performance because they know it's pretty

significant.

So again, I think at the end of the day it's about care coordination. And I would think if the ADA thought it was important enough to lead an initiative on this based on their research findings that perhaps if they looked at evidence again it may not be the same as it was years ago.

Chair Padden: Okay. Will?

Member Fleischman: Oh, thanks. Yes, I was impressed by a few things. I agree with the very thoughtful response by the American Ophthalmological Society.

I also, the things that struck me was, and this will be contrast to the, I think the next or one of the other measures, the last measures we're discussing. The referral, or the loop if you will, that's required here is to the physician managing ongoing diabetes care as opposed to, I don't know if that should be provider in the title as opposed to physician, as opposed to the refer and provider.

This, from my understanding, requires the ophthalmologist, actually requires work to collect who is managing your diabetes. And yes it is not a, it is a process or performance measure it is not a patient outcome measure.

But from my understanding of outpatient diabetes care it is critical. Be the outcome of what the eye, what the eye looks like, the retinopathy, the potential retinopathy absence or present of retinopathy, significantly impacts how aggressive potentially the diabetes care is.

So, I agree with all the societies that ask for this to be retained, despite being just a process measure. And again, I like the idea that this is, whoever is taking care of it as opposed to who referred you because this takes care of patients who are not directly referred to this ophthalmologist by a

primary care provider.

Even in that scenario the primary care provider or endocrinologist will get information about the absence or presence of retinopathy. So, I think it's a well-designed measure and should remain. Thanks.

Chair Padden: Sorry, I had myself muted. Dan.

Member Albright: Yes, sorry. So I was going to agree with Will. I saw the same thing.

I will be talking a little bit about the loop feedback for referrals and the burden of the work is on the primary clinician to receive it back. And then that's a little bit harder proposition than the specialists responsible to get information back to the referring provider. And I think this one does it a little bit better.

I still think there is probably a disadvantage with independent practices in rural groups versus multi-specialty groups with EMRs that integrated. So perhaps some tweak as to somehow risk adjust that in some way. But it's easier for bigger groups with EMRs to exchange information.

Chair Padden: Any other comments? Yanling?

Member Lu: Yes. Thank you. I just think, you know, echo what has been said. We all know in care communication is so important for the quality of care and the safety and for patient satisfaction.

So I think this measure focuses on, you know, whether proper or timely communication in this situation I think is very important to patients for managing their care in coordinating with their care team and their physician. So I would thing we should support this.

Chair Padden: We should support to retain the measure, is that what you're saying?

Member Lu: Yes. Yes, that's what I think.

Chair Padden: Are there any additional comments? Questions?

Ms. Hines: I have one additional comment. So I believe that this is a very important concept in terms of quality of care, but that the measure itself could benefit from some improvement. So my recommendation would be conditional support for removal.

Chair Padden: So do we have the specifics that you would put with that condition?

Ms. Hines: So I recommend that this be maintained because we do need measures that these specialists can report on. And I think that we all agree that this is an important quality construct.

I don't want to ignore the NQF review information. It was quite meaningful, that review. And if you even looked through that submission.

So I think that there are, I have concerns about the measure meeting the criteria of a good quality measure. And would recommend additional measure development in this area, that this measure be maintained until there are further measures.

Chair Padden: Helen?

Member Burstin: I guess I would frame it instead as maintained with conditions, because I think you've heard pretty strongly people thing the care coordination aspect of this is really, really important. And again, keep in mind this is, it's been quite awhile the measures and widespread use. And it wasn't a requirement for it to go through the NQF process.

Chair Padden: Okay. Yes, I wrote that as well, conditional. Retain with condition, support.

Okay, one more look.

Ms. Williams-Bader: Diane, this is Jenna. I guess

I'm still not clear. I'm hearing a rather vague, the measure should be improved, but if we could get to specific conditions I think that would be helpful.

Chair Padden: Okay. There was some discussion about because of the quality of the measure not being NQF endorsed. I believe I heard Lisa talk about that as she described the measure, as well as the individual from Blue Cross and Blue Shield.

Ms. Hines: I just don't want to ignore the NQF review. And I realize that some measures just have a set review and how resource intensive it is. That that was concerning and I think it should be noted. That those criteria were not met.

Chair Padden: Okay, Wendee?

Member Gozansky: I mean, I think that what I am hearing is the concept that we think this should be a good measure because if the information is being provided back to the person managing the diabetes, it should be a signal to potentially intensive high treatments if retinopathy is present.

But it sounds like the evidence does not support that. And I guess we then have the ADA doing some research to figure out how we get that to happen.

So perhaps the condition is around reevaluating what the best practices are to actually get this to change behavior. I mean, it goes back to, this is a process measure but it may be that this process measure doesn't actually change outcomes currently. Which is sort of the prior state.

So is there a way to change it to something that would improve outcomes for the member? For the patient.

Chair Padden: Okay. Dan?

Member Albright: Yes, I agree. Outcomes measures is probably ultimate goal. Kind of steps towards that could be, you know, in addition to communicating

back to the referring clinician, perhaps through some time element of usually every year that we want these done from a community measure standpoint. So perhaps there is no more responsibility for them to also coordinate that follow-up.

Maybe the time lag between when an exam is done and when the communication back to referring clinician is done. Those kind of things.

But, yes, ultimately it would be some measure of hemoglobin A1C or other complications with diabetes.

Chair Padden: Okay. Helen?

Member Burstin: I may be just building on Wendee's comment. Maybe there is just an opportunity that the condition is for them to further engage with ADA as they go through this process and see how the measure could be more meaningful for improvement.

Chair Padden: Thank you. So we've had several suggestions for ways to improve the measure for conditions, but I'm hearing that we will retain it at this time. Conditional support to retain.

And then is there enough information for CMS on the discussion for moving forward on the conditions? Did that help, Jenna?

Ms. Williams-Bader: I think so. I guess I would welcome, if CMS has any thoughts on if this is specific enough for CMS use as well?

Member Gomez: We have all the information we need. Unless, Dan, you want to ask for anything more specific. But I believe we have the information relative to the thoughts of this workgroup on this measure.

Dr. Green: No. We'll take some notes and take a look at it.

Chair Padden: All right. Okay, so then I believe we're ready for the vote which would be conditional support to retain the measure.

Ms. LeFlore: Voting is now open for 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care. Do you vote conditional support for retaining?

And I'll give everyone 15 more seconds. Okay, voting is now closed. Seventeen members voted yes, zero members voted no. And that would give us a hundred percent for yes.

05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (eCQM)

Ms. Williams-Bader: All right. The next measure is 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, eCQM.

So this is the eCQM version of the measure we were just discussion. Endorsement has been removed for this measure as well. Three survey respondents selected this measure for discussion.

I will see if CMS would like to make any comments.

Member Gomez: Hi, this is Lisa Marie with CMS. I don't have anything else to add unless the workgroup wants me to repeat what I had said, but I don't have anything.

But if there are questions I can address them now. But I don't need to repeat, but let me know if you would like me to repeat the information that I did for the previous measure.

All right, it doesn't sound like the information I provided needs to be repeated, so I'm good with this measure for our introduction for this measure. Thanks.

Ms. Williams-Bader: Thank you. I'll turn it over to the same set of lead discussants as the previous measure. Anything about this measure, specifically as an eCQM, you wanted to raise?

Member Ying: No. This is from Blue Cross Mass. No, it's the same comment as the previous one.

Member Nichols: Likewise.

Ms. Hines: No additional comment.

Ms. Williams-Bader: Okay, great. And then moving along. Beth, if you're still on, anything new for this version of this measure?

Ms. Godsey: No additional comments.

Ms. Williams-Bader: Okay. And same thing for the Rural Health. Well actually, okay, so Rural Health, the vote was a little, or poll was a little bit different for this measure. Two supported retaining the measure in the program, or 25 percent, six, or 75 percent, did not.

They did have the, bring up the issue with the lack of endorsement. Or losing endorsement.

Someone did note that the measures are voluntarily reported in MIPS. So balancing burden of benefit should be more manageable than in other settings.

And an advisory group member shared a stronger preference for outcome measures than intermediate outcome measures. And yes, that was all the comments from the Rural Health Group, so, Diane, I'll turn it over to you.

Chair Padden: Okay. So now are there questions, discussion related to this measure that perhaps are similar or different from the previous discussion? No hands.

Am I to take that that we would use the same, we would have the same concerns about this measure

and that we would vote to conditionally support to retain with the same stipulations or considerations for improving the measure?

Having -- I do not see one hand so I am going to ask that we move to vote to conditionally support to retain with those same considerations.

Ms. LeFlore: Voting is now open for 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, eCQM. Do you vote conditional support for retaining?

And I'll give everyone ten more seconds. Okay, voting is now closed. Eighteen members voted yes, zero members voted no. So that would be a hundred percent yes.

Ms. Williams-Bader: Thank you. I'll turn it over to Taroon, who will be taking us through the last two measures.

05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report (eCQM)

Mr. Amin: Great. 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report, eCQM.

This assess the percentage of patients with referrals regardless of age for which the referring provider receives a report from the provider to whom the patient was referred. The measure is not endorsed and three is selected as for discussion today.

This is a version of the measure reported as an eCQM. And a version reported via registries, the CQM. The registry based CQM is not being discussed today because it did not rise to the top of the survey results.

I'll invite CMS to provide any contextual comments on the measure.

Member Gomez: Thank you. This is Lisa Marie with CMS. Based on the highlight that this is a high

priority measure, it has brought applicability, the measure is not topped out and shows room for improvement with the performance gaps. And it's also digital quality measure.

Communication and coordination of care is a priority. And programs that work towards this goal have been found to improve quality of care for patients and reduce hospitalization.

MIPS offers different collection types, as you all have heard. Such as Medicare Part B claims.

So for Medicare Part B claims data, clinical quality measures, which is just like registry or eCQMs, which is electronic clinical quality measures, is all based upon clinician group preference. So they get to choose how they report this measure.

But each of these collection types have different measure analytics in order to communicate how to extract data, permit data sources available to the clinician. Therefore having this as an eCQM does not penalize those clinicians who do not utilize an EHR, but allows those who do utilize one for the capture of data to report this measure.

Historical benchmarks indicate, historical benchmarks indicate a gap in care. Average performance rate is 34.98 percent. Based on performance data and the 2022 historical benchmark file.

It is much lower than the MIPS CQM collection tab, which has an average performance rate of 81.25 percent. MIPS allows choice in measure collection so if they find it too burdensome they can pick a different collection type to report the measure.

Additionally, by offering measures for multiple collection types clinicians and groups can choose the one that is most appropriate for their use. NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has evidence

based focused, as required by statute.

That's all I have for this measure, thank you.

Mr. Amin: Thank you, Lisa Marie. I'll turn it over to our lead discussants, Health Partners and the Council of Medical Specialty Societies. I'll start with Health Partners.

Member Albright: Okay, Yes, Dan Albright here. Yes, so we commented it before with the diabetes communication. This was a bit different where it's a loop of communication from the referring provider and back to, from the specialists and back.

And so the burden is on the clinician who referred such things as, was it an appropriate referral, what if the patient got better and didn't need that consultation. Those are kind of lost perhaps in the measure.

It mentioned with the diabetes that there is a robust systems with EMRs. Multiple specialty groups where this could be easier to perform in integration of the EMRs between systems that make it easier than perhaps over entities.

And with that said, there is room to grow. Looking at the reporting, it's really low. It's three percent of groups, less than one percent of individuals are using this.

And surprising to me is that there is a twice the rate for those who use registry versus EMRs. Which I would think it would be reverse. It would be easier to just use the electronic record to capture this. So there is some manual care that provides improved, finishing the loop here.

So my recommendation is that there is some work to do on this. And I would perhaps favor using more of a diabetes communication approach so this becomes a specialty measure back to the primary care clinician.

Also would be a loop just from a different direction. And then you would note that the patient got there. There would be more communication back to the person who gave the referral in the first place.

And perhaps a little bit more focus on individual providers, rural areas that have less EMR. Is there some way to improve their responses compared to others.

Mr. Amin: Thanks, Dan. Helen.

Member Burstin: Yes, thanks. Not to too much to add than what's already been said. It is a priority area. Care coordination measures are notoriously difficult to develop and maintain. And this just doesn't seem like a logical time to remove an e-specified care coordination measure, even if it isn't ideally maybe what we want yet.

I also did note what was also just noted. Dan just noted about the significantly higher rate of performance for those submitting via registry versus EHRs.

And given our whole collective move to digital measures really feels like something we should maintain and try to understand what's causing those differences. That's a pretty striking difference.

So there is definitely, you know, regardless of which version you're looking at there is still pretty significant room for improvement. Just as any unintended consequence associated with the measure.

And one of the commenters pointed out, which I thought was interesting, that it really provided a key incentive to practices to engage in clinician-to-clinician communication and practices, find this measure to be really meaningful to the patients and their practice. So it seems like a measure I would certainly maintain for now, particularly as it's already e-specified. Thanks.

Mr. Amin: Thanks, Helen. Beth, are you still with us?

Ms. Godsey: I am. I'm still here.

Mr. Amin: Thank you.

Ms. Godsey: Related to the health equity perspective, I think the group initially was having some challenges in finding some health equity. I think later in the discussion the group did bring up the possibility of stratifying this measure in that there would be the absence of historically marginalized populations from this group. And so you would see a lot of White patients potentially in this group with not a lot of Black, Hispanic patients and people of color represented in this group.

So there was certainly a recommendation to evaluate this, stratified this. But also look to see how these referral are happening for historically marginalized groups.

Mr. Amin: Right. Thank you, Beth. And from the Rural Health Advisory Group, the main topic of discussion there was around the difficulty that rural providers may have in the limited technology to receive feedback from referrals to urban centers.

The results on the voting was two for retaining, six against retaining and one unsure for retaining of the proposed program. Those are the initial focused comments.

Diane, I'll turn it over to you for discussion and clarifying discussion of the committee.

Chair Padden: Okay, thank you. Are there any additional questions or comments from the Committee?

So, it's the end of the day, is that why? I guess so, 4:20.

I am hearing that there is definitely support to

retain this measure. What I am unclear about is if it's retained as is or there is a desire to ask for a conditional support in improving on the measure. I think I heard that, but I didn't hear the specifics on how we might provide CMS with some additional information on how it might be improved. Dan?

Member Albright: So one would be, similar to diabetes, that make this is a specialist free completing the loop for the referring provider versus the other way around. Just to flip it.

Perhaps you can even fold in the diabetic communication to the same measure. You know, it's basically the same concept of a specialist referring back to those who gave the referral would be one change.

Chair Padden: And, Helen?

Member Burstin: I am not sure I want to direct the combing of measures. That's pretty, we haven't really looked at the specifications closely enough to know that that works.

I'm not sure I have a condition. I just think one would just really appreciate understanding better why those differences are so striking by EHR versus registry. But that's not typically a condition.

I haven't heard anything anybody said that's actually a condition. I agree with you.

Chair Padden: Condition.

Member Burstin: Yes.

Chair Padden: And I guess, you know, we use diabetes but I am reading this and it's basically all referrals.

Member Burstin: Yes.

Chair Padden: So it may not be quite as easy from some of the other specialty areas to go back and

forth and how that impacts the outcome of the patient. We know that certainly the diabetes and the retinopathy from the previous, what that really does. But there are other places where closing the loop is also equally as important.

I mean, from a primary provider sometimes we send those referrals and we may not know what's coming back. So it is important because if the patient doesn't feel comfortable with the specialists and they've only seen them once, they're going to come back to the primary care and say what needs to happen next.

So I would support that retaining for sure.

Okay, I'm going to check to see if there is any other comments? Hearing none --

Ms. Williams-Bader: There is a hand raised. Sorry, Diane.

Chair Padden: Oh, I see it now. Yes, I was flipping through the pages. Go ahead, Yanling.

Member Lu: I got a hands up. Yes, thanks. I think, like you said, a referral falling through the referral loop, sometimes it's common. And sometimes it can be devastating.

I know a couple cases that the referral fall through between the physician who referred and the physician who was supposedly doing the test or imagining or the biopsy. And that, for cancer patients, this could be a devastating.

And so I think this apply very broadly to all kind of referral situations that could have greatly benefit, improve the care, follow communications, follow the care, coordination of the care for patient and for clinicians in all specialties.

So I think we don't need a condition, I think that we should just support it as that.

Chair Padden: Okay. Thank you. All right, I'm going to make one more swipe through my collage here. I do not entail. Okay, I believe we're ready for the vote.

And the vote is support for retaining the measure.

Ms. LeFlore: Voting is now open for 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report, eCQM. Do you vote support for retaining?

And I'll give everyone 15 more seconds. Voting is now closed. Sixteen members voted yes, one member voted no. And that would give us a percentage of 94 percent for yes.

05837-E-MIPS: Children Who Have Dental Decay or Cavities (eCQM)

Mr. Amin: Okay. And moving on to the last measure of the day. 05837-E-MIPS: Children With Dental Decay or Cavities, eCQM.

The percentage of patients, six months to 20 years of age at the start of the measurement period who have had dental decay or cavities during the measurement period. The measure is not endorsed, and three have selected it for discussion.

I will invite the program lead for any contextual comments and then turn it over to PBGH, Purchaser Business Group on Health. And then Magellan Health for lead discussants. But let's start with CMS.

Member Gomez: This is Lisa Marie with CMS. Thank you.

I just want to highlight that this measure is a high priority outcome measure. The removal of the measure would have an impact to the number of measures available for the specialty, particularly dentistry.

It is a digital quality measure. As I noted, there are a limited number of dentistry measures and we

want to allow for continued participation with MIPS.

Right now in our dental set of measures there are two measures. Dental cavities are one of the most clinic disease among use age of 6 to 19 years. The measure is not duplicative of other measures found within MIPS.

I just want to highlight that NQF endorsement, which was initially endorsed on August 15th, 2011, and then the last endorsement date is August 15th, 2011. And it was removed from the pediatric measure, pediatric performance measure Phase 2 for that.

So that's what I want to provide relative to this measure. Thank you.

Mr. Amin: Thank you, Lisa. I'll turn it over to the Purchaser Business Group on Health.

Member Brodie: Hi. My apologies but I didn't see my name on the agenda. I didn't see Purchaser Business Group listed. And I'm a bit new to this process so I'm not sure if I just didn't --

Mr. Amin: That's --

Member Brodie: -- send in the right materials.

Mr. Amin: Yes, sorry for that oversight, Rachel. No worries. We'll just continue on here --

Member Brodie: Thank you.

Mr. Amin: -- with Magellan Health. Yes. Do we have a representative from --

Member Parrott: This is Lou Parrott, I'm with Magellan Health. But I'm not a psychiatrist so I'm not sure I'd be qualified to talk about this measure --

Mr. Amin: Hey, no worries. Not a problem. I will just review some of the criteria that lead this measure to

be on the discussion for today.

That the measure does not contribute to the overall goals or objectives of the program. It is not endorsed by the CBE. And it may have negative unattended consequences, including potential negative impacts on rural populations. And potential contributions to disparities.

I know that there was quite a bit of discussion on this measure in the Health Equity Advisory Group. I'll ask Beth if she wants to start. Beth, are you still with us from the Health Equity perspective?

Let me just see if Beth, we might have lost Beth. That's okay. No problem.

There was significant conversation among the Health Equity Advisory Group related to this measure, specifically discussing difficulties for primary care physicians to educate family members and patients regarding the dangers and preventative care required for tooth decay.

Again, just noting however it's important from an equity perspective. Further noting that there was concern that the measure is only examining prevalence but overall the measure contributes to overall holistic health care.

And then the final comment here, related to the equity perspective, was that the measurement may disincentives physicians or dentists who work in communities that have a lack of healthy food or available dental care. That there are various upstream components from a community perspective and structural components to consider when implementing this measure.

I will just note from the rural perspective, again, there was high costs of treating tooth decay and cavities that may also be a barrier for accessing care in the rural environments. And it may not be the most appropriate to hold the dentist accountable

for these outcomes.

I'll stop there and see, turn it over to the Committee. See if there is any other, Beth, I don't know if just wanted to confirm that you're not on the line? And if not, I'll turn it over to you, Diane, on those topics that were raised from the various inputs.

Chair Padden: Right. As you read through that summary sheet. And you know, I guess I have this one specific question.

Is this measure specific for dentists or also for physicians because it states that. Who is this measure, who is treating the patient in terms of them being held accountable for it?

It's a, the question is, who is the measure for?

So when we talk about --

Member Gomez: May I just --

Chair Padden: -- physicians in rural areas.

Member Gomez: So this measure, this is Lisa Marie with CMS. This measure is specific for those in the dental profession.

Chair Padden: Okay. And there is only two measures?

Member Gomez: Yes. For dentistry, yes. There was very limited number of measures.

Dr. Green: And that's a critical point because they're part of, they have to be part of the program.

Chair Padden: All right, is there any other comments? Concerns, questions? Is the measure okay as it is to retain? Okay. We need any other discussion? I am not seeing any hands. No comments.

So I find that interesting because we're looking at,

our task today was to look at measures to remove but we don't even say really that we have a reason to remove it, rather it's the opposite. To retain it. Wendee?

Member Gozansky: Yes. And I think that's exactly my question is, do we have, understanding why this would be recommended for removal.

And I think that's the question then, that if we're trying to mitigated the unattended consequences, it seems then that there should be a recommendation to say, should we be looking at incidents of dental decay and cavities rather than prevalence because that would suggest that then you would be trying to actually coach to better dental habits, et cetera, et cetera.

Chair Padden: Any additional comments? I agree with you, Wendee. It seems like it's the opposite of why. Because we have a measure here that we're being asked that specific question now.

Member Fleischman: Well I'm surprised. So who actually does, dentists are not part of Medicare generally, so who actually does submit this measure?

Because I'm surprised the ADA didn't submit anything. Any comments. You would think they would.

Ms. Somplasky: Dentists are a part of, are considered eligible clinicians for the MIPS program.

Member Gomez: Yes.

Member Fleischman: An actual --

Member Gomez: Right now dentists are considered MIPS eligible clinicians so they would, if they are considered eligible, because it's not just being eligible clinicians there is other criteria to make you eligible in our program. But if they are considered eligible they would report on this measure.

Member Fleischman: Well, yes, eligible, but does Medicare actually cover dental decay treatment or cavity treatment?

Dr. Schreiber: For dual-eligible patients that does sometimes occur. And so that may be where some of this comes from.

Member Fleischman: Hm.

Member Condon: It just seems like this is, that the concerns that this could only exasperate disparities I think those are legitimate concerns. And to think of this as a measure that would be specifically applied to dual-eligible patients seems like that's a really challenging population in order to have a measure that looks at a percentage of dental decay or cavities.

I'm just not sure that this measure really accomplishes what it sets out to accomplish. Which I believe is to encourage dentists to educate patients and parents about the need for good dental hygiene.

Chair Padden: Was that you, MJ?

Member Condon: It was. Sorry.

Chair Padden: Okay. You didn't light up initially and I saw your hand. Just wanted to make sure I was capturing everybody.

Member Fleischman: Yes. So basically we have a measure that applies essentially only to a disadvantaged population. And we're asking dentists, let's just say rating or measuring the performance of, supposedly measuring the performance of the clinician, the dental clinicians, by seeing what percentage of their patients have tooth decay.

While I'm not a dentist, but it doesn't seem right to me. It's just, I feel like we're operating a bit in the blind not having any kind of specialty comment

about what to do with this.

It doesn't seem like a good measure to me. I don't know who the measure steward is, or measure creator is, initially. But I would --

It seems like the ADA, I don't know, I'm just reading into it, but it almost seems like they just decided to ignore instead of even engaging in this. It's a bit odd.

Mr. Amin: I think we have a hand raised from Yanling. I'm going to look up the measure developer on this, unless CMS can clarify that.

Member Lu: Thanks. I think (audio interference) -- oh, should I wait?

Chair Padden: No, go ahead.

Member Lu: I'm sorry.

Chair Padden: Please go ahead.

Member Lu: Okay. To me I don't think of this as actually exasperate the disparity issue because if you look at the population, I don't know if the evidence is support or not.

In a rural or underserved population they may have this tooth decay for their kids. They may not be able to take the same level of care as kids growing in the big cities. You know, raised in the big cities. And people on Medicaid.

And so with an outcome measure like this, it wouldn't bring more attention to how the care is served to this vulnerable population with a certain, the social disadvantaged population. So I think you would actually highlight what needs to be done. That's how I look at it. And maybe I just look at it, again, through a different lens.

Chair Padden: I was --

(Simultaneous speaking.)

Ms. Williams-Bader: Go ahead, Diane.

Chair Padden: I was just looking to see on the summary, in terms of how many people are actually using the measure. And I'm not seeing those numbers as we did in others.

Member Fleischman: It seems, I'm sorry, it just seems like a poorly designed measure and that's why probably no one is using it. Also, as we talked about, it's a very limited narrow group of clinicians who this would actually apply to in terms of treating dual-eligible things.

And what is the, I don't see the, just thinking of how dentistry works, a lot of patients only show up when they have issues with their dental care. Usually dental decay and cavities.

It just, it does not seem like a fully thought through measure and I wonder if that's why the ADA just ignored it. Or didn't even find it worthwhile to comment.

Chair Padden: Dan?

Member Albright: Yes, I agree. That may the condition is to redefine usefulness of the measure. It's more, this is more of a measure of where you practice than how you practice, which doesn't feel right. And so perhaps it's changed from baseline.

It could be other measures that improve dental health that they're doing and they can show in a measure. Yes, so I think just shows absolute percent of cavities.

And it was just perhaps unrelated to what they're doing, it's just that they're recording things in their community.

Ms. Williams-Bader: Can I actually, before, I see there are hands raised, but I just want to make sure

folks are clear about how this measure is reported.

So, CMS, could you speak to who gets included in the patient population? It's not just dual-eligibles it's the, if you can speak to that.

And then also, I heard a question about how long, or somewhat of a question about how long the measure has been in the program. Can you comment on those two things?

Dr. Green: So I can't really say --

Member Gomez: Yes, so --

Dr. Green: Sorry.

Member Gomez: Oh.

Dr. Green: I can answer one of those questions.

Member Gomez: I'll answer the first one, and then if you want to answer how long it's been in the program.

Dr. Green: The first one is the one I got.

Member Gomez: So for all of our measures --

Dr. Green: Go ahead.

Member Gomez: Okay. The measure -- so for those who report the measure, and in terms of like their patient population, it's all payers. It's not just Medicare or Medicaid patients it's also payers. So we also include private insurance. So it's everyone.

And then with regard to the second question, in terms of how long this measure has been in the program, this measure has been in the program even before when our legacy programs merged and formed the Quality Payment Program.

I'm going to defer to Colleen if she is able to identify when the measure was in the program, but it's at least been in the program since 2011.

Dr. Green: So this is Dan. Just to echo what Lisa Marie said. I mean, it is an e-specified measure so it would be all payer data. So it's not going to be limited just to the dual-eligible clinicians.

I mean, there has been limited uptake of the measure because many dentists choose not to report period. But still in all, we do have to measures in the program that they can report, if they choose to report.

Many dentists either don't take Medicaid, or Medicare, or take very limited Medicare. And of course their remuneration is based on their Medicare charges, either in a positive or negative way.

So if they're not required to participate, some will choose to participate and some will choose not to participate. But as I said, statutorily we need to have measures in the program for those that do want to participate. But it would be all payer data because it's an e-measure.

Mr. Amin: So, Diane, I see three hands raised, with Dan, Will and then Wendee. Could, perhaps in the spirit of time as well, perhaps we can get a straw man proposal in terms of where we might be landing in terms of a category and perhaps some conditions.

Certainly the prevalence for incidents and where you're practicing seems to be one of the concerns of the measure design that I'm hearing, but not totally clear we have a sense of where we're landing. So, Diane, I'll turn it back to you to address the hands.

Chair Padden: I'm sorry, I keep muting myself because it's noisy here. I apologize. Wendee.

Member Gozansky: I was just going to suggest that, I thought the one like evidence based USPSTF thing for kiddos was like the fluoride varnish type of thing. So why would we not be looking at like doing

something that would prevent decay? So, just a thought.

Chair Padden: All right. Will?

Member Fleischman: The basic thing that I would, if you we would just do a conditional retention, the basic point of feedback I would give is, in terms of attribution, the measure should have some sort of requirement in terms of attribution for a child to have, for the patient to be attributed to the dental clinician for X period of time to count in this measure. Otherwise we're essentially grading the performance of the dental clinician without necessarily having a background of the dental clinician having responsibility for this set of patients essentially.

Chair Padden: Okay. So we have one suggestion for conditional support to retain with that added qualification or that added suggestion.

And then I also heard fluoride as being a possibility as part of a measure improvement. Is there anything else?

Ms. Williams-Bader: Diane, I wonder if CMS wants to speak to that because I believe the other dental measure in the program is a fluoride measure?

Chair Padden: Okay.

Ms. Somplasky: Yes, I put that in the chat there, Jenna --

Chair Padden: Okay.

Ms. Somplasky: -- that there is another, yes, there is a primary care prevention intervention is offered by either primary care providers, including dentists.

Chair Padden: The fluoride?

Ms. Somplasky: Yes.

Chair Padden: Okay. All right, so we'll scrap that. But we can use Will's suggestion about the attribution for a period of time to be considered there.

Anything else? Okay, one last time. Wei Ying is at the end of my screen and she pops her hand up occasionally at the end. I don't see her hand right now.

Okay. In the interest of time I'm going to see if we can get a vote. And I believe I'm hearing conditional support to retain with some modifications around the measure in terms of attribution that Will suggested.

Because this is one of the few measures that dentists can use in the set.

Mr. Amin: Diane, again, I hate to interrupt here, but I just would like to note the comment in the chat from Wei Ying which does perhaps suggest a different voting category. But again, I don't have a sense from the group of whether that would carry either so you can start where we are. If Wei Ying wants to jump in on rationale, but otherwise, Diane, we can start with conditional support for retaining.

Chair Padden: Go ahead. And do you want to speak to your comment in the chat?

Member Ying: Sure, very briefly. It sounds like this measure, everyone agrees --

(Simultaneous speaking.)

Member Ying: Oh, go ahead. Sorry.

(Off-microphone comment.)

Mr. Amin: That's just a, sorry, can we mute that line. Wei Ying, please go ahead.

Member Ying: Oh, okay. Yes, very briefly. It sounds like most of us agree this is the measure is not that

mature and the intended usage is not very clear. And we are not even sure how the dentists are using it.

The only reason, again, just to be clear in my own mind, I think the only reason we're saying conditional support to retain, the reason for support is just a limited number of measures for the dentist. Is that correct?

Like there, so that's all of the practical necessity, not speak to the value of the measure itself.

Ms. Williams-Bader: Yes. And I do want to remind the group that there is the option for conditional support for removal, which means that the measure itself, again, you feel is not meeting the goals of the program or there are other potential issues of the measure but you feel like removing it at this point would create a gap. So there is that option.

Member Ying: Yes, I would feel that option is a better one than the conditional support to retain.

Chair Padden: Okay. I hear you, and I thank you, Jenna, for providing that additional. Any other thoughts about, I guess the category.

So to me, if we remove it, it would be a gap. If there is no other very limited measures.

So, having said that, the vote would then be a conditional support to remove. In other words, we would not remove this measure unless there was something to replace it. Folks? Dan?

Member Albright: -- to, I think it was the Barrett's, you know, that -- because there was limited other options it would stay there until there was another replacement measure for dentistry.

Chair Padden: Okay. All right, any other hands up? All right, I do not see any. There is a chat. There is a value for this measure to fill a measure in the gap of value for quality. Okay.

Let's go with the vote then to conditionally support a removal of this. In other words, right, we would not remove because if we did it would create a gap.

Ms. LeFlore: Voting is now open for 05837-E-MIPS: Children Who Have Dental Decay or Cavities, eCQM. Do you vote conditional support for removal?

And I'll give the Committee 15 more seconds. I think some members have joined the meeting.

Okay, voting is now closed. Sixteen members voted yes, two members voted no. And that would give us a percentage of 89 percent for yes.

Mr. Amin: Thank you, Diane. And thank you to the discussants in that measure. I'll turn it over to Jenna.

Ms. Williams-Bader: Great, thank you so much. And thank you all for staying engaged with this discussion. I know there were a few measures for us to get through today.

We'll now have an opportunity for public comment. And Diane, I will turn it back to you for this public comment.

Opportunity for Public Comment

Chair Padden: Okay, thank you. At this time, if there was anybody on the line that would like to make a public comment please raise your hands. And once called upon we would ask that you keep your comments to approximately two minutes. Jennifer?

Ms. Gasperini: Hi. Jennifer Gasperini with the National Association of the ACOs.

I made some comments in regard to the MSSP measure set earlier in the meeting today about kind of the process and the bigger picture and the scope. And I know I've heard some folks mention along the way today that we're really evaluating each

measure on its own but of course the context really matters. And especially in a program like MSSP.

So I really want to emphasize that as we consider measures for removal we think about what would be left and what might be added and combine the processes so that we can provide more valuable feedback in the future.

I also wanted to talk about a measure gap that I hadn't heard discussed in the MSSP measure set discussion. And that's around health equity.

There are some MIPS measures looking at social determinates of health, screenings and other issues, similar issues. So, I would just, again, mention that that's been a gap in the MSSP program for some time. And NAACOs feels it's a very appropriate place for testing of those measures in trying out those measures in the MSSP space.

In terms of individual measures, I really agreed with a lot of the comments made during the MSSP discussion. But a couple of things that I wanted to echo and emphasize with the depression screening measures, both web interface and eCQM measures, there are some concerns with some of the specifications.

But I want to emphasize, when moving to eCQMs, so looking at the eCQM version of that in particular, there are additional problems when you're pulling in additional specialists for that measure because of the all payer requirement associated with the eCQMs. So I just wanted to emphasize that a little bit more.

Additionally, CAHPS for MIPS. There were not a lot of comments about some of the scoring changes in particular with that measure as it related to applying the MIPS measure to MSSP ACOs and the impact on those ACO scores.

So I just really urge caution there in continuing

some monitoring of the performance and how it's been altered by the scoring changes. Those just took effect in 2021 so I know CMS has that information now but just urge them to be cognizant of that in watching the effect of those changes.

Chair Padden: Thank you, Jennifer. Any other public comments? I don't see --

(Simultaneous speaking.)

Ms. Williams-Bader: I'm not seeing any -- yeah. Any hands raised at this time. Don't see anything in the chat.

Chair Padden: Okay. Is there -- oh, yeah. I think that I'm to pass it back to you.

Ms. Williams-Bader: Yeah. Just was wanting to see if there's anyone on the phone line who had a comment?

Okay. Yes, it sounds like we're done with public comment.

We've got two more agenda items today and we hope -- we know, again, it's been a long day. We hope you've got the energy to help contribute to these two discussions.

Discussion of Gaps in Clinician MSR Programs

So, first, we'll talk about gaps in the clinician program -- in the Clinician Measure Set Review program, so the two we discussed today. And, Rob, I'll turn it over to you for that discussion.

Chair Fields: All right. Sorry. So we'll open it up for discussion here on -- from the group. Please feel free to raise your hand if -- you know the drill by now, I think.

No questions on gaps. I mean, I think -- I'll speak to what -- and, I'm sorry, Jenna, in terms of the questions we're asking, in terms of gaps, is there

gaps for, like, additional room review -- additional measures that we need to review for removal, is that the context of this?

Ms. Williams-Bader: More-so the -- again, we do recognize that we had fairly narrow discussions today, they were about measures specifically. But if there are any broader comments about these programs, or about gaps, that folks would like to make, this is an opportunity. It does look like Amy's got her hand raised.

Chair Fields: Yeah. No, for sure. And in that context, I also have a comment. But I'll go to Amy first, since she had her hand raised. Go ahead.

Member Nguyen Howell: Oh, thanks, Rob. Yeah. And I don't know if it applies to this or to Jenna, to what you're going to bring up. But I just wanted to compliment the team and being -- for you Rob and Diane, for the wonderful facilitation.

I enjoyed the fact that it was combined, right? And we were able to hear additional feedback from the other workgroups, and I thought it was very helpful in having that consolidated approach. So I wanted to offer that feedback and gratitude.

(Simultaneous speaking.)

Chair Fields: Thank you. Appreciate it.

My comments, I think, mostly an echo of comments made from all the way in the early part of the morning down to now, but I do think that one of the downsides of this process is the inability to really understand what might be coming next, in terms of additions or substitutes. And understanding that the main goal is to evaluate the measures on the merits of the measure.

But the context is still important relative to what we're trying to get done in the big picture, so I do think that's an improvement for next year.

For the MSSP program, you know, I think I would kick myself if we didn't leave today without at least mentioning the idea that, there are still major concerns about an all-payer approach to the eCQMs and its impact on those facilities and clinicians that take care of a higher percentage of disadvantaged folks. In particular in Medicaid or uninsured patients, and I think it'll really skew and cause differentials in reported outcomes of using eCQM, so I just think that's a huge problem.

And one thing that I just mentioned briefly earlier in the morning is that, I do think that there will be -- I think it is sometimes problematic to adapt measures that are meant to be measured at the individual clinician level to large groups, like an ACO.

So -- they're just not the same, and I just -- this has come up in multiple other meetings, so I just -- as this continues, this trend continues of trying to consolidate the programs, I just -- I feel like we're going to run into performance issues with some of these measures that weren't intended to be measured at the level that they're being used for.

And I'm glad there's -- you know, we're doing correlation studies, which helps, and that's reassuring but I feel like we'll just need to be very vigilant in watching for that.

I see Peter has his hand up, I'll go to Peter next.

Member Briss: I wanted to add to the compliments to the NQF staff and the CMS staff, this has been really well designed. I think, on the gap discussion, it feels to me like we often do some variant of the process we're trying to do now, which is take a lot of, kind of, exhausted people who have been doing something else all day long, and try to brainstorm.

And so I suspect we could do better about teeing this up on the front end. So we've sort of danced around corners of gaps in the earlier discussions, but it strikes me that we might be able to tee up on

the front end either, some big ticket population health needs that aren't being met in the current set, and/or some particular specialties, or provider groups, or patient groups that don't have enough options, or don't have enough important options. And I'd love to see us get, maybe, more systematic about trying to do some of that on the front end. Over.

Chair Fields: Thank you. And I agree, it requires a certain amount of energy doesn't it.

All right. Looking for more hands. Going once, twice -- all right. Jenna, I think I turn it back over to you.

MAP Clinician Workgroup Feedback on MSR Process

Ms. Williams-Bader: Yes, that's right. So, last major agenda item for today -- and, yes, definitely recognize that folks are tired, but hopefully you can at least give us some feedback on the process so far.

If we could go to the next slide, please. So we'll be getting on the measure set review process. Next slide.

And we'll start with three poll questions, just to get a sense for how people felt. So if we could switch over to those, and then we'll take your verbal feedback as well.

All right. So our first question is, the measure set review survey to nominate measures for discussion worked well. So thinking back to that -- as a reminder, we did that in April, at the end of April. And the options are, one, strongly disagree, to five, strongly agree.

I imagine some folks may have dropped off. Let's go ahead and close the poll. Okay. So a fair number, neutral, in the middle, and then a few disagree, and a few agree or strongly agree.

Okay. And we'll circle back to all of this, like I said.

If we could go to the next question, please.

Oh, and I've got a little timer in the corner that's blocking the question. I had what I needed to respond to the MSR survey, I think that might be what that says. So one is strongly disagree to five, strongly agree.

Let's go ahead and close. We don't need quorum on these responses, this is just to give us a sense. Okay. So, again, sort of split. People -- a fair number, neutral, and then the same numbers on the strongly disagree to disagree side as on the agree side.

And last question. The workgroup review of the measures under review worked well. So that's more-so thinking about the -- leading up to this meeting today, and today's discussion, how did this go. So the meeting materials we sent to support this meeting discussion, the actual discussion we had today. So, one, strongly disagree, to five, strongly agree.

And we have 14, let's go ahead and close. All right. And strong agreement here, it looks like that the review today has gone -- and leading up to today -- has gone well.

So thank you all very much for that feedback. Definitely seems like a place for us to focus will be the survey, and what we provided along with the survey.

So let's start with what worked well during this survey and what didn't work well. What do you wish had been different about that process, or what additional information would you have liked?

Chair Fields: You know, I think I was -- this was mentioned in the beginning, and I'm just sort of echoing comments that were said during the public comment period. But it sounds like some of the stakeholders would enjoy some visibility into some

of the detail that we got a little bit later on, in terms of why the measures were nominated.

And, I think, just some additional descriptions and details about the measures and the process in advanced would have been helpful, but I think in particular just a little bit more context for why they were nominated, I think, was the feedback we got early on. Just echoing that again. So, yeah, the same as what Peter was saying on the chat.

Ms. Williams-Bader: Thank you, Rob. I see Geoff has his hand raised?

Chair Fields: Oops. Sorry.

Member Rose: Yeah, I was just going to say -- again, I want to echo the comments that others have said about the process. This was my first meeting, I thought it was incredibly well organized, incredibly well run. So thank you very much.

Information that I think will be helpful, as was just mentioned, is, you know, why a specific measure was brought up. But importantly, how the metric performs in vulnerable groups. Because I think we're still trying to learn about that, and we know the importance of it.

And I don't think we're quite there yet, in really being able to evaluate these metrics more broadly across the population, so whatever data we have in vulnerable populations would be really helpful.

Ms. Williams-Bader: Great, thank you. See here -- Yanling?

Member Lu: Yeah. Well first of all, what has worked well. I'm thinking work well because I really appreciate the NQF staff really help out -- when first they introduced the survey I was really confused as to what's going on. So I really appreciated, you know, to provide needed information to really understand what we supposed to do it, because I

couldn't figure out what I supposed to do. So I really appreciate the patience.

And also, I think what work well is this group. We listen to each other, we discuss, you know, different perspective and share your expertise and what we know.

One of the things that I hope I have the information prior to the discussion, are the comments by, you know, the Rural Health Committee and the Equity Committee, what their comments on those measures. And I would like to -- I'm the person like to read it, so if I could have a print out to read it beforehand to see what their, you know, views are.

And also, I was really confused about why the measure was not resubmitted, therefore not re-endorsed, and then the sponsors came out and said, we support the measure. So I was kind of confused about why you supported, then you didn't resubmit it. So I wish I have some background information so I would know, you know, the continuity, why -- because of difficulty or whatever it is -- is have a category on that. That would help me.

Ms. Williams-Bader: Great, thank you --

(Simultaneous speaking.)

Ms. Williams-Bader: Yeah. No, thank you so much. And one note, we did just meet with the Royal Health and Health Equity groups about two weeks ago, and so unfortunately that's why we weren't able to summarize their comments in the measure summary sheets.

There was just not enough time in between those meetings, and in particular we started our workgroup meetings last week with the hospital workgroup. So it was just a very short turnaround time, but we definitely wanted to bring those comments forward today, and appreciate that they were helpful and we'll keep that in mind for the

future.

All right. Lisa?

Ms. Hines: Again, compliments. I think that today's meeting went so well, and kudos to NQF staff, the co-chairs, and all of the lead discussants. I thought it went really well, especially for a new process.

In terms of the survey, I actually had a hard time filling out the survey, and felt ill-equipped, based on the information that was provided, to provide any recommendations for measures to be up for discussion.

So, I don't know if there's -- and I know you tried to cast a wide net, but could there be some kind of triggering criteria recommendations during, you know, other public comment periods to CMS, related to removal. Or just a better understanding rather than a whole set of measures, I think would have more thoughtful recommendations for bringing some things up for voting for something to come up for discussion.

But today I felt like I had all the information needed at my fingertips, greatly appreciated. I know you guys are working under a very tight turnaround time, and of course stakeholders always want more time to review, and you have competing priorities. Thanks for the opportunity.

Ms. Williams-Bader: Thank you so much, Lisa. And I'll ask you a follow up question, if I may. And then, Peter, I see you've got your hands raised as well.

So, again, this process differs from the MUC list in a couple of ways. One, the universe for MUC on any given year is smaller across all the workgroups than when you're talking about measures already in a program.

And then also, for the MUC list, information's actually submitted. It's sort of all together in one

place, and here we're pulling it from several different sources.

Is there particular information that you felt would have been really critical to see at the time of the survey? And information that you'd be willing to sort of sort through for the number of measures that were on the survey? And I don't remember how many there was but this is our number.

Ms. Hines: No, that's a fair question to put it back on me. And my thought was actually, it would've -- some kind of pre-vetting, or pre-evaluation. Just for certain triggers to be looked at before the workgroup evaluates the measures based on the criteria. Which means more work for you, or more money for CMS, so that may not be feasible.

If I can think about it, I might just provide some written feedback that came through when I received the survey and the materials, what would've been helpful, then I can provide more information.

Ms. Williams-Bader: That sounds good, thank you. Yes, hard to remember it at this point, I'm sure. Especially after talking -- after having the meeting today.

Peter, I'll go to you.

Member Briss: I wonder about whether there are ways to make the Rural Health group's comments even more helpful. So sometimes the feedback that we got was sort of along the lines of, a service or a set of services that seem really good for everyone are difficult in a rural environment. And if you give too much credence to that, you're just making -- you're likely to make disparities worse.

So I wonder whether we could also ask for advice from that group about how we could make things feasible, from their perspectives. And so I was thinking about this with the depression measures, where they said rightly that, there often aren't

mental health providers in rural areas. And so, you know, I wonder if the explosion of telemedicine kind of approaches during the pandemic might be applied to those kind of problems, or something.

I'd love us to get past, we can't do it here, to, what would it take to do it here? Over.

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

While others are thinking, and thinking about raising their hands or putting comments in the chat. To follow up on a suggestion that Lisa made -- although this question's not directly to Lisa, it's to all of you. Are there criteria -- beyond the measure review criteria we used today -- but are there criteria that you all think would be good to use as triggers to either, pull measures onto a list for discussion for possible removal, or reasons not to discuss a measure for potential removal?

I know that's a double negative but I think in the past we had thought about, for example, if a measure had not been in the program for very long that maybe we would not talk about it until it had been in the program for a while. So that's one idea. But, Peter, go ahead.

Member Briss: I'm sorry to be not quite exhausted yet, I'm talking a lot. So it struck me that there are -- we had a couple of buckets of discussions that it might be good to disentangle.

So there was a first -- there was a, kind of a, something that I think of as the front of the discussion that's about how important is the measure concept for inclusion in the program?

So it's really important for -- it was usually either, because it's a really important public population health topic, and/or it's really important for -- at the more individual level -- for certain kinds of patients or providers.

And then there was sort of a discussion that was more about the measure -- what's actually being measured -- and I suppose we could've said, the measures is perfect the way it is, or it's pretty reasonable with some opportunities for discussion, or in spite of the fact that the topic is really important we don't think that the measure meets muster, right?

And it strikes me that it might be easier to structure these discussions if we sort of separated the issue of, how important is the measure concept, and then, is there room for improvement in the measure. Over.

Member Parrott: This is Lou Parrott. As I was listening across the board to all the measures, I was imagining that, you know, a lot of times people brought up the idea that maybe a measure could be improved upon, but if there was not another redundant measure that was better than that would be maybe a reason to keep the measure.

So maybe, you know, one thing to look at is, where you have some, you know, duplicative measures out there -- maybe they're doing slightly different things -- that's a trigger for picking one to remove. So bring everybody together, which one of these is best, we remove one, but the specific field under scrutiny, you know, still has a measure.

So that might be one way to try to have a trigger, another would be, you know, if you're recognizing that, since -- I think most of these measures, the providers have a choice to use them or not -- if no one's using the measure, maybe that's a reason to get rid of it. But again, it sounds like you might want to make sure that there's some other measure that they still have the opportunity to use. You don't want providers to have, like, no measures in their measure box to pick from.

So those are two thoughts that I kind of, maybe, came up with, listening across the board here for

some triggers. And those could maybe be, you know, assessed, you know, just by the CMS or NQF team to bring forward, that maybe don't require a lot of pre-meeting surveying kind of a thing.

Ms. Williams-Bader: Great, thank you. Wei Ying?

Member Ying: I'm not sure whether this is redundant, but on the other side, in terms of the measures, probably may not need to be brought into this discussion. For example those MIPS measures, you mentioned that there are hundreds and hundreds of measure out there, so actually you select a subset.

For those specialty measures, if the starting set is very small then there's probably almost no -- at the end of the day the worst case -- probably no measure will be outright dropped as a proposal, probably the worst proposal would just be, hey, let's still keep it, if there's a better one then it will get dropped.

So it will not change the measure set -- I guess that's what I'm trying to say, that for those measures, because those specialty areas, because the starting set is so small no matter how much discussion we have here, the measure set will be the measure set until there is a better measure comes onboard.

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

I don't want to take too long on this, but were there things from today's review that you think worked really well, that you want to make sure we keep in the process in the future?

Wendy, I see your hand's raised?

Member Gozansky: Yeah, I would just say that, I think it was helpful when we actually had information specifically about, you know, how long the measure had been in effect, how many folks

were reporting on the measure, and, sort of, the trend over time data.

Most of that was in the materials but there were a couple, were you all were able to provide that for us, it would have been nice to have had that in advance. I think that, sort of, standard approach is very helpful to understand, you know, what -- kind of, you know, what the performance of the measure has been.

Ms. Williams-Bader: Great, thank you.

I don't think anyone would be upset if we wrap up early today, so let me just pause here and see -- any last questions, and I'll see, does my team have any questions, either?

Any other suggested improvements to the logistics or the meeting process?

Member Fleischman: It was helpful to have some of the measure stewards, or supporters, on to be able to provide some context or reasons for being on one side or the other of the discussion.

I don't know if that's -- obviously, I think, it sounds like these are self-invited folks. If they're not on the panel already then they're members of the public, but it's incredibly helpful to have them here. I don't know if there's a more systematic way of inviting folks more proactively.

I don't know -- for example, it would've been really helpful to have someone from the Dental Association to comment on the dental measure.

Ms. Williams-Bader: Thank you.

Okay, and we -- I noticed some people have been putting comments in the chat as well, we'll make sure to capture those comments. Thank you for that.

See some support for the distinction between the

measure focus or topic versus measure meeting criteria of the good measure.

Well we can go ahead and wrap up this portion, I'll just make some closing comments. We'll run quickly through next steps. Joelencia, I believe I'm turning in this over to you?

Next Steps and Closing Comments

Ms. LeFlore: Yes. Thanks, Jenna. I will now provide an overview. So the last workgroup, PAC/LTC, LTC will convene June 30. Additionally, the Coordinating Committee will convene in late August. Once all the MSR meetings are completed there'll be a public comment on the final recommendations occurring July 22 through August 5. To conclude, the final recommendations report will be issued to CMS in September. Next slide.

This slide provides an illustration of the timeline that was previously stated. Again, the PAC/LTC workgroup will convene and then the Coordinating Committee, public commenting will occur, and the final recommendations report will be sent to CMS. Next slide.

Finally, this slide provides the contact information for the MAP Clinician team. And I will now turn it back to you, Jenna.

Ms. Williams-Bader: Thank you.

And before I invite Diane and Rob to make closing remarks, Michelle, would you like to say something?

Dr. Schreiber: Thanks, Jenna, I really appreciate it. First, on behalf of CMS, I'd like to thank everybody on today's call. In particular NQF, I think the staff did a wonderful job, thank you very much. To the co-chairs certainly, Rob and Diane. To everybody who was a measure discussant.

I think the conversation actually is the most important part of the meeting, not that the vote

isn't nice but the conversation around this is always very important. Many people had very thoughtful and insightful comments that will really help us move these measures forward.

You know, as we get into this cycle of the committee being able to make recommendations on removals and then see the new measures that are coming through and make recommendations there, over time I think this will become a nice complimentary process to help shape these programs really, to be even of more value and better going forward.

You know, CMS does put a lot of activity and work into deciding what measures actually get put in these programs, how these measures are constructed to the best of our ability. We do this, obviously, through public rule-making, so for those of you, you can look forward to the PFS rule coming out around MIPS and MSSP, hopefully shortly. And then there's public comment following that.

So there is a lot of input to this, but I think you guys had particularly great comments today and we really, very much appreciate it and we'll take all of this into consideration as we continue to make these programs better.

I do want to thank, from CMS, Lisa Marie Gomez for really coordinating a lot of the efforts. We do invite the measure stewards, by the way. So they don't just join as part of the public, although they can. We try to reach specifically to the measure stewards so that we can give you the best information possible, and if there are other people that you would like to hear from, let us and NQF know, and we can probably make those arrangements too.

Anyhow, don't want to prolong a meeting any further than needed. But, to everybody, on behalf of CMS, thank you very much.

Ms. Williams-Bader: Great, thank you.

And now I'll turn it over to Rob and Diane for any closing remarks you'd like to make.

Chair Fields: I just appreciate the discussion and the discourse, as Michelle said, it's always interesting and, I think, gets us to the best outcome. So I appreciate everyone's cooperation and conversation. Diane?

Chair Padden: Yes. I would like to extend my thanks to the NQF staff who have been extremely helpful for us co-chairs, to get all the documents together and the pre-meetings, and to keep us on track, right? I looked at the clock at one time going, okay, we're running a little late. So yes, keeping us on track is very important, and I also appreciate all of the discussion. Excellent comments, thank you very much.

Ms. Williams-Bader: All right. Well thank you all very much. I agree with everyone's comments about how useful and thoughtful the discussion has been today, we really appreciate your participation in this process and your feedback on how we can make it better in the future. And hope you all have a wonderful rest of your week. Thank you.

(Whereupon, the above-entitled matter went off the record at 5:31 p.m.)