NATIONAL QUALITY FORUM
Driving measurable health improvements together

Summary

Measure Applications Partnership (MAP) Coordinating Committee Strategic and Measure Set Review (MSR) Web Meeting

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) Coordinating Committee on February 23, 2022. There were 129 attendees at this meeting, including Coordinating Committee members, NQF staff, government representatives, and members of the public.

Welcome, Review of Meeting Objectives, and Roll Call

Dr. Tricia Elliott, NQF Senior Managing Director, welcomed participants to the web meeting. She then reviewed housekeeping reminders and the meeting agenda. MAP Coordinating Committee co-chairs Chip Kahn and Misty Roberts welcomed participants to the meeting, calling attention to the time and dedication Coordinating Committee members provided during the January Measures Under Consideration (MUC) review meeting. Co-chairs highlighted the opportunity for Committee members to provide feedback heading into the 2022 MSR cycle.

Dr. Dana Gelb Safran, NQF President and Chief Executive Officer, provided opening remarks and noted that it is NQF's privilege to partner with CMS to convene MAP. Dr. Gelb Safran highlighted the work of the 2021-2022 MAP pre-rulemaking cycle (final report) and the broad representation of its multistakeholder group. Dr. Gelb Safran then introduced Dr. Elizabeth Drye, NQF's new Chief Scientific Officer, who provided additional welcoming remarks to the meeting participants. She echoed the sentiment that NQF and CMS welcome Coordinating Committee member feedback. Dr. Elliott then introduced Jenna Williams-Bader, NQF Senior Director, as a new addition to the MAP team.

Dr. Elliott reviewed the meeting objectives, which were to:

1. Review and refine approach to the scope of work, timeline, and activities for the 2022 MAP MSR.
2. Seek Coordinating Committee feedback on the process and documents provided by NQF staff during the MAP MUC 2021-2022 cycle.

Dr. Elliott facilitated introductions and roll call of the Coordinating Committee members. Of the 23 Committee Members, 18 attended the meeting (see Appendix A for detailed attendance). Dr. Elliott also introduced the NQF team and CMS staff supporting the MAP Coordinating Committee activities.

CMS Opening Remarks

Dr. Michelle Schreiber, CMS Deputy Director for Quality and Value, offered opening remarks and thanks to the MAP Coordinating Committee members. Dr. Schreiber noted that the comments provided during MAP meetings are important to CMS and that CMS considers those comments during the rulemaking process. Dr. Schreiber stated that CMS looked forward to the day's meeting and the discussion about the 2022 MSR process. Dr. Schreiber also expressed appreciation for the MAP Health Equity Advisory Group, in particular, which NQF convened for the first time during the 2021-2022 MUC cycle.

Dr. Schreiber highlighted the Coordinating Committee January MUC review meeting and noted that there are potential strategic opportunities to modify the meeting structure moving forward. These opportunities could help to ensure that there is time in future review meetings to hear comments about measures that need extended conversation. Dr. Schreiber said that CMS values the Coordinating Committee.

MAP 2022 MSR Cycle Scope of Work and Process

Ms. Williams-Bader introduced MSR by commenting that the Consolidated Appropriations Act grants the consensus-based entity (CBE), currently NQF, the ability to provide input on the removal of quality and efficiency measures. Ms. Williams-Bader reiterated the importance of multistakeholder feedback for measures being considered for removal and stated that the MSR process will increase the transparency about measures being considered for removal. Ms. Williams-Bader then introduced the federal programs reviewed during the MSR pilot (final report) and those prioritized by CMS/NQF for potential review during the 2022 MSR cycle.

The four Hospital programs proposed for review during the 2022 MSR cycle are as follows:

1. Medicare Promoting Interoperability Program for Hospitals
2. Hospital Outpatient Quality Reporting (HOQR) Program
3. Ambulatory Surgical Center Quality Reporting (ASCQR) Program
4. Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The two Post-Acute Care Long-Term Care (PAC/LTC) programs proposed for review during the 2022 MSR cycle are as follows:

1. Home Health Quality Reporting Program (HHQRP)
2. Hospice Quality Reporting Program (HQRP)

The two Clinician programs proposed for review during the 2022 MSR cycle are as follows:

1. Merit-based Incentive Payment System (MIPS): one-third of program measures will be reviewed
2. Medicare Shared Savings Program (SSP): one-third of program measures will be reviewed

For the Clinician programs, Ms. Williams-Bader noted to obtain one-third of measures for review, NQF staff will group measures by clinical topic or meaningful measure area.

Ms. Williams-Bader provided a high-level overview of the proposed 2022 MSR process. In general, the MSR process falls into four categories:

1. Prioritize: NQF refines list of measures by program and creates survey.
2. Survey: Workgroup and Advisory Group members nominate measures for removal. NQF staff select measures with highest number of votes for the Workgroup and Advisory Group members to discuss.
3. Prepare: NQF staff posts narrowed list of measures for public comment and prepares measure summary sheets, including summary of public comment.
4. Discuss: Workgroups discuss measures; Advisory Group members are integrated into Workgroups. Coordinating Committee votes to uphold Workgroup recommendations or to change recommendation category.

Mr. Kahn asked the Committee for feedback on the proposed MSR programs and/or MSR process. Dr. Schreiber sought clarification on the programs for review, specifically the Medicare Promoting

Interoperability Program for Hospitals and the Home Health Value Based Purchasing Program. Later in the discussion, a co-chair also raised a question whether the Home Health Value Based Purchasing Program is separate from the Home Health Quality Reporting Program. Dr. Schreiber suggested that she would follow up with NQF staff outside of the meeting to clarify the inclusion of these programs.

Regarding selecting measures for the initial survey, a co-chair suggested keeping measures with a statutory requirement within the MSR process, in order to look at MSR strategically. Dr. Schreiber noted that while it is harder to remove measures that are required by statute, she supported leaving those measures in the MSR process and suggested flagging those measures.

The Committee then discussed how to group measures for the MSR process. A Committee member suggested grouping the measures by category (e.g., patient safety), instead of by program. The Committee member noted this takes a strategic look at measures and how those measures affect quality. Committee members agreed with the potential grouping of measures; however, a co-chair questioned whether that would allow for a clear overview of the specific programs. Dr. Schreiber supported grouping measures by category and indicated this process may give a concentrated voice to MAP on a specific topic. Other Committee members supported grouping and reviewing measures by category in order to recognize a broader view of gaps in quality. One Committee member noted this opportunity may make the NQF process more person centered and less siloed. Dr. Drye acknowledged the Committee member's comments and the challenge to look beyond the MAP "silos." However, Dr. Drye noted the need to ensure the process fits within the construct of MAP and the statute put forth for MSR.

Ms. Williams-Bader reviewed the post-pilot feedback regarding multistakeholder input and the proposed revisions, including Advisory Group integration into Workgroups and NQF staff seeking increased patient and/or caregiver feedback during the MSR process. Ms. Williams-Bader noted that, during a meeting with Advisory Group co-chairs, the co-chairs expressed a desire to have a separate meeting of Advisory Group members prior to the Workgroup meetings, as this separate meeting allows for a rich discussion. Ms. Williams-Bader said that NQF staff would work with the Advisory Group co-chairs after the Strategic meeting to finalize the process for integrating Advisory Group members into the MSR process.

Ms. Roberts opened the floor for comments on the proposed revisions. Committee members agreed that the integration of Advisory Group members into the Workgroup meetings would give a stronger voice to the Advisory Groups, but also noted the need to allow those members to meet as a group separately. In addition, Committee members agreed there is a need for an increased patient and/or caregiver voice within MSR meetings. Several Committee members provided suggestions on ways to increase this voice, including member mentorship, increased recruitment of patients and caregivers, and a guidebook specifically written for patients and caregivers. Committee members noted that it is important to help lay-people or non-clinicians feel more comfortable within Workgroup meetings and to help clinical Workgroup members recognize that lived experience is an area of expertise.

Ms. Williams-Bader reviewed the eight pilot Measure Review Criteria (MRC) used to determine if MAP should recommend a measure for removal, a summary of post-pilot feedback regarding the criteria, and proposed MRC revisions. The nine proposed MRC for 2022 are:

1. Measure does not contribute to the overall goals and objectives of the program
2. Performance or improvement on the measure does not result in better patient outcomes
3. Measure is not endorsed by a CMS Consensus-Based Entity (CBE), or lost endorsement

4. Evidence base for measure has changed and measure no longer reflects current evidence
5. Measure performance is uniformly high and lacks variation in performance overall and by subpopulation
6. Measure is not feasible to implement, or measure is in a program but not used
7. Measure is duplicative of other measures within the same program
8. Measure has negative unintended consequences, including Rural Health and Health Equity negative unintended consequences
9. Measure does not differentiate between excellence and adequacy of performance.

Mr. Kahn asked for Committee feedback on the proposed MRC revisions. Regarding criterion number six, Committee members noted feasibility is different from use; feasibility is about an operational challenge and suggested splitting criterion number six into two separate criteria. Regarding criterion number nine, a Committee member noted the need for a measure to demonstrate "proof of purpose" for a program, in relationship to excellence and adequacy. Dr. Schreiber commented on the need for each measure to contribute value. After further discussion, Committee members did not reach an agreement on the revision to criterion number nine but agreed on the need for more clarity within this criterion.

Committee members also discussed how to streamline or group the MRC. A co-chair suggested that the criteria should be grouped around improvement, accountability, and transparency. Other Committee members suggested utilizing an algorithm, flowchart, or hierarchy instead of or alongside the MRC revisions.

Ms. Williams-Bader presented an example of information that NQF staff shared about measures during the pilot, post-pilot feedback, and potential information that NQF staff will include in the measure summary sheet for the 2022 MSR cycle. Ms. Roberts asked the Committee members for feedback on the proposed measure summary sheet, calling attention to the data points added since the pilot. For measures that have lost NQF endorsement, a Committee member suggested adding the summary, concerns, and final vote from the Consensus Development Process (CDP) to the summary sheet. Another Committee member noted that measures may be endorsed by other CBEs (e.g., Pharmacy Quality Alliance). Another Committee member noted that it is very important for NQF to be clear about which questions it is trying to address in the summary sheet (for example, some measures may be technically feasible but difficult to implement).

Ms. Williams-Bader reviewed the pilot MSR voting process, post-pilot feedback, and proposed decision categories for the 2022 MSR. For the MSR pilot, Committee members voted yes/no to support removing a measure from a program. For the 2022 MSR, Ms. Williams-Bader presented the proposed decision categories: support for removal, conditional support for removal, and do not remove. Mr. Kahn asked for feedback from the Committee members. Although Committee members appreciated the addition of the "conditional support for removal" category, they suggested that NQF add a fourth category of "conditional support for retention." Committee members discussed needing the ability to decipher between a measure that should be retained and one that should be removed, both with conditions that need to be met. A co-chair recommended that voting start with "support for retention," rather than "support for removal." Committee members ultimately agreed on four potential categories: (1) support for retention, (2) conditional support for retention, (3) conditional support for removal, and (4) support for removal. A co-chair noted that NQF staff might want to identify examples for the four different categories, paying particular attention to the two "conditional support" categories.

Ms. Roberts concluded the MSR discussion by opening the floor to the Committee members for general feedback on the proposed 2022 MSR process. Dr. Elliott posed a further question to the Committee members based on the suggested categorial approach and how that would translate to a survey process to prioritize measures. A co-chair suggested that the MAP could review the measures by program first, and then discuss by category in order to identify gaps related to that category. Another co-chair noted that there may be disadvantages to reviewing the measures by category, rather than program, and that it would be important to think about these disadvantages. Dr. Drye reiterated the need for NQF to review the categorical approach and how it could fit within the construct of the specified MSR process. Committee members highlighted the need for a holistic review of measures to fully recognize gaps within programs. A Committee member noted one key gap area is likely to be transitions of care across settings, where safety is part of the concern. Dr. Elliott acknowledged the challenge may be how to reach a reasonable number of measures to evaluate and thanked the Committee members for their feedback.

MAP Measures Under Consideration (MUC) 2021-2022 Cycle

Dr. Elliott provided an overview of the MAP 2021-2022 MUC cycle (final report), including a summary of the measure recommendations from the three setting-specific Workgroups: Clinician, Hospital, and PAC/LTC. Dr. Elliott also reviewed a summary of the two new concepts utilized during the Coordinating Committee MUC meeting held on January 19, 2022, the consent agenda and the timing of public comment. Mr. Kahn asked for feedback on these two concepts or any general feedback from the 2021-2022 MUC cycle that could be applied to the 2022 MSR cycle. A co-chair suggested having both clarifying questions and discussion prior to the initial measure voting, rather than only allowing clarifying questions before the vote. The co-chair also noted lead discussants assigned to measures were unsure of the role and suggested having the Workgroup co-chairs attend the Coordinating Committee meeting so they could serve as the direct source of information. The co-chair indicated that Workgroup co-chairs could help better focus the discussion of the measures. The other co-chair agreed and noted this approach may help to reduce or mitigate questions regarding the Workgroup decision. The co-chair further reiterated that the role of the Coordinating Committee is to rely on the work already completed by the Workgroup. Multiple Committee members voiced agreement with the co-chairs, noting that this would reduce duplication of the Workgroup effort. One Committee member noted that it might also be helpful for the Coordinating Committee to hear from Workgroup members representing the dissenting opinion when the Workgroup did not have a unanimous vote.

Regarding the consent agenda, a Committee member indicated agreement for the consent agenda but desired criteria for which measures NQF staff would put on this agenda. The Committee member also expressed that Committee members should be able to pull measures off the consent agenda for discussion. A co-chair noted endorsement may be a key criterion for the consent agenda, stating that the Committee should discuss measures that are not endorsed. The co-chair also noted that measures could be considered for the consent agenda if there was no controversy at the Workgroup. A Committee member noted the need to be mindful of how the adoption of the consent agenda could change the tone of the MAP work and suggested that it might shift the Coordinating Committee to be more like an appeals board. The Committee member agreed there are pros and cons to the consent agenda but recognized the need to be aware of the process.

Dr. Elliott presented an update to the NQF policy regarding the recording of Workgroup voting. Specifically, she reviewed that NQF staff will not change the decision status for a measure if NQF receives new information about the measure after the Workgroup vote but will instead highlight the

latest information received and add discussion items to appropriate agendas. Dr. Elliott opened discussion for any comment or questions and there were none.

Dr. Elliott provided MAP 2021-2022 MUC project updates, including the publication of the Final Recommendations Spreadsheet on February 1, 2022 (final spreadsheet), and the publication of the Final Recommendations Report on March 3, 2022 (final report).

Ms. Roberts opened discussion to the Committee members for any further feedback from the MUC process that could be used to inform the 2022 MSR process. A Committee member noted that during the MUC meeting the Coordinating Committee had difficulty recommending measures that did not have testing data. The Committee member recognized this would be less of a problem for measures that have already been implemented; however, the Committee member it would be important for Committee members to have measure testing information for the MSR process. A co-chair concurred that this is a key point and noted that the Coordinating Committee reviewed measures during the MUC cycle that did not have adequate testing. The co-chair indicated concern for measures brought forward that have not been tested or that have failed endorsement. Ms. Roberts opened discussion for public comment on any items from the day's discussion to that point; there were no public comments.

Coordinating Committee Discussion about Federal Program Measure Sets

Dr. Drye transitioned the meeting to allow Committee members the opportunity for an open discussion with Dr. Schreiber about Federal program measure sets. Dr. Drye acknowledged the January Coordinating Committee MUC review meeting was a marathon session and there was a need to accommodate a space for a broader range of discussion about Federal programs and program measure sets.

Dr. Schreiber thanked the Committee members and indicated that this section of the agenda was an opportunity for her to address questions from the Committee to the best of her ability. Dr. Schreiber noted that there is a collaborative and cooperative relationship between CMS and the Coordinating Committee, and that the Coordinating Committee is a well thought out group of individuals who represent not only diverse stakeholder backgrounds, but also many years in healthcare and healthcare quality. She stated that the ability for CMS to hear the consensus discussions of the Coordinating Committee provides for better policy. Dr. Schreiber reiterated the public private partnership helps drive quality programs, and that the inputs are invaluable. Dr. Schreiber, however, also noted the government decides and sets policy and observed that some of the questions posed during the MUC review meeting (e.g., whether or not some measures could be in a program) are legal questions. She said it is up to CMS attorneys to decide whether measures meet the statutory intent of a program. Dr. Schreiber noted the need to be careful not to overstep, specifically with mitigation strategies for measures. Nonetheless, she said that CMS is deeply committed to the process of hearing from external stakeholders. Dr. Schreiber said she looked forward to a valuable and meaningful conversation with Committee members.

Dr. Schreiber called upon a co-chair for feedback. The co-chair raised concern for measures moving forward that have not been tested or do not have complete testing. The co-chair indicated that this gray area may drive the Committee members into discussion about mitigation. Dr. Drye prompted the Committee members for further feedback on this topic of endorsement. The Committee members had no further comments about this topic.

A Committee member posed questions to Dr. Schreiber regarding the development of the MUC list. The Committee member asked, "Does CMS reflect on the MAP process? Does MAP help CMS? How can MAP help?" Dr. Schreiber noted appreciation for the questions as they present potential opportunities. Dr.

Schreiber reviewed the extensive and lengthy process to develop measures and noted that discussions about measures should start with measure conceptualization; who is weighing in on the measure, and what is the national strategy for its program? Dr. Schreiber mentioned that CMS will present a national strategy at the upcoming CMS quality conference in April. She indicated the measure conversation needs to be earlier than the Coordinating Committee; otherwise, she noted that measure developers will develop measures that are not important for programs. Dr. Schreiber pointed out that measures under development are publicly available on the CMS Measures Inventory Tool (CMIT) website and noted that CMS is also considering whether to list concepts on CMIT, as that could be a signal for future measures. Dr. Schreiber reviewed the general process for MUC measure submission and noted anyone can submit a measure to the MUC list. She explained that there is an open platform for submission, and it closes around the end of May. She explained that CMS reviews all submitted measures using multiple evaluation methods. Dr. Schreiber noted that currently, equity is at the top of CMS' priority list. She then said that CMS reviews the MUC list, narrows it down to a list of measures for programs, and it is released by December 1. Dr. Schreiber noted the importance of the Coordinating Committee discussions about gap areas but said that there is an opportunity to set strategies much earlier. Dr. Schreiber indicated CMS could consider whether to allow the Coordinating Committee to review all measures on the MUC list. A Committee member asked Dr. Schreiber if it would be helpful for the Coordinating Committee to have a formal process to review concepts prior to the MUC list. Dr. Schreiber said that she gave a "guarded yes" and noted those conversations are important. However, Dr. Schreiber also noted that the statutory obligation for the consensus-based entity is to make recommendations for measures to be included in and removed from Federal programs. Dr. Schreiber noted the need to review whether reviewing measure concepts is within the authority of the CBE to do so.

Another Committee member commented on measures reviewed at the MUC review meeting that were upstream and that didn't have testing data; the Committee spent more time discussing these measures during the review meeting, especially the equity measures, because the Committee saw value in these measures. The Committee member suggested there be a separate category, such as support for continued development, for these types of measures. Dr. Schreiber supported the suggestion but voiced the need for the Coordinating Committee and NQF to decide on the need for another voting category. Dr. Drye also supported the suggestion but acknowledged the complexity of the idea, as it would apply not just to MAP but also other parts of NQF, like endorsement.

A Committee member supported the idea of a continued development category but also wondered if there was a way for CMS to add measures to programs to incentivize further measure reporting; this way, there could be more data for measure testing. The Committee member noted there are situations in which a measure is important, meets strategic priorities, or fills a gap in a national quality strategy, but does not yet meet other requirements (like reliability). The Committee member noted that additional patient data could help measures meet standards. Dr. Schreiber responded that this was an important point but noted that the ability to do this depends on the program. She mentioned that some programs start with pay for reporting first and then pay for performance, but others do not. Dr. Schreiber also noted that CMS cannot collect data unless a measure is in a program. She wondered if CMS should have a way to introduce new measures to programs without requiring public reporting first.

Another Committee member reiterated earlier comments about measure testing and mitigation recommendations. The Committee member noted that, at least in the recent past, they believed that measures had to be tested in order to be included on the MUC list. The Committee member suggested that this requirement should be reinstituted and noted that if there is a reason for a measure to be included on the MUC list without testing, such as the measure meeting a national health priority, this

should be flagged. The Committee member also commented that NQF criteria indicated the Coordinating Committee should review a measure as submitted, rather than suggesting measure changes during the review. Dr. Schreiber reminded the Committee that new measures are allowed to have face validity for three years, even in the NQF endorsement process. Dr. Drye acknowledged the Committee member comment but noted there may be benefits to moving upstream and open discussions.

A Committee member noted support for CMS' focus on increasing the patient and caregiver voice. The Committee member indicated there is a power differential in these meetings and frequently the consumers/patients get frustrated when the physician or provider groups veto a measure on technical purity or testing. The Committee member said there are consumer/patient groups that are enthusiastic about CMS expanding measure topics, specifically the social determinants of health (SDOH) and hospital equity measures. Dr. Schreiber thanked the Committee member for the comments and reiterated that CMS makes the decision of what will be in the proposed rule, based not only on the considerations of MAP and the Coordinating Committee, but also on public comments. Dr. Schreiber noted the voice of the patient and caregiver is of utmost importance to CMS. A co-chair expressed support for these comments but noted that there is a cost to data collection and that measure results need to be meaningful. The co-chair also said that if measures are in the formative stages, it can be difficult to know if the measure results are meaningful. Dr. Schreiber reminded the Committee that the SDOH measures were used in the Center for Medicare & Medicaid Innovation (CMMI) programs for several years and did have experience across the country. Another Committee member stated that the MAP reviewed several cross-cutting measures, including the SDOH measures, for which testing occurred in one setting but not in other settings. The Committee member noted the Committee paused on those measures and highlighted it more as an upstream problem but one for the Committee to be aware of. Dr. Schreiber noted that testing setting may be a new nuance in the MUC application process but also said that testing across all settings for which a measure could be used takes a long time. Dr. Drye noted this topic is important with the desire for measure alignment across care settings. Dr. Drye questioned how to facilitate the extension of measures across programs without undue delay. Dr. Schreiber agreed that having a broader view across programs would be helpful. She noted that it would be helpful to identify if there are measures in certain settings that should be used in other settings. A co-chair said that this is important as procedures change settings and Dr. Schreiber noted that outcomes should be setting neutral. A Committee member noted that it can be difficult to find information about surgeries and also mentioned the importance of transitions of care.

Dr. Schreiber posed a question to the Committee members regarding the timing of the MUC list release. By statute, CMS releases the list by December 1 and Committee meetings need to occur in December because rule writing starts in January. Dr. Schreiber asked the Committee if that timing works and asked if the meetings should occur at a different time. Committee members agreed that the day long review meeting was a challenge and suggested that there were measures that may have warranted more attention, but there was not enough time. The Committee members agreed on the need for more time, both leading up to the meeting to review measure material, and the day of the meeting. A co-chair suggested that the review meeting should be longer than one day and also suggested giving the Workgroups and NQF staff more time for their part of the process. Dr. Schreiber agreed with Committee members that one day may not be long enough, specifically for the Coordinating Committee review meeting, and there may have been valuable discussion missed. A co-chair noted that the discussion may be the most important product of the Coordinating Committee.

Dr. Schreiber also asked the Committee members if CMS could provide more information about the programs to help MAP understand the Federal programs better. Dr. Drye agreed that having more details on programs would be helpful. A Committee member noted wanting to know not only about the programs in more detail, but also about priorities, as sometimes those change.

Dr. Drye thanked Dr. Schreiber for her generous time and support. A co-chair indicated that Dr. Schreiber's and CMS support is key to the MAP process. Dr. Schreiber noted the collaborative public private partnership makes for better policy.

Opportunity for Public Comment

Mr. Kahn opened discussion for public comment on any items from the day's meeting; there were no public comments. Co-chairs thanked participants for their participation and discussion throughout the meeting.

Next Steps

Ms. Williams-Bader reviewed the timeline and upcoming activities for the 2022 MSR cycle. The MSR cycle will continue with the CMS planning meeting in March, the All MAP education meeting in April, the Workgroup and Advisory Group meetings in June, and the Coordinating Committee meeting in August. The MSR cycle will culminate with the MSR final recommendation spreadsheet and final report to be published in September. Ms. Williams-Bader noted that NQF staff will distribute calendar invitations soon for the All MAP Education Meeting, currently scheduled for April 19, 2022.

Appendix A: MAP Coordinating Committee Attendance

The following members of the MAP Coordinating Committee were in attendance:

Co-chairs

- Chip Kahn, MPH
- Misty Roberts, MSN

Organizational Members

- American Association on Health and Disability
- American College of Physicians
- American Health Care Association
- America's Health Insurance Plans
- AmeriHealth Caritas
- Blue Cross Blue Shield Association
- Civitas Networks for Health (formerly Network for Regional Healthcare Improvement)
- Covered California
- HCA Healthcare
- The Joint Commission
- The Leapfrog Group
- National Committee for Quality Assurance
- National Patient Advocate Foundation
- Purchaser Business Group on Health

Individual Subject Matter Experts (SMEs)

- Dan Culica, MD, PhD
- Janice Tufte